

## **APPENDIX C: POWERPOINT PRESENTATIONS BY PANELISTS**

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### **GERALDINE TONICH**

*Parent Representative*

*Family Resource Specialist*

*Family Ties*

*Westchester County, NY*

### **Federal Interdepartmental Meeting:**

**Children & Adolescents with  
Developmental Disabilities & Emotional  
&/or Substance Abuse Disorders**

***“A Parent’s Story”***

**Geraldine Tonich  
Family Ties, Parent Coordinator**



GERALDINE TONICH

## A Parent's Story

### Matthew, Age 9

- **Early Years**
  - Birth to Age 3 Opportunities
  - 3 Years to 5 Years Pre-Ed.
  - Age 5

**Missed**

**Committee on School Special**

**Diagnosis of Autism**



## Family Support Advocacy

**Introduction to Family Support (Family Ties)  
through a Community Based System of Care.**

1. **Advocacy**
2. **Peer Support**
3. **Sibling Group**



GERALDINE TONICH

## Systemic Issues

- **Role of Pediatrician**
- **School Response**
- **Autism “Catch 22”:**  
Autism diagnosis may prevent a child from receiving mental health treatment services



## On-Going Challenges

- **Effect on other children in the family**
- **Families Need In-Home Help**
- **Difficulty in finding a child psychiatrist for a younger child**



**MYRA ALFREDS, C.S.W.**

*Director, Children's Mental Health*

*Westchester County Department of Community Mental Health*

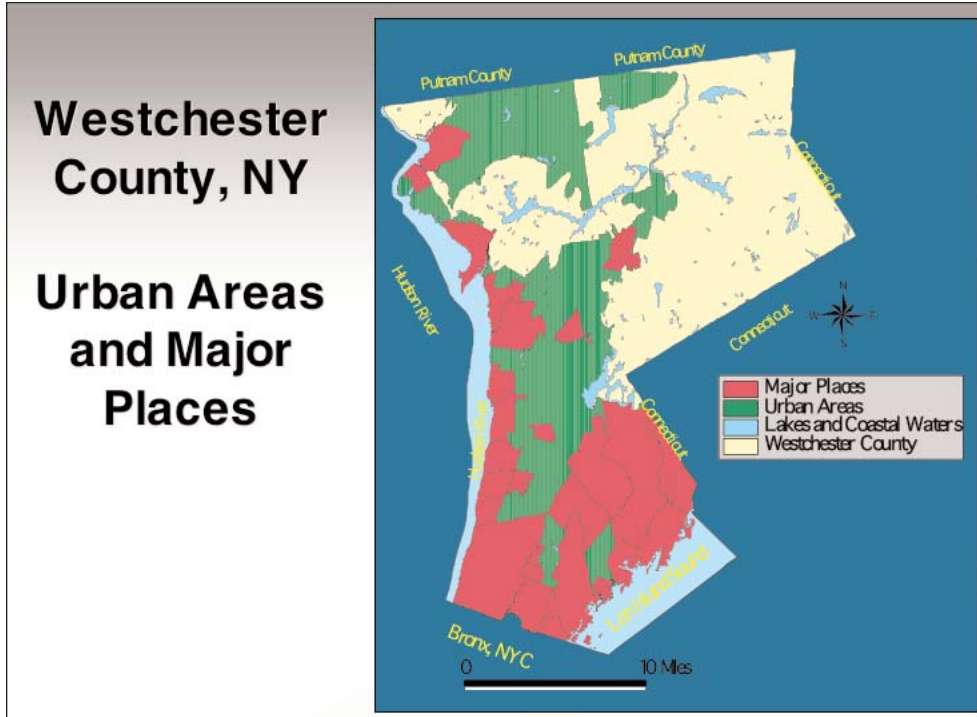
**Federal Interdepartmental Meeting:**

**Children & Adolescents with  
Developmental Disabilities & Emotional  
&/or Substance Abuse Disorders**

**Myra Alfreds, Director  
Children's Mental Health Services  
Westchester County, New York**



MYRA ALFREDS, C.S.W.



## Challenges & Differences

### MR/DD

- State Driven
- Higher Ratio Service Coordination
- Programmatic Family Support
- Dispute Resolution
- Adult Driven
- Life long

### Mental Health

- County Driven
- Lower Ratio Intensive Case Management
- Community-Based Family Support
- Collaborative Model
- Child/Adult
- Time Limited



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## Cross System Issues

- **Pediatricians do not routinely screen for Mental Health & Developmental Disabilities.**
- **Parents must often choose one system or the other.**



## Definition of a System of Care

***A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.***




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## System of Care Principles & Values


- **Community-Based**
- **Family Driven**
- **Culturally Competent**
- **Team Developed & Supported**
- **Never Give Up**
- **Individualized**
- **Strength Based**
- **Flexibly Funded**
- **Supports & Services that Every Child Needs**



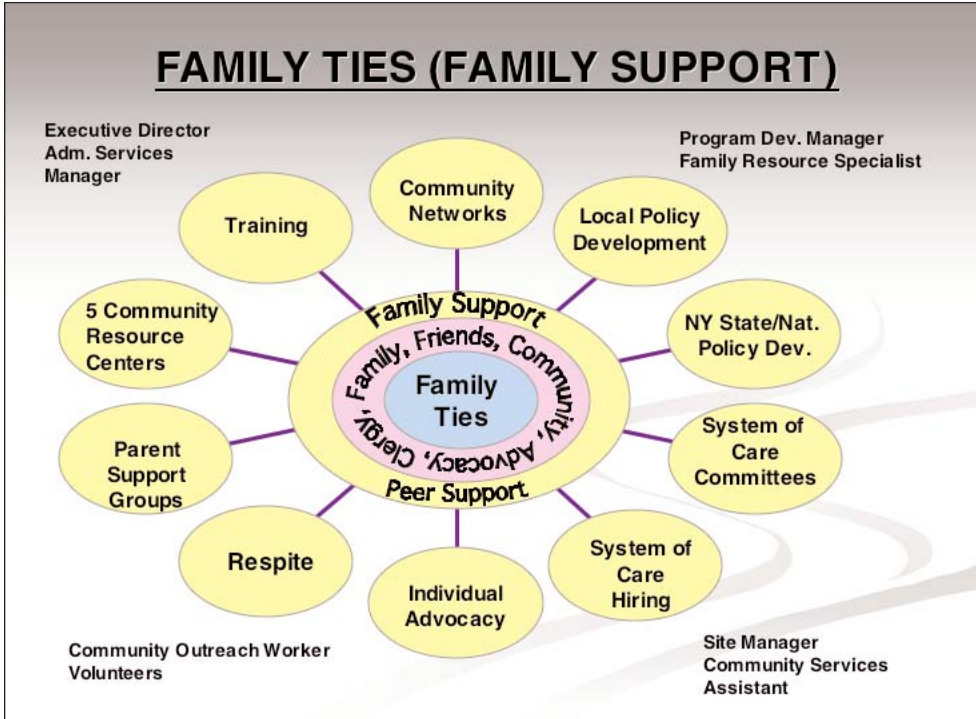
## Community Network for Children & Families




10 Community-Based Networks  
 2 Early Childhood Networks  
 1 Transitional/Aging-Out Network  
 (County-Wide)



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- ### Westchester County System of Care Strategies
- **Ongoing Cross System Planning**
  - **Collaborative Care Coordination**
  - **Annual Multi-Session Training &  
Resource Book for Children**
  - **Peer Support/Supervision**
- 



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## FEDERAL RECOMMENDATIONS

- Put the Needs of Children with Co-Occurring Disorders Front & Center in the Federal Agenda. Utilize the New Freedom Commission Report as a Social Marketing tool and foster Policy Development, Planning, & Partnerships with Parents & Professionals across all Federal Agencies;
- Use the System of Care Approach as a Best Practice Model. Include all children who could benefit from help from more than one system, not only those who meet strict eligibility criteria. Support the establishment of independent *Wraparound Committees* that are separately funded and could replace the current “dispute resolution” committees;
- Create real incentives in all applicable Federal Funding Streams, such as Medicaid, Medicaid Waivers, as well as in federal grant programs to insure that children with Co-Occurring Disorders are a priority for services.

## For additional information



[www.westchestercommunitynetwork.co](http://www.westchestercommunitynetwork.co)

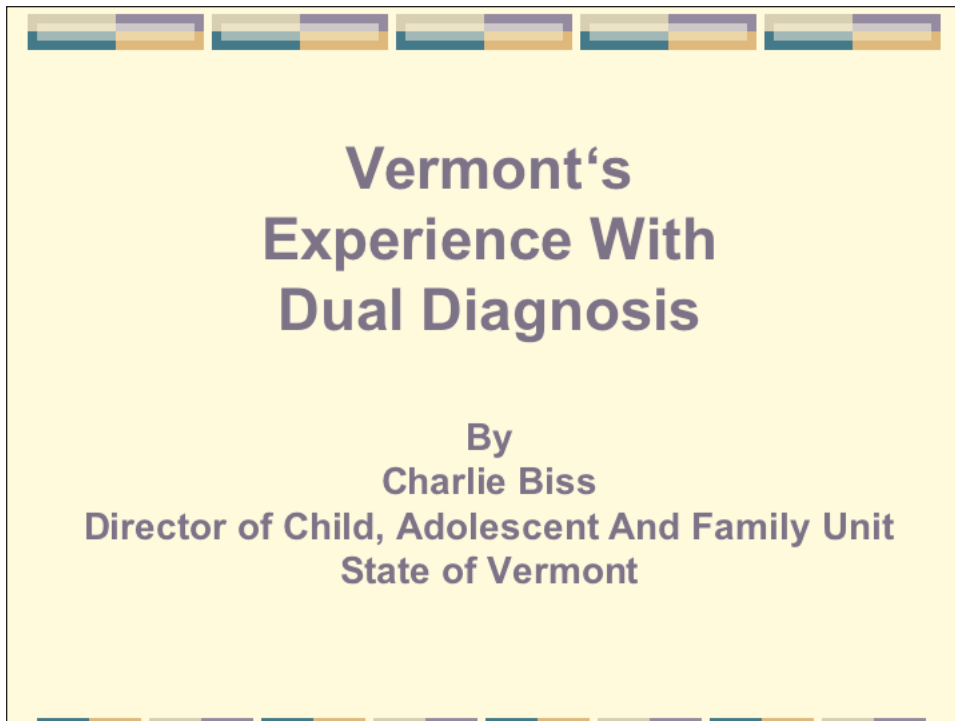
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**CHARLIE BISS, M.S.W.**

*Directory, Child, Adolescent and Family Services*

*Department of Mental Health*

*Vermont Department of Health*



CHARLIE BISS, M.S.W.

## Issues Experienced

- Increased incidence of Autism, Pervasive Developmental Disorder, and dual diagnosed.
- Lack of leadership to claim this vulnerable population.

## Issues Experienced Continued

- Mental Health and Developmental Disabilities have a long history of cultural differences, turf battles, diversity of funding and lack of cross-training.
- Developmental Disabilities is not a full mandated partner in Act 264 (interagency coordination law).
- High number of dual diagnosed children in child welfare, Juvenile Justice, out-of-state educational placement, and hospital.

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## Issues Experienced Continued

- These children are usually identified at times of significant family and school crises.
- There is a lack of trained professionals to make effective differential diagnoses and to treat and support these children and their families.

## Action Taken

- Invited Developmental Disabilities to become part of Act 264.
- Interagency groups at the local and state level discussed the policy and treatment issues for this population and their families were invited to these discussions.

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### Action Taken Continued

- Encouraged treatment teams to develop appropriate plans of care for these children regardless of the funding.
- Discussed the poor outcomes as a result of not serving these children well:
  - inappropriate hospitalization
  - out-of-state placements by school
  - custody relinquishment to child welfare
  - incarceration by Juvenile Justice.

### Action Taken Continued

- **Mental Health and Developmental Disabilities jointly applied for and received state funds for children with Pervasive Developmental Disorders.**
- **Mental Health works collaboratively with early childhood professionals (e.g., Part C) and with pediatricians to identify early onset of social/emotional problems.**

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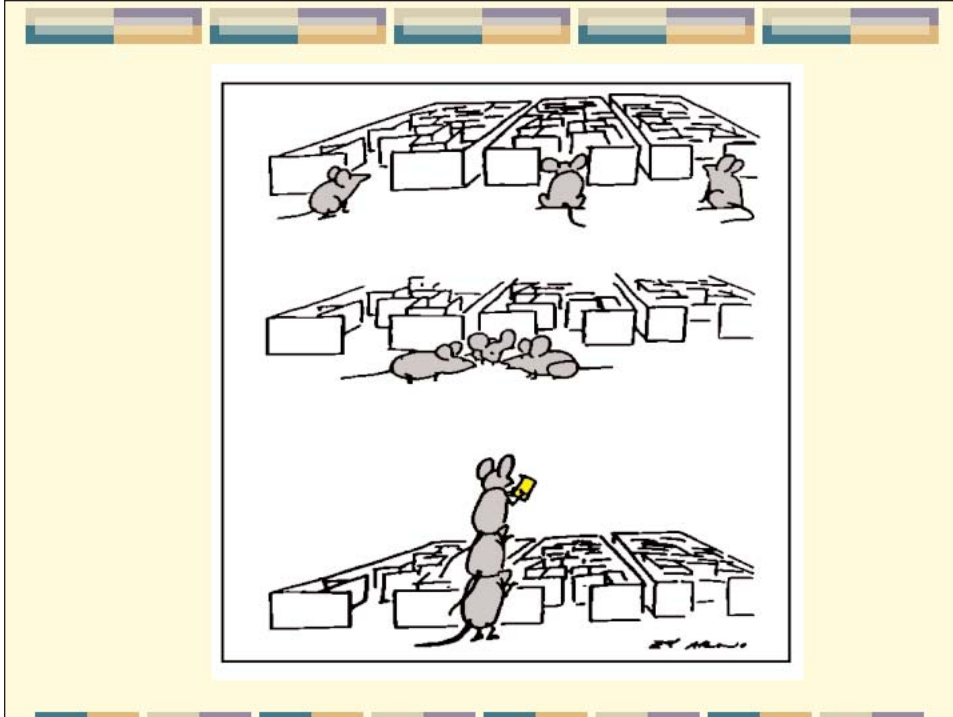
## Lessons Learned

- System of Care model works for these children.
- Training professionals is large infrastructure issue.
- Early detection is essential.

## Lessons Learned Continued

- System of Care philosophy takes a long time to learn.
- This population is growing in numbers and we must act now!
- Interagency councils at the state and local level that are mandated to meet regularly can address barriers.

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## Best Practice

- Interagency collaboration, early detection, a trained workforce and family involvement are essential in providing the effective services and supports to a child with dual diagnosis and their family.

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## Recommendations

- Insist on interagency collaboration and the system of care model when awarding any grant, waiver, cooperative agreement, etc.
- Allow for a mental health/developmental disability child home and community based waiver (1915c).
- Develop a multidisciplinary training program for staff working with this population.



**CHERYLL BOWERS-STEPHENS, M.D., M.B.A.**

*Assistant Secretary, Department of Health and Hospitals  
Office of Mental Health  
State of Louisiana*

**Comprehensive and  
Coordinated Systems of  
Care**

The Developmental  
Neuropsychiatry  
Program

Louisiana Office of Mental Health  
Cheryll Bowers-Stephens, MD, MBA

CHERYLL BOWERS-STEPHENS, M.D., M.B.A.

## **The Developmental Neuropsychiatry Program (DNP)**

- System of Care serving youths who have both a psychiatric illness and a developmental disability
- The program has been in operation for over 10 years
- It was designed for youth that have not responded to traditional mental health and developmental services

## **History of Program Development**

- Youths with Mental Illness and Developmental Disabilities were falling through the cracks and clogging up isolated service systems ill-equipped to address their needs
- Unacceptable given the prevalence: mental illness occurs in a higher percentage of persons with DD (3-6 times the rate in the general population)
- Rates of physical and sexual abuse are higher

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## History of Program Development

- Unique Challenge to service systems both with regard to diagnosis and treatment
- Correctly diagnosing MI in persons with DD is difficult
- Mental Health professionals are ill-equipped to make correct diagnosis
- Repeated misdiagnoses resulting in repeated ineffective treatments and ineffective pharmacotherapy

## System of Care Overview

- Goal is to break the cycle of multiple hospitalizations and institutionalization by promoting community inclusion.
- Outpatient assertive community treatment program serving ages 2 to 22.
- Inpatient adolescent unit serving ages 13 through 18.
- ICF-MR Waiver Demonstration Project
- Long term follow up

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## DNP Service Model

- Learning-based, structured teaching approaches
- Encourages healthy, prosocial behaviors promoting social inclusion and reintegration or stabilization in the community
- Therapies adapted to the cognitive abilities and developmental needs of the individual.
- Family and School integrated into treatment

## DNP Service Model

- Treatment promotes social skills development and builds upon the youths' personal goals and competencies
- Promotes interagency support and coordination

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## Evidence Based Practices

- Integration of behavioral and pharmacological interventions
- Functional Analysis and Behavioral Modification (Applied Behavioral Techniques; Cognitive Behavioral Therapy; Classical Behavioral Therapy)
- Continuity of Care
- Modified Linehan Approach (Dialectical Behavioral Therapy)
- Relaxation Training

## Prevalence of Psychotropic Usage by Drug Class (Prior to Admission)

<u>Drug Class</u>	<u>Percentage</u>
Neuroleptics	85.0%
Mood Stabilizer	73.5%
Anti-Depressants (non-SSRI)	54.4%
SSRI's	55.8%
Anti-Depressants (combined)	78.2%
Psychostimulant	46.3%
Anxiolytics	24.5%
Anti-Convulsants	16.3%
Anti-Hypertensive	36.1%

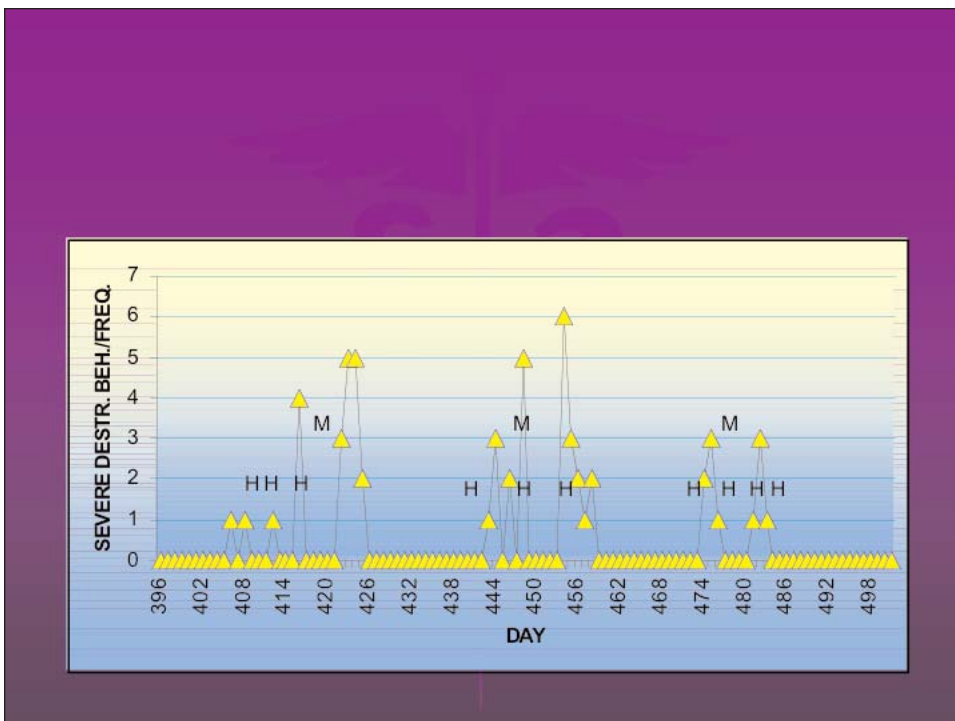
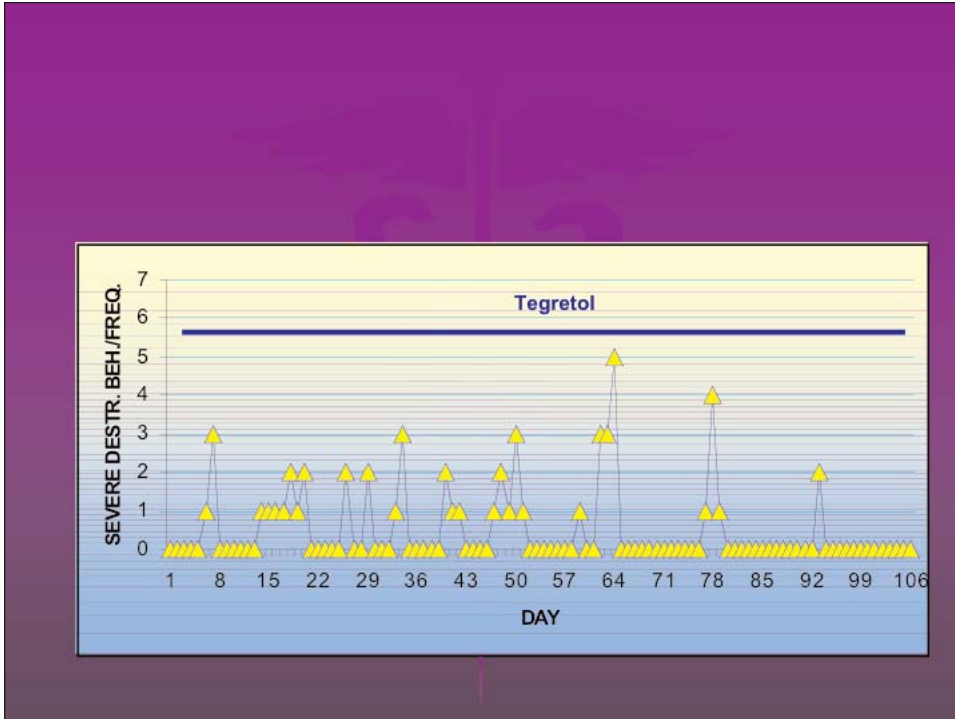
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### Prevalence of Psychotropic Usage by Drug Class (Prior to Admission)

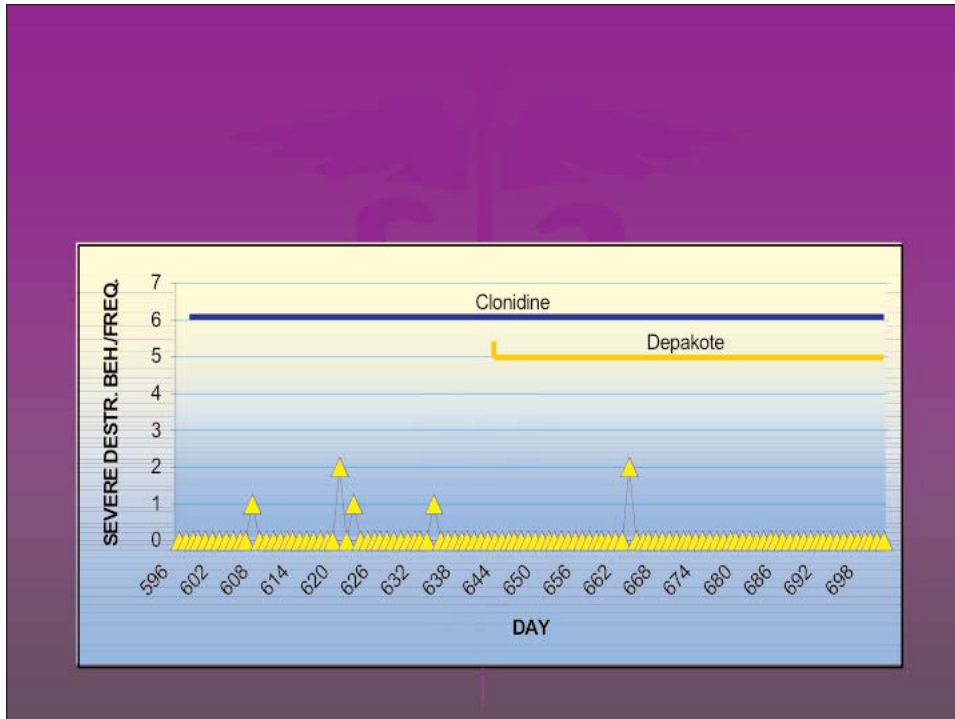
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- ### Not Uncommon Errors in Diagnosis
- Psychosis based solely on invalid self-report of auditory hallucinations
  - PTSD diagnosed as Psychosis
  - PTSD diagnosed as Conduct Disorder
  - Bipolar Disorder diagnosed as Conduct Disorder

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## AACAP Work Group/1999

- Replacement Behavior Training
- Social Skills Training
- Disability Education
- Individual, Group and Family Therapy
- Behavioral Interventions
- Establish concrete goals
- Treatment delivered by clinicians with experience working with MR
- Concrete emphases (developmentally appropriate)



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## **AJMR – Consensus Guidelines (May 2000)**

- Applied Behavioral Techniques
- Cognitive Behavioral Techniques
- Classical Behavior Therapy

## **Behavioral Treatments of Depression**

- Increasing Pos. Activities/Stimulation (Lewinsohn)
  - Increase Fun and Success Experiences
- Operant Approaches
  - Positive Statements
  - Engagement in Activities
  - Social Skills Training
- Cognitive Behavior Therapy
  - Modifications

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## MODIFIED DAILY MOOD LOG

Sad Thoughts	Happy Thoughts
<i>Nobody likes me. I don't have any friends.</i>	<i>I guess when I think deep down inside that there are a lot of people who do like me. (Lists them).</i>
<i>I'm fat and ugly.</i>	<i>Other people say these things are nice about me. My hair, eyes, I'm pretty when I smile my eyes my personality</i>

## Summary/CBT for persons with MR

- Simplify Basic Model of CBT
- Use Simple Explanations
- Use Simple Language
- Teach to Challenge Distorted Thinking
- Teach to Distract Self with Positive Cognitions
- Simplify Task by Refraining from Teaching Categories of Cognitive Distortions

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## Behavioral Treatments of Anxiety Disorders

- Phobia Studies
  - Peck (1977) and Jackson (1983)
- Standard Systematic Desensitization
  - Establish Fear Hierarchy
  - Teach SUDS Rating
  - Introduce Counterconditioning Element
  - Introduce Exposure
- Modifications for MR
  - Participant Modeling
  - Reinforced practice
  - In Vivo Exposure

Behavioral Treatments of Anxiety Disorders (cont')

## Obsessive Compulsive Disorder

Case Example

Gradual Negotiated Change  
Exposure with Response Prevention  
Positive R+ (Social/Tangible) of Goal Attainment  
Generalization to Home Setting

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**Behavioral Treatments of Anxiety Disorders (cont')**

## **Post-Traumatic Stress Disorder**

Hamilton (1994) – Managing Acute Distress

1. Relaxation training/Self-calming strategies
2. Removal from triggers
3. Cognitive Distraction

Protocol III

1. Counterconditioning Strategies
2. Imaginal Flooding
3. Planning for Possible Triggers
4. CBT

## **Borderline Personality Disorder**

Linehan – Psychosocial Skills Training for Borderline Personality Disorder

1. Emotion Regulation Skills
2. Interpersonal Effectiveness Skills
3. Distress Tolerance Skills
4. Mindfulness Skills

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## AACAP Work Group Commentary (1999)

- Some clinicians target symptom suppression without regard for habilitative functioning
- Informed consent often overlooked
- Medication often is not integrated as part of comprehensive treatment plans
- Medications often don't match diagnosis
- Polypharmacy is overused
- There is often no active monitoring for side effects

## Outcomes

- 207 patients served
- 184 served inpatient
- 60 served outpatient
- 23 outpatient only
- 123 inpatient only
- 37 both inpatient and outpatient

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## Outcomes

- 56% male and 44% female
- Mean age at admission is 15
- At admission 50% state custody

## Diagnosis

- 75% have MR
- 25% Autism, PDD, LD, or met federal definition of DD
- 14% had autism or a PDD
- 35% mood disorder
- 25% anxiety disorder with PTSD most common
- 23% ADHD and 4% with thought disorder

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Level of Care	Initial (177)		Current (131)	
Supported/IN	6	(3%)	27	(21%)
Parent/Family	86	(49%)	51	(39%)
Foster Family	25	(14%)	5	(4%)
Group Home	34	(19%)	21	(16%)
Residential	6	(3%)	6	(5%)
Hospital	6	(3%)	5	(4%)
Detention	3	(2%)	4	(3%)
ICF-MR	7	(4%)	11	(8%)
Eloped	4	(2%)	0	
Deceased	0		1	(1%)

## Outcomes

- 86% in community/non-institutional settings
- 67% no re-hospitalization
- 74% have not served time in a correctional facility
- 88% have not been admitted to an ICF-MR
- 50% have had none of the above

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## Juvenile Justice Involvement in DNP Youth

147 INPATIENTS	Pre- Treatment	Post- Treatment
Legal Involvement	57%	36%
Arrests	46%	26%

## Mental Health Treatment can Reduce Arrest Rates in this Population

Post treatment 90% of these youth had either no jail time or no jail time less than 30 days.



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## Lessons Learned

- These youth are at risk for substance abuse and dependence. Need specialized services.
- These youth are at risk of entering the juvenile justice system and adult corrections.
- These youth are institutionalized as adults.
- Failure to meet the needs of these youth is the most costly mistake that policymakers at both the state and federal level make.

**PEGGY NIKKEL**

*Executive Director*

*UPLIFT (parent advocacy organization)*

*Casper, Wyoming*

**PANEL II: Comprehensive &  
Coordinated Systems of Care:  
Eligibility and Access Barriers**

***Family Perspective***

*Peggy Nikkel*

*Executive Director*

**UPLIFT**

*(Federation of Families for Children's Mental Health)*

*Casper, Wyoming*

PEGGY NIKKEL

- Families struggle to access services
- Stigma
- Selective eligibility requirements
- Funding tied to eligibility categories

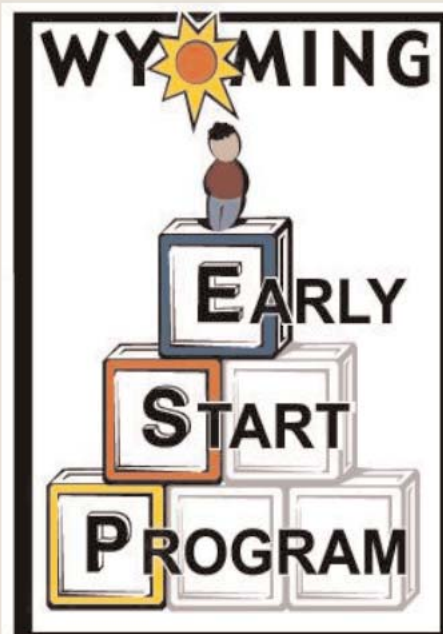
- Most programs and services are restricted to one population
- Disparity of services for mental health
- Screening instruments may not be comprehensive

PEGGY NIKKEL

- Lack of adequate training for service providers
- Lack of coordinated treatment team approach
- Families have to find the services and piece them together

Lack of consistent early screening and intervention in Wyoming led to the development of UPLIFT's

*Wyoming Early Start Program*



PEGGY NIKKEL

## Steps to Enhanced Early Screening in Wyoming

- Family advocacy organization identifies gap in services.
- Secured funding to conduct community consensus building meetings regarding the need for early screening and identification for emotional disorders.

- Researched available screening instruments. Focused on the *Early Screening Project: A Proven Child-Find Process* and *Ages and Stages: S/E*
- Established partnership with screening instrument researcher/developer and TA consultants at Georgetown University.

PEGGY NIKKEL

- Developed Wyoming trainers to train early childhood providers in the use of research-based early screening and intervention models.
- Collaborated with existing early childhood state initiatives to include strong component in social and emotional development.

- Assembled funding partners to plan and implement annual statewide children's mental health conference with a focus on early childhood.
- All Wyoming child development centers and at-risk preschool programs now receive training in early screening and intervention.

PEGGY NIKKEL

- Preschool children are being screened for delay in social/emotional development and referred for more intense early intervention services as needed.
- UPLIFT, Wyoming's Federation of Families for Children's Mental Health now serves as the Grant Administrator for all Wyoming's TANF At-Risk Preschool Programs.

- Through continued collaborative activities, Wyoming's Comprehensive Early Childhood System Planning Grant will implement a multi-level professional development program with a focus on developmental and social/emotional components in the coming year.
- Family members CAN make a difference!

PEGGY NIKKEL

## **Recommendations**

- Develop multiple access points for families.
- Increase access of non-clinical supports to families.
- Availability of services and supports should be based on need of child and family, not diagnosis.

- Provider training should include developmental disabilities and mental health.
- Integrate primary care with developmental disabilities and mental health.



PEGGY NIKKEL



## Contact Information

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**STEVEN LAFRENIERE, M.S.**

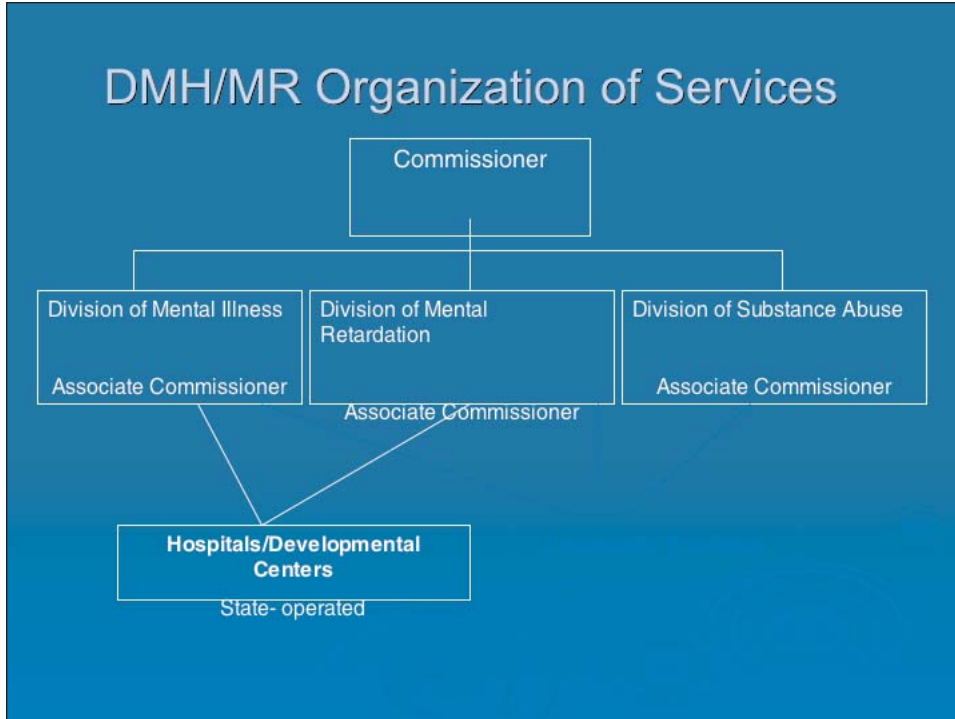
*Directory, Office of Children's Services*

*State of Alabama Department of Mental Health and Mental Retardation*

*Mental Health systems  
don't provide services that  
families need; they provide  
services that they get  
paid for.*

Quote: Parent Advocate/ Georgetown Training Institute,  
San Francisco CA.

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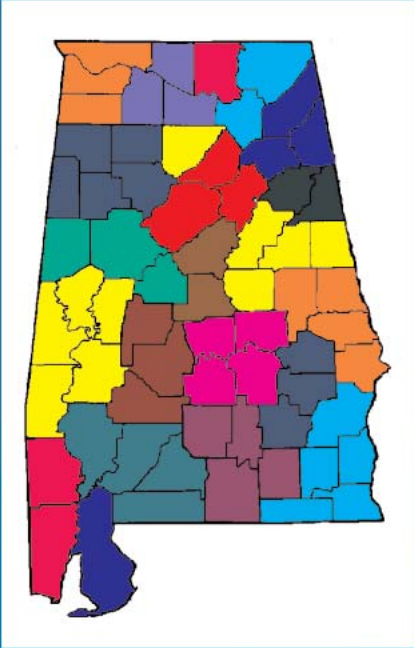


## 310 Boards

Public Corporations established to contract with DMH/MR and provide Planning, Studies, and Services for a given area.

<p><b>Comprehensive 310 Board</b></p> <ul style="list-style-type: none"> <li>➤ Planning, Studying and Services for Mental Illness, Mental Retardation and Substance Abuse.</li> <li>➤ May Contract one of these areas out.</li> </ul>	<p><b>Specialty 310 Boards</b></p> <ul style="list-style-type: none"> <li>➤ Provides Planning, Studying, and Services for <u>one or more</u> service areas</li> </ul>
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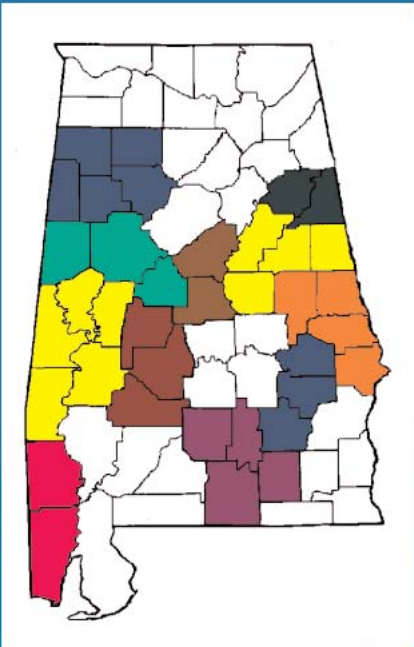
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### Catchment Areas

Children/Adolescent  
Mental Health Services

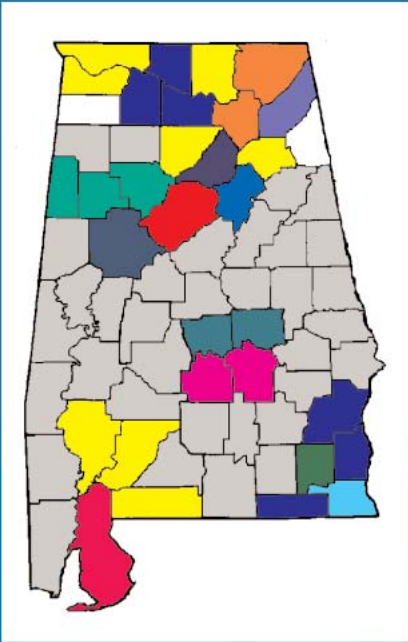
- Geographical areas based on population
- Responsible for serving persons in that area with a few exceptions



### Comprehensive 310 Boards

There are 11 Comprehensive 310 Boards responsible for MI/MR/SA Services in their catchment areas.


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MR 310 Boards

There are a total of 22 Specialty MR 310 Boards

This slide features a map of Alabama with 22 counties highlighted in various colors (yellow, orange, blue, green, red, pink, purple, and light blue) to represent Specialty MR 310 Boards. The remaining counties are shown in grey. The map is set against a white background within a blue-bordered frame.



MR Regional Areas

- ★ Region 1
- ★ Region 2 West
- ★ Region 2 West
- ★ Region 3
- ★ Region 4

This slide features a map of Alabama divided into five regional areas, each represented by a different color: yellow (Region 1), green (Region 2 West), red (Region 2 West), pink (Region 3), and dark blue (Region 4). The map is set against a white background within a blue-bordered frame.

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## DMH/MR Division of Services for Children

- MI Division (Seriously Emotionally Disturbed)
  - 2 FTEs for SED Services
- MR Division (Intellectual disabilities)
  - 1FTE (Early Intervention)
  - Children's Issues shared responsibility
- SA Division (Substance abuse/ dependency)
  - No FTE dedicated to Adolescent Treatment Issues
- 2001 Office of Children's Services
  - 1FTE
  - Cross divisional responsibility/ emphasis on Co-Occurring (SED/SA and SED/MR)

## Barriers to Access

- Fragmentation of services/ responsibility/ separate provider systems
- Historical funding challenges created service cultures of minimal responsibility
- Availability of services/ specialized services in rural settings
- Stigma/ sometimes providers don't see past the ID symptoms for other needs
- Work force Issues
  - Shortage of service workers/ capacity
  - Training needs
  - Service Culture shifts

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## Barriers to Access Cont.

- Cross-certification of programs  
(Is it MR or MI? -sometimes tied to funding sources)
- Appropriateness of Services
  - Services delivery orientation creates different expectations
  - Cognitive capacity to participate in certain programs (IOP, In-home, residential)
  - Services Structure (O.P. 1 or 2x per month may not be intense enough) More info needed on Best Practices/ especially with this target group
  - Medication issues can be complicated
  - Lack of community resources/Residential services may not be specialized/leads to unsuccessful completion of programs/ longer LOS

## Barriers to Eligibility

- State funds / most MR state funds support waiver services/ waivers not easily accessible
- Eligibility determined by what the professional determines as “primary issue”
- Collaboration between multiple systems not always reimbursed (case management)
- MR service system adult focused/ Waiting List

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## Barriers to Eligibility cont.

- Some Mental Health services have been historically unavailable to youth with ID, especially intensive in-home and residential type services.
- Barriers to eligible services in school or community can lead in involvement with juvenile justice system

## 2000 Children's Task Force: Recommendations to Alabama DMH/MR

- 37 stakeholders (child-serving agencies, parents & advocates) recommended:
  - Priority given to children with multiple disabilities & other specialized treatment needs "Gap Kids"
  - Tobacco Settlement/Children First funding will not supplant current funding
  - Entry into the DMH/MR service system should be a single point of contact



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## Task Force further recommended:

- Pursue greater collaboration with other agencies to meet the needs children
- Priority given to community-based services
- Consolidate MH/MR children's services into a single organizational unit reporting directly to the Commissioner.

## Promising Initiatives in Alabama for Children with ID and SED or SA needs

- Multiple Needs Child Legislation 1993
  - 4 mandated agencies (Mental Health/ Child Welfare/ Juvenile justice and Education)
  - Eligibility (need services of two or more agencies and at risk for out-of-home placement)
  - *Braided funding*
- Children's Task Force of 2000 Enhancement and development of services for "Gap Kids"
  - Establishment of Children's Office/ Director with responsibilities for this population
  - In-home teams
  - Crisis evaluation/ respite

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## Promising Initiatives cont.

- OUR Kids Initiative
  - Collaboration with Mental Health/ Child Welfare/ and Juvenile Justice to jointly fund community services for youth whose needs cross agency jurisdiction
  - Each service can serve children with ID and SED.
  - *Pooled Funding*
- Mental Health Juvenile Court Liaisons
  - 22 community mental health clinicians/ youth involved with juvenile justice and have MH/ SA/ or MR needs
- Co-Occurring (MH/SA and Juvenile Justice) Pilot Project for screening/assessment of youth and referral to evidence-based interventions
  - *Pooled funding*

## Recommendations

- Follow the momentum generated by Co-Occurring (MH/SA) initiatives when creating new service paradigms and integrated models of care (State & Federal)
  - What is the primary diagnosis/issue, may not be the best question for children.*
- Federal grant initiatives to highlight or target this population to build capacity as well as provide services/ systems need new competencies
- Advocate for federal incentives to have professionals enter front-line child serving mental health fields (i.e. student loan relief)

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## Recommendations Cont.

- Identify and remove federal barriers to braiding and blending of funds within and between agencies.
- Increase training opportunities for multi-level issues (financing – best practices) that encompass this issue
- Increase Federal-State partnerships with Education and MH to work more collaboratively on school-based services
- Federal Medicaid cuts will have devastating effects on efforts to transform systems at the state level
- Identify Best practices for this population and encourage reporting of data on Evidence-Based Practices that have significant differences with this population

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**KENNETH RITCHEY, M.ED., M.A.**

*Director, Ohio Department of Mental Retardation  
and Developmental Disabilities*



**Comprehensive and Coordinated  
Systems of Care:  
Eligibility and Access Barriers**

**Kenneth Ritchey, Director  
Ohio Department of Mental  
Retardation and Developmental  
Disabilities**

KENNETH RITCHEY, M.ED., MA.


## Ohio's Current System

- **Department level agencies**
- **88 CBMRDD**
- **51 Mental health boards**
- **Local authority**
- **Local taxes**

## The "State" of Ohio


- **Services were fragmented**
- **Systems did not talk to each other**
- **Each system "blamed" the other**
- **"Primary diagnosis"**
- **Virtually no shared funding**

KENNETH RITCHEY, M.ED., MA.



## Ohio's Efforts to Coordinate Care

- **Directors Ritchey and Hogan(ODMH) establish MI/MR Advisory Board to:**
- **Identify Best Practices**
- **Recommend ways to overcome barriers between systems**
- **Train staff in both systems.**



## More Efforts

- **Interagency Agreement between ODMRDD and ODMH**
- **Ohio's Coordinating Center of Excellence for MR/MI**
- **Professorship in MR/MI at Wright State University funded by ODMRDD, ODMH, Montgomery CBMRDD, and Montgomery County Board of Alcohol, Drug Addiction, and Mental Health Services**
- **ODADAS has become a part of CCOE Advisory Board.**
- **Currently developing an interagency agreement between ODMRDD and ODADAS**

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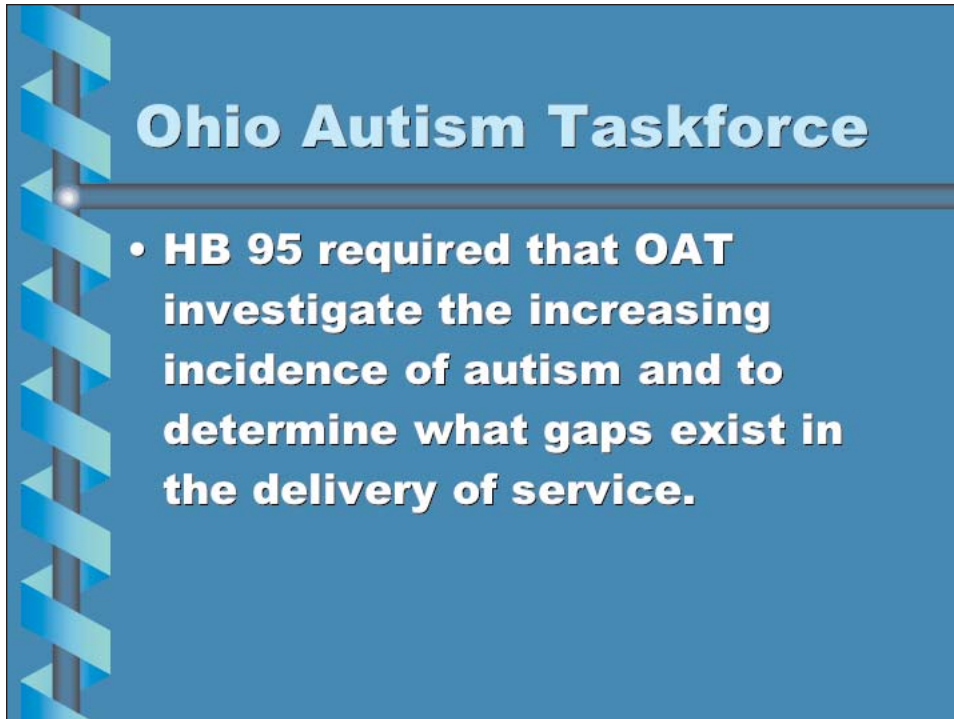
## **Access to Better Care**

- **Leading adolescent health challenge**
- **Leading cause of death among teens via suicide**
- **Major driver of school failure**
- **Major challenge in Ohio's child welfare system**
- **Major challenge in juvenile justice**

## **ABC Recommendations**

- **Focus prevention efforts**
- **Intervene earlier with children and their families**
- **Reduce treatment gaps and empower parents so children with behavioral disorders do not fall through the cracks, and families do not have to trade custody for care.**

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A blue rectangular slide with a decorative vertical border on the left side consisting of a dark blue vertical line and a light blue ribbon-like pattern. The title "Ohio Autism Taskforce" is in white bold font at the top. Below it is a single bullet point in white bold font.

**Ohio Autism Taskforce**

- **HB 95 required that OAT investigate the increasing incidence of autism and to determine what gaps exist in the delivery of service.**

A blue rectangular slide with a decorative vertical border on the left side consisting of a dark blue vertical line and a light blue ribbon-like pattern. The title "Autism Taskforce Recommendations" is in white bold font at the top. Below it are five bullet points in white bold font.

**Autism Taskforce Recommendations**

- **Establish a standard practice of autism diagnosis**
- **Regional disparity of services be eliminated.**
- **Maintain or increase funding for programs**
- **Quality and quantity of family support services increased**
- **Autism waiver should be submitted to CMS**




KENNETH RITCHEY, M.ED., MA.



## Screening and Eligibility

- **Federal Eligibility Determination**
- **COEDI (MRDD System)**
- **DSM IV Diagnosis**



## Barriers

- **Qualified and trained staff in both systems**
- **Housing**
- **Employment**
- **Lack of waivers for mental health services**
- **Lack of waivers for children**

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## **More Barriers**

- **Funding in silos**
- **Parents relinquish custody**
- **Waiver match**
- **Significant barriers exist as a result of the institutional bias of Medicaid.**

## **Recommendations for Federal government**

- **Create incentives to serve children in the community.**
- **Medicaid waivers for services across systems.**
- **National Centers of Excellence**
- **ICF/MR should not be required to be offered but should be last resort.**
- **Funding should be same between ICF/MR and waivers.**

**SHEILA PIRES, M.P.A.**

*Human Service Collaborative  
Washington, DC*

*State-Community Response to Barriers for Children with Co-Occurring  
Developmental Disabilities and Emotional/Substance Abuse Disorders*


Comprehensive and Coordinated Systems of Care:  
Addressing Financing Challenges

Sheila A. Pires  
Human Service Collaborative

April 27, 2005

*Office on Disability  
U.S. Department of Health and Human Services  
Rockville, Maryland*

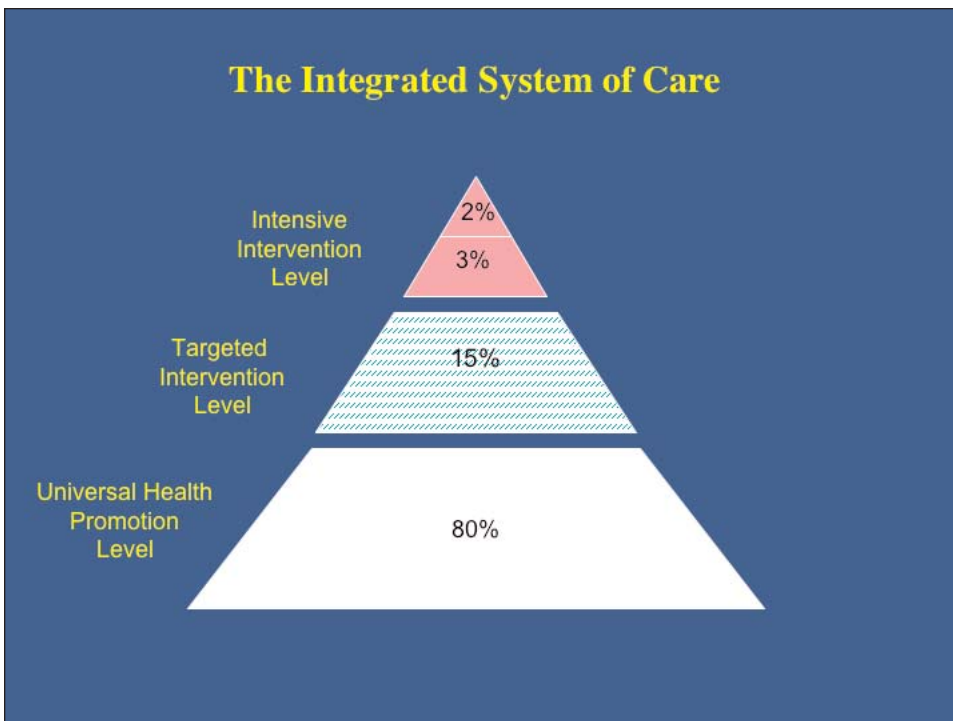
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### The Total Population of Children/Youth and Families Who Depend on Public Systems

- Children/youth and families eligible for Medicaid
- Children/youth and families eligible for the State Children's Health Insurance Program (SCHIP)
- Poor and uninsured children/youth and families who do not qualify for Medicaid or SCHIP
- Families who are not poor or uninsured but who exhaust their private insurance, often because they have a child with a serious disorder
- Families who are not poor or uninsured and who may not yet have exhausted their private insurance but who need a particular type of service not available through their private insurer and only available from the public sector.

Pires, S., 2003. Building systems of care: A primer. Washington, D.C.: Georgetown University



SHEILA PIRES, M.P.A.

**Examples of Sources of Funding for Children/Youth and Families with Special Needs in the Public Sector**

- Medicaid**
  - Medicaid In-Patient
  - Medicaid Outpatient
  - Medicaid Rehabilitation Services Option
  - Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)
  - Targeted Case Management
  - Medicaid Waivers
  - Katie Beckett Option
- Substance Abuse**
  - SA General Revenue
  - SA Medicaid Match
  - SA Block Grant
- Mental Health**
  - MH General Revenue
  - MH Medicaid Match
  - MH Block Grant
- Child Welfare**
  - CW General Revenue
  - CW Medicaid Match
  - IV-E (Foster Care and Adoption Assistance)
  - IV-B (Child Welfare Services)
  - Family Preservation/Family Support
- Juvenile Justice**
  - JJ General Revenue
  - JJ Medicaid Match
  - JJ Federal Grants
- Education**
  - ED General Revenue
  - ED Medicaid Match
  - Student Services
- Other**
  - WAGES
  - Children's Medical Services/Title V—Maternal and Child Health
  - Mental Retardation/Developmental Disabilities
  - Title XXI-State Children's Health Insurance Program (SCHIP)
  - Vocational Rehabilitation
  - Supplemental Security Income (SSI)
  - Local Funds

Pires, S. (1995). *Examples of sources of behavioral health funding for children & families in the public sector*. Washington, DC: Human Services Collaborative.

**Fundamental Challenge to Building System of Care**

No one system controls everything.  
Every system controls something.

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

SHEILA PIRES, M.P.A.

### Examples of Medicaid Promise/Reality

#### EPSDT

- Broadest entitlement
- Cost concerns so states use various ways to control access through EPSDT

#### Home and Community-Based Waivers

- Flexibility, broader coverage, waiver of income limits and comparability
- Alternative to hospital-level of care but RTC may be the issue
- Cost and management concerns so limited to certain number

#### Targeted Case Management

- Can be targeted to high need populations (e.g., co-occurring)
- Not sufficient without other services
- Administrative rulings from CMS?

### Some Medicaid Challenges Relevant to Children with Co-Occurring Disorders and Their Families

- Service definitions, esp. for home and community-based
- 15-minute billing increments vs. case rates, esp. for evidence-based services
- Billing for interagency coordination
- Billing for team meetings
- Billing for services to family (as opposed to identified child)
- Billing for non traditional services and supports
- Administrative rulings (e.g., coverage of non-psychiatric medical services in psychiatric hospitals under Psych Under 21 Option)
- States/localities must generate match and manage costs
- Not every child is eligible for Medicaid

SHEILA PIRES, M.P.A.

**Lots of Medicaid “Urban Legends” But  
If Something Exists Somewhere, It’s Possible Elsewhere**

Covering Parents as Care Managers: KN, NJ

Covering Respite in Medicaid FFS: NY

Covering Wraparound Team Process: NE

Covering Non Traditional Services  
(i.e. traditional Native healers): AZ


Covering Independent Living Services: SC

**Diversity of CMHS Grant Sites Funding**


SOURCE	SYSTEM	DESCRIPTION
Federal/ State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds, and funds allocated as a result of court decrees
	Child Welfare	Title IV-B (family preservation), Title IV-B (foster care services), Title IV-E (adoption assistance, training, administration), and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to states for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts.
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor’s Office/Cabinet	Special children’s initiatives, often including interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children with Special Needs	Title V federal funds and state resources

## APPENDIX C: POWERPOINT PRESENTATIONS

SHEILA PIRES, M.P.A.

 Diversity of CMHS Grant Sites Funding (continued)

SOURCE	SYSTEM	DESCRIPTION
<b>State</b>	Health Department	State funds
	Public Universities	In-kind support, partner in activities
	Department of Children	In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above
	Vocational Rehabilitation	Federal- and state-supported employment funds
	Housing	Various sources
<b>Local</b>	County, City, or Local Township	General fund
	Juvenile Justice	Locally controlled funds
	Education	Courts, probation department, and community corrections
	County	May levy tax for specific purposes (mental health)
	Food Programs	In-kind donations of time and food
	Health	Local health authority-controlled resources
	Public Universities and Community Colleges	
	Substance Abuse	In-kind support


 Diversity of CMHS Grant Sites Funding (continued)

SOURCE	SYSTEM	DESCRIPTION
<b>Private</b>	Third Party Reimbursement	Private insurance and family fees
	Local Businesses	Donations and in-kind support
	Foundations	Robert Wood Johnson, Annie E. Casey, Soros Foundation, and various local foundations
	Charitable	Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, and food programs (in-kind)
	Family Organizations	In-kind Support

Kovanagi, C. & Feres-Merchant, D. (2000). For the long haul: Maintaining systems of care beyond the federal investment. *Systems of care: Promising practices in children's mental health*, 2. American Institutes for Research, Center for Effective Collaboration and Practice, Washington, D.C.




SHEILA PIRES, M.P.A.



## Definition of a System of Care


*A system of care incorporates a broad array of services and supports for a population of children and families that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery, management, and policy levels.*

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

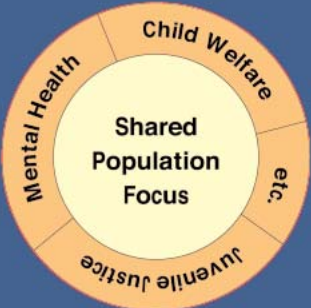


## Categorical vs. Non-Categorical System Reforms

Categorical System Reforms



Non-Categorical Reforms



Pires, S. (2001). *Categorical vs. non-categorical system reforms*. Washington, DC: Human Service Collaborative.

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## Financing Strategies to Support Improved Outcomes for Children & Families

- **FIRST PRINCIPLE:**
  - System Design for Target Population Drives Financing
- **REDEPLOYMENT:**
  - Using the Money We Already Have
  - The Cost of Doing Nothing
  - Shifting Funds from Deep End Treatment to Early Intervention and Home and Community-Based
  - Moving Across Fiscal Years
- **REFINANCING:**
  - Generating New Money by Increasing Federal Claims
  - The Commitment to Reinvest Funds for Families and Children
  - Foster Care and Adoption Assistance (Title IV-E)
  - Medicaid (Title XIX)

Adapted from: Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Center for the Study of Social Policy, Washington, D.C.



## Financing Strategies to Support Improved Outcomes

**RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN:**

- Donations
- Special Taxes and Taxing Districts for Children
- Fees and Third Party Collections Including Child Support
- Trust Funds

**FINANCING STRUCTURES THAT SUPPORT GOALS:**

- Seamless Services: Financial claiming invisible to families
- Funding Pools: Breaking the lock of agency ownership of funds
- Flexible Dollars: Removing the barriers to meeting the unique needs of families
- Incentives: Rewarding good practice

Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Center for the Study of Social Policy, Washington, D.C.

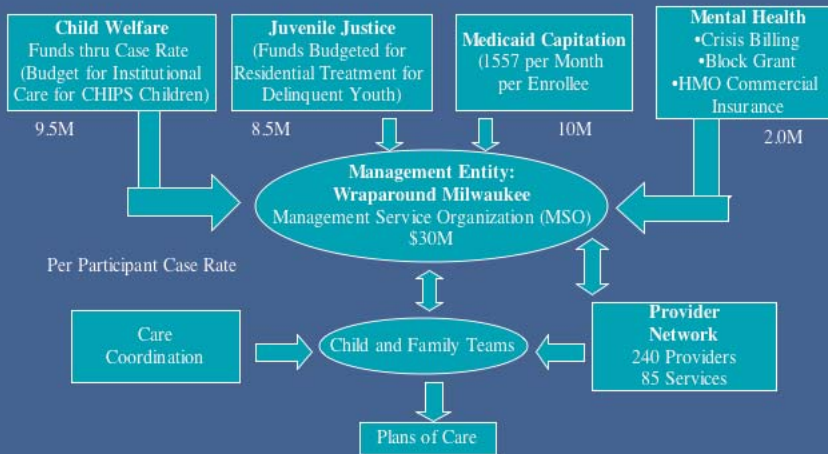
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## New Generation of Managed Care

- Integrates payer, manager and provider ^ of care into an integrated delivery system  
*and family/consumer*
- Focuses on a delivery system that provides (treatment) ^ for a defined population of (patients) ^ in a defined geographic area  
*services and supports*  
*children and families*
- Provides continuity of care over a full continuum of care through the entire (episode of the patient's illness) ^  
*period a child and family needs services*
- Has a results orientation that measures not only the process of care, but the satisfaction of (patients) ^ and the outcome of the ^ (treatment) provided  
*families/ consumers*      *services and supports*

*Adapted from MEDCO Behavioral Health Care Corporation, 1994*

## Wraparound Milwaukee



Wraparound Milwaukee. (2002). What are the pooled funds? Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch

SHEILA PIRES, M.P.A.

## DAWN Project Indianapolis, IN

### How Dawn Project is Funded

\$4,088	+	\$166	=	\$4,254 PMPM
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Child Welfare

Or

Juvenile Justice

Department of Mental Health

Or

Special Education

### Dawn Project Cost Allocation

DAWN Funding – Utilization		
<b>90%</b> Direct Services 550 Vendors	<b>6%</b> Indirect Expenses	<b>4%</b> Administrative

**Management Entity:**  
Non profit behavioral health organization

## More Dawn Features

**Life Domains**

- Health/medical
- Safety/crisis
- Family/relationships
- Educational/vocational
- Psychological/emotional
- Substance abuse
- Social/recreational
- Daily living
- Cultural/spiritual
- Financial/legal

- Service coordination plans, including safety and crisis plan
- Broad array of treatment and supportive services
- Extensive provider network, paid fee for service

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## Dawn Service Array

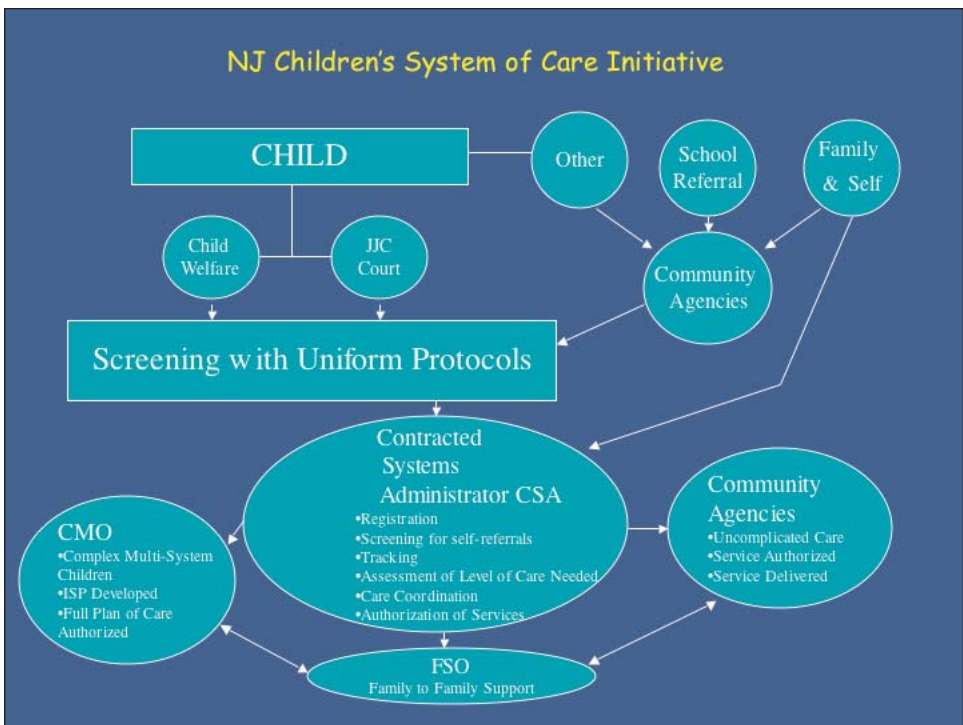
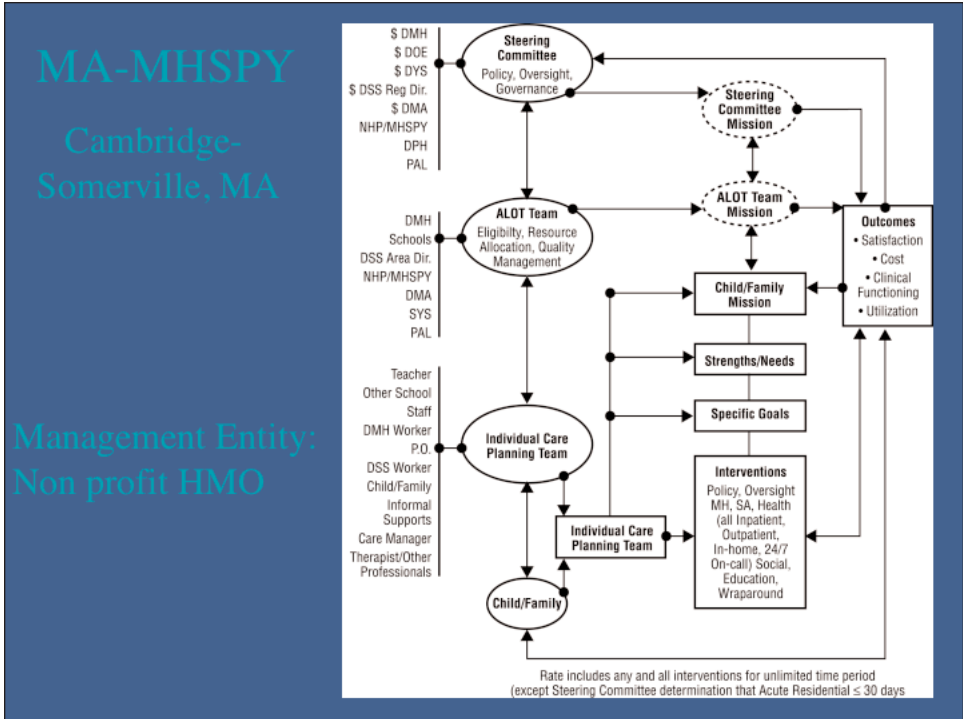
<p><b>Behavioral Health</b></p> <ul style="list-style-type: none"> <li>Behavior management</li> <li>Crisis intervention</li> <li>Day treatment</li> <li>Evaluation</li> <li>Family assessment</li> <li>Family preservation</li> <li>Family therapy</li> <li>Group therapy</li> <li>Individual therapy</li> <li>Parenting/family skills training</li> <li>Substance abuse therapy, individual and group</li> <li>Special therapy</li> </ul>	<p><b>Psychiatric</b></p> <ul style="list-style-type: none"> <li>Assessment</li> <li>Medication follow-up/psychiatric review</li> <li>Nursing services</li> </ul> <p><b>Mentor</b></p> <ul style="list-style-type: none"> <li>Community case management/case aide</li> <li>Clinical mentor</li> <li>Educational mentor</li> <li>Life coach/independent living skills mentor</li> <li>Parent and family mentor</li> <li>Recreational/social mentor</li> <li>Supported work environment</li> <li>Tutor</li> <li>Community supervision</li> </ul>
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## Dawn Service Array, Continued

<p><b>Placement</b></p> <ul style="list-style-type: none"> <li>Acute hospitalization</li> <li>Foster care</li> <li>Therapeutic foster care</li> <li>Group home care</li> <li>Relative placement</li> <li>Residential treatment</li> <li>Shelter care</li> <li>Crisis residential</li> <li>Supported independent living</li> </ul> <p><b>Respite</b></p> <ul style="list-style-type: none"> <li>Crisis respite</li> <li>Planned respite</li> <li>Residential respite</li> </ul>	<p><b>Service Coordination</b></p> <ul style="list-style-type: none"> <li>Case management</li> <li>Service coordination</li> <li>Intensive case management</li> </ul> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>Camp</li> <li>Team meeting</li> <li>Consultation with other professionals</li> <li>Guardian ad litem</li> <li>Transportation</li> <li>Interpretive services</li> </ul>	<p><b>Discretionary</b></p> <ul style="list-style-type: none"> <li>Activities</li> <li>Automobile repair</li> <li>Child care/supervision</li> <li>Clothing</li> <li>Educational expenses</li> <li>Furnishings/appliances</li> <li>Housing (rent, security deposits)</li> <li>Medical</li> <li>Monitoring equipment</li> <li>Paid roommate</li> <li>Supplies/groceries</li> <li>Utilities</li> <li>Incentive money</li> </ul>
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APPENDIX C: POWERPOINT PRESENTATIONS

SHEILA PIRES, M.P.A.



SHEILA PIRES, M.P.A.

### OUTCOMES (Milwaukee Wraparound)

- 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 (MA-MHSPY AND OTHER MA-WRAPAROUND)

- Reduction in use of prescription meds
- Reduction in overall cost
- Improved functioning at home, school, and in the community
- Parents feeling more confident and capable in managing their children's challenging behaviors
- Reduced utilization of out-of-home care

SHEILA PIRES, M.P.A.

### Outcomes (Monroe County Youth and Family Partnership – Rochester, NY)

- Year One cost savings of \$3,189 pmpm - \$38,274 annual
- Year Two cost savings of \$3,813 pmpm - \$45,751 annual
- Year One CAFAS score improvements for 69% of youth
- Year Two CAFAS score improvements for 71% of youth

Levison-Johnson, J. 2004. Using data for continuous quality improvement in an integrated setting. Coordinated Care Services, Inc. Rochester, NY

### Common Elements of Re-Structured Systems

- ✓Identified target population, costs associated with population, funders
- ✓Locus of accountability (and risk) for target population
- ✓Single pathway to services for target population
- ✓Strengths-based and individualized service planning and care monitoring (e.g., wraparound approach)
- ✓Intensive care management

continued ...

Pires, S. 2004. Human Service Collaborative. Washington, D.C.



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### Common Elements of Re-Structured Systems

- ✓ Flexible financing and contracting arrangements (e.g., case rates, qualified provider panel – fee-for-service )
  - ✓ Broad provider network: sufficient types of services and supports (including natural helpers)
  - ✓ Combined funding from multiple funders (e.g., Medicaid, child welfare, mental health, juvenile justice, education)
  - ✓ Real time data across systems to support clinical decision-making, utilization management, quality improvement
  - ✓ Outcomes tracking – child/family level, systems level
- continued...

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

### Common Elements of Re-Structured Systems

- ✓ Values-based systems/Family and youth partnership
- ✓ Utilization management
- ✓ Mobile crisis capacity
- ✓ Judiciary buy-in
- ✓ Re-engineered residential treatment centers
- ✓ Shared governance/liability
- ✓ Training and technical assistance

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

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### Infrastructure-Building Technical Assistance Needs

- How to analyze expenditures and utilization across systems
- How to use risk-based financing approaches to re-direct expenditures from “deep-end” to home and community-based (e.g., how to build case rates, develop risk pools)
- How to collapse budget structures to create flexibility across line items
- Medicaid state plans (e.g., benefit design, service definitions, rate structures)

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

### Infrastructure-Building Technical Assistance Needs

- How to develop purchasing collaboratives to support a coordinated financing approach (NM)
- Purchasing strategies and reimbursement mechanisms; paying for non traditional supports and for family and sibling supports
- How to develop clinical practice guidelines and quality monitoring systems tied to cross-system outcomes (MI, TX, NJ)
- How to develop utilization management systems
- Cost/benefit data

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

SHEILA PIRES, M.P.A.

### Infrastructure-Building Technical Assistance Needs

- Planning (strategic planning, population definition and sizing, capacity issues, stakeholder involvement, etc.)
- Cultural and linguistic competence – supportive state infrastructure
- HRD strategies
- Governance (and liability) structures
- Provider issues (e.g., re-engineering RTCs, natural helping networks, evidence-based capacity, etc.)

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

### Infrastructure-Building Technical Assistance Needs

- Data (MIS) systems
- Social marketing strategies
- Information dissemination strategies (e.g., web-based)
- Public health approaches to youth with co-occurring disorders (e.g., tracking incidence, screening, public education, stigma reduction, prevention, etc.)
- Integrating related reform initiatives
- How to use technical assistance and consultants strategically

Pires, S. 2004. Human Service Collaborative. Washington, D.C.

APPENDIX C: POWERPOINT PRESENTATIONS

SHEILA PIRES, M.P.A.



To Obtain Copies of *Building Systems of Care: A Primer*  
Contact:

Mary Moreland, Publications Manager  
Georgetown University National Technical Assistance  
Center for Children's Mental Health  
202 687-8803  
E-mail: [deaconm@georgetown.edu](mailto:deaconm@georgetown.edu)

For Further Information About Building Systems of Care,  
Contact:

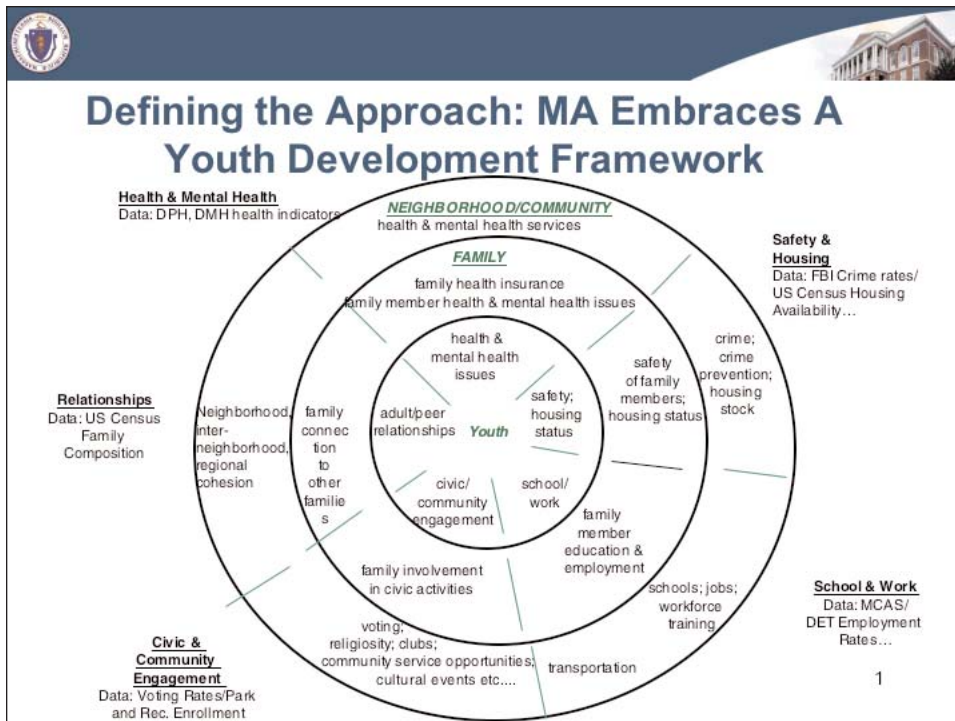
Sheila A. Pires  
Human Service Collaborative  
202 333-1892  
E-mail: [sapires@aol.com](mailto:sapires@aol.com)

**KATHLEEN D. BETTS, M.P.H.**



*Deputy Assistant Secretary*

*Office of Children, Youth and Families*

*Commonwealth of Massachusetts*

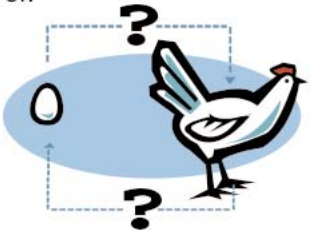


KATHLEEN D. BETTS, M.P.H.



## Defining the Population:

- ❖ A classic problem of:



- ❖ Which Trumps Which DD or SED?
- ❖ Relevant for eligibility and treatment decisions. Particularly important when youth “ages out” of child system into adult services.

2



 

## Defining Medicaid Covered Services

- ❖ New services developed- no guidance from CMS
- ❖ If one state covers a service using Medicaid dollars, does that mean it is a covered service? Medical Necessity Criteria Rules.
- ❖ Federal Waivers/ cost neutrality factor

3

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## Defining Terms: Rehabilitation versus Habilitation & Early Intervention as a Hybrid

**Habilitation-** The cause of the condition

**Rehabilitation-** treatment to optimum functioning- covered by Medicaid

**Early Intervention-** Rehabilitation services covered by Medicaid



4

## Defining Appropriate Care: Treating Youth with SED and DD is a Specialty

Youth Hospitalized

- ❖ Specialty Units
- ❖ 1:1 Specialing





Differential Diagnosis

- ❖ Limited ability to describe problems


5

KATHLEEN D. BETTS, M.P.H.



 

## Defining Trained Staff: NCQA

- ❖ Utilizing Services across systems-credentialing barriers
- ❖ Training Programs specific to this population
- ❖ Incentives to providers to develop specialty services



6


## Defining Responsibility: When Does The School Day End?

- After school services identified by families as most needed service
- Respite
- Children awaiting a disposition regarding a cost share

7



KATHLEEN D. BETTS, M.P.H.





## Defining Payment Options: Case Rates


- ❖ Flexibility with Case Rate
- ❖ Outcomes Driven
- ❖ Need to itemize services
- ❖ Lack of Direction



8





## Defining The Way We Do Business: Examples of Best Practices



- Care Coordination/Targeted Case Management
  - ❖ Covered but under great federal scrutiny
- Individualized Flexible Plan (and only one!)
  - ❖ Team meetings/ administrative expense
  - ❖ Data systems for sharing the IFP
- Involve Families in Planning
  - ❖ Pay for time/daycare etc.

9


KATHLEEN D. BETTS, M.P.H.

## Defining Expectations: Collaboration

### Planning Review Teams



- ❖ Best efforts at collaboration \_
- ❖ Family Participation in the design \_
- ❖ Attempt to be responsive to families bumping multiple systems utilizing Systems of Care Principles \_
- ❖ Major drawback- no new \$\$\$



### DOE/DMR Partnership

- ❖ Family supports to avoid residential placement


10

## Blended Funding System of Care Model:



- ❖ Youth with Co-Occurring Disorders Enrolled in Systems of Care Pilots

Case Example:



11

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## Defining the Future: Grant/Learning Opportunities

Provide funding for programs to provide wrap around services to children (and their families) with SED and DD

Provide information on best practices for the treatment of this population including regular guidance as the science evolves


Link actions, across HHS agencies, to the New Freedom Commission report. Current actions undermine the principles established in it.

Clarify Medicaid covered services for kids under EPSDT

12

**MARC CHERNA, M.S.W.**

*Director, Allegheny County Department of Human Services  
Pittsburgh, Pennsylvania*




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**State-Community Response to Barriers for  
Children with Co-occurring Developmental  
Disabilities and Emotional/Substance Abuse  
Disorders**

***Comprehensive and Coordinated Systems of  
Care: Addressing Financial Challenges***

**Marc Cherna, Director  
Allegheny County Department of Human Services**



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## Allegany County Statistics

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- 28<sup>th</sup> largest county in the nation
- 1.3 million residents
- 130 municipalities
- 91 neighborhoods in the City of Pittsburgh



## Allegany County Statistics

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**Persons Served Annually** - Approx. 250,000

**Total Staff** – approximately 1,100

**Service Providers** - Approximately 400

- 820 contracts for over 1,800 discrete services


**Total Budget** - \$757.4 million

- (55% federal, 42% state, 3% county)

**Funding Sources** - 80

- each with separate laws, regulations, and reporting requirements

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## Allegheny County Department of Human Services

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### Executive Office


### Program Offices

- Area Agency on Aging
- Office of Behavioral Health
- Office of Children, Youth and Families
- Office of Community Services
- Office of Mental Retardation/ Developmental Disabilities

### Support Offices

- Office of Administration
- Office of Community Relations
- Office of Information Management

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## Department of Human Services Active Caseload

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Children with co-occurring disabilities served in multiple systems

- CYF - MH = 2210
- MH - D&A = 798
- MH - MR/DD = 728
- CYF - EI = 480
- CYF - D&A = 311
- CYF - MH - D&A = 246
- CYF - MR/DD = 117
- CYF - MH - MR/DD = 84
- D&A - MR/DD = 9

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## Department of Human Services Children's System

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- 63% Served by more than one system
- 0 Children placed out of state
- Traditional and non-traditional services
  - Heavy family involvement
- Parents don't have to relinquish their rights
- County Interagency process
- Multi-System Rapid Response
- Children's Cabinet



## Department of Human Services County Interagency Process


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Systems, providers, and consumers and their families are brought together to ensure that the comprehensive needs of the individual are addressed through a full continuum of services and tangible assistance when needed.

Reduces system fragmentation, discontinuity of service and conflict/competition over scarce resources.

County Interagency process is always able to arrive at recommendations with families.

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 **Department of Human Services  
County Interagency Process**

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**During FY '03/04:**

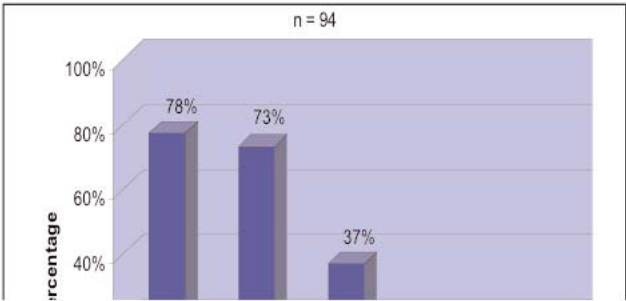
- 109 Interagency meetings were held for 94 individual children/adolescents.
- Of the 109 Interagency meetings, only 10 required referrals to the multi-system team for additional planning.

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 **Department of Human Services  
County Interagency**

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**Multi-system Involvement**



Category	Percentage
1	78%
2	73%
3	37%

85% of those children /adolescents referred for County Interagency Review have multi-system involvement.

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## Multi- System Rapid Response Team

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**Function**

- Identify gaps in service, practice, and policy
- Find *or* create solutions
- Research
- Negotiate
- Respond
- Forecast-tracking & identifying trends
- Plan
- Communicate
- Cross-System Train/Consult
- Make decisions
- Determine best course of action

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## Multi- System Rapid Response Team

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**Statistics**

- 8 Cases reviewed in fiscal year 2001-2002
- 14 Cases reviewed in fiscal year 2002-2003
- 13 Cases reviewed in fiscal year 2003-2004

Although the number of cases referred yearly is generally small, the complexities of their needs are great.

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## Multi- System Rapid Response Team

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All of the children have co-occurring disorders. Some of the more prevalent diagnoses include:

- 76% have MR/DD;
- 53% have an impulse control disorder;
- 53% have a mood disorder;
- 46% have an anxiety disorder;
- 38% have attention deficit disorder; and
- 38% have a pervasive developmental disorder

*(Diagnoses are not mutually exclusive.)*




## Multi- System Rapid Response Team

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All 13 children/adolescents served by the Multi-System Team are multi-system involved.

- 8% of the cases referred are involved in 4 systems
- 62% of the cases referred are involved in 3 systems.
- 31% of the cases referred are involved in 2 systems

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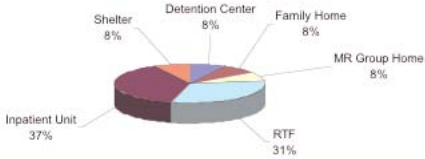


## Multi- System Rapid Response Team

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The greatest number of children at the time of referral were inpatient with no viable discharge options.

### Consumer Placement At Referral FY 03-04

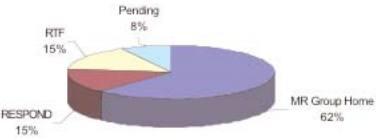


Placement	Percentage
Inpatient Unit	37%
RTF	31%
Shelter	8%
Detention Center	8%
Family Home	8%
MR Group Home	8%


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“Packages” of tailored support services and resources from multiple systems were put together to allow the child to return to a community setting, resulting in the majority (62%) of individuals going to MR group homes.

### Disposition Setting FY 03-04



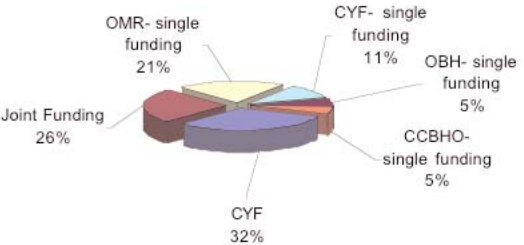
Disposition Setting	Percentage
MR Group Home	62%
RESPOND	15%
RTF	15%
Pending	8%



## Multi- System Rapid Response Team

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### Funding Distribution




Funding Source	Percentage
CYF	32%
Joint Funding	26%
OMR- single funding	21%
CYF- single funding	11%
OBH- single funding	5%
CCBHO- single funding	5%

Funding is determined after the needs are identified. It typically is not on the table for discussion during the planning process.


Shared funding from all three program offices occurs frequently based on eligibility.

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 **Multi- System Rapid Response Team**

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**Sustainability FY 03-04**



Status	Number of consumers
Remain in RRT placement	12
Pending	1
Have been stable for 6+ Months	8
Hospitalizations	1

92% of cases that were referred have secured a viable placement (1 pending)

92% of RRT placements have been sustained. One individual, who had maintained placement for 8 months, experienced a brief hospitalization.

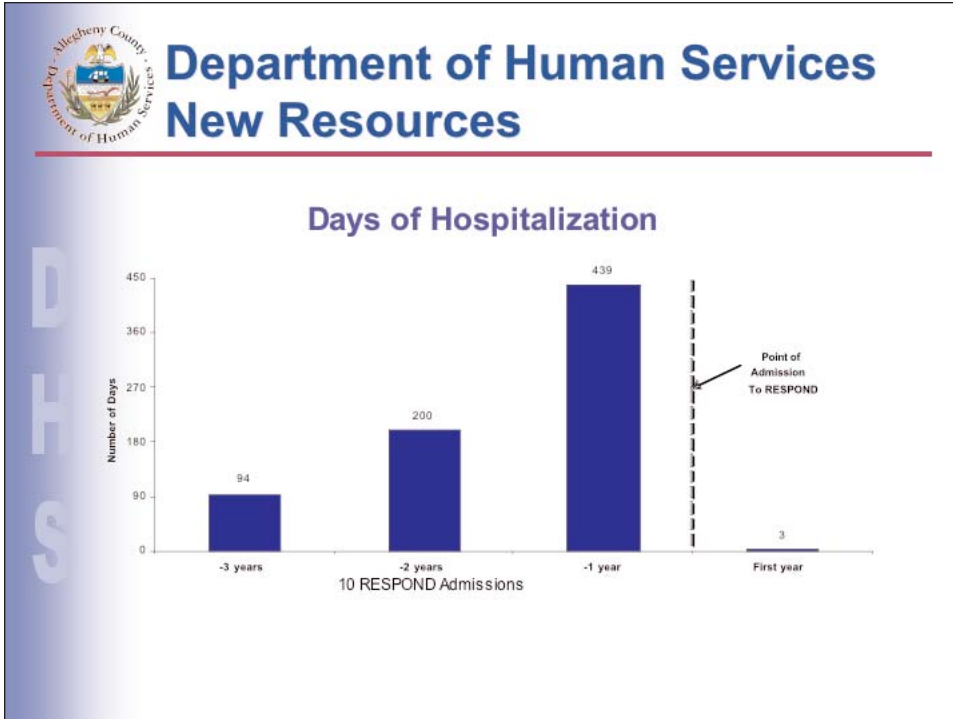
 **Department of Human Services New Resources**

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**RESPOND**

- 10 admissions to the program
- 5 Successful discharges to community settings- with no hospital admissions post-discharge.
- Only one individual of 10 experienced a 24-hour hospitalization as a resident of RESPOND
- 5 Individuals who had failed or plateaued in RTF level of care demonstrated progress/success in this unique level of care
- Medications have been reduced for each individual
- Better coping skills have been obtained as evidenced by the reduction in aggressive behaviors for each resident
- Successful discharge planning for all residents
- Better systems collaboration and communication

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**Department of Human Services  
Integrated Children's Plan**

New requirement of Pennsylvania Department of Public Welfare in 2004

- Brings together key stakeholders in child welfare, drug & alcohol, mental health and mental retardation systems


Focus on launching and expanding cross-systems initiatives that don't fit neatly into existing silos

- Examples: Building common information systems, providing coordinated case management services, serving children with physical disabilities

Process currently includes child welfare budget only

- Possibility of folding in mental health and mental retardation budgets for children in the future

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## Department of Human Services Recommendations

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### Increase Block Grants

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- *Undefining* the money allows funds to be moved where they are needed.
- Gives consumers the ability to “One Stop Shop” for services.
- Reduces red tape associated with eligibility requirements.
- Enables holistic service delivery – truly “wrapping” services around the individual.
- Enables provision of services to at-risk youth without requiring a diagnostic label.



## Department of Human Services Recommendations

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Eliminate insurance companies cost shift to government.


- MH and D&A parity
- Reimbursement for autism services
- Reduction of reliance on medical necessity criteria

Medicaid behavioral health care carve out.

MR Medicaid waivers

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## Department of Human Services Recommendations

Federal government needs to reduce demonstration grants.

- Costs applicants a lot of time and money – very few grants
  - Match is a problem
- Expand on what works
- Ongoing funding

Coordination amongst government entities.  
Reduce unfunded mandates.

- HIPAA requirements huge cost to state and local government

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## Department of Human Services Recommendations

Consistent priorities between government entities.

- CSFR process
  - Program improvement plans

Consistent rules and regulations between government entities.

Consistent confidentiality regulations.


Focus on outcomes.

Focus on consumer satisfaction.

Resist pressures of special interests.

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## Department of Human Services Perspective on Funding

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**D** Demand for human services in Allegheny County (just like in the rest of the country) continues to outweigh the supply.

**H** As a result, any new funding that enters the system tends to be used to satisfy urgent needs and not system reform.

**S** Dollars for prevention activities, the best way to save high costs down the line, are especially hard to come by.