

PRIMER HANDS ON – CHILD WELFARE

TRAINING FOR CHILD WELFARE STAKEHOLDERS
IN BUILDING SYSTEMS OF CARE

TRAINING GUIDE

MODULE 8 PROVIDER NETWORK AND PURCHASING

A Skill Building Curriculum

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Based on

Building Systems of Care: A Primer

By Sheila A. Pires

Human Service Collaborative

Washington, D.C.

Sponsored by the National Child Welfare Resource Center for Organizational Improvement, University of Southern Maine, in partnership with the National Technical Assistance Center for Children's Mental Health, Georgetown University, and the National System of Care Technical Assistance and Evaluation Center, Caliber/ICF, with funding from the Administration for Children and Families, U.S. Department of Health and Human Services.

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Provider Network, Natural Supports; Purchasing and Contracting

This section draws primarily on material from Section I of *Building Systems of Care: A Primer* (pages 93-95; 111-117) and Section II (pages 157-159).

Function: Provider Network

Provider Network Options

SLIDE 2 (193)

Pros and Cons of Some Particular Provider Network Structures

- Selective Network (contracts)**
 - Allows for greater quality control over the network
 - May disenfranchise some providers who do not get selected
 - May reduce the choice of providers available to families
- "Any Willing Provider" Pool (meets standards)**
 - May give families considerable choice of providers
 - May be difficult for the system of care to exercise sufficient quality control over providers
- Qualified Provider Pool (designated)**
 - May give families and service planners considerable choice of providers
 - May be difficult for some providers to manage too much or too little service volume

Ferre, S. (2006). *Primer: Hands On - Child Welfare*. Washington, D.C.: Human Service Collaborators.

“Provider network” has to do with *who* will provide the needed services and supports in the system of care. Will some services/supports be provided by in-house staff? Will some or all be contracted? To one main provider? To multiple providers? How will informal providers and parents and youth be included as providers?

There are many ways of structuring the provider network, such as allowing any “willing provider” to provide services and supports within the system of care as long as the provider meets the system’s standards and criteria, or designating a qualified provider pool, or creating a selective network through contracting arrangements. There are pros and cons to all of these arrangements. For example, a selective network may allow for greater quality control over the network on the positive side, but it may disenfranchise some providers who do not get selected, and it may reduce the choice of providers available to families. An “any willing provider”

Trainer’s Notes

Goals

This presentation provides a brief introduction to the topics of provider networks, integration of natural supports in provider networks, purchasing, and the concept of financial risk in systems of care.

Method

PowerPoint Presentation; didactic; large group discussion

Training Aids

Microphone if necessary; projector, laptop computer, screen; Slides #1-21 (slides #193-112 if utilizing the complete curriculum version with no module cover slide); Case Scenarios; Questions for Team Work.

Approximate Time

30 min.

Expected Outcomes

At the end of Module 8, participants should be familiar with:

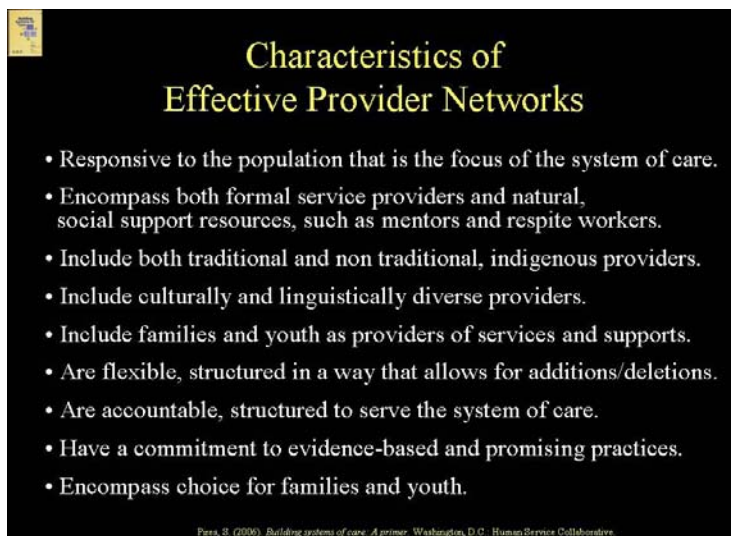
- 1) Pros and cons of various provider network options
- 2) Characteristics of effective provider networks, including aspects of trauma – informed services
- 3) Incentives to providers
- 4) Roles and importance of natural helping networks and social supports and examples
- 5) Families and youth as providers
- 6) Purchasing and contracting structures
- 7) Capitation and case rates
- 8) Progression of risk in contracting arrangements
- 9) Purchasing quality care
- 10) Purchasing strategy tied to reform goals

pool may give families considerable choice on the positive side, but it may be difficult for the system of care to exercise sufficient quality control over providers. A “qualified provider pool”, from which families and service planners may draw, provides flexibility and choice, but it may create management difficulties for some providers who do not get “chosen” frequently enough and face revenue losses, or for providers who are chosen too frequently and cannot sustain the volume. System builders need to engage in a strategic analysis of which provider network structures make sense for their particular circumstances.

Trainer’s Notes

Characteristics of Effective Provider Networks

SLIDE 3 (194)



Characteristics of Effective Provider Networks

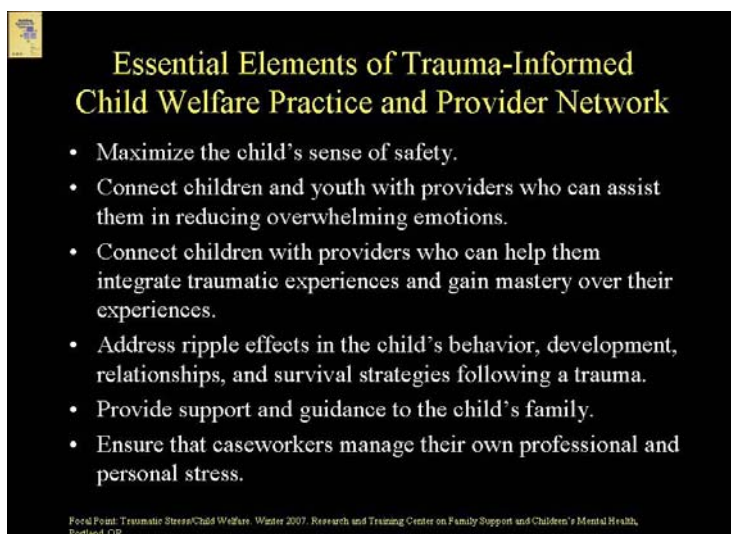
- Responsive to the population that is the focus of the system of care.
- Encompass both formal service providers and natural, social support resources, such as mentors and respite workers.
- Include both traditional and non traditional, indigenous providers.
- Include culturally and linguistically diverse providers.
- Include families and youth as providers of services and supports.
- Are flexible, structured in a way that allows for additions/deletions.
- Are accountable, structured to serve the system of care.
- Have a commitment to evidence-based and promising practices.
- Encompass choice for families and youth.

Perez, S. (2006). *Building systems of care: A primer*. Washington, D.C.: Human Services Collaborative.

To illustrate the point that provider arrangements need to be responsive to the populations of focus, you may want to use an example of what a provider network might look like if the target population is infants and young children versus if the population is youth in transition.

Whatever provider structure is employed, it needs to be guided by some common principles. These include: responsiveness to the populations using the network; inclusion of both formal service providers and natural helpers, traditional and non traditional services and supports; commitment to evidence-based practices and other promising approaches; culturally and linguistically diverse providers; families and youth in provider roles; flexibility and accountability.

SLIDE 4 (195)



Essential Elements of Trauma-Informed Child Welfare Practice and Provider Network

- Maximize the child's sense of safety.
- Connect children and youth with providers who can assist them in reducing overwhelming emotions.
- Connect children with providers who can help them integrate traumatic experiences and gain mastery over their experiences.
- Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma.
- Provide support and guidance to the child's family.
- Ensure that caseworkers manage their own professional and personal stress.

Ford Post, Traumatic Stress/Child Welfare: Winter 2007. Research and Training Center on Family Support and Children's Mental Health, Portland, OR.

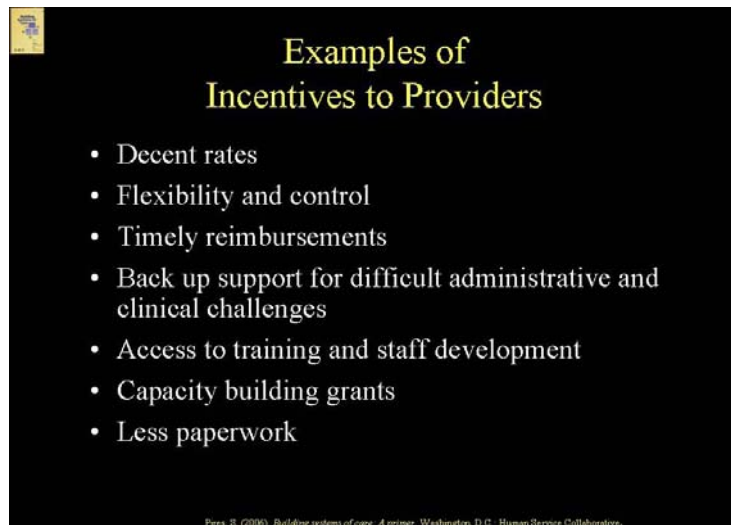
Trainer's Notes

For more information about traumatic stress and trauma-informed service provision, go to the National Child Traumatic Stress Network website at: www.nctsnet.org

Many children in the child welfare system are exposed to multiple or complex traumas, such as abuse, neglect, and domestic violence. Children are often further traumatized by their involvement in the child-serving systems (i.e., child welfare, mental health juvenile justice, etc.), through insensitive interviews, repeated changes in treatment providers or placement, court testimony, and removal from home and loved ones. The National Child Traumatic Stress Network has begun to address this issue and recently identified eight essential elements of trauma-informed child welfare practice. This list can be used to begin a discussion in your community about the capacity of your provider network (including both in-house staff and contracted providers) to practice trauma-informed service provision. Achieving these essential elements requires work at the individual family, child and youth level, the direct service (front-line practice) level, and the system level.

Examples of Incentives to Providers to Change Practice

SLIDE 5 (196)



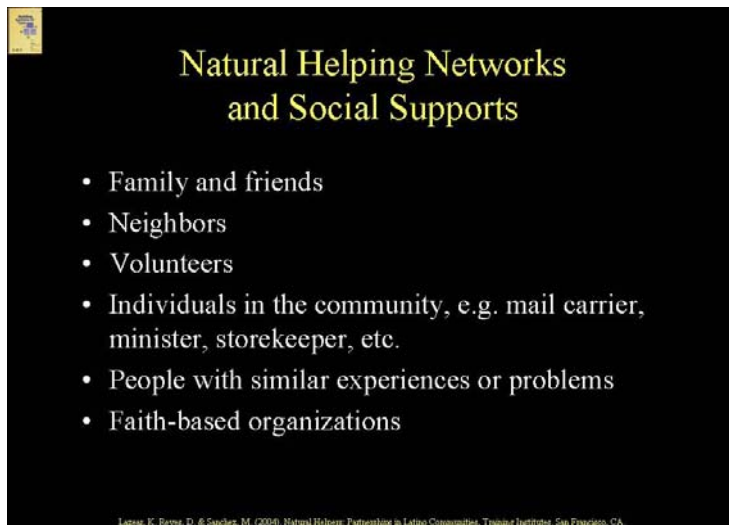
System builders seek ways of creating incentives for providers to change practice. Provider payment rates obviously have a major bearing on the interest and quality of providers. System builders may not control the rate structure for all providers, however. For example, Medicaid providers will be in the network, and their rates may be controlled by the state Medicaid agency, not by child welfare. In this case, system builders need to strategize how to provide other incentives to providers, such as allowing them greater flexibility and control, offering training and staff development, providing back up support when especially difficult administrative or service challenges arise, providing more timely reimbursements, providing them with capacity development grants, and the like. System builders need to consider the issue of provider rates *across systems* because differences in rates among key child-serving systems for the same services aggravates the problem of fragmentation in children's services as providers abandon one system to obtain more decent rates from another.

Trainer's Notes

You may have examples you wish to share from your own experience about incentives that systems have developed to encourage providers to change practice.

SLIDE 6 (197)

Importance of Natural Helpers



Natural helpers and social supports may be family members, youth, representatives from culturally diverse neighborhoods, and others who can provide a more “normalized” and enduring form of support to families and youth than can formal services. Natural helping networks may include groups such as faith-based organizations, neighborhood watch groups, or informal social groups such as a neighborhood scrap booking club. A major concept underlying “Family-to-Family” initiatives in child welfare is the importance of natural supports for families at risk.

SLIDE 7 (198)

Roles for Natural Helpers



Trainer's Notes

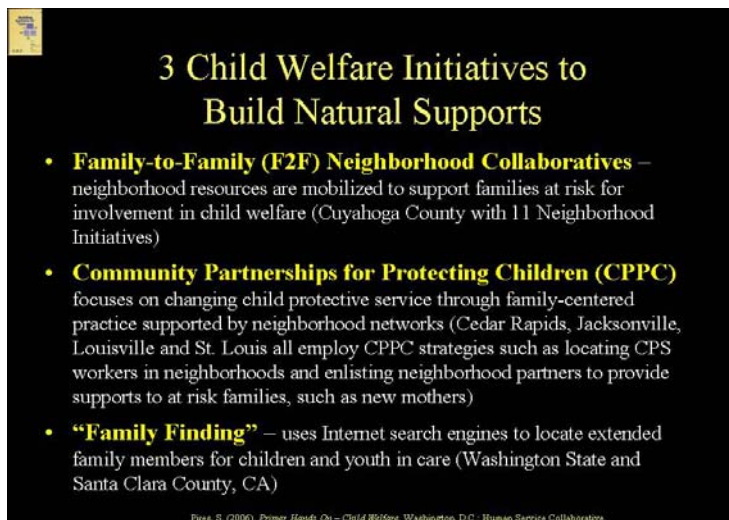
Provide examples from your own experience of systems that incorporate natural helpers.

Often, the parent or youth co-trainer can speak from personal experience about roles of natural helpers.

Examples of what natural helpers can provide include: skill building (for example, a grandmother teaching a younger woman about child care); emotional support; resource acquisition (for example, providing information about how to obtain housing or food assistance or linking families to support organizations); and concrete help, such as transportation. Natural helping networks and social supports may also provide a potential “pool” of foster or adoptive parents or help to identify individuals who may be interested in fulfilling these roles.

Trainer’s Notes

SLIDE 8 (199)



3 Child Welfare Initiatives to Build Natural Supports

- **Family-to-Family (F2F) Neighborhood Collaboratives** – neighborhood resources are mobilized to support families at risk for involvement in child welfare (Cuyahoga County with 11 Neighborhood Initiatives)
- **Community Partnerships for Protecting Children (CPPC)** focuses on changing child protective service through family-centered practice supported by neighborhood networks (Cedar Rapids, Jacksonville, Louisville and St. Louis all employ CPPC strategies such as locating CPS workers in neighborhoods and enlisting neighborhood partners to provide supports to at risk families, such as new mothers)
- **“Family Finding”** – uses Internet search engines to locate extended family members for children and youth in care (Washington State and Santa Clara County, CA)

Perez, S. (2006). *Primer Hands On – Child Welfare*. Washington, D.C.: Human Service Collaboratives.

You might wish to share examples from your own experience of communities that are utilizing Family-to-Family Neighborhood Collaboratives, Community Partnerships for Protecting Children, and Family Finding strategies.

Increasingly, children’s systems, including child welfare, are recognizing the importance of including natural helpers in provider networks. For example, the following national reform initiatives in child welfare seek to build natural supports for children and families in or at risk for involvement in child welfare:

- Family-to-Family (F2F) Neighborhood Collaboratives, in which neighborhood resources are mobilized to support families at risk for involvement in child welfare;

EXAMPLE

Cuyahoga County (Cleveland), Ohio is one of the older examples of F2F, with 11 Neighborhood Collaboratives throughout Cleveland.

- Community Partnerships for Protecting Children (CPPC), which focuses on changing child protective services through family-centered practice supported by neighborhood networks;

EXAMPLE

Cedar Rapids, Jacksonville, Louisville and St. Louis all are employing CPPC strategies, such as locating CPS workers in neighborhoods and enlisting neighborhood partners to provide supports to at risk families, such as new mothers.

- “Family Finding”, which uses Internet search engines to locate extended family members for children and youth in care;

EXAMPLE

Family Finding is being used in **Washington State** and in **Santa Clara County, CA**, among others.

EXAMPLE

Mecklenburg County, North Carolina is an example of a child welfare system of care initiative that is structuring formal partnerships between child welfare staff that are geographically assigned to specific communities and family partner neighborhood agencies in order to implement best practice strategies of Multiple Response System and Family-to-Family, move the system toward a family-centered approach, and improve system performance as measured by CFSR.

EXAMPLE

In **Pinellas County, Florida**, the Sheriff's Office has reached out to neighborhood churches and other faith-based entities to partner with child protective service investigators to wrap supports around families first encountering the child welfare system.

SLIDE 9 (200)

Other Examples of Initiatives to Build Natural Supports

- Community Partnerships in Child Welfare: San Antonio, Texas – to involve the community in developing a network of support for at-risk families, change the culture, policies and practices of the child welfare agency to more family-centered
- EQUIPO: Abriendo Puertas Family Center, East Little Havana, Miami, Florida – focused on developing a partnership between formal and informal helpers in the community through a curriculum based training initiative to strengthen neighborhood supports and services.

Latham, K. (2007). Primer Hands On - Child Welfare. Washington, D.C.: Human Services Collaborative

More information about Community Partnerships in Child Welfare can be found at:
www.emcf.org/programs/children

EXAMPLE

In **San Antonio, Texas**, the Community Partnerships in Child Welfare was established to involve the community in developing a network of support for at-risk families, changing the culture, policies and practices of the child welfare agency to be more family-centered and building a stronger base of community leaders. The Partnership also encourages strong ties between families and their support systems, including both formal and informal helpers.

Trainer's Notes

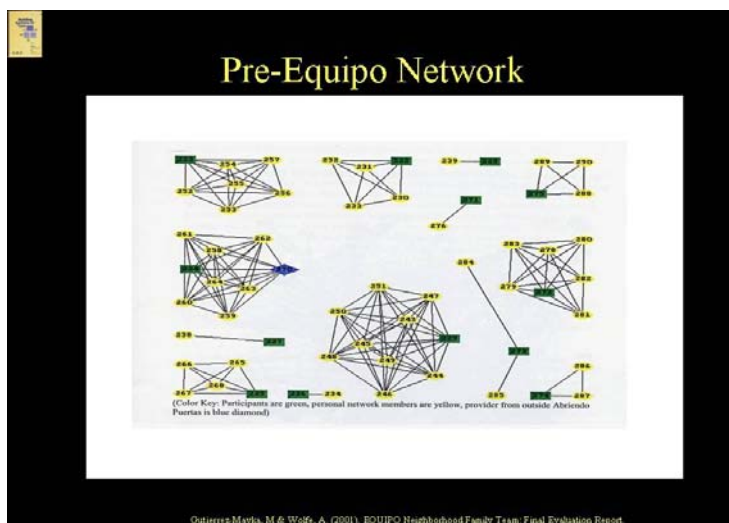
EXAMPLE 52

In **East Little Havana, Miami, Florida**, the Abriendo Puertas Family Center implemented a training initiative – *EQUIPO* – to develop partnerships between the formal service providers and informal providers or natural helpers.

One of the most important and now recognized roles of the natural helper is that of “connector”, helping to connect families to basic supports and resources, formal services, and informal support systems, as illustrated by the example of the Abriendo Puertas Family Center’s “*Equipo* Network” in the following illustrations. *Equipo*, which means “team”, was an initiative that trained natural helpers in a community, as well as formal service providers, to work in partnership to engage families at risk and implement family-centered practices. The illustrations below are from an evaluation of *Equipo* in the year before and year after its implementation.

The first graphic illustrates the connections that recently arrived immigrant families had to natural and formal helpers prior to development of the *Equipo* natural helpers initiative; the second depicts connections after the development and implementation of the natural helper network.

SLIDES 10 (201)



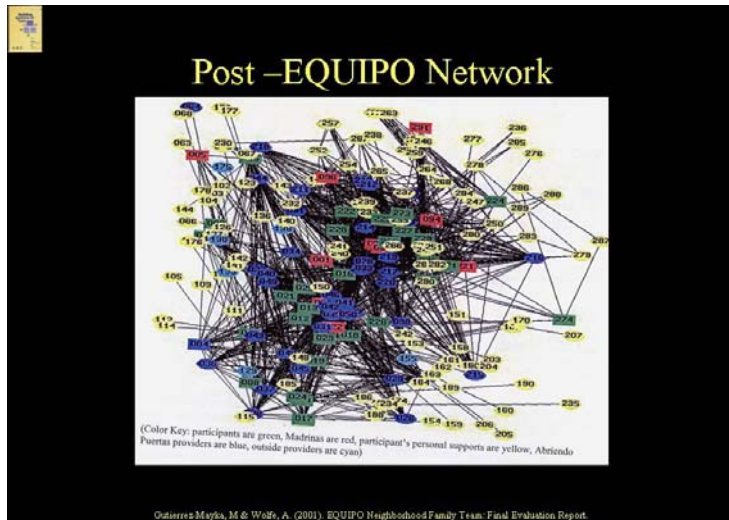
More information on the EQUIPO Initiative at Abriendo Puertas can be found in: *Lessons from the EQUIPO del Barrio at Abriendo Puerta, Inc., and EQUIPO “Neighborhood Family Team” Final Evaluation Report (2001)*. These publications were prepared for the Annie E. Casey Foundation by the University of South Florida. For copies of the publications, contact lazear@fmhi.usf.edu.

The pre-*Equipo* network shown above is composed of 33 sets of largely disconnected clusters in the year prior to implementation of *Equipo*. The green blocks represent 13 families; the blue triangles represent formal providers; the yellow blocks represent natural supports (e.g., neighbors, faith-based organizations, extended family.) The following slide illustrates the connections for these 13 families after implementation of *Equipo*.

Trainer's Notes

You may wish to share research findings with which you are familiar about the effectiveness of natural helping networks.

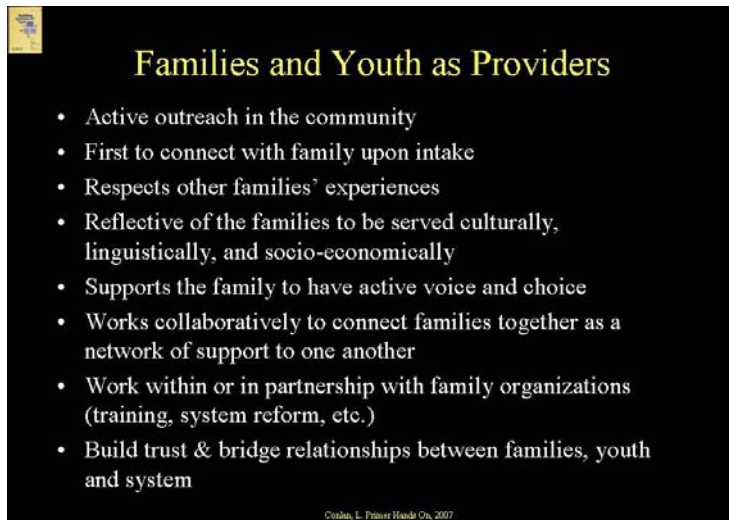
SLIDE 11 (202)



In the post *Equipo* network, there are many more relationships, so the network has a much higher density. It is a complete network of 204 persons. Although clusters can be found, there are no more clusters isolated from all the others. This decrease in isolation led to greater access to services.

Families and Youth as Providers

SLIDE 12 (203)



Families and youth can play an important role as providers if they are supported by systems that recognize their role as providers. Roles that families can play as providers include the following (and many also can be applied to youth):

- Active outreach in the community
- First to connect with family upon intake
- Respected for family experience
- Reflective of the families to be served culturally, linguistically, and socio-economically
- Supports the family to have active voice and choice
- Work collaboratively to connect families together as a network of support to each other
- Works within or in partnership with family organizations (training, system reform)
- Build trust & bridge relationships
- Co-location to create a family-driven working environment and culture

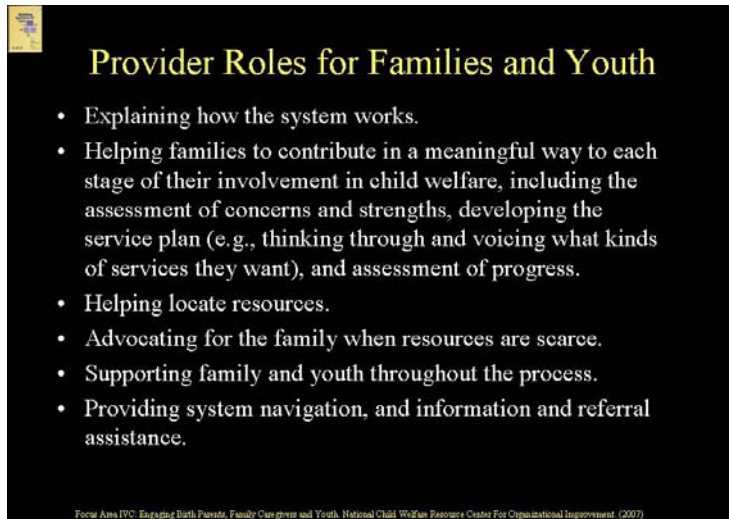
Family organizations, state and county government, and local community provider agencies are hiring family members who have had experience with child welfare and the other interacting child and family service agencies to be on the front line. This has helped to establish trust, diversify the work force, and increase family and youth engagement in the delivery of services and supports. It is important, though, that as these new positions are created, there are clear job descriptions, supervision models, and training.

Trainer's Notes

The following three slides are most effectively presented by the parent co-trainer. Provide participants with clear examples of families and youth as providers in systems of care based on your own knowledge and experiences in working with communities and their family organizations.

For more information about ways to involve families and youth in the system of care, go to the CFSR TTA document Focus Area IVC – *Engaging Birth Parents, Family Caregivers and Youth*, developed by the National Resource Center for Family-Centered Practice and Permanency Planning and National Resource Center for Youth Development (www.nrcoi.org)

SLIDE 13 (204)



Provider Roles for Families and Youth

- Explaining how the system works.
- Helping families to contribute in a meaningful way to each stage of their involvement in child welfare, including the assessment of concerns and strengths, developing the service plan (e.g., thinking through and voicing what kinds of services they want), and assessment of progress.
- Helping locate resources.
- Advocating for the family when resources are scarce.
- Supporting family and youth throughout the process.
- Providing system navigation, and information and referral assistance.

From Anna IPC: Engaging Birth Parents, Family Caregivers and Youth. National Child Welfare Resource Center For Organizational Improvement. (2007)

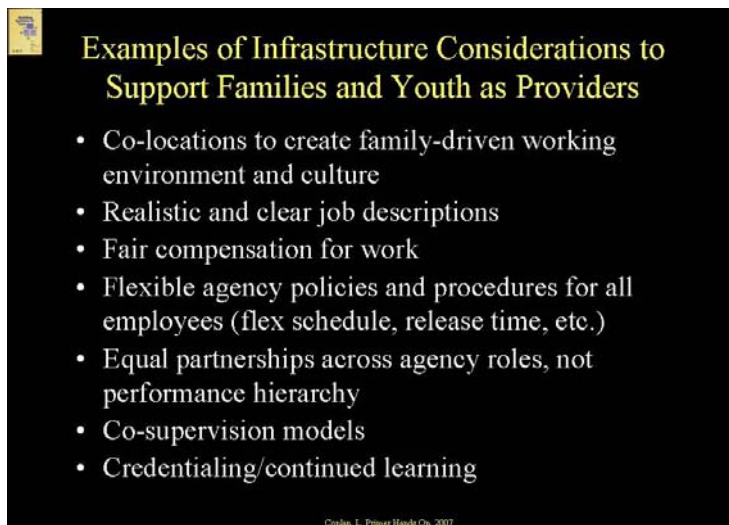
Trainer's Notes

Provide examples from your own experience of how systems of care have structured supports for families and youth to function effectively as providers.

Specific roles for families and youth as providers include: providing basic information to families about how various systems operate, such as child welfare, the courts, special education, etc.; orienting families to service planning processes, such as Family Group Decision-making or Wraparound and helping them think through strengths and needs; helping families locate resources; helping families navigate systems, etc. Families and youth also may provide specific services, such as respite and mentoring.

Infrastructure to Support Families and Youth as Providers

SLIDE 14 (205)



Examples of Infrastructure Considerations to Support Families and Youth as Providers

- Co-locations to create family-driven working environment and culture
- Realistic and clear job descriptions
- Fair compensation for work
- Flexible agency policies and procedures for all employees (flex schedule, release time, etc.)
- Equal partnerships across agency roles, not performance hierarchy
- Co-supervision models
- Credentialing/continued learning

Crosby, L. Parent Hands On, 2007

It is not sufficient simply for systems of care to hire parents and youth; the system itself needs to be structured in ways that embrace family and youth

partnership. For example, families will feel isolated if they are the lone family member working in the system and are not connected to a larger family movement. Families and youth need clear job descriptions and fair compensation. Agency policies may need to be changed to support more flexible working arrangements (which should then be changed for all employees, not just for family members and youth; otherwise, a two-tiered system is created.) Systems of care can model partnerships, such as co-supervision and joint training.

Trainer's Notes

Function: Purchasing/Contracting

Purchasing/Contracting Structures

SLIDE 15 (206)

Purchasing/Contracting Options

Pre-Approved Provider Lists:

- Flexibility for system of care +
- Choice for families +
- Could disadvantage small indigenous providers –
- Could create overload on some providers –

Risk-Based Contracts

- Flexibility for providers +
- Individualized care for families +
- Potential for under-service –
- Potential for overpaying for services –

Fixed Price/Service Contracts

- Predictability and stability for providers +
- Inflexible-families have to “fit” what is available –

Pera, S. (2002). Building systems of care. A primer. Washington, D.C. Human Service Collaborative.

The discussion now moves from considerations as to who will provide services and supports within the system of care (e.g., in-house staff, providers, families and youth) to how services/supports will be purchased.

Once system builders determine the array of services and supports that are needed and the types of providers (and/or in-house staff), then they must decide what purchasing or contracting options to use. There are a number of different purchasing or contracting structures for services and supports, and pros and cons associated with all of them. Some of them include the following:

- **Pre-approved provider lists**, such as qualified provider panels, which create flexibility for the system of care and choice for families but can disadvantage small providers who are not guaranteed a set volume of services or dollar amount in this arrangement; also, this arrangement could overburden some providers who get used a lot;
- **Risk-based contracts**, which create flexibility for providers and potentially for families but create a potential as well for under-service or for over-payment for services;

- **Fixed price or fixed service contracts**, which create predictability and stability for providers but families then have to “fit” what has been “fixed”.

Performance-based bonuses or penalties could be built into any of these approaches. In addition, one could combine various options – for example, creating qualified provider panels and having a fixed price contract in place as well with a given provider to help support their capacity to participate on the panel.

EXAMPLE

A southern state replaced a contracting structure in which each system serving children, youth and families issued its own Request for Proposal, leading to separate contracts, with a structure that puts approved, qualified providers on a “provider list”. Agencies purchase services from providers on the list at rates not to exceed Medicaid rates. Providers in this arrangement have no guarantees as to a specific number of units of service or amount. On the other hand, they do not have to grapple with multiple contracting arrangements and differential rates across systems.

Trainer’s Notes

Explain to participants that purchasing/contracting has to do with *how* a system buys services and supports after determining which types of services and supports are needed and the types of providers that are desirable. Note that you will describe “risk-based” contracts more fully after this discussion of various options as some of the participants may not be familiar with risk-based arrangements.

Capitation and Case Rates

SLIDE 16 (207)

Capitation and Case Rate Distinctions

Capitation: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *eligible* user
Incentive:
 #1: Prevent eligible users from becoming actual users (e.g., make it difficult to access services; engage in prevention)
 #2: Control the type and volume of services used

Case Rate: Pays Managed Care Organizations (MCOs) or providers a fixed rate per *actual* user
Incentive:
 #1: Control the type and volume of services used

Pasek, S. Building systems of care. Apr 2010. Washington, D.C.: Human Service Collaborative.

Child and family services, including child welfare systems and systems of care, increasingly are using managed care purchasing strategies. These strategies introduce the notion of financial “risk” into purchasing structures. Medicaid managed care systems often use *capitation*, while child welfare systems and systems of care often use *case rates*, if they are using risk-based purchasing strategies. The differences between capitation and case rates can be explained as follows:

Capitation arrangements pay managed care entities or providers or lead agencies a fixed amount per *eligible* user of services, that is, for every child/family that is enrolled in services, regardless of whether the child/family actually uses services. **Case rates** pay a fixed rate per *actual* user of services, based typically on the service recipient's meeting a certain service or diagnostic profile. In a capitated arrangement, a potential incentive is to prevent eligible users from becoming actual users. This can be accomplished through positive steps, such as prevention activities, or through negative steps, such as constraining access to services. In a case rate arrangement, there is no such incentive, although case rates do create an incentive, like capitation, to control the type and amount of services provided. This can be positive, for example, reducing use of out-of-home placements, or it can be negative if it leads to under-service.

Case rates, rather than capitation, seem to be more appropriate for systems of care serving children, youth and families with serious and complex issues, such as families involved in child welfare systems. Because these children and families need to use services, it does not make sense to try to prevent them from using services (an incentive in capitated arrangements), but it *is* appropriate to try to manage the types and cost of service to prevent over-utilization of restrictive settings and expensive services, such as out-of-home placements. A number of states, when they privatized their child welfare systems, combined out-of-home and family preservation and support dollars in a case rate arrangement, paying the case rate to lead non-profit agencies; the case rate gives the lead agency flexibility to provide different types of services and supports as needed in exchange for assuming a level of financial risk (i.e. all services have to be provided within the amount of the case rate or the provider loses money) and for meeting outcomes, such as reduced use of out-of-home placements and increased permanency (Outcomes monitoring is essential to ensure that the provider is not providing a low level of services in order to save money.)

Example of System Using Capitation and Case Rate

The following illustration provides an example of the El Paso, County, CO system serving children and families in child welfare that is using both capitation and case rates – capitation on the Medicaid managed care side and case rates on the child welfare side.

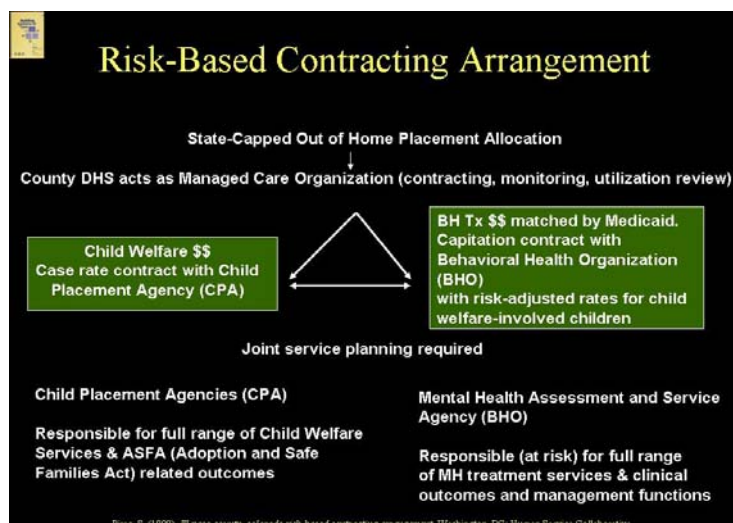
Trainer's Notes

This discussion allows for the opportunity to define risk-based financing approaches, specifically, capitation and case rates. Point out to participants that both types of arrangements affect children and families involved in child welfare. For example, Medicaid dollars may be capitated to managed care organizations, and children in child welfare, typically, are Medicaid-eligible, using Medicaid for physical and behavioral health care; child welfare may be using case rates with lead agencies to achieve CFSR outcomes, such as reduced out-of-home placements and increased permanency.

Additional information about risk-based financing in child and family services can be found in:

Managed Care and Children and Family Services and *Managed Care: Challenges for Children and Family Services*, available from the Annie E. Casey Foundation at: www.aecf.org

Resource materials also are available from the Health Care Reform Tracking Project at: <http://rtckids.fmhi.usf.edu>



Progression of Risk

From a financial standpoint, all purchasing/contracting structures carry some degree of risk for systems of care as purchasers, as well as for providers or lead agencies. The following graphic, borrowed from work done by Tony Broskowski for the Annie E. Casey Foundation, illustrates the progression of risks to systems of care as purchasers, compared to providers/lead agencies, based on the type of purchasing/contracting structure. It illustrates how risks to each operate in inverse proportion to one another. For example, the risk to the system of care as purchaser is highest in a grant structure because the system of care has little leverage over the provider once the grant has been made, but a grant carries the lowest risk to the provider/lead agency. Capitation, on the other hand, carries a low financial risk for the system of care as purchaser (because expenditures are capped) but a high risk for the provider/lead agency, which has to manage the dollars and achieve outcomes within the “cap” (or lose money if expenditures exceed the cap). Not surprisingly, case rates tend to cluster in an area where the “risk” is more balanced between purchaser and provider.

You may wish to use another example from your own experience to illustrate the use of risk-based financing.


SLIDE 18 (209)



Purchasing Quality Care

SLIDE 19 (210)

Move from a mentality of “funding programs” to one of “purchasing quality care”



What do you want to buy that will really make a difference for your identified population(s)?

How do you want to use your dollars to promote practice change?

Parr, B. 2004. Human Service Collaborative. Washington, D.C.

Because contracting is a powerful tool for achieving (or hindering) system of care goals, system builders need to be strategic in determining what mechanisms to employ. Families and culturally diverse constituencies need to be involved in decision-making about contracting structures because they are directly affected by them. Contracting structures have a bearing on such factors as whether families will have choice of providers, whether there will be incentives for providers to under-serve, whether there will be performance incentives to provide quality home and community-based care, and the like.

Trainer's Notes

More information about how different contracting arrangements assign financial “risk” to purchasers (i.e. state or local agencies) versus providers can be found in the Annie E. Casey Foundation resource cited earlier -- *Managed Care: Challenges for Children and Family Services*, available from the Annie E. Casey Foundation at: www.aecf.org.

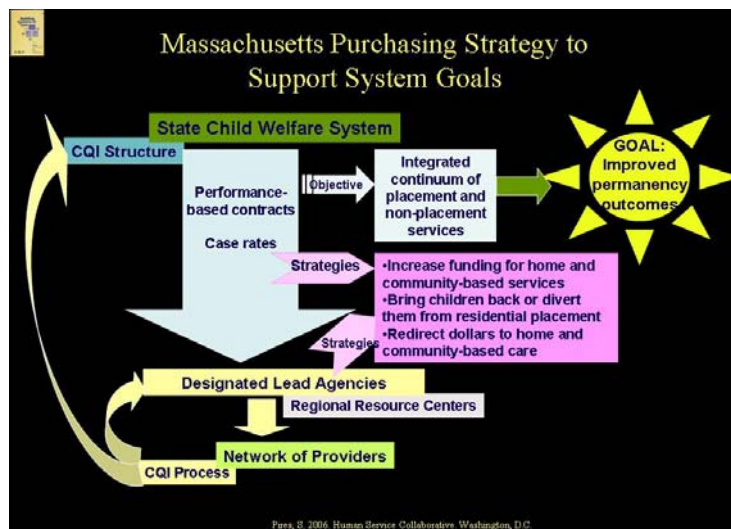
This slide returns the discussion to the overall theme of *Primer Hands On-Child Welfare*, that system builders need to think strategically about the pros and cons of the purchasing/contracting mechanisms they are using to ensure that they will lead to desired outcomes for the population(s) of focus.

In addition, sponsoring or funding agencies that award contracts should have requirements concerning practice standards and training and staff preparation to address diverse needs and provide culturally competent services and supports. In systems of care, system builders are moving from a mentality of “funding programs” to “purchasing quality care” and need to think about the purchasing/contracting strategies that will best support their goals.

Trainer’s Notes

Example of Purchasing Strategy Tied to Reform Goals

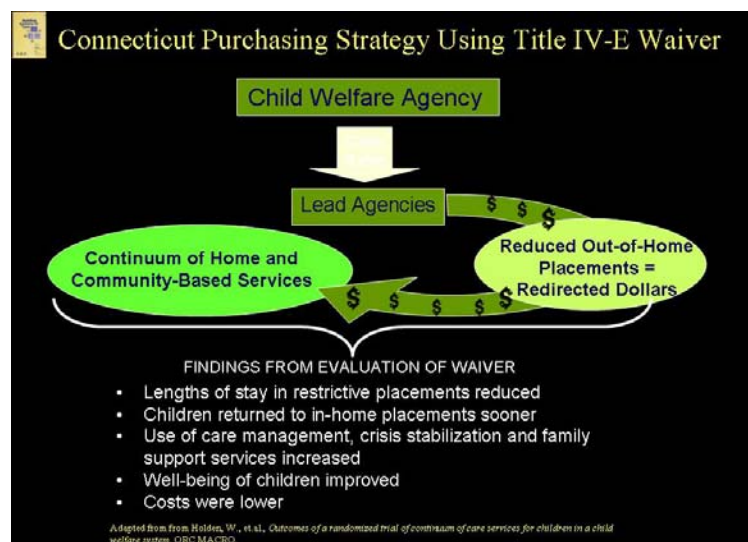
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You may want to share other examples from your own experience of states or localities that have used various contracting arrangement to support system of care goals.

EXAMPLE

Massachusetts provides one example of a state child welfare system that has changed its purchasing strategy to support system goals. The agency utilizes performance-based contracts with designated lead agencies on a case rate basis to create an integrated continuum of placement and non-placement services. The goal is to improve permanency outcomes by increasing the funding for home and community-based services, bringing children back or diverting them from residential placements, and re-directing dollars to home and community-based services/supports. Lead agencies, supported by regional resource centers, will manage a network of providers using measurable performance standards in a Continuous Quality Improvement (CQI) process linked to the state child welfare system’s own CQI structures.



EXAMPLE

Connecticut is another state that changed its purchasing strategy, using a Title IV-E waiver. The child welfare agency provided case rates to lead service agencies to provide a continuum of home and community based services, re-directing dollars from out-of home placements. Evaluation of the waiver found that lengths of stay in restrictive placements were reduced, children returned to in-home placements sooner, use of care management, crisis stabilization and family support services increased, the well-being of children improved, and costs were lower.

Team Work (Team Meeting #4)

You will now have an opportunity to work within your respective teams to address a number of questions with respect to your case scenarios, which represent your system of care sites. The team meeting is an opportunity for you to apply didactic material from *Primer Hands On-Child Welfare*, as well as your own knowledge and experience, to a strategic analysis of system of care issues and challenges. In the course of your team meeting, you need to designate a recorder and lead “reporter” to report back to the large group after the team meeting. Your team is free to add details and particulars to your case scenarios, as long as all team members agree on them, and they are within the realm of possibility. In some cases, your “system of care” may not yet have a given structure in place, in which case your strategies will be geared toward developing, rather than improving, that structure. Teams need to be creative and strategic as they wrestle with the following questions:

Team Meeting and Report Back Session

Method

Team work and Large Group Discussion

Training Aids

Flip charts with markers (one chart for each table); Case Scenarios U, S, A

Approximate Time

1 hr. 45 min. (for both team work and group discussion)

Goals

Participants will work within their respective teams to address a number of questions with respect to their case scenarios, which represent their system of care sites.

1. How is the provider network, including natural supports, structured in our system of care? What are the strengths and shortcomings in our current structure(s)? How does our provider network incorporate partnership with families and youth, and what makes the network culturally competent? What strategies can we implement to improve the provider network structure, including natural supports? What are the pros and cons of these strategies?
2. What is our contracting/purchasing structure(s)? What are the strengths and shortcomings of our current contracting structure? How does our contracting structure incorporate partnership with families and youth, and what makes the structure culturally competent? What strategies can we implement to strengthen the contracting structure(s)? What are the pros and cons of these strategies?

Remind participants that in some cases, a team's "system of care site" may not have structured a particular function. Encourage team members to develop appropriate structures in these cases. Also, advise them that they are free to add details to their case scenarios as long as all members of the team agree to them, and they are within the realm of possibility.

Report Back and Large Group Discussion

The designated reporter from each team reports back to the large group, providing a concise summary of the team's deliberations, how the team answered the questions posed, and the team's observations on its own group process. Each team has 10 minutes for this report. After each team reports, the large group has the opportunity to weigh in with observations that can add to understanding about both the process and the strategic work undertaken by the team. The team meetings and large group discussion provide an opportunity for peer learning and exchange, taking advantage of the collective "best thinking" of participants.

Report Back and Large Group Discussion -

Explain that the designated reporter from each team will report back to the large group, providing a concise summary of the team's deliberations. The trainer(s) facilitate this discussion, offering their own observations as well.

While the participants will surface many important points and strategies, some ideas for discussion include:

Heartland: Figuring out a way of creating a cadre of family navigators as providers in this system might be a very effective way to support families to use available services and supports. This initiative also needs to expand its concept of providers to include all available resources in the counties since the families that are the focus of the initiative have many needs, not only a need for substance abuse services.

Fairview: This is a community in which the providers seem to be interested in performance-

based and risk-based contracts in return for more flexibility in use of funds. Performance standards need to include use of non traditional and racially/culturally diverse providers, or else the system of care needs to develop the capacity of these non traditional providers to compete effectively with the larger, more traditional providers.

Metro: Metro might want to use the many youth involved in the initiative to map provider capacity in the city to provide relevant services and supports to youth. The mapping could serve as the basis for development of a qualified provider panel, tailored to youth in transition that the system of care could draw from to individualize services and supports for this population.