**PRIMER HANDS ON - CHILD WELFARE**

TRAINING FOR CHILD WELFARE STAKEHOLDERS IN BUILDING SYSTEMS OF CARE

TRAINING GUIDE

**MODULE 9**
Care Management

A Skill Building Curriculum
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Based on
*Building Systems of Care: A Primer*
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Module 9

Care Management, Utilization and Quality Management

This section draws primarily on material from Section I of *Building Systems of Care: A Primer* (pages 63-68 and 124-132).

Function: Care Management

Service Coordination Versus Care Management

Children and families in or at risk for involvement in child welfare often have multiple issues and stressors in their lives and involvement with multiple agencies. Many need support to manage and coordinate their involvement with many systems and providers. Some need a basic level of support in managing and coordinating service requirements, which may be court-ordered or other types of needed services; other families require far more intensive service coordination or “care management” support. System builders need to define what they, collectively, mean by service coordination or care management before they can implement effective service coordination/care management structures, and this will be driven by the characteristics and needs of the defined target population(s).

**Trainer's Notes**

**Goals**

This is a didactic presentation of material from *Primer Hands On-Child Welfare: A Skill Building Curriculum*. It provides a brief introduction to the topics of care management, utilization and quality management in systems of care. While these functions and the others discussed in the remaining Modules lend themselves to team meeting deliberations, due to time constraints in the two-day *Primer Hands On-Child Welfare* training, these and remaining functions are dealt with in a large group discussion format only, rather than in team meetings. However, trainers that may be training this as an individual Module (and not within the two-day training) may wish to add a team meeting component.

**Method**

PowerPoint presentation; didactic; large group discussion

**Training Aids**

Microphone if necessary; projector, laptop computer, screen; Slides #2-21 (slides #213-232 if utilizing the complete curriculum version with no module cover slide).

**Approximate Time**

30 min.

**Expected Outcomes**

At the end of Module 9, participants should be familiar with:

1) Service coordination versus care management
2) Care management principles
3) Importance of structuring care management
4) A continuum of service
The Primer makes a distinction between service coordination and care management. Service coordination is defined as assisting families with basic to intermediate needs to coordinate services and supports, usually has other responsibilities and/or is assisting large numbers of families. Care Manager: Primary job is to be the accountable care manager for families with serious and complex needs; works with small number of families (e.g., 8-10), has authority to convene child/family team as needed and often has control over resources.

Child welfare stakeholders may not be familiar with, or use differently, the terminology used in this section. The Primer is not wedded to its terminology but is trying to make a distinction between “service coordination” and what we are referring to here as “care management”. Increasingly, systems of care are demonstrating that, for families who have multiple needs with involvement in many systems, when the system of care creates a “locus of care management responsibility”, with dedicated care managers who actively work with families and have no other assignments except to help families access services and supports and ensure that the services remain helpful, outcomes for these families are better. Other families may need help coordinating services, but not with the same intensity level or dedicated use of resources. For these families, service coordination (as used here) makes sense.
Nebraska has developed Integrated Care Coordination Units in which care managers work with only 10 families each and utilize informal supports as well as formal services, an approach that is decreasing the time it takes to meet the permanency goals of children with multiple and serious issues.

The Primer intentionally does not use the term, “case management”. Many families, youth and other stakeholders find the term, “case management” off-putting since no one likes to be thought of as a “case”. The Primer uses the term, “care management”, but others also use the term, “care coordination”.

Trainer’s Notes
You may want to share an example from your own experience of a system of care that is utilizing one accountable care management structure for populations of children, youth and families involved in multiple systems.
Care Management Principles

SLIDE 4 (215)

There is no one “correct” care management or service coordination structure, but there are principles that need to underpin these structures. These principles include:

- Support one plan of services/supports, even when multiple agencies and systems are involved;
- Support the goals of continuity and coordination of services/supports over time and across systems;
- Encompass families and youth as partners in managing services/supports;
- Utilize a strengths-based focus that incorporates use of natural helpers and social support networks on which families rely and cultural and linguistic competence.

Trainer’s Notes

You may want to share principles governing care coordination from systems of care with which you are familiar.
Importance of Structuring Care Management

SLIDE 5 (216)

If care management is not deliberately structured across systems for children and families involved in multiple systems but left to each agency to design its own, regardless of whether the system of care has a goal of “one plan of services/supports”, the result is likely to be multiple plans and multiple service coordinators – with no one accountable “care manager” as the term is being used here. The above graphic illustrates this point, showing multiple systems involved in developing plans of services/supports with no one accountable care manager.

A Continuum of Service Coordination/Care Management

SLIDE 6 (217)

A purpose of this discussion is to help participants think strategically about the types of service coordination/care management assistance that will be needed by their population(s) of focus. Not all families need or want a dedicated care manager (as the term is used here), nor can the system of care afford to provide a dedicated care manager for every family. Some families only need a basic level of service coordination help, and families using very few services may not need any service coordination help per se, but only information and assistance to find the right services.
Depending on the population focus, a system of care may incorporate both service coordination and a care management structure. For example, it may have an intensive care management structure for children and families with serious, complex problems and more of a service coordination structure for children and families using fewer services or services intermittently.

Types of Care Managers

SLIDE 7 (218)

Examples of Types of Care Coordinators

- Re-assigned case workers
- Paraprofessional care managers
- Clinical care managers
- Family members as care coordinators

Systems of care utilize many different types of individuals in care management structures, including family members, those with professional social work or other clinical training, and paraprofessionals.
Pros and Cons of Different Structures

The following graphic can be used to illustrate the pros and cons of different care management structures.

This illustration shows three structures: one in which care managers remain in their home agencies, such as child welfare and mental health; one in which care managers are detailed from the home agency to the system of care; and one in which the care managers are hired directly by the system of care. There are pros and cons to each of these. For example, care managers staying in their home agencies might find it difficult to implement a new practice model if their surrounding agency culture is very different; on the other hand, they might become catalysts for change within their home agencies. Care managers on detail to the system of care may be more likely to implement the new practice model, but they also might feel like they are serving two masters. Newly hired care managers can be hand-selected by the system of care for their adherence to the practice model, but their positions could be vulnerable if their role is not embraced by the other agencies. There is no one perfect structure, but system builders need to think strategically about the structures that best fit their particular communities.
Function: Utilization Management

Utilization Management

SLIDE 9 (220)

Utilization management (UM) has to do with the system of care’s paying attention to how services are being used by children and families, both at an individual level and at a system’s level, how much service is being used, what services are being used, the cost of those services, the effect those services are having on those using them, and whether children and families are satisfied with what they are using and experience the system as empowering. UM’s areas of concern are essential to address from both a quality and a cost standpoint, and at a systems level, UM data can guide quality improvement. Monitoring and review of service provision at the level of individual children and families, i.e. managing utilization, ensures that children do not remain “stuck” in placements, for example, or that families do not have to continue using services that are no longer appropriate or helpful, and that costs do not escalate. Family representatives are key partners in this review process to ensure that family and youth views are part of the service decision making process.

Trainee’s Notes

“Utilization management” may not be a term familiar to child welfare stakeholders and, in fact, child welfare systems, historically, have not managed the use of services and supports by families and children involved in the system. Systems of care, however, which are data-driven systems with an understanding that dollars are finite, do pay attention to this function. Utilization management pertains directly to achievement of CFSR outcomes as well. If systems do not know who is using services at any given time or over the course of time, how much the service is costing, and what effects or results use of services/supports is creating, the system will not know if it is achieving outcomes such as increasing permanency, reducing out-of-home placements, or improving functional outcomes in families and children.
Principles for Utilization Management

SLIDE 10 (221)

There are different ways to structure UM. For example, a system of care may do its own in-house UM, or it may contract with an external entity, such as a managed care organization, a provider agency, or a family or neighborhood organization, to handle some or all UM functions. The pros and cons to these different structures have to do with technical capacity, values, readiness, interest, etc. However UM is structured, it needs to be informed by certain key principles, including being understood as an important function by all stakeholders, such as child welfare workers, providers, families, and managers, focusing on both cost and quality issues, and being tied to the quality improvement structure and to CFSR and PIP objectives.
Utilization management may be structured as a shared responsibility among care managers, child and family teams that conduct service/support planning, providers, families, and system managers. Service/support planners, for example, may build “trigger dates or events” into service/support plans to ensure timely review; care managers or providers may be charged with reporting back on some regular basis to service/support planning teams; families and youth as active partners often know when a service has outlasted its usefulness or it is time for a change, and monitoring and review functions can be structured to ensure that the family and youth voice is heard.

Utilization management structures need to respect the circumstances and cultural diversity within families. When service/support plans are not authorized and service barriers and gaps arise as a result, or when children are stuck in inappropriate placements, monitoring and review structures need to ensure appropriate changes in service authorization and service provision procedures. To be culturally competent, UM structures need to pay particular attention to service utilization among diverse children and families to ensure that there is not a perpetuation of either the under-service (i.e., lack of access to supportive services) or over-service in restrictive services such as residential treatment or other out-of-home placements that has characterized traditional service delivery to diverse populations. This may require a change in the way service data are collected and analyzed and outreach to diverse populations regarding service utilization issues.
Pennsylvania’s managed care system, for example, has an “Early Warning System” that, among other things, flags disparities and disproportionality in use of behavioral health services by racially and ethnically diverse members.

Function: Quality Management (Continuous Quality Improvement)

Quality Management
Quality management has to do with putting structures in place that are capable of telling system builders and other key stakeholders whether what is being done is making any difference for the better in the lives of the children and families being served, the taxpayers who support the system, and for the community in which the system operates. It is especially critical to partner with families and culturally diverse constituencies in the design and implementation of Continuous Quality Improvement (CQI) structures because definitions and perceptions about “quality” vary, and these stakeholders are directly impacted by the system’s expectations about quality service provision. Also, it is important to understand families’ experiences, not only as ultimate outcome issues, but as quality of life issues; family and youth voice is critical to this understanding and, therefore, to any CQI activity. CQI structures and methods need to include both quantitative and qualitative data collection and entail a participatory evaluation framework.

SLIDE 12 (223)
Handout 9.1 provides an example of the Massachusetts child welfare system CQI structure that uses both qualitative data – e.g., foster parent satisfaction survey - and quantitative data – e.g., Family-Centered Behavior Scale and Child and Adolescent Needs and Strengths (CANS) assessment tools. The handout also includes a CQI process scenario developed by Massachusetts that illustrates how use of data can lead to a better understanding of what is actually occurring in the system and to more effective implementation strategies to improve the system.

**Example: Utilizing Data to Drive Quality**

**Contra Costa County’s CQI Structure**

- Developing activities to ensure CQI for:
  - Youth with multiple placements
  - Transition-aged youth
  - Multi-jurisdictional youth
  - Youth at risk for multiple placements

- Developing and tracking quality and outcome measures:
  - I.E. reduction in number of youth with 3 or more placements, linkage to needed resources upon emancipation

**Contra Costa County, California**, a child welfare system of care grantee, is an example of a jurisdiction that has developed structures for utilizing data to drive quality. It formed an in-house team of “internal evaluators”, contracted with an external, university-based evaluator, and created an evaluation subcommittee representing diverse stakeholder partners, including families. These entities are responsible for developing activities to ensure CQI with respect to their identified target populations, which include youth with multiple placements, transition-aged youth, multi-jurisdictional youth, and youth at risk for multiple placements. The CQI partnership has developed and is tracking quality and outcome measures specific to these populations, such as reduction in the number of youth with three or more placements and linkage of youth to needed resources upon emancipation.

CQI systems are strengthened by the involvement of stakeholders affected by or involved in child welfare, such as families and providers.
EXAMPLE

The Missouri child welfare system involves community partners in conducting Quality Assurance Practice Development Reviews, which mirror the CFSR reviews.

Purposes of UM and Evaluation Data

SLIDE 14 (225)

Types of Data Reports and Their Use

- Resource focused
  - Workloads (case/client lists), length of stay
- Policy focused (provide feedback to managers on adherence to agency policies and procedures, i.e., compliance)
  - Approved foster homes, adoptive homes, etc., staff rosters, budgets
- Family focused
  - Repeat maltreatment within 6 months; maltreatment of children in care; children achieving permanency within 12 months (reunification), or 24 months (adoption/guardianship); children re-entering care within 12 months, multiple placement – no more than 2 within 12 months
- Service response (results of actions taken that contribute to achieving outcomes)
  - Reduction in residential placements, stability in placement, placement of children in proximity to their homes; parent-child visitation (unless detrimental to the child)

Effective systems of care use UM and other types of evaluation data for many reasons, including: planning and decision support; changing practice, supporting a continuous quality improvement (CQI) structure, for cost monitoring, and for media and marketing results to legislators, the community and others. Data, of course, also are critical to inform CFSR reviews and PIPS.

Trainer’s Notes

The next two slides provide examples of types of data and how data from utilization and quality management structures (as well as data from other sources, such as evaluations) can be utilized in systems of care, including to inform CFSR reviews and PIPs.
Types of Data Reports and Their Use

SLIDE 15 (226)

**Purposes of Utilization and Quality Management Data**

- Planning and decision support (day-to-day and retrospectively)
- Quality improvement
- Cost monitoring
- Research
- Marketing and media
- Accountability
- Changing casework practice

The CFSR Comprehensive Training and Technical Assistance Package Focus Area – Using Information and Data in Planning and Measuring Progress - includes a section on “Using Reports as Tools” and identifies various types of reports and the information each may convey.

**Example of Use of Data for Continuous Quality Improvement**

**EXAMPLE**

**Michigan** requires its local community mental health authorities to use the Child and Adolescent Functional Assessment Scale (CAFAS), including for children in child welfare, and uses data from the CAFAS to inform quality improvement and use of evidence-based and effective practices (e.g., Cognitive Behavior Therapy for depression).

**Trainer’s Notes**

For more information about using data see the CFSR Comprehensive Training and Technical Assistance Package Focus Area – Using Information and Data in Planning and Measuring Progress, which can be viewed at: [www.nrcoi.org](http://www.nrcoi.org).

You may want to share other examples from your own experience of how systems use data to improve quality.
Examples of Outcomes Measures Related to CFSR

Example: Statewide Quality Improvement Initiative

Michigan: Uses data on child family outcomes (CAFAS) to:
- Focus on quality statewide and by site
- Identify effective local programs and practices
- Identify types of youth served and practices associated with good outcomes (and practices associated with bad outcomes)
- Inform use of evidence based practices (e.g., Cognitive Behavior (CBT) for depression)
- Support providers with training informed by data
- Inform performance-based contracting

QI Initiative designed and implemented as a partnership among State, University and Family Organization

Example: Proposed Outcomes Measurements of Success for a System of Care in Oregon

1. The array of services available to children and families will increase and there will be evidence in case records that the community is collaborating to provide wraparound services.
2. The number of parents actively involved in planning for reunification or preservation of their families will increase.
   (i.e., the number of Family Meetings will increase, more voluntary agreements, earlier compliance, increase in skill and partners trained to facilitate Family Meetings; parents will be able to articulate their child’s needs and understand how to meet those needs, increase in direct family contact, when a child is re-abused or at risk for re-abuse, parents will be able to recognize the need for assistance and make a voluntary request for services)
3. There will be an increase of foster care beds in targeted recruitment areas of minority and medically fragile providers.
4. Every child entering foster care will have a full physical and mental health assessment by two weeks time in placement.
5. Case records will clearly document practice change that supports identified child needs (i.e., children will make fewer moves in care; the Service Plan clearly reflects children’s needs and is based on sound assessment practices, continued...

The following two slides present Oregon’s Proposed Outcomes: Measurement of Success for a System of Care. Emphasize the ability of the system to measure each of the identified outcomes.
The Oregon system of care approach was a voluntary settlement agreement to a law suit that kept child welfare out of court, but included close monitoring and involvement from the plaintiff attorneys. According to Beth Englander, who was the first multi-field administrator and then the system of care manager, a major reason for the success of the implementation of the system of care in the pilot district was developing buy-in from the community throughout the process. The pilot district also implemented system of care at the same time it was selected as a demonstration for Oregon’s IV-E Waiver, which created financial flexibility. The state eventually rolled out system of care implementation statewide, which reached about 75% of the state’s foster care caseload, connecting the system of care to Oregon’s initial CFSR and the PIP. The PIP was heavily built around system of care for the well-being objectives and a good portion of the permanency actions and benchmarks.
Nebraska provides another example of a system of care approach to achieve CFSR-related outcomes.

**Integrated Care Coordination Unit**
- At enrollment, 35.8% of children served were living in group or residential care; at disenrollment, 5.4% were in group or residential care.
- At enrollment, 2.3% of children were living in psychiatric hospitals; at disenrollment, no children were hospitalized.
- At enrollment, 7% of youth served were in juvenile detention or correctional facilities; at disenrollment, no youth were in these facilities.
- At enrollment, 41.4% of children were living in the community (at home – 4.4%; with a relative – 1.5%; in foster care – 35.5%); at disenrollment, 87.1% were living in the community (at home – 53.5%; with a relative – 7.6%; in foster care – 14.5%; independent living – 11.5%).
- Improvement in Child and Adolescent Functional Assessment Scale scores.
- Generation of $900,000 in cost savings (by reducing cost per child served).

**Early Integrated Care Coordination Unit**
- Prevention of placement in state custody for 88.1% of children referred.

Trainer's Notes
Information about Nebraska’s Integrated Care Coordination Units can be found at: [www.regionsix.com/iccu.htm](http://www.regionsix.com/iccu.htm)
Wraparound Milwaukee reports and collects outcome data related to children involved in child welfare as well as the experience of families. They then use these results to track progress, inform CQI internally, and inform legislators and others.

Example: Outcomes for Milwaukee Wraparound

- Reduction in placement disruption rate from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily RTC population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

Example: Family/Caregiver Experience Wraparound Milwaukee

*Nearly half had previous CPS referral

91% felt they and their child were treated with respect

91% felt staff were sensitive to their cultural, ethnic and religious needs

72% felt there was an adequate crisis/safety plan in place

64% reported Wrap Milwaukee empowered them to handle challenging situations in the future

For more information about Wraparound Milwaukee, go to: www.milwaukeecounty.org
### LARGE GROUP DISCUSSION

You have an opportunity during the large group discussion to ask questions and make contributions about the covered topics. The large group discussion provides an opportunity as well for peer learning and exchange, taking advantage of the collective “best thinking” of participants.

### Trainer’s Notes

**Goal**

The goal of this session is to provide participants with the opportunity to ask questions or contribute examples from their own communities. The large group discussion provides an opportunity for the group as a whole to explore some of the issues and strategies raised by the didactic presentation related to Care Management, Utilization Management, and Quality Management in systems of care.