Introduction and Overview

Institute Objectives

- Offer a strategic framework for building systems of care based on *Building Systems of Care: A Primer, 2nd Edition*
- Describe elements of an effective system-building process, key functions requiring structure in systems of care, and approaches to organizing and financing delivery systems for systems of care
- Identify strategies for infusing core values into system of care processes and structures (e.g., family and youth partnership, cultural and linguistic competence, cross-sector collaboration)
- Provide examples of system of care approaches from around the country
- Draw on the Rhode Island experience with statewide system of care implementation

System of Care Definition, History, Reform Characteristics, Values

Definition of a System of Care

A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, has supportive policy and management infrastructure, and is data-driven.

National System of Care Activity

- CASSP - Child and Adolescent Service System Program
- RWJ MHSPY – Robert Wood Johnson Mental Health Services Program for Youth
- CASEY MH – Annie E. Casey Foundation Urban Mental Health Initiative
- FEDERATION OF FAMILIES FOR CHILDREN’S MENTAL HEALTH
- STATEWIDE FAMILY NETWORK GRANTS
- YOUTHMOVE - Center for Mental Health Services grants
- CMHSSOC and TRIBAL SOC GRANTS – Center for Mental Health Services
- CSAT GRANTS – Center for Substance Abuse Treatment
- ACF GRANTS – Administration for Children and Families
- CMS GRANTS – Center on Medicare and Medicaid Services
- PRESIDENT’S NEW FREEDOM MENTAL HEALTH COMMISSION
- STATE CHILD AND ADOLESCENT INFRASTRUCTURE GRANTS
- SAMHSA TRANSFORMATION GRANTS – Substance Abuse and Mental Health Services Administration
- SAMHSA STATE SYSTEM OF CARE PLANNING EXPANSION GRANTS
System of care is, first and foremost, a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.


System of Care Core Values

**Public Health Approach**
- Systems of care have moved closer to a public health framework: focusing not only on treatment for individual children with serious conditions but also encompassing prevention, early intervention, and education to improve outcomes and health, developmental and behavioral health status for identified populations of children.

**SOC Core Values**
- Care that is coordinated across multiple systems and providers and is:
  - Family-driven and youth-guided
  - Home and community based
  - Strengths-based and individualized
  - Trauma-informed
  - Culturally and linguistically competent
  - Connected to natural helping networks
  - Data-driven, quality and outcomes oriented

**Child Welfare Principles**
- Child and Family Services Review (CFSR):
  - Family-centered practice
  - Community-based services
  - Strengthening the capacity of families
  - Individualizing services

Definition of Family Driven

*Family-driven means* families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:
- Choosing culturally and linguistically competent supports, services, and providers
- Setting goals
- Designing, implementing, and evaluating programs
- Monitoring outcomes
- Partnering in funding decisions

**Definition of Youth Guided**

*Youth Guided means to value youth as experts, respect their voice, and to treat them as equal partners in creating system change at the individual, state, and national level.*

www.youthmove.us

Why Culture Matters

It affects…
- Parenting and child rearing
- Coping strategies
- Help-seeking behaviors; help-giving behaviors; stigma
- Expression of symptoms
- Attitudes and beliefs about services, social support, kinship support, and what constitutes successful services
- Utilization of services and social supports
- Appropriateness of services and supports (i.e., trauma-informed care); setting priorities
- Acculturation
- How we see the world

Culture, Race and Ethnicity – Realities, Disparities and Mandates

- Demographic changes in the United States
- Issues of disproportionality.
  - Over-representation in restrictive levels of care, child welfare systems and in out-of-home placements, e.g., African Americans represent only 15% of the total population but their children comprise 40% of the foster care population
- Issues of disparities
  - Racial and ethnic minorities... have less access to mental health services... are less likely to receive needed care... often receive a poorer quality care... are underrepresented in research
  - Rural America needs improved access to behavioral health services
- Legislative and regulatory mandates
- Class action lawsuits
- Financial impact of racial and ethnic health inequalities
Historic/Current Systems Problems

- Lack of home and community-based services and supports
- Patterns of utilization; racial/ethnic disproportionalities and disparities
- Cost
- Administrative inefficiencies; fragmentation
- Knowledge, skills and attitudes of key stakeholders
- Poor outcomes
- Rigid financing structures
- Deficit-based/medical models, limited types of interventions

Characteristics of Systems of Care as Systems Reform Initiatives

FROM
- Fragmented service delivery
- Categorical programs/funding
- Limited services
- Reactive, crisis-oriented
- Focus on “deep end,” restrictive
- Children/youth out-of-home
- Centralized authority
- Creation of “dependency”

TO
- Coordinated service delivery
- Blended/brided resources
- Comprehensive service array
- Focus on prevention/early intervention
- Least restrictive settings
- Children/youth within families
- Community-based ownership
- Build on strengths and resiliency

Frontline Practice Shifts

Control by professionals
- Partnerships with families/youth
  (I am in charge)

Only professional services
- Partnership between natural and professional supports and services

Multiple case managers
- One service coordinator

Multiple service plans
- Single, individualized child and family plan
  (meeting needs of agencies)

Family/youth blaming
- Family/youth partnerships

Deficits focused
- Strengths focused

Mono Cultural
- Cultural & Linguistic Competence

Examples of Family Members Shift in Roles and Expectations

- ServiceRecipient
  - Support youth to share their point of view and feelings about their own mental health during service planning and help them to see the positive outcomes through choice and incentives
- Evaluation
  - Support youth to have input in evaluation questions (surveys, focus groups, and one to one) that are relevant to youth and to inform youth about mental and seeking help and support
- Youth Peer Support Provider
  - Youth knowing he/she is not alone and able to get the support and help from others who have had similar lived experiences
- Trainer
  - Youth opportunities to share their leadership and knowledge in presenting to peers and system of care partners
- Advocate
  - Youth are able to have a strong voice as an individual and as a collective movement to ensure services and positive outcomes for youth
Categorical vs. Non-Categorical System Reforms

Categorical System Reforms

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Child Welfare</th>
<th>Juvenile Justice</th>
<th>etc.</th>
</tr>
</thead>
</table>

Non-Categorical Reforms

Example: Transition-Age Youth

What outcomes do we want to see for this population?

Policy Level

- What systems need to be involved? (e.g., Housing, Vocational Rehabilitation, Employment Services, Mental Health and Substance Abuse, Medicaid, Schools, Community Colleges/Universities, Physical Health, Juvenile Justice, Child Welfare)
- What dollars/resources do they control?

Management Level

- How do we create a locus of system management accountability for this population? (e.g., in-house, lead community agency)

Frontline Practice Level

- Are there evidence-based/promising approaches for this population?
- What training do we need to provide and for whom? (e.g., culturally diverse providers)

Community Level

- What are the partnerships we need to build with youth and families?
- How can natural helpers in the community play a role?
- What need to be put in place to provide opportunities for youth to contribute and feel a part of the larger community?

Building Systems of Care: Strategically Managing Complex Change

Vision + Skills + Incentives + Resources = Action Plan = CHANGE

Vision + Skills + Incentives + Resources = Action Plan = CONFUSION

Vision + Skills + Incentives + Resources = Action Plan = ANXIETY

Vision + Skills + Incentives + Resources = Action Plan = RESISTANCE

Vision + Skills + Incentives + Resources = Action Plan = FRustration

Vision + Skills + Incentives + Resources = Action Plan = TREADMILL

Prevalence/Utilization Triangle

More complex needs

| Intensive Services – 60% of $$ |
| Home & community services and supports; early intervention – 35% of $$ |
| Prevention and Universal Health Promotion – 5% of $$ |

Less complex needs

| 2 - 5% |
| 15% |
| 80% |

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)
OUTCOMES:
Family/Caregiver Experience Milwaukee Wraparound

- Nearly half had previous CPS referral
- 91% felt they and their child were treated with respect
- 72% felt there was an adequate crisis/safety plan in place
- 64% reported Wrap Milwaukee empowered them to handle challenging situations in the future
- 72% felt there was an adequate crisis/safety plan in place (n=172)
- 91% felt staff were sensitive to their cultural, ethnic and religious needs (n=189)
- 91% felt they and their child were treated with respect (n=191)

OUTCOMES

- New Jersey estimates it has saved over $40m in inpatient costs alone over the past three years
- Wraparound Maine experienced 30% reductions in Medicaid spending with increases in Targeted Case Management and in-home service expenditures and reduction in inpatient and residential expense (net overall 30% spending reduction)

Findings: Youth Progress in School in System of Care Communities

- Youth grades improved
- Youth spent more time in school
- Youth changed schools less often
- Youth with supportive adults in school attended school more regularly
- Youth at highest academic risk made strong gains.

Findings: Cost Savings for Education in System of Care Communities

- The average annual cost of a student repeating a grade in public education is $9,154.
- Only 8% of youth in systems of care for 12 months had repeated a grade, compared to nearly twice as many American students in the general public (15%).
- This difference translates to a cost savings of $4,544,412 for 7,092 youth aged 14-18 years who entered systems of care while enrolled in school.

RI SOC History

RI Department of Children, Youth and Families Mission, Vision and Guiding Principles
Until 2005, innovative programs remained separate and a statewide integrated system had not been achieved.

The outcomes for children, youth and their families had not changed significantly.

In 2005, RI DCYF Senior Leadership committed to full system transformation based on system of care (SOC) principles.

**EXERCISE ON ASSUMPTIONS & VALUES**

**Process**

How system builders conduct themselves

**Structure**

What gets built (i.e., how functions are organized)

**System of Care Functions Requiring Structure**

- Planning
  - Governance-Policy Level Oversight
  - System Management
  - Benefit Design-Service Array
  - Evidence-Based Practice
  - Outreach and Referral
  - System Entry/Access
  - Screening, Assessment, and Evaluation
  - Decision Making and Oversight at the Service Delivery Level
    - Care Planning
    - Care Authorization
    - Care Monitoring and Review
    - Care Management of Care Coordination
  - Crisis Management at the Service Delivery and System Levels
  - Utilization Management
  - Family Involvement, Support, and Development at all Levels
  - Youth Involvement, Support, and Development at all Levels

- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- Internal and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management & Communications Technology
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation
- Cultural and Linguistic Competence

**Effective System-Building Process**

- Leadership & Constituency Building
- A Strategic Focus
- Orientation to Sustainability
How Systems of Care Are Structuring Family and Youth Involvement at Various Levels of the System

### Level Structure

**Policy**
- Meaningful membership on governing bodies; as members of teams to write/review request for proposals and contracts; as members of system design workgroups and advisory boards; raising public awareness; state and local committees

**Management**
- As administrators; part of quality improvement processes; as evaluators of system performance; as trainers; as advisors in selecting personnel; full time youth coordinator

**Services**
- As members of team for own children/youth; service delivery providers, such as family support workers, case managers, peer mentors, youth group development, system navigators

---


---

Structuring Youth Partnerships

- Youth involvement takes time, planning and a willingness to learn new ideas and adapt old ones
- What do you want your youth partnerships to look like?
- “Scan your environment” for youth groups and organizations that are doing similar work
- Assess the landscape of youth involvement in your community. What are the strengths and gaps of those partners?
- Values check- where do you and your partners stand in regard to partnering with youth at all levels?

---

**Keenan, A. 2010. Parent Support Network of Rhode Island**

---

Building Capacity for Family and Youth Partnership at All Levels of the Rhode Island System of Care

- Statewide Family & Youth Leadership Coordinators co-located between family organization and state department
- Participation on state policy boards, working with state department executive leadership on policies and grant applications
- Recruitment, training & technical assistance for parent and youth participation to become 51% on the state and regional Family Community Advisory Boards (FCABs)

---


---

Example #2: Structuring Planning and Governance

- **Planning**
- **Governance**

---

Critical Steps in a Planning Process

- Identify your population(s) of focus.
- Agree on underlying values and intended outcomes.
- Identify services/supports and practice model to achieve outcomes (map existing strengths and needs)
- Identify how services/supports will be organized (so that all key stakeholders can draw the system design).
- Identify the administrative/system infrastructure needed to support the delivery system and capacity building reqs (e.g., training)
- Conduct an expenditure and utilization analysis (e.g., how population has used services and can be expected to) - Cost out the system of care.
- Develop a strategic financing and sustainability plan.
Planning for Sustainable Change

The more that planning is directed to making systemic or structural change, the more sustainable the changes will be.

Example #1
Launching a newsletter for families – good goal, not a structural change
Amend the State Medicaid Plan to cover family peer support – good goal and a structural change

Example #2
One-time legislative appropriation to expand home and community services – good goal, not a structural change
Amend the State Medicaid Plan to cover an array of home and community-based services and pool or braid dollars across systems – good goal and a structural change

Example #3
Educating providers about partnering with families and with youth – good goal, not a structural change
Contractual requirements for child/family teams – good goal and structural change

System of Care Planning in RI

- 1992 through 2003: Statewide Children’s Mental Health Advisory Board/ CASSP Board and 8 Local Coordinating Councils
- 2001-2003 Governor’s Task Force meets to produce report to guide planning
- State Redesign planning: Focus groups and Public meetings to gain community, family and youth input with concept papers and then final RFPs
- Ongoing bi-annual retreats with state agencies, current and potential providers, community, family, and youth involvement
- Present: Statewide Family Community Advisory Board and four regional Boards
- Rhode Island State Expansion Team: Strategic Plan and National Consultation

Definition of Governance
Decision making at a policy level that has legitimacy, authority, and accountability.

Key Issues for Governing Bodies
- Has authority to govern
- Is clear about what it is governing
- Is representative
- Has the capacity to govern
- Has the credibility to govern
- Assumes shared accountability across systems for populations of focus

Examples of Types of Governance Structures
- State and/or local interagency body
- Non profit board of directors
- Quasi governmental entity
- Tribal governance
- Hybrids
**Governance in RI**

**2003:**
The Governor’s Task Force names the RI Department of Children, Youth and Families (RI – DCYF) as the agency to implement the system of care reform:

“The Department is the single authority to establish and provide a diversified and comprehensive program of services for the social well-being and development of children, youth and their families.”


**Example #3: Structuring Integrated Care for Children with Complex Challenges and Their Families and Children at Risk**
Wraparound is a practice approach for the planning and provision of services and supports that can be applied to any population of children and families with or at risk for intensive service needs – not just to those with the most serious and complex problems.

Wraparound puts system of care values and principles into practice for service planning and provision.

Wraparound is “a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes.”

Wraparound is Increasingly Considered Evidence-Based
- Under review by SAMHSA National Registry of Effective Practices and Programs (NREPP)
- State of Oregon Inventory of EBPs
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: “Full fidelity wraparound” is a research-based practice

Service Coordination/Care Management Continuum
- Children/youth needing only brief short-term services and supports
- Children/youth needing intermediate level of services and supports
- Children/youth needing intensive and extended level of services and supports
- Intensive care management

What Wraparound is Not
- A system of care
- A new funding source
- A “service”
- A way to get “stuff” – services that are not typically reimbursable
- Only for a small group of kids
- Case management
- A specific intervention or program
- A categorical approach where services reflect what’s available rather than what’s really needed

Wicomico County, MD System of Care Structure

Adapted from Wicomico County, MD
Intensive Care Coordination Using Wraparound

Care Management Entities
An organizational entity – such as a non profit organization* - that serves as the legal entity accountable, for the ongoing care of youth with serious challenges, multisystem involvement, and severe mental health needs.

High Quality Wraparound Team
Embedded in a supportive organization, such as a CMHC, School, FQHC (e.g. Oklaholma and others)
Accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes

*Resource: CHIPRA Care Management Entity Quality Collaborative

Care Management Entity Functions
At the Service Level:
- Child and family team care planning and oversight using high quality Wraparound practice model
- Screening, assessment, clinical oversight
- Intensive care coordination at low ratios (1:3-10)
- Care monitoring and review
- Peer support partners
- Access to mobile crisis supports

At the Administrative Level (directly or in partnership):
- Information management – real time data; web-based IT
- Provider network recruitment and management (including natural supports)
- Utilization management
- Continuous quality improvement; outcomes monitoring
- Training

New Jersey – 1115 waiver

Massachusetts (1115 Waiver)

State Medicaid Agency – Purchaser

MCO

MCO

MCO

PCCM

BHO

Standardized tools for screening and assessment

*Locally-Based Care Management Agencies (called) Community Services Agencies – Non Profit Specialty Organizations

- Ensure Child & Family Team Plan of Care
- Ensure Intensive Care Coordination
- Link to peer supports and natural helpers
- Manage utilization, quality and outcomes at service level

*Country Coordinates Rate: Determined through local CCOs determination of rate.

Adapted from State of New Jersey 2010

Provider Network

Family support organizations

Family Support


*Care coordination rate of $1034 pcpm

All inclusive rate (services, supports, placements, population level tracking/UM/UR/Quality assurance and/or Quality improvement)

$5,000,000

$2000 pcpm to $4300 pcpm

$47M

$11.0M - 11.5M - 16.0M - 8.5M

$440,000

$2000 pcpm to $4300 pcpm

$1557 per month

Intensive Care Coordination using Wraparound

Intensive Care Coordination at low ratios (1:8-10)

Screening, assessment, clinical oversight

Intensive care coordination at low ratios (1:3-10)

Care monitoring and review

Peer support partners

Access to mobile crisis supports

Information management – real time data; web-based IT

Provider network recruitment and management (including natural supports)

Utilization management

Continuous quality improvement; outcomes monitoring

Training

Outcomes tracking

Utilization management

Screening

Outcomes monitoring

Peer support partners

Family educators,

Family liaisons,

Youth peer mentors

Funds budgeted for Institutional Funds thru Case Rate

CW, JJ and ED range from about

$2000 pcpm to $4300 pcpm

Per Participant Case Rates from

High Quality Wraparound Team

An organizational entity – such as a non profit organization* - that serves as the legal entity accountable, for the ongoing care of youth with serious challenges, multisystem involvement, and severe mental health needs.

Care Management Entities

Embedded in a supportive organization, such as a CMHC, School, FQHC (e.g. Oklahoma and others)

Accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes

*Resource: CHIPRA Care Management Entity Quality Collaborative

High Quality Wraparound Team

Embedded in a supportive organization, such as a CMHC, School, FQHC (e.g. Oklahoma and others)

Accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes
Example of Care Management Entity
Cuyahoga County (Cleveland)

- System of Care Oversight Committee
- Funders Group
- Care Coordination
- Reinvestment of savings

- County Administrative Services Organization
- Neighborhood Collaboratives & Lead Provider Agency
- Task & Community Partnerships
- Community Providers and Natural Helping Networks

Potential of High Quality Wraparound Team as a Health Team - Oklahoma

- Community Mental Health Center
- Health Team for Adults with SMI
- Nurse Care Manager
- ACT Team
- Adult Peer Consumer

- Wraparound Facilitator
- Intensive Care Coord.

- Improve quality and cost of care

Transforming RI’s System of Care:

- **Phase I - Family Care Community Partnerships (FCCP)** - Implemented January of 2009
  - Designed for families not involved with the Department: Prevention and early intervention through family preservation and community-based behavioral health programs and family supports
- **Phase II - Networks of Care** - implemented July of 2012
  - For families and youth active with the Department

Who is Eligible for FCCP?

- Children and families who are:
  - At risk for child abuse, neglect and/or dependency and DCYF involvement
  - Children birth to age 18 years old who meet criteria for having a serious emotional disturbance to youth with SED 18 to 21 years old in accordance with DCYF Policy 700.0240, Services to Youth Ages 18-21
  - Youth concluding sentence to the RITS who agree to participate, including youth leaving the RITS and youth leaving temporary community placement (TCP)

RI Results: Family Care Community Partnerships

- **Families Served:**
  - 1992 Families; 3660 children were served in CY2013
  - Average length of stay in FCCP is four months
  - Median age of child served is 9 years
RI Results: Family Care Community Partnerships

Top 4 Reasons for Case Closure During Calendar Year 2013 (1791 closed cases):

- Team agrees wrap goals have been met – 46.1%
- Unable to contact family – 14.6%
- Family declined services
- Of those children with a “non-positive completion”, 6.4% had a subsequent DCYF indicated investigation

System of Care - Phase II Implementation Date: July 1, 2012

RI Networks of Care: Ocean State Network and RI Care Management Network

- Phase II is serving families who are open to the department and actively receiving services. The department established two statewide Networks of Care that partner with the department and families to consolidate the management of services and supports for each child and family according to their unique strengths and needs.
- Each Network of Care has a Network Lead that is responsible for building a collaborative, comprehensive array of accessible formal and informal services and supports, including residential and home-based services, and support that will strengthen and support the home setting during and following out-of-home placement.
- The Networks must integrate wraparound principles, trauma and evidenced-based practices into service delivery and include strong partnerships with education and other entities in order to improve educational stability and success.

RI Outcomes:

Over the past five years, the Department of Children, Youth and Families has:

- Reduced the number of youth placed out of state by over 57.9% from 2008 - 2014
- Lowered the number of children entering out of home care by 29.7% from 2007 - 2013
- Developed and implemented Phase I of the System of Care (FCCP) as a front end diversionary program that has successfully reduced the number of families becoming open to the department and reduced the number of children in our care
- Launched Phase II of System of Care (Networks of Care)

Accomplishments: Reduction in Out-of-State Residential Placements

Placement Solutions
Out of State Residential Placements
Quarter 1 by Fiscal Year

- As of June 2012 - Reduced to 44 Out-of-State
- Most are nearby

Role of the Family Partner

The Family Partner is a family member who is a formal member of the wraparound team. The family partner’s role is to serve the family, help them engage and actively participate on the team, and make informed decisions that drive the process. (National Wraparound Initiative – Resource Guide to Wraparound)

- Peer-to-Peer Support
- Advocate
- Cultural Broker

Example #4: Structuring the Array of Services and Supports, Including Evidence-Informed Practices and Family and Youth Peer Support
Example: Broad Service Array

Dawn Services & Supports

**Behavioral Health**
- Supportive Management
  - Crisis intervention
  - Day treatment
  - Evaluation
  - Family assessment
  - Family navigation
  - Family therapy
  - Individual therapy
  - Individual skills training
  - Individual therapy
  - Individual and group
  - Family therapy
  - Supportive independent living

**Psychiatric**
- Medication management
- Medication follow-up
- Psychiatric review
- Nursing services

**Crisis**
- Community case management/case aide
- Clinical mental
- Behavioral therapist
- Child and independent living skills
- Parent and family service
- Supported work environment
- Day
- Community supervision

**Rehab**
- Crisis needs
- Residential needs
- Residential service

**Services/Coordination**
- Case management
- Service coordination
- Intensive care management

**Other**
- Telehealth
- TANF training
- Consultation with other professionals
- Grief and loss
- Transportation
- Travel

**Discretionary**
- Assistance
- Cash support
- Clothing
- Educational expenses
- Educational supports
- Housing (non-foreclosure)
- Medical
- Medical equipment
- Medications
- postage
- Prescription
- Telephone
- Utilities
- Grocery
- Medicine

**Incentive**
- Basic needs
- Roommates
- Medical
- Dental
- Physician
- Supplies
- School
- Social work
- Home health
- Physical therapy
- Speech therapy
- Transportation
- Vehicle

**Other**
- Interpreters
- Guardians
- Legal services
- Transportation
- Independent living
- Volunteer

**Social Policy Report**


**Evidence-Based Practice**

**Evidence-Based Practices**

Show evidence of effectiveness through carefully controlled scientific studies, including random clinical trials – e.g., Multisystemic Therapy, Multidimensional Treatment Foster Care, Parent-Child Interaction Therapy, Integrated Co-Occurring Treatment

**Promising Approaches or Practice-Based Evidence of Community Defined Evidence**

Show evidence of effectiveness through experience of key stakeholders (e.g., children, families, administrators) and outcome data - e.g., Family Peer Support, Mobile Response and Stabilization, Wraparound

**Examples of What You Don’t See Listed as Evidence-Based Practice (though they may be standard practice)**

- Traditional office-based “talk” therapy
- Residential Treatment
- Group Homes
- Day Treatment

**Trauma-Informed Care**

Services that:
- Incorporate understanding of the psychological, neurological, biological, and social impact of trauma and violence
- Promote dignity, respect, trust and safety in therapeutic, healing environments
- Promote well-being and resiliency
- Reflect youth and family satisfaction, engagement and self-empowerment. Youth and families work in partnership with staff
- Allow youth and families time to build trust with staff and safety to share their story of what has happened
- Understand the role of caregiver’s trauma history

**Effectiveness Research**

(Barbara Burns’ Research at Duke University)

- Most evidence of efficacy: Intensive case management, in-home services, therapeutic foster care
- Less evidence (because not much research done): Crisis services, respite, mentoring, family education and support
- Least evidence (and lots of research): Inpatient, residential treatment, therapeutic group home

**Types of Medicaid Services in Systems of Care**

- Assessment and diagnosis
- Outpatient psychotherapy
- Medical management
- Home-based services
- Day treatment/partial hospitalization
- Crisis services – mobile & residential
- Behavioral aide services
- Behavioral management skills training
- Therapeutic foster care
- Therapeutic group homes
- Targeted Case Management
- Inpatient hospital services
- Case management services
- School-based services
- Respite services
- Wraparound
- Family peer support/education
- Youth peer support
- Transportation
- Mental health consultation
- Early intervention and prevention services
- Supported independent living
- Residential treatment centers
- Telehealth
Implications for How RTCs are Utilized

- Movement away from “placement” orientation and long lengths of stay
- Residential as part of an integrated continuum, connected to community
- Shared decision making with families/youth and other providers and agencies
- Individualized treatment approaches through a child and family team process
- Trauma-informed care

For more information, go to Building Bridges Initiative: www.buildingbridges4youth.org

Growing Conclusion by State, Tribal and Local Purchasers

Redirect spending from out of home placements with high costs and/or poor outcomes to evidence-informed home and community-based services in a system of care

The Cost of Doing Nothing

If Milwaukee County had done nothing: the $18m. spent by child welfare ten years ago would be $48m. today

Project Bloom “Cost of Failure Study” – Early childhood services at an average cost per child of $987/year save $5,693/year in special education

If New Jersey had done nothing, it would have spent $40m more in inpatient psychiatric hospitalization over the last three years

The Cost of Doing Nothing: Racial & Ethnic Disparities/Disproportionality

“...youths of color were less likely to receive outpatient therapy...and more likely to receive residential services.” (Source: MccMillan, J., Scott, L. et al. Use of Mental Health Services Among Older Youths In Foster Care. 2004. Psychiatric Services 55:811-817. American Psychiatric Association)

“The study finds greater use of residential treatment centers by black persons and Hispanic persons that is attributable in part to (public sector) managed care” (Source: Snowden, L., Cuellar, E. & Libby, A. Minority Youth in Foster Care: Managed Care and Access to Mental Health Treatment. 2003. Med Care. 41(2): 264-74. University of California Berkley)

Where Families, Youth and Family and Youth Organizations Fit Into the Service Array

<table>
<thead>
<tr>
<th>As technical assistance providers &amp; consultants</th>
<th>As direct service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>Family Liaisons</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Care Coordinators</td>
</tr>
<tr>
<td>Research</td>
<td>Family Educators</td>
</tr>
<tr>
<td>Support</td>
<td>Specific Program Managers (respite, etc)</td>
</tr>
<tr>
<td>Outreach/Dissemination</td>
<td>Youth Peer Mentors</td>
</tr>
</tbody>
</table>

Roles of Families and Youth in RI System of Care:

- Parent Support Network-Peer Mentor Program
- Family Support Partners integrated into wraparound model-positions at the family organization and within agencies
- Family Evaluator who is engaging parents to conduct the WFI EZ and Family Support Partner survey with parents formally involved with DCYF and wraparound
- Family & Youth Leadership Training for participation on state and regional Family Community Advisory Boards, responsible for quality assurance
- Youth Leadership Academy
- Youth Strategic Plan- working with youth to evaluate the system of care and define new roles for youth
DCYF has an innovative plan for children, youth and families, intended to unify its services across divisions, while demonstrating a strong commitment to System of Care principles.

**Phase I**
Prevention services offered through Family Care Community Partnerships (FCCP)

- Community-based services and supports using the wraparound planning model to prevent family involvement with DCYF, and to support family preservation and child wellbeing
- Each of the 4 FCCPs is advised by a Community Advisory Board

**Phase II**
Development of the Family Care Networks

- Services include congregate care, treatment foster care and community-based services.
- The Title IV-E waiver to support traditional placement services as well as enhanced family support services and home and community-based services for at risk and post placement children, youth, and families.
- The Global Medicaid waiver to support evidence-based practices: Multi-Systemic Therapy, Parenting with Love and Limits, Strengthening Families and Preserving Family Networks.

Grants and Awards

- Implementation Cooperative Agreements with SAMSHA for the expansion of the Comprehensive Community Mental Services for Children and Their Families Program ($4 million over 4 years)
- Title IV-E waiver to add flexibility to the System of Care
- Diligent recruitment grant from federal government
- Grant for promoting well-being and adoption after trauma
- Early Childhood – Race to the top – Collaborating with RIDE

DCYF has developed many innovative systemic practices and been awarded grants and waivers to support these practices

System-wide Innovations

- Bringing commitment to community and parent engagement and prevention, including development of FCCPs, and commitment to Evidence2Success
- Development of and support for System of Care, and movement to the Family Care Networks
- Contract with Foster Forward to support foster parents, and being a model site for services to older youth with the Consoliated Youth Services Program which includes the Jim Casey Youth Opportunities Initiative’s ASPIRE services and the RICORP-managed YESS Affiliates Services
- Participation in the Incorrections Alternatives Initiative to reduce the use of detention for youth
- DCYF is participating in the Pew Foundation’s Results First Initiative, which emphasizes the use of evidence-based practices and provides a cost benefit model for evaluating the effectiveness of services and programming. RI DCYF will be one of the first states in the country to apply the Results First Initiative to both juvenile justice and child welfare programs
- In 2014 Successfully completed the Program Improvement Plan as part of the Child and Family Service Review
- Partnering with the RI Family Court in the establishment of a Permanency Committee focused on improving and supporting the permanency planning process for children, youth and families

Other Initiatives

- Improving the Use of Psychotropic Medication Among Children and Youth in Foster Care
- Mobile Crisis Team
- Right-sizing Congregate Care
- Redesign DCYF LEA to Improve Educational Outcomes
- Trauma Intervention
- Improving Older Youth Transitions
- Development of the Joint Permanency Committee
- Wellness For Staff, Children, Youth And Families
- Recruiting, Hiring, Promoting & Retaining A More Diverse Workforce

DCYF has a clear vision and system improvement plan for children, youth and families

Within its mission of partnering with families and communities to raise healthy children in a safe and caring environment, the Department has articulated clear goals, strategies, objectives, action steps and the rationale for change.

- Children and youth in families
- Diligent foster care recruitment
- Right sizing and improving congregate care
- Wellness for staff
- Each of these represents best practice in the field today
- The focus is on children living with families, and preventing the trauma they meet within the family setting
- The focus on staff wellness is recognition of the importance of early intervention in the field of foster care (i.e., staff must clean the way they are treated in the workplace)

Structuring the Array of Services and Supports in Rhode Island

- DCYF utilized prevention and earliest intervention, community-based dollars to support the preservation of families, early childhood and school-based programs;
- The state established the foundations of an evolving infra-structure to support:
  - The strengths of families;
  - Develop and connect families to effective, evidence-based practices;
  - Identify kinship and protective factors, ensuring that families are connected to natural helping networks.
Community agencies are working together in partnerships to reduce duplication and identify the appropriate resources for families.

Prevention dollars are being utilized across the state for mental health awareness and prevent child abuse events to support families in healthy, fun and “normalized” activities.

State inter-agency collaborative work is demonstrating fruitful results:

1. RI DCYF and RI Medicaid are working to ensure the best use of State and Federal Funds.

2. The activities of the Wraparound process may now be billed through the State Consumer Waiver (HCBS Demonstrations), “Cost Not Otherwise Matchable” (CNOM).

DCYF has implemented much innovative change over the last few years and needs to refine its model and continue to enact system improvements.

- Rhode Island has been innovative in its vision and system improvement plan for children, youth and families.
- Children and youth in out-of-home care with DCYF have unique challenges.
- With both phases of DCYF’s plan implemented, it’s time to step back and assess performance and adjust the model – reflecting on both system strengths and challenges.
- Several modifications are underway as the next phase of system improvements.

**Evidence-Based and Effective Practices in Rhode Island – Building the Base**

- Established a Continuous Recruitment Request for Qualifications (CR-Q) in 2002 for EVIDENCE-BASED AND PROMISING PRACTICES: CHILD AND FAMILY INTERVENTION.

- Result: current array of practices including Multi-Systemic Therapy, Strengthening Families, Functional Family Therapy, Parents as Teachers, Cognitive Behavioral Therapy (CBT) and Alternatives for Families-CBT, Parenting with Love and Limits (PLL), Incredible Years and other promising practices.

**Evidence-Based and Effective Practices in Rhode Island: Additional Supports**

- DCYF collaborated with large community child welfare provider, received funding by the National Child Traumatic Stress Network to establish training in trauma specific treatments.

- DCYF partnered with Department of Health for Infant and Early Childhood Evidence-Based Home Visiting practices development such as Nurse Family Partnership, Healthy Families America, and Parents as Teachers.

- Cross-agency commitment among Health, Education and Children, Youth and Families to collaborate to establish integrated system to insure coordinated assessment and referral/access to most appropriate evidenced-based treatments.

**Evidence-Based and Effective Practices in Rhode Island: Continuous Commitment**

- Currently collaborating with Annie E. Casey Evidence 2 Success initiative in Providence RI, to better match proven Evidence-Based Practices to specific populations of need.

- Collaboration with contracted System of Care providers to shift practice to those that demonstrate the best outcomes for child and family well-being.

DCYF Funded:
- Multi-systemic Therapy (MST)
- Cognitive Behavioral Therapy (CBT)
- Alternative for Families
- Trauma-Focused
- Parenting with Love and Limits (PLL) - not yet ERP, but promising practice

Other ERP’s Available:
- Incredible Years
- Strengthening Families
- Parents as Teachers

Programs will be operational by July of 2014:
- Teen Assertive Community Treatment (Teen ACT)
- Triple P (Positive Parenting Program levels 4 and 5)
- Family Centered Treatment
- Trauma Systems Therapy - pending revised proposal for service.
While modifications to the model need refinement and some modification, the goals are on target.

- Every large system change takes time to implement through the many levels of bureaucracies, both public and private.
- The implementation issues identified in Rhode Island are not exceptional, they should be expected.
- With 2 years experience with the Family Care Networks, it's a good time to re-evaluate how the system is working to maximize benefits for children and families.
- Six areas identified by Annie E. Casey assessment process that are especially important for improvement.

Example #5: Workforce Development & Practice Improvement and Capacity Building

Human Resource Development Functions

- Assessment of workforce requirements (i.e., what skills are needed, what types of staff, how many staff) in the context of systems change.
- Recruitment, retention, staff distribution.
- Education and training (pre-service and in-service).
- Standards and licensure.
- Credentialing for family and youth providers.

Hawaii’s University Partnership for Workforce Development

- State contracted with State University to:
  - Enable university faculty to teach courses on systems of care, EBPs, and other subjects critical to public child MH system.
  - Enable university faculty to serve on EBP development and other State committees.
  - Support trainees across disciplines to rotate through public child MH system, including psychiatric residents, MSW students, Ph.D. candidate psychology students, and Advanced Practice Registered Nurses.
  - Supports psychiatric consultation to Family Guidance Centers and youth corrections from medical school faculty.

A Developmental Training Curriculum
A Developmental Training Curriculum

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>TRADITIONAL</th>
<th>MODIFIED</th>
<th>INTEGRATED</th>
<th>UNIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in professional conferences on individual basis within agency boundaries. Services are provided within agency boundaries.</td>
<td>Staff receive training that promotes collaboration, but receive it within agency boundaries. Specialty focus predominant. Services remain within agency boundaries.</td>
<td>Service training is provided through cross-agency training.</td>
<td>Service training with full family inclusion are the norm. Redefined specialty practice roles develop to support professional identity while promoting collaboration.</td>
<td></td>
</tr>
</tbody>
</table>

Examples of Cross-System Training

State of Maryland

Wraparound Curriculum with goal of developing a consistent practice model statewide to support intensive care coordination using fidelity Wraparound.

Examples of How States Have Put Structures in Place to Support Capacity Building

Maryland Institute for Innovation and Implementation
California Institute of Mental Health
Ohio Center for Innovative Practices

Technical Assistance Taxonomy

<table>
<thead>
<tr>
<th>Technical Assistance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Providing advice and opinions.</td>
</tr>
<tr>
<td>Coaching or Mentoring</td>
<td>Acting as a “trusted guide”, providing direction, prompting, instruction and support.</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Providing support to a system building process to make the process run more smoothly.</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Acting as a “provocateur” or “national expert” when systems are stuck.</td>
</tr>
<tr>
<td>Facilitation</td>
<td>When systems are stuck, the system builders cannot carry the message themselves.</td>
</tr>
<tr>
<td>Persuasion</td>
<td>Sometimes simply because it is difficult to be “a prophet in your own land”.</td>
</tr>
<tr>
<td>Training</td>
<td>Teaching and skill building.</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Support provided by someone who has had similar experience.</td>
</tr>
</tbody>
</table>

RI Wraparound Training & Certification

- Coach/Supervisor Certification requires all of the below trainings, passage and approval of wrap practice and documentation skill sets for coach/supervisors; and demonstrating of coaching of wraparound staff.
- Wraparound staff including DCYF social workers, Family Support Partners complete below trainings; weekly individual supervision with coach/supervisor; participation in monthly group supervision; and approval of wraparound practice and documentation skill sets according to roles.
- Safety & Risk Training
- Wraparound Team Based Training
- Data Management Training
- Advanced Family Support Partner Training
- Wraparound Coach/Supervisor Training
- Child Welfare, Juvenile Justice: Navigating the Department of Children, Youth, and Families (DCYF) system
- Visual Diagnosis
- Domestic Violence Training
- Substance Abuse Training
- Mental Health Training
- Trauma Informed Training
- Positive, Behavioral, Interventions, and Supports (PBIS) & School-Based Wrap Training

RI Peer Support Provider Certification & Medicaid Reimbursement

- RI Peer Support Workforce Initiative with State agency partners Department of Health, Department of Children, Youth, and Families, Behavioral Health Development Disabilities & Hospitals, and Office of Health & Human Services.
  - Competencies & Curriculum
  - Pathway to Medicaid Reimbursement by December 2015
- National Technical Assistance with National MCH Workforce Development Center, FFCMH, and FREDLA
Common Elements of Re-Structured Systems (1)

- Values-based systems/family and youth partnership
- Identified population of focus, costs associated with population, funders
- Locus of accountability (and risk) for population of focus
- Single pathway to services for population of focus
- Strengths-based, individualized service planning, care monitoring (e.g., wraparound approach)
- Intensive care management/service coordination
- Flexible financing and contracting arrangements (e.g., case rates, qualified provider panel – fee-for-service)
- Combined funding from multiple funders (e.g., Medicaid, child welfare, mental health, juvenile justice, education)

Common Elements of Re-Structured Systems (2)

- Broad provider network: sufficient types of services and supports (including natural helpers)
- Real time data across systems to support clinical decision-making, utilization management, quality improvement
- Outcomes tracking – child/family level, systems level
- Utilization and quality management
- Mobile crisis capacity
- Judiciary buy-in
- Re-engineered residential treatment centers
- Shared governance/liability
- Training and technical assistance

For further information, contact:

- Sheila A. Pires
  sapires@aol.com
- Janice DeFrances
  janice.defrances@dcyf.ri.gov
- Ginny Stack
  Ginny.Stack@dcyf.ri.gov
- Lisa Conlan
  LisaConlan2@aol.com
- Ana Santana Pena
  asantana pena050@g.rwu.edu