

Metropolitan Hospital Center

A. Background and Introduction

This case study was conducted in a large, inner-city public hospital and describes the organization and management of strategies to: 1) identify mental health/behavioral health needs of children within a general pediatric clinic; 2) refer children with potential mental/behavioral health needs to an appropriate level of care; and 3) integrate mental/behavioral health and physical health services for children with special physical, mental, and behavioral health needs.

The identification, appropriate and timely referral, effective management, and integration of mental/behavioral and physical health services is often a major health service delivery issue for all children and most particularly for children with special health care needs (SHCN). The purpose of the case studies is to describe identification and integration strategies currently implemented in several regions across the country and to identify lessons learned from the experiences of these systems. These experiences and lessons may then provide guidance to other organizational entities as they strive to improve the integrated delivery of physical and mental/behavioral health and physical health services to typical children as well as to those with special needs.

This case study describes efforts within a metropolitan public hospital to promote the integration of behavioral/developmental/mental health services for children with chronic health problems or disabilities. It describes not so much a specific program, but rather a philosophical and organizational approach to the creation and implementation of a variety of strategies to promote the provision of appropriate, timely, continuous and integrated services to SHCN and their families.

1. Structure and Approach to Site Visit

The information presented in this case study was drawn from interviews conducted by researchers from Health Systems Research, Inc. as a component of the National Policy Center for Children with Special Health Care Needs. Specifically, the researchers interviewed a range of key informants including state and local officials, providers, program administrators, and parents through both telephone and in-person meetings, as follows:

- # In November and December 2000, researchers conducted structured telephone interviews with program administrators of the integrated services for children with special health care needs effort at Metropolitan Hospital Center regarding their development, implementation, and operational experiences, as well as to determine how mental and physical health services are integrated for children. These interviews also permitted researchers to discuss and identify other key informants to be interviewed during a follow-up site visit that explored more deeply the structure and operations of the project at Metropolitan Hospital Center.
- # In January 2001, researchers conducted numerous in-person and telephone interviews with individuals and small groups representing the CSHCN integration effort, including the Developmental Clinic at Metropolitan Hospital Center, the Department of Pediatrics, and the Department of Child and Adolescent Psychiatry as well as parents of children with special health care needs in the clinic. In addition, key state officials were also interviewed to obtain a sense of the state's efforts in the area of CSHCN integration of services. (A list of key informants can be found in Appendix A.) Each of the interviews was guided by one of several structured protocols targeted to the particular orientation of the interviewee.

2. Organization of Case Study

The remainder of this report is divided into three sections. The next section discusses in detail the structure and operation of CSHCN services integration efforts at Metropolitan Hospital Center, including a description of providers, identification of service needs, financing, family involvement, and evaluation and monitoring. Section C describes the New York State perspective on services integration and Section D provides a review of the factors seen by key informants as promoting or impeding the integration of services, along with a summary of

lessons learned from the site visit regarding the integration of mental and physical health services for children with special health care needs.

B. The Structure and Operation of CSHCN Services Integration Efforts at Metropolitan Hospital Center

1. Background and Historical Context

A variety of staff within the hospital are responsible for efforts to integrate mental/behavioral health and physical health services with support for targeted developmental/behavioral health consultation and care coordination provided through a federal maternal and child health grant. The targeted mental/behavioral, developmental consultation and care coordination activities are housed within a Child Development Clinic which is conducted in tandem with the Specialty Clinic for CSHCN. Both of these clinics are housed within the general pediatric unit of Metropolitan Hospital Center (MHC). The physicians conducting the CSHCN Clinic each care for a panel of children with special needs in the clinic sessions. The clinic is not organized by condition or disease; the term “specialty” is used to differentiate this clinic from the general pediatric clinic.

MHC is a full-service acute and ambulatory care facility located in Northern Manhattan and is a component of the New York City Health and Hospitals Corporation (HHC) public hospital system that includes 20 acute care hospitals and ambulatory care facilities with locations in each of the five Boroughs (counties) of New York City.

HHC is a very large health care delivery system with total annual revenues of approximately four billion dollars and provides primary care visits in excess of five million per year. HHC is administered by a Board of Directors and is financially supported with city and state funds, patient revenues, and public and private grant funds.

Metropolitan Hospital has been affiliated with New York Medical College since 1875 and all attending physicians are on the faculty of the Medical College. The hospital serves a multi-

cultural population that includes those whose primary language may be Arabic, Creole, French, Patois, or Spanish as well as English. New Yorkers using the services at Metropolitan come from all of the city's five Boroughs, although the majority of patients come from the East Harlem area of Manhattan, the South Bronx, and western Queens. The hospital serves an inner-city population with low to moderate incomes and who are racially/ethnically diverse and mobile. Included in the population are large numbers of immigrants, many of whom are undocumented and have low literacy levels, not only in English, but also in their native languages.

To better understand the environment that eventually gave rise to the establishment of the Specialty Clinic, the Developmental Clinic and the focus on integrated services, a brief overview of health care delivery trends within the New York City HHC system may be helpful. Metropolitan Hospital Center, along with other hospitals in the HHC system, has, over time, been shifting to an emphasis on the provision of ambulatory rather than inpatient services and to a focus on comprehensive primary versus acute care. Another trend has been an increased awareness of community involvement and the importance of linking hospital-based services with community-based agencies.

In 1978, as part of the hospital's efforts to establish a health maintenance organization, the MHC Department of Pediatrics initiated a primary care practice and training program using a "continuity of care" model. The pediatric residency program was based on this model, with the residents following children with a range of health issues and pediatric care needs, including psychiatric services. Although the model was implemented for several years, due to HHC budget constraints and a reduction in federal training grant resources, staffing and services were ultimately reduced, making it difficult to sustain the "continuity of care" approach.

However, this experience contributed to an environmental and practice climate in which the importance of comprehensive, continuous, integrated, community-linked care was recognized and valued by a critical mass of practitioners. Several of the pediatric and mental health providers who participated in the "continuity of care" project are currently involved with activities designed to integrate the delivery of comprehensive, continuous services through the

MHC's current general pediatric clinic, the CSHCN specialty clinic, the Development Clinic and through targeted consultation and care coordination.

2. Organizational Structure of Delivery System and Services

The relationship between the various pediatric clinics serving children at MHC is complex due to the permeability of clinic boundaries and the variety of opportunities available to access the clinics from both within and outside of the hospital. Three of the most common scenarios to access and receive care are summarized in Figure I:

Figure 1. Common Referral Patterns
Hospital General Pediatric Clinic ◦ CSHCN Specialty Clinic ◦ Developmental Clinic
Community Referral ◦ CSHCN Specialty Clinic ◦ Developmental Clinic
Neonatal Intensive Care Unit ◦ CSHCN Specialty Clinic or Developmental Clinic

The following is a brief description of each of the three pediatric clinics involved in services integration for CSHCN and the organizational relationships between them.

- # **General Pediatric Clinic.** The children utilizing the MHC general pediatric clinic present with a full range of primary care medical, social, emotional, cognitive, and developmental issues. Typical well-child care, including immunizations, screenings and anticipatory guidance, is provided within the pediatric clinic; however, the delivery of care is often complicated by other issues, as the parents of these children are frequently immigrants new to the United States and unfamiliar with the complexities of living and raising children in New York City.

A questionnaire to identify potential behavioral/developmental problem areas (developed by the Developmental Clinic Director) is completed by the parents during intake and registration in the general pediatric clinic. This form, in Spanish and English, lists a set of 15 behaviors (e.g., fidgety, unable to sit still, worries a lot, doesn't like school) and then asks the parents to report whether their child never, sometimes, or always displays each behavior. The questionnaire is currently being used in the general pediatric clinic by many of

the pediatric physicians to assist in their assessment of actual or potential behavioral/developmental needs of the child and/or family.

- # **CSHCN Specialty Clinic.** Addressing the special behavioral/developmental issues of children along with chronic health conditions and disabilities within the context of a general pediatric clinic is not feasible for a number of reasons, including the lack of physician time in relation to hospital productivity expectations and providers' lack of confidence in their ability to provide appropriate care for CSHCN. Therefore, if a child has complex physical or behavioral/developmental needs, the primary care physician (PCP) in the general pediatric clinic will often refer the child to the CSHCN Specialty Clinic.

The three pediatricians who conduct the special needs clinic have a professional interest and advanced training (primarily through in-service opportunities) in working with CSHCN. In addition, they are able to devote more time during the clinic visit to explore and discuss with the family the child's behavior and development as well as his or her physical condition. Parents and children are asked about the child's school experiences, relationships at home and with friends, and how they perceive themselves, along with questions about the child's physical condition and needs.

There are no specific condition categories for referral to the Specialty Clinic; any child with behavioral/developmental needs that requires further assessment, multi-disciplinary care and coordination of services can be referred to the clinic by their PCP. Once a child is referred to the Specialty Clinic, the pediatrician in this clinic can become the PCP, or the general pediatrician can continue to be the PCP while the child receives care from either the Specialty Clinic or the Developmental Clinic for specialized services.

Other categories of children, such as premature infants, are referred directly to the Specialty Clinic from the Neonatal Intensive Care Unit. Children being cared for by private practitioners or in one of the local community health centers may also be referred to the CSHCN Specialty Clinic either for ongoing care or consultation.

- # **The Developmental Clinic.** The Developmental Clinic was initiated by a developmental pediatrician, on staff at MCH for over 12 years, who saw the need to provide integrated physical, developmental, and behavioral services within the context of a general pediatric unit. The Developmental Clinic was organized with the collaboration of both pediatric and mental health staff within the hospital, with the core team comprised of a developmental pediatrician, a pediatric psychologist, a care coordinator and a registered nurse.

Children may be referred to the Developmental Clinic from the CSHCN Specialty Clinic within the hospital or by other health care providers in the community. Children are referred to this clinic for more targeted, intensive

behavioral, developmental, mental health assessment, consultation or care that cannot be provided through the general pediatric clinic, the CSHCN Clinic, or the community-based provider.

When a child is referred to the Developmental Clinic, the developmental pediatrician performs a developmental/behavioral screening by first talking with the parent to determine issues and concerns. The physician then interviews the child and performs a qualitative assessment of the child's developmental age and abilities using appropriate tools such as the Denver Development Test, Gessell Schedules, Pre-School Language Scale, and CAT-CLAMS. As needed, the mental health staff, who devote half of their time to the CSHCN Specialty Clinic and Developmental Clinic, also arrange to meet with the child and the parent(s) for further mental health/behavioral assessment.

A child may receive ongoing care through the Developmental Clinic, or he or she may receive only consultation services and return to the CSHCN Specialty Clinic or the community provider for ongoing care. If it is determined that the mental health needs of the child are beyond the scope of the Developmental Clinic, the child will be referred to the mental health unit for further assessment and treatment planning.

In addition to these clinical services, a range of other support and referral services are available to families, as described below.

- # **Integrated Services for CSHCN - Care Coordinator.** While the integration of physical, behavioral, and developmental health is the overarching goal and driving philosophy of the relationships behind all the pediatric clinics at MHC, much of the success of these relationships is due to the presence of a CSHCN Integrated Services care coordinator housed within the Developmental Clinic. The care coordinator position is solely supported by a federal Maternal Child Health Bureau *Special Projects of Regional and National Significance* (SPRANS) grant obtained by the director of the Developmental Clinic. This is a four-year grant ending in 2002. The care coordinator participates in the development of a care plan and the identification, mobilization, and coordination of resources, both inside and outside the hospital setting, on behalf of the child and the child's family. Services of the care coordinator are available to all families using the Developmental Clinic and, as time allows, to families using the CSHCN Specialty Clinic.
- # **On-Site Mental Health Services.** Available on the pediatric service to staff and families using the Developmental Clinic and the CSHCN Special Clinics are the half-time services of a child psychologist and a child psychiatrist. If it is determined that the child can be appropriately cared for through the Developmental Clinic by the care coordinator, the developmental pediatrician,

and the on-site pediatric psychologist or psychiatrist, a care plan will be developed by the team. Often, co-treatment is conducted by the Developmental Clinic and the mental health staff when the child has significant mental health as well as developmental needs. If it is not appropriate for the child to receive mental health services through this arrangement, the child will be referred to the hospital's mental health clinic for further assessment and follow-up.

- # **Family Support Services.** Services provided through the Developmental Clinic are designed not only to strengthen the child's behavioral and developmental health and well-being but also to support family members so that they, in turn, can provide more nurturing parenting to all their children, including the child with special physical and behavioral needs. These services range from assistance with obtaining employment to a referral to English language classes at a library in the family's neighborhood to enrollment in Head Start.

It is interesting to note that all those interviewed who provide direct care to CSHCN expressed the willingness to do "whatever it takes" to support the physical, behavioral and developmental needs of the child and the family through the active mobilization of services within the hospital and the larger community.

There are no rigid protocols between the general pediatric unit, the special needs unit and the Developmental Clinic for obtaining consultation and treatment services for mental health, behavioral, or developmental issues. However, there are general guidelines that focus on the needs and circumstances of the child and the family. While these are informal, they seem to be well understood and appropriately used by those providing care. Currently, approximately 300 children have received integrated services through the Developmental Clinic and its relationships with the CSHCN Specialty Clinic. The configuration of services and the site of service delivery are determined by the pediatric and mental health providers on the basis of what is best for the child and the family, within the limits of financing and billing requirements. While this system seems to be working extremely well, it depends upon relationships among the staff and their acceptance of a shared agenda.

3. Relationships with Other Programs and Agencies

Important to the ability of the program to provide needed services is the development and maintenance of relationships with other service units within the hospital and the surrounding community. With the implementation of regionalized services, the relationship with agencies and facilities more geographically distant from MHC have also become important.

a. Relationships within MHC

- # **Pediatric and Mental Health Provider Relationships.** Clearly, an important relationship within the hospital setting is that between the pediatric and the mental health units. The Chief of Child and Adolescent Psychiatry stresses the importance of collaboration with the Pediatric Department as a primary way to avoid duplication of effort and a rigid division of responsibilities. She indicated that the intensity of the mental health pediatric relationship was largely determined by the pediatrician, as some are more interested than others in strengthening the relationship between the two services. Important to the mental health pediatric relationship is the emphasis on the mutuality of the two treatments, with neither service feeling a sense of ownership of the child's care. The Chief of Service stressed that, for the relationship to be effective at any level, it is important that each service have a solid understanding of the other.

According to the Chief of Pediatrics, all primary care pediatric physicians have been sensitized to some degree to the importance of identifying behavioral health and developmental needs as well as physical health needs, and subsequently will refer appropriately. This has occurred through informal contact with developmental pediatricians and grand rounds. General practice pediatricians frequently refer children with mental retardation and autistic behaviors to the Developmental Clinic rather than to the mental health clinic. The pediatricians believe that clinicians on the mental health service are often reluctant to accept these referrals as they either do not believe the children with these diagnoses can be helped with mental health interventions, or they feel they are more appropriately served elsewhere, such as at a facility dealing exclusively with mental retardation issues.

Several of the key informants felt that, too often, mental health practitioners do not have a good understanding of children with special physical health needs and many pediatricians do not have a good understanding of the practice parameters of the mental health professionals. Inappropriate referral to the mental health unit can be a distressing and time-consuming process for the child and the family. While children with special needs are not discriminated against in the mental health unit, they must have a mental health diagnosis to be seen. The Chief of Child Psychiatry pointed out that CSHCN may have behavioral,

developmental, or mental health issues resulting from their chronic health problem or disability that are not necessarily treatable through psychiatric interventions or are embedded in social or environmental problems. She is reluctant to add a mental illness label to a child and family already dealing with difficult circumstances and added that a family may not follow through with treatment due to the stigma of a mental health diagnosis.

- # **Organizational and Financing Relationships.** While the mental health unit is attached to the main hospital that houses pediatric services, it is at some physical distance from the pediatric unit and is accessed from different points at the street level. The mental health unit is also organizationally separate from other hospital units, including pediatrics, and maintains a charting system distinct from other departments. The pediatric staff may not record in the mental health chart and, while they may access mental health charts of patients under their care, the chart must be ordered individually from the medical records department. However, the child psychologist or psychiatrist who is on-site half time at the CSHCN Specialty or Developmental Clinics may enter mental health notes into the pediatric chart on the pediatric unit.

The relationship between the pediatric and mental health units is also affected by managed care contracting arrangements. The mental health unit contracts as a department with managed care plans, which may not be the same plans that hold contracts with the Pediatric Department. Therefore, a child followed in the general pediatric, Specialty Clinic or Developmental Clinic may be enrolled in a managed care plan that does not include the hospital's mental health unit in its provider network, making referral for specialty care problematic.

b. **Community Relationships**

- # **School System.** The New York City school system is another important component in the integration of services for children with physical and behavioral/developmental needs. Difficulties in school often signal the need for more or different help than a child is currently receiving. The pediatricians in the Specialty Clinic often initiate their assessment of potential problems with questions about school. To involve the school when a child has presented with behavioral/developmental issues, a *School Report Form*, and a *Conner's Questionnaire* are sent to the child's teacher by the pediatric psychologist or the developmental pediatrician. It requests information on the child's basic education skills, visual-motor skills, language skills, and attention, work, and social behaviors.

Following this contact, mental health staff send a follow-up form to the child's school every three months. The level of ongoing contact with the school depends on the school staff, which could be the school nurse, the school psychologist, or teacher. Contact with the school is seen as important to obtain

information about the child for treatment purposes, to share information for integration into the school's management plan for the child, and to assess the efficacy of treatment interventions using school performance and school social relationships as indicators.

- # **Early Intervention.** The Developmental Clinic has also established relationships with the New York City Early Intervention (EI) Program, which uses an array of providers throughout the city to provide services to eligible children. Infants and toddlers from birth through age three who live in New York City and have a diagnosed physical or mental condition with a high probability of resulting in a developmental delay or who are suspected of having a developmental delay or disability are entitled to a developmental evaluation to determine eligibility for additional early intervention services. Delays may be in one or more of the following areas of development: cognitive, physical, communication, social/emotional, and/or adaptive.

A nurse practitioner who works with the pediatric, special needs, and development clinics is the EI contact within the hospital (MHC is not itself a provider of EI services). As it may take several months for a child to be enrolled in EI, the NP provides services designed to teach parents how to stimulate developmentally delayed children until the child is enrolled. Each enrolled child is assigned a community EI service coordinator to arrange for services. Parents are asked to bring their child's IFSP to the Developmental Clinic to aid in the coordination of services by staff. Several of the key informants expressed concern regarding a perceived lack of consistency in the EI program between educational and social, emotional, and mental health services, feeling that the emphasis is on motor services rather than behavioral services.

MHC CSHCN Specialty Clinic and Developmental Clinic staff also have established relationships with numerous other agencies within the community. While these relationships have not been formalized, they are used extensively by the CSHCN care coordinator and the hospital pediatric social worker. These are the primary staff in direct contact with the community agencies, but all the pediatric and mental health staff associated with the pediatric service include referral to community agencies as an integral component of their care planning.

4. Family Involvement

It is clear that the CSHCN Speciality Clinic and Developmental Clinic staff at Metropolitan Hospital work diligently to keep families and their needs at the center of care and decision-making. Key informants frequently spoke of the director's long and impressive record of providing individual care to his patients and their families. The care coordinator and registered

nurse in the Developmental Clinic were also described as invaluable resources to parents. Parents reported that the staff not only involve them in decisions regarding the care of their children, but also assist them by providing information and advocacy to obtain community services and were readily available to answer their questions and provide support. Parents frequently spoke of the comfort it provided them to know they always had someone to call.

Parents also expressed satisfaction with the parenting and support groups for families offered as part of the effort to integrate behavioral and physical health services for CSHCN. The care coordinator plans monthly parent groups based on feedback from parents regarding the challenges they face in caring for their child. These include topics such as discipline, stress reduction, toy selection, and patients rights and advocacy. The staff also refer parents to appropriate outside groups and encourage their involvement in *Family Voices*.

Overall, parents indicated that they were satisfied with the services they received, that they felt that they had a voice in determining their child's services, and that they appreciated the extra time staff took to be sure they were heard and understood. However, staff expressed frustration with attempts to promote leadership among parents as advocates for program improvement. Much of this was attributed to the busy, complicated lives led by parents of CSHCN, while another important factor is what was described by the staff as "cultural submissiveness" on the part of mothers who come from cultures where women are socialized not to be assertive.

5. Financing

The Metropolitan Hospital Center, as a facility of the New York City Health and Hospitals Corporation, does not turn away patients for lack of payment. The MHC accepts both privately and publicly financed health insurance, including Child Health Plus, the state's SCHIP program, and individual service units (e.g., pediatrics and mental health) within the hospital have contractual arrangements with an array of managed care plans. Another component to the financing of service delivery at MHC is the hospital's affiliation agreement with New York Medical College.

The managed care environment in New York City is complex and includes a wide array of managed care plans, some of which serve all the Boroughs, others of which serve some of the Boroughs. While, as public policy, the Medicaid-enrolled population is encouraged to enroll in a managed care plan, enrollment is currently mandated in only selected zip code areas within the city. Joining a health plan is voluntary for Medicaid consumers unless they live in one of the zip codes in NYC in which the program is mandatory. Therefore, many families using the general pediatric, Specialty, or Developmental Clinics may use their Medicaid insurance in a fee-for-service capacity. Consumers enrolled in a managed care plan can also use their Medicaid card to obtain other selected services from any provider who accepts Medicaid. These include pharmacy, dental, mental health, mental retardation and developmental disabilities, and alcohol and substance abuse services.

The majority of managed care program enrollees served in the CSHCN Specialty/Developmental Clinic are members of MetroPlus, which is a health maintenance organization owned and operated by the New York City Health and Hospitals Corporation. The plan uses a network model and is licensed to enroll Medicaid recipients, Child Health Plus enrollees, and HHC employees. Other plans available to participants are Fideles Care and CenterCare Health Plan. The Child Health Plus enrollees must enroll in one of these managed care plans.

Each of the key informants described some aspect of the impact of financing structures on the delivery of coordinated/integrated services. Many issues related to managed care were identified; in fact, one provider stated that she encouraged her patients not to enroll in a managed care plan. The major issues described related to access and reimbursement, as discussed below.

- # **Access.** A significant number of managed care problems identified by the informants related to accessing mental health services. One provider felt that “managed care was destroying the system” and expressed the opinion that managed care organizations have no idea of what it means to care for CSHCN needing mental health services. Specific problems identified included the limit of 15 minutes per mental health visit, reimbursement rates so low that providers could not care for children in the managed care plan, restrictions on access to needed medications, lack of reimbursement for meetings with parents and school personnel, and limits on the number of allowable follow-up visits.

Pediatric primary care providers identified difficulties obtaining approval to refer children to mental health services and locating mental health services once they are approved. The physicians cannot directly contact someone at the health plan and are uncomfortable leaving detailed messages concerning mental health assessments, as they are asked to do. The provision of mental health services usually requires several visits and returning to MHC for those visits may be a hardship for families. Therefore, community-based mental health services are needed, but these services often very difficult to obtain, due to low reimbursements and other restrictions described above. Even when the family is able to return to MHC to obtain mental health services, this may not be possible, as their managed care plan may not contract with the hospital's mental health service.

- # **Reimbursement.** All the pediatric and mental health staff interviewed identified the lack of reimbursement through private or public insurance for the planning and coordinating of care as a significant barrier to integration of services. As a result, formal cross-disciplinary team meetings to discuss the child's and family's needs, assess progress, and plan for care are conducted infrequently; instead, much coordination is conducted informally through discussions in the hall. Since many payers will only reimburse for one visit per patient per day, when formal case conferences are conducted, only one of the providers attending the conference can bill for their time.

Physicians providing care to the general pediatric population, children with special health care needs, and children and families requiring mental health services are members of the New York Medical College faculty, are salaried by the College, and provide clinical services through an affiliation agreement between Metropolitan Hospital and the Medical School. In accordance with the affiliation agreement, physicians are to generate 25 percent of their salaries through practice activities conducted at the hospital. The implementation of the Resource-Based Relative Value Scale (RBRVS) System, which is based on uniform definitions of physician work, is also having an effect on the pediatric units' ability to generate practice revenue. The case mix in pediatrics is less varied than that of other services; therefore, when the total relative value units (RVUs) are converted into payment amounts, these are lower than those of a service with a broader case mix.

The impact of financing and billing was summed up by one provider with long practice and health care policy experience. Following her description of new, creative strategies for improving the integration of physical and mental health service for CSHCN, she said that “we want to do innovative things, but billing gets in the way.”

6. Monitoring and Evaluation

Monitoring and evaluating the impact of a range of service integration activities on child health outcomes are daunting but important tasks. To assess the impact of coordination/integration of services, the CSHCN project staff are comparing the levels of stress perceived by parents of children with special needs with the level of integrated services available to them. The project director has completed a pre-test comparing stress levels in a group of parents of children with HIV/AIDS with those of parents of children with behavioral/developmental needs. The parents of children with HIV/AIDS received a full range of comprehensive and integrated services, while parents of children with behavioral/developmental needs received less comprehensive services provided in a traditional, categorical fashion. (A copy of the tool used is attached in Appendix B.) Preliminary findings indicate that the parents of children with HIV/AIDS report much lower levels of stress than those of parents of children with behavioral/developmental special needs. Next, the director plans to test the stress levels of the parents of children with special behavioral/developmental needs after they have been receiving comprehensive, integrated services through the Developmental Clinic for a period of time.

Each of the key informants was asked to share their assessment of the impact of improved services integration on the children and families using the project. While their responses were based on anecdotal information, their comments are interesting not only for their consistency but also for their potential usefulness as outcomes that could be used to measure the effectiveness of improvements in services integration. Indicators of success identified by staff include: rates of school attendance, number of visits to the emergency room, the number of friends identified by the child, and level of compliance with the care plan. Each of the staff interviewed cited examples of children followed by the Specialty and Developmental Clinic staff who had improved school attendance, fewer ER visits, an increase in school friends, and better compliance with their care plans.

C. The State Perspective on Integrating Physical and Mental Health Services for CSHCN

To obtain an overview of state level perspectives and activities in regard to the integration of physical and mental health services for CSHCN, an interview was conducted with the Pediatric Medical Director and the Children with Special Health Care Needs Coordinator of the New York State Department of Health. The Health Department is the Title V Agency and the states' CHIP program and Office of Medical Assistance are also housed within this Department.

There is significant support in New York State at the Commissioner of Health level for integrated planning and service delivery. An interagency group called "Partners for Children," which also includes private sector partners such as the United Way, has been organized to focus on issues related to the integration of services. As a result of Medicaid expansions and the implementation of Child Health Plus (SCHIP), many of the Title V resources are now targeted to systems development activities at the state and county levels. These activities include working with other state agencies such as the Department of Education and the Office of Mental Health on issues related to CSHCN.

In an effort to strengthen services for all children, including CSHCN, and to promote the integration of physical and mental health care, the Department has developed several programs, often in collaboration with sister agencies. These include the *Filling the Gaps Program* and the *Adolescent Health Care Initiative*. From a policy perspective, there is a focus on the school as a focal point for the identification of both physical and mental health needs and as an entity where services can be brought together to comprehensively meet the needs of children and adolescents. Much interagency work is directed toward coordinating and integrating services through the schools.

Barriers to the integration of physical and mental health services identified by state officials include the philosophical differences that are influenced by the professional discipline of those planning, financing and delivering services, the effects of categorical funding, and the organizational and financial pressures placed on the mental health system by caring for children

with severe emotional disorders. The state staff stressed the importance of helping agencies develop a shared understanding of the full range of issues faced by CSHCN and their families, including mental health issues, and eventually developing creative strategies to address these.

The state staff provided the Metropolitan Hospital CSHCN project staff with guidance and consultation during the start-up phase of the program and are in regular contact with the project. They also continue to participate in other efforts within New York City in collaboration with the State Education Department, the Office of Mental Health, and the New York City Board of Education and Health Department to explore opportunities to further promote the integration of physical and mental health services for all children, including CSHCN.

Clearly, the state's philosophy toward CSHCN is to support improved integration of behavioral and physical health services and to explore a variety of strategies to promote this philosophy.

D. Lessons Learned: Factors Promoting/Impeding Coordination/Collaboration/Integration

Each of the key informants was asked to identify and describe the factors that they believe promote some level of improved integration of physical/mental health services for children with special needs. The staff involved in facilitating and/or providing pediatric and mental health integrated services identified the following factors as important to the promotion of integration:

- # Mental health and pediatric staff must understand each other's issues and speak the language of each other's fields.** Providers spoke of the importance of "having a foot in both worlds." This can be accomplished through joint mental health and pediatric training and can be facilitated through shared training opportunities such as grand rounds. Staff stressed that pediatric training emphasizes the treatment of physical conditions and does not sufficiently recognize behavioral/developmental issues as significant concerns. Likewise, the training of mental health professionals does not usually include an emphasis on the behavioral, developmental, or mental health effects of living with a chronic health condition or disability.

- # **Co-location of pediatric and mental health staff expedites the integration of services.** Each of the key informants stressed the importance of mental health and pediatric staff being physically available to each other for the care of CSHCN. This permits immediate on-site consultation and facilitates the development of an accepting relationship between the pediatric and mental health staff that is essential to the development of trust and respect that leads to a shared understanding of the needs of the child and the family.
- # **Shared record-keeping facilitates shared care.** The presence of a medical record on the pediatric unit used by both pediatric and mental health staff was identified as important to the sharing of information, the development of a complete picture of the child and family, and the maintenance of a common agenda in the provision of care. With a common pediatric chart, each provider has immediate access to information about the care delivered by other providers and consequently has the opportunity to weave that information into a child and family-focused treatment plan.
- # **Care coordination and social support staff must be physically available on the pediatric unit on a regular, consistent basis to arrange and manage follow-up services.** Opportunities for coordination and integration of services can be lost if support staff are not on-site at the time care is provided to bring together and manage provider recommendations, family circumstances and community resources.
- # **Staff flexibility and problem-solving abilities allow for a child and family focus and promote the integration of services needed to sustain that focus.** Respectful give and take between the pediatric and mental health providers focusing on how to make the system work on behalf of the child and family, rather than on who “owns” the case, facilitates the integration of services.

Key informants also identified factors that impede movement toward the integration of physical and mental health services. These factors included:

- # **The mechanisms used to finance pediatric and mental health services can work against access to mental health services and the delivery of integrated services.** For example, a family may be enrolled in a managed care plan that contracts with pediatric and mental health providers who are not co-located and not with providers who are co-located. Staff time needed for case conferencing to develop and monitor treatment plans may not be billable. Aspects of mental health services for the child may either not be included as a benefit or be limited as a benefit by the health insurance plan.
- # **Mental health providers may be reluctant to provide services to children with certain diagnoses.** For example, pediatric staff caring for children with

mental retardation or autistic disorders were not able to refer and work with mental health staff on the mental health issues of children with these diagnoses. Mental health staff may feel that children with these conditions do not have issues that they can address. However, this position leaves the family and the pediatric staff without an important resource.

- # **The structural and organizational separation of the mental health and pediatric units creates disconnects in the provision of services.** For children with significant mental health problems that cannot be managed through the Developmental Clinic, obtaining care in the hospital's mental health unit can be difficult. The mental health unit is not part of the hospital's primary care system and a child referred to this unit must go through the formal intake process despite having been a patient in the pediatric service. The mental health unit also maintains a separate medical record that is retained in the mental health unit and not routinely accessible to the pediatric staff.
- # **Pediatric providers may have unrealistic expectations of mental health staff and mental health staff may not have a useful understanding of issues faced by CSHCN and their families.** Pediatricians may make inappropriate referrals to the mental health unit, creating additional stress for the child and family and mental health providers may have a limited understanding of the effects of having and living with a chronic health condition or disability.

Strategies developed through efforts of the general pediatric clinic, the special needs clinic, and the mental health-pediatric staff of the Developmental Clinic illustrate the variety of opportunities that can be developed to promote the integration of physical and mental health services for CSHCN and their families. Some of the strategies developed involve the coordination of services (e.g., coordination of appointments at the Developmental Clinic and on the Mental Health Unit), others reflect collaboration (e.g., on-site consultation on the pediatric unit by a mental health practitioner), while still others have resulted in the integration of an important aspect of care (e.g., the sharing of the pediatric unit medical record by the pediatric and mental health staff for all services provided on the pediatric unit).

Lessons learned from the experience of this project include:

- # **Integration of services is both a process and a goal that includes coordination and collaboration.** Some aspects of care may be coordinated, others collaborative and others fully integrated. It may not be appropriate or feasible to fully integrate every aspect of physical/mental health services for

CSHCN and their families, while it may be appropriate and feasible to coordinate and collaborate around different aspects of care. This can significantly improve the effectiveness and efficiency of the care provided.

A variety of strategies can be developed and continually improved upon to promote better coordination and integration of services for CSHCN. Waiting for the perfect environment in which the full integration of services is assured can prevent the immediate implementation of selected strategies that can improve the coordination and integration of aspects of care that can make a significant difference in the lives of children and families.

- # **Pediatric and mental health providers must perceive common ground in the intersection of pediatric and mental health practice.** Critical to the implementation of the process is the involvement of a pediatric provider(s) who understands behavioral, developmental, and mental health issues and is sensitive to the language and practice styles of mental health providers, and a mental health provider(s) who understands CSHCN and their families, and is sensitive to the language and practice styles of pediatric providers.
- # **Financing strategies and billing requirements can either promote or impede the process of services integration.** While most will agree that the focus of care is on the needs of the child and the family and that systems should be structured and implemented to address these needs, it is also clear that financing structures often drive service delivery. The effect of financing on the organization, availability, and accessibility of services and the subsequent impact on CSHCN and their families may not be considered when financing resources and arrangements are under discussion. For example, the impact of managed care contracting procedures, composition of provider networks, and gatekeeper practices all affect the integration of services for CSHCN at MHC. Medical assistance rules prohibiting the same day billing of two providers for the same patient act to discourage the planning and case conferencing needed to provide truly integrated services to children with both physical and mental health needs.

E. Conclusions

The work being done at MHC illustrates how the integration of behavioral, developmental, and mental health services and physical health services can be promoted within a general pediatric clinic system. Factors which have fostered these efforts include a history within the facility of an emphasis on integrated, continuous care, providers with experience in the delivery of integrated, comprehensive services, staff with a shared understanding of the pediatric and

mental health “worlds”, determined leadership, and a concern with the whole child and family versus an emphasis on the condition or diagnosis.

This case study illustrates the need to focus on the “integration” of a service integration philosophy and clinical approach within the structure, organization and delivery of *all* services to *all* children.

Appendix A: Key Informants

Metropolitan Hospital Center

Key Informants

V.B. Gupta, MD,MPH, FAAP
Chief of Developmental Pediatrics
Director of Integrated Services for CSHCN Program
Assistant Professor of Clinical Pediatrics - New York Medical College

Sarla Inamdar, MD
Chief of Pediatrics

Nayibe Manjarres
Program Coordinator
Integrated Services for CSHCN

Evelyn Cumps-Bakst
Attending Pediatrician

Vivian Lind, MD
Assistant Professor of Psychiatry - New York Medical College
Director of Child and Adolescent Psychiatric Outpatient Program
Director of Child and Adolescent Day Treatment Program

David Szuster, MD
Child and Adolescent Psychiatrist

Kent Davis, PhD
Associate Professor of Clinical Pediatrics
Senior Child Clinical Psychologist

Joseph George, CSW
Senior Supervisor II

Christopher Kus, MD
Pediatric Medical Director

Parents in Pediatric Clinic Waiting Room
Department of Health
New York State Department of Health

Nancy Kehoe
Program Director, CSHCN

Appendix B: Psychological Assessment

Metropolitan Hospital Center

Pediatrics Department

Checklist for behavior problems in children and adolescents

Instructions: Please select only one answer (**T**) for every question (Never, sometimes or always).

Instrucciones: Por favor seleccione una respuesta solamente para cada pregunta (Nunca, a veces, o siempre).

		Never	Sometimes	Always		Nunca	A veces	Siempre
1.	Fidgety, unable to stay still	G	G	G	Incapaz de quedarse quieto	G	G	G
2.	Fights with other children	G	G	G	Pelea con otros niños	G	G	G
3.	Worries a lot	G	G	G	Se preocupa mucho	G	G	G
4.	Blames others for his mistakes	G	G	G	Culpa a otros de sus errores	G	G	G
5.	Does not get along with teachers	G	G	G	No se lleva bien con los maestros	G	G	G
6.	Does not listen to you or teachers	G	G	G	No escucha a los padres o maestros	G	G	G
7.	Does not follow rules	G	G	G	No sigue las reglas	G	G	G
8.	Teases others	G	G	G	Molesta a otros	G	G	G
9.	Steals	G	G	G	Toma lo que no le pertenece	G	G	G
10.	Is irritable or angry	G	G	G	Es irritable o se enoja fácilmente	G	G	G
11.	Is distracted easily	G	G	G	Se siente triste o infeliz	G	G	G
12.	Feels sad or unhappy	G	G	G	Se distrae fácilmente	G	G	G
13.	School grades dropping	G	G	G	Va mal en la escuela	G	G	G
14.	Does not like school	G	G	G	No le gusta la escuela	G	G	G
15.	Has trouble concentrating	G	G	G	Tiene dificultad en concentrarse	G	G	G

The Center for the Vulnerable Child

A. Background and Introduction

The Center for the Vulnerable Child (CVC) is located within Children's Hospital Oakland, and serves children who are homeless or at risk of homelessness, including foster children. The Center provides case management services to assist families in maintaining housing and basic needs, coordinating medical needs, accessing referrals to health and/or social services, and improving parenting and employability skills. Housed in one of Children's Hospital Oakland's outpatient clinics, the Center also provides any necessary direct mental health services for families. The majority of CVC families are either enrolled in or eligible for Medi-Cal, California's Medicaid program, but CVC does not turn anyone away from their services, regardless of clients' insurance status or ability to pay.

Established in 1986, the impetus for CVC was the extreme need for a comprehensive program of this nature. During the last two decades, Oakland has faced (and continues to face) a severe housing shortage. Homelessness is both a risk factor for and a result of health problems such as impaired mental health, weakened physical health, inadequate nutrition, infectious disease, stress, substance abuse, children's developmental disabilities, and domestic and family violence. Therefore, the CVC represents a hospital-based care coordination model serving a special subset of disadvantaged children with a multitude of psychosocial risk factors. Using this care coordination approach, children who otherwise may not be able to access physical and mental health services are linked to community providers. CVC's framework can provide an effective model for addressing the needs of other children with various risk factors.

To collect information on CVC's services and their efforts to coordinate mental and physical health care, researchers from Health Systems Research, Inc. (HSR) conducted a site visit in February 2001 to interview CVC staff members, medical providers, and community partners. The interviewees included: the CVC Program Director, two CVC case managers, two Children's Hospital Oakland pediatricians, two representatives from Alameda Alliance for Health, two representatives from Oakland Head Start,

and the Executive Director of Oakland Ready to Learn. A telephone interview was later conducted with a representative of the county mental health program for children. Unfortunately, CVC family members could not be contacted due to confidentiality concerns. A list of key informants is included here as Appendix A.

This case study begins with a description of the project, then goes on to describe its efforts to collaborate with other community-based organizations. The identification of service needs and services and providers are discussed next, followed by financing, family involvement, and evaluation and monitoring. Finally, lessons learned from CVC's efforts to integrate physical and mental health services are presented.

B. The Program

Having served underprivileged families in Oakland for over fifteen years, CVC has become very well known in the community. Their mission is to improve the health and social welfare of vulnerable children and families by coordinating medical services and providing housing assistance, developmental testing, parenting education, family counseling, parent and child support groups, and information and treatment referrals for children with developmental and behavioral conditions. In addition to providing services and referrals, the Center conducts health services research and policy analysis on issues affecting the vulnerable populations that it aims to serve.

As part of its mission, the CVC considers a child vulnerable if he or she is at increased risk for health, emotional, developmental or social problems. This classification includes children who experience poverty, family disruption, teenage parenting, foster care placement, alcohol or drug exposure, abuse and neglect, or other psychosocial risk factors. In practice, however, CVC's target population is children who are homeless or at-risk for homelessness, not children with specific health care needs, as the broad definition of vulnerability may imply. Nonetheless, CVC staff report that these children are disproportionately likely to have unmet physical and mental health needs and chronic conditions.

CVC is divided into three functional branches: a clinical division, a research division, and a policy division, as described below.

- # **Clinical Division.** The Clinical Division is responsible for delivering intensive case management services to vulnerable children and their families, as well as referring clients to partner organizations for health and social services. The scope of these services will be described in greater detail below.
- # **Research Division.** The Research Division conducts studies on the health and well-being of high-risk children and families served by the Clinical Division. For example, the division has investigated the effects of alcohol and drug exposure on young children's health and development, as well as the efficacy of various service models on subpopulations of vulnerable children. The Research Division also collaborates with the Policy Division to examine the effects of health policy changes on health services utilization.
- # **Policy Division.** The Policy Division analyzes legislative initiatives and provides recommendations for county, state, and Federal policies. Key policy issues addressed by the division include financing comprehensive health care systems for children, strategies to improve children's access and overcome barriers to health care, and improving service delivery for special populations of vulnerable children.

Our case study focuses primarily on the Clinical Division. CVC's Clinical Division comprises two distinct programs based on the population each serves. Its two major programs are the Case management, Outreach, Referrals and Education (C.O.R.E.) Program and the Foster Care Program. Both programs receive funding for their services through an umbrella Healthy Kids Program under a Federal Health Care for the Homeless (HCH) Grant, and provide specialized primary health care and case management services in Children's Hospital Oakland's ambulatory center. The programs are described briefly below.

- # **C.O.R.E. Program.** The C.O.R.E. Program provides services to families who are homeless or at risk for homelessness. Children are eligible for the program if they are clients of Children's Hospital Oakland Ambulatory Care Services and either do not have a permanent home or are at risk for losing their permanent home.
- # **Foster Care Program.** The Foster Care Program serves children who are in kinship or non-kinship foster care. By definition in California, foster children are at risk for homelessness. Embedded within the Foster Care Program are two even more specialized programs: the SEED and SEED II programs, and the PASSAGE program. The SEED Programs focus on early permanent placement of younger foster children, while the clinical-based PASSAGE program offers direct mental health assessments and services for long-term foster children with emotional or behavioral problems.

Currently, the Center has a total of 17 staff members, including psychologists, social workers, chemical dependency counselors, nurses, social scientists, policy analysts, and epidemiologists. All service staff are master's or doctoral qualified. Ideally, highly-trained staff are believed to save service costs by requiring less instruction and providing higher quality, more streamlined, and more efficient services.

1. Interagency Relationships

CVC is not administered through formal interagency agreements. However, it has established partnerships with other community-based organizations. These community partners include Head Start, Oakland Ready to Learn, California Children's Services, and Alameda Alliance for Health. Collectively, these organizations all help CVC maximize its resources, increase its visibility in the community, and maintain a consistent caseload through ongoing referrals.

- # **Head Start.** Oakland Head Start and CVC have a collaborative partnership whereby both agencies refer children to each other. When CVC refers a child to the program, the application processing time is significantly reduced because CVC case managers alert Head Start, fill out the enrollment forms for families, and know to include the child's complete medical information. Head Start and CVC also have a collaborative project funded by HRSA, The San Francisco Foundation, and the Cleveland Foundation to provide on-site services such as individual case management, needs assessments, and parenting education classes for Head Start families; behavioral modification skills for Head Start children; and trainings for Head Start staff. Also, since Head Start children are required to undergo a developmental/cognitive screening upon entry to the program, CVC and Head Start have developed a behavioral screening tool together. Using this tool, CVC case managers meet with Head Start children, parents, and teachers to conduct a comprehensive behavioral evaluation. CVC case managers also work with foster families in Head Start by providing information about the Foster Care Clinic's medical services and by serving as a point of contact for CVC's specialized foster care services.
- # **Oakland Ready to Learn.** A collaborative of over 200 agencies, this organization seeks to enhance existing, effective community programs to strengthen parenting skills and child development. Similar to Head Start, Oakland Ready to Learn has also contracted with CVC case managers for services such as facilitating parent training workshops. Oakland Ready to Learn is currently working to expand services to CVC clients by leveraging available funds to coordinate mental health services to be provided at Head Start and Oakland Unified School District Child Development Centers.
- # **Alameda Alliance for Health.** As the local community-based managed care Medi-Cal provider, Alameda Alliance for Health (AAH) provides medical services for the majority of CVC's clients. The close proximity of AAH to CVC, and the longstanding relationship between the case managers of the two organizations, has facilitated strong communication, and, in turn, coordination and collaboration between the CVC and AAH.

For example, CVC case managers work with AAH case managers to clear up claims disputes and answer benefit questions, and CVC case managers are knowledgeable about how the managed care organization makes care decisions.

- # **California Children's Services (CCS).** The county CCS agency authorizes and coordinates specialty care for children with any of an extensive list of chronic conditions and disabilities. The Alameda County Public Health Department, which administers the CCS program in the county, is also involved in service integration on the system level. As a member of the Alameda County Children and Families Commission, the department is involved in the development of a strategic plan known as *Every Child Counts*. This plan focuses on the use of newly-available tobacco tax funds, and the ability to use these funds to leverage other sources of state and local funding, for early intervention and prevention services for children, including services provided by CVC. The plan includes provisions for "intensive family support" for families of children with physical, behavioral, and developmental disorders, to be financed through a combination of Medi-Cal, TANF, private insurance, and other sources of funding depending on the range of agencies the families are involved with, with the tobacco tax funds serving as a safety net to finance services for uninsured children. This represents an innovative attempt to integrate both funding sources and services for high-risk children and families, but it is still in the planning stage.

CVC also has informal referral relationships with a number of community service organizations, including Harrison House Homeless Shelter, Through the Looking Glass, and Horembe, among others. These connections are mainly unstructured, in that formal Memoranda of Understanding have not been developed. However, the CVC has letters of support that allow case managers to do outreach at shelters and refer to, and receive referrals from, these service agencies. In developing formal or informal interagency relationships, the CVC focuses on organizations that share its philosophy, mission, and vision, such as the organizations described above. This strategy helps to maintain the Center's cohesiveness by safeguarding any unnecessary extra burdens that may result from an unlikely partnership.

2. Identification of Service Needs

At CVC, case managers assist families with identifying service needs and accessing services. The Center has five part-time case managers (3.25 FTEs) and sees over 500 children yearly. Case managers have a caseload of about 60 children (or approximately 30 families) each, but they are given some degree of flexibility in being encouraged to take only as many cases as they can handle. When the Center has reached its full capacity, its referral sources are alerted and potential clients are referred elsewhere (although most of these other organizations are likely to be full as well). Since the majority of clients need services immediately, waiting lists are not an option. The CVC program director estimates that approximately 40 percent of clients are served through the C.O.R.E. Program, while the remaining 60 percent are served under the Foster Program. Theoretically, C.O.R.E. and Foster Program case managers serve distinct populations, but since so many clients move in and out of the foster care system regularly, a significant amount of cross-over occurs within the two programs.

CVC does not have a formal needs assessment or service plan protocol, but does use a standardized charting system. The charts consist of an intake form, demographic sheet, medical flow chart, psychosocial notes, case management notes, and release of information form used by all of the case managers, regardless of which populations they serve. In determining clients' needs, case managers look at the whole spectrum of critical issues and clients' history rather than their medical or mental health needs. Referrals are recorded in clients' charts, and range from therapy and counseling to special education, housing, and medical referrals.

Although the needs of a homeless child may differ substantially from the needs of a foster child, both the C.O.R.E. and Foster Care Programs have similar referral, case management, and treatment processes, as described below.

- # **C.O.R.E. Program.** C.O.R.E. uses a hospital clinic-based case management model whereby clients are referred through Children's Hospital Oakland outpatient clinics or through the inpatient hospital's social workers. The C.O.R.E. Program only has three case managers, of whom two are relatively new. Homeless clients have needs of varying intensity; the scope of services used ranges from insurance issues to housing and safety. CVC is applying for a grant for emergency housing vouchers for their homeless clients. Mental health is a major problem for both children and families. The most prevalent mental health issues are behavioral, developmental, and school-based issues. The greatest needs of clients include housing/social service needs and health care needs to

treat diagnoses of behavioral disorders, ADD/ADHD (and other learning disorders), chronic asthma, and developmental disorders. Under these circumstances, the work of the case managers is characterized by flexibility and dedication to meeting each client's unique needs. CVC case managers provide a significant amount of care through home visits, which is not only more accommodating for clients, but also more effective for monitoring the progress of families. One case manager emphasized the importance of home visiting in providing a more complete picture by allowing her to see families' resources first-hand. C.O.R.E. clients tend to use case managers' services for an average of 6-8 months, but the case manager will generally continue to monitor families for another four months. The goal is to connect families to as many services as possible, without overwhelming them.

- # **Foster Care Program.** The case managers' casework begins at the point of the initial clinic contact; the Foster Care Program case managers participate in two morning Foster Care Clinics per week. Children are referred to the Foster Care Clinic through the Department of Social Services, foster family agencies, or foster parents with previous CVC experience, and case managers work with both foster children and foster families. The foster care case manager evaluates the child's relevant health, mental health, and developmental history (including what little may be known about the biological family's services, well child services, etc.) to pull all the pieces together and develop a prioritized list of the child's identified needs. They also provide medical evaluations and financial assistance for emergency foster parents.

Both programs attempt to use a comprehensive approach by addressing the full spectrum of families' needs; however, this is not always feasible, due to limits on the capacity of the county's mental health system, as discussed below.

3. Services and Providers

California's counties vary in the structure of their Medi-Cal programs. Managed care is mandatory for Medicaid enrollees in Alameda County under the "two-plan model." As mentioned above, Alameda Alliance for Health provides the local county-based plan for Medi-Cal recipients, while Blue Cross/Blue Shield provides the commercial option. Given that their network includes the county providers whom Medi-Cal recipients are familiar with, the local provider has considerably more beneficiaries than the commercial one. Specialty mental health services are carved out of California's Medicaid managed care program and provided through county-based plans in each county. In addition, foster children are excluded from Medi-Cal managed care. Because these children may move frequently across county lines, enrollment and re-enrollment in managed care plans (which are county-based) would be nearly impossible to manage, and foster children are therefore better served on a fee-for-service basis.

For CVC's clients, obtaining physical health services seems to be significantly less complicated than obtaining specialty mental health services. Most physical health services are provided directly in Children's Hospital Oakland or its outpatient clinics, and hospital providers are reimbursed through Medi-Cal, as the vast majority of the Center's families are enrolled in the program. If an eligible family is not enrolled in Medi-Cal, case managers will assist them to enroll or re-enroll. The Center's connection with the hospital seems to be a valuable catalyst in getting children the physical health services they need. CVC case managers and hospital pediatricians refer children to each other, but most often, pediatricians take care of children's immediate needs, and case managers help to ensure that their psychosocial and support service needs are addressed. Since physicians are often unable to follow up on referrals due to the many demands on their time, case managers provide essential support both to families and physicians. Case managers also have better connections to community resources than hospital physicians.

Another factor promoting children's physical health services involves Alameda Alliance's unique provider incentives. The managed care organization has worked with an external county-based Committee on Children with Special Health Care Needs (made up of local pediatricians, CVC staff, and various health and social service agency representatives) to compensate providers for caring for children who may be at higher risk for health problems. Through a Special Needs Risk Factor Scale, the system identifies these high-risk children and attempts to increase the quality of their care by compensating their primary care providers with a supplemental fee. The Risk Factor Scale includes medical risk factors (which includes severe mental retardation or developmental delays, drug or alcohol fetal exposure, and high-risk behavioral problems), family risk factors (including homelessness, foster care, kinship care, parent with psychological, developmental, or medical disability), and agency involvement (including Child Protective Services, in-home medical services, school IEP, etc.) Although this effort is not formally coordinated with CVC, the Center's primary care providers (Children's Hospital Oakland primary physicians) receive this additional fee for their time with CVC's high-risk clientele. However, the absence of mental health or behavioral risk factors from the scale may limit the program's usefulness for this population.

Intensive mental health services for CVC families, on the other hand, are not as readily available as physical health services, despite the existence of a psychiatric residency program at Children's Hospital

Oakland. This is mainly due to a shortage of accessible mental health providers accepting Medi-Cal; although there are numerous psychiatrists, psychologists and counselors in Alameda County, they tend to be clustered in Berkeley, not in the lower-income areas of the county where they are needed. In addition, low reimbursement rates contribute to providers' unwillingness to accept Medi-Cal patients; the county mental health agency pays \$42.35 per hour, compared to private managed care plans' rates of \$50 to \$60 per hour. Finally, CVC providers note a particular problem finding sources of mental health services for preschool-aged children. Eligibility for the county mental health system is based on diagnosis, and few children under age five have a confirmed diagnosis (and providers may be reluctant to give a diagnosis to a child that young). Moreover, few mental health providers exist for this age group, causing a severe access problem.

Alameda County Behavioral Health Care Services (ACBHCS), the county behavioral health services agency, serves as the gatekeeper for Medi-Cal mental health services. Clients can be referred to the agency by a case manager, provider, or parent; when they call the county's hotline, they are initially screened and referred to an available provider. To assign these cases to appropriate providers, ACBHCS has developed a system of "Non-Hospital Referral Levels." The referral levels range from one to five, with Level I indicating a need for intensive services (using community support service teams), Level II for moderately intensive services, Level III for solo practitioner services in an office-based practice (this may include independent or organizational providers), and Levels IV and V for families who do not qualify for the Alameda County Mental Health Plan services but who need a referral to other community mental health resources or agencies. The CVC and Children's Hospital Oakland are considered Level III providers of mental health services by ACBHCS. However, the Center and its hospital-based providers may believe that Level I is a more appropriate designation for the services they provide for their vulnerable populations, and have been working with ACBHCS to negotiate their Level III reimbursement rates, but with little success. Thus, due to the lack of intensive mental health services supported by ACBHCS, CVC social workers often provide family therapy, behavioral interventions, and group counseling themselves.

In addition to linking children to medical services, CVC case managers also support pediatricians. Pediatric providers report that case managers assist them tremendously by making connections with families and their external supports. Case managers assist in the communication process by going with

families to physician visits and sharing “vital information” when necessary to get families the services they need. This information may include the therapy treatments the child is receiving, or the services the school is providing. Providers also call case managers when they are trying to communicate specific information to families, or to refer families to the county behavioral health care services program. In the Foster Care Clinic, case managers and pediatricians have case meetings regularly to discuss the status of patients, and pediatricians receive background information about patients prior to the patient’s appointment. CVC case managers will also advocate on behalf of their clients; for instance, in situations when providers are in disagreement with schools about medicating a child who has behavioral problems, the case manager may defend the physician’s decision if it is in the best interest of the child.

CVC case managers also ensure service delivery by coordinating with the following sectors:

- # **Schools.** Case managers work with schools in developing Individualized Education Plans (IEPs) for clients, attending attendance review board meetings, observing students in their classrooms, and meeting regularly with teachers to discuss students’ progress. Often, they act as advocates on behalf of clients’ parents, who may lack the competency to fill that role themselves. CVC staff have faced considerable challenges in working with schools, given the differences in agendas, priorities, and cultures between the two organizations. Whereas CVC case managers are more concerned with their families’ individual needs, schools have to consider the multifaceted needs of their faculty, staff and student body as part of a larger, more complex system, while at the same time adhering to state and county regulations. Overall, however, establishing school relationships has proven to be a beneficial step in accessing special education services for CVC children.
- # **Housing.** Case managers assist clients with housing needs by providing outreach to housing shelters, as well as helping families find and maintain housing.

To assist in the coordination of physical and mental health services, case managers often request clients’ medical records after obtaining parental consent for the release of information. According to CVC staff, families are fairly cooperative about granting consents for these records; the main challenges arise when clients are unsure about who provided a service, or when providers are unable to locate patients’ records. Since the majority of physical health services are provided directly at Children’s Hospital Oakland, the Center’s connection with the hospital facilitates information sharing by default, giving case managers an advantage over other county case managers and providers.

Although information sharing can be extremely beneficial in coordinating services, sharing program data across mental and physical health care systems in California is hindered by confidentiality barriers. California state law protects the confidentiality of all mental health records. Therefore, because mental health is carved out from managed care plans' responsibilities, the plans and their providers do not routinely have access to their patients' mental health records. Providers report that, even when their patients sign releases, they often cannot get records from the county mental health agency.

4. Financing

The Center receives funding from a variety of sources, including grants and contracts from Federal, state and county agencies. Both the C.O.R.E. and Foster Care Programs are primarily funded through a grant from HRSA's Bureau of Primary Health Care through its Health Care for the Homeless (HCH) program. Because the case management staff are clinical social workers and often provide direct mental health services to their clients, Center staff are pursuing the possibility of receiving Medi-Cal reimbursement (under the Child Health and Disability Program, the state's EPSDT program) for their time. Since EPSDT is obtained through the state but administered through the county, CVC expects the billing to be processed through the county. This would involve negotiating a cost-based contract (fee-for-service per unit minute) that included overhead expenses. However, the bulk of the case managers' time is devoted to care coordination services, which are supported by the HCH grant funds, despite the fact that these services appear to meet the definition of Targeted Case Management under Medi-Cal.

Additional funding sources for the Foster Care Program include grants from the state and private foundations (for the SEED program, which promotes early placement of foster children) and county contracts (for clinical mental health services for children in long-term foster care).

The program's reliance on grants, rather than reimbursement by Medi-Cal or other insurers, has advantages and disadvantages. In general, grants are seen as sources of start-up funds for new programs, not sustainable sources of funding for ongoing services. However, the CVC has largely been successful in renewing its core funding, the Health Care for the Homeless grant, every five years. This funding has allowed the program to serve all clients who meet its criteria without regard for Medi-Cal or other program eligibility. However, some of the agencies with which CVC collaborates are more categorical

in their eligibility standards; for example, county-based social services to which they refer foster children may become unavailable after a child is permanently placed.

The experience of CVC provides an excellent example of the limits of both grant and Medicaid funding. Thus, the current discussions about the use of Medi-Cal and Child Health and Disability Prevention (CHDP) funds, California's EPSDT program, for CVC services appear to offer a promising avenue toward more sustainable support for clinical services for high-risk children.

5. Family Involvement

CVC does attempt to involve families in the decision-making process at all levels of treatment. The Center's case management focuses on family empowerment skills in trying to help families build self-sufficiency, as opposed to simply providing services and referrals for children.

Comprising about half of CVC's Advisory Group, families are also involved in the program planning process. This is an on-going effort by the Center, but CVC staff acknowledge that it is a process which could be improved. Given that the majority of CVC's active clients are not in the position to be able to participate in the Advisory Group, most families are former clients who may be somewhat out-of-touch with their C.O.R.E. or Foster Care Program experiences. As a result of prioritizing multiple obligations, their attendance rates and motivation levels are fairly low. Despite these barriers, the voices of families have helped CVC change its intensive mental health care approach by setting up a general framework for the Oakland Ready to Learn collaboration, and families have also generated ideas to improve the program's evaluation and monitoring systems.

6. Evaluation and Monitoring

To evaluate the CVC program's success, family satisfaction mail surveys have been distributed every year, but not surprisingly, finding homeless families has posed considerable challenges for the Center. Yet the Center recognizes that limiting the study population to those with permanent addresses biases their findings toward the positive. One way to deal with the problem of trying to track down these mobile populations is to hire a person to administer the questionnaires at clinics, but this idea was rejected because it may also create bias since clients will no longer remain anonymous. Next year, CVC

is going to try to get a non-CVC volunteer to make phone calls so respondents can feel more comfortable in revealing their honest opinions. They will also modify the survey to ask families to describe any behavior changes they've experienced as a result of CVC, as a means of measuring family empowerment.

The Research Division has conducted a number of studies to analyze relevant risk factors and outcomes based on their experience serving specific high-risk populations. CVC's studies published to date have examined the relationship between foster care and family homelessness, the impact of childhood foster care and other out-of-home placement on homeless women and their children, the impact of outpatient drug services on abstinence among pregnant and parenting women, the identification of essential case management services for foster care families, and the impact of welfare reform on foster care and children's mental health. The major findings include an association between family homelessness and children placed into foster care, along with the prevalence of homeless women who had childhood histories of foster care (providing evidence of an intergenerational cycle of foster care and homelessness). Although young foster children were found to have significant medical, psychosocial, and psychomotor developmental problems, CVC's research found that foster parents need more intense case management services (specifically, counseling and parent education) than the young foster children. Finally, abstinent pregnant and parenting women in outpatient drug programs were found to receive more family therapy services than their non-abstinent counterparts.

In studying homeless populations, the CVC has encountered many challenges in identifying valid and meaningful outcomes. For instance, the definitions of "homelessness" versus "housed" are limited to the point in time of data collection, and it is especially difficult to measure prevention of homelessness. The ideal evaluation for CVC would verify long-term (longitudinal) outcomes to measure families' and children's social, developmental, health, and economic well-being. At this time, however, the clinical staff cannot use their already limited time and resources to collect such long-term, detailed information.

C. Conclusions and Lessons Learned

According to the CVC Associate Research Scientist, the Center differs from other HCH programs by focusing on families, offering a wider breadth of services that includes more intense case management services, following up with families after they obtain housing, and having smaller caseloads (and the ability to establish more long-term relationships) than other social service programs serving similar populations. These features are especially important for the center's target population, considering the well-documented cycle of homelessness and its effect on continuity of care. Most of CVC's personnel agree that the project can be replicated elsewhere to serve other high-risk populations, if the sponsoring agency has a clear vision and philosophy, and people with credentials and experience to fulfill the mission.

CVC presents a valiant effort to coordinate mental and physical health services despite limited access to mental health care. Indeed, those interviewed identified a range of barriers to care coordination or integration in California, including the following:

- # **Medi-Cal Mental Health Carve-Out.** The most basic barrier in the California Medi-Cal system is the separation of mental and physical health care enforced by the carve-out policy. As with most carve-outs, disputes about which system is responsible for services are common; moreover, physical health care providers and managed care plans are often unable to get even basic information about patients' mental health treatment or medications.
- # **Low Reimbursement Rates.** Although Medi-Cal's mental health carve-out allows for unlimited services, accessing mental health services has actually proven to be fairly challenging for Medicaid recipients due to a shortage of providers (as a result of low reimbursement rates) and providers' full schedules of appointments.
- # **Confidentiality Barriers to Information Sharing.** Information sharing between physical and mental health providers may help reduce duplication of services (while also comprehensively addressing multi-factorial problems), but information-sharing between managed care and mental health carve-out entities is not possible due to state mental health confidentiality laws.
- # **Limitations in Grant Funding and Medicaid Reimbursement.** While the categorical nature of grant funding limits the type of populations served by CVC, it does allow the Center to try flexible, innovative approaches and demonstration projects. Medi-Cal reimbursement, on the other hand, limits the Center in terms of the services it may or may not provide, but generally covers a broader range of low-income populations than grant funding typically does.

Despite these challenges, the CVC has found a number of strategies to be effective in helping high-risk families to navigate complex social and health services systems. These include the following:

- # **Connection to Children's Hospital Oakland.** The hospital-based care coordination approach appears to be the main support in helping CVC families receive the physical health services they need. CVC case managers' relationship with hospital providers facilitates increased communication and coordination of services for clients, while the Center's location in the hospital's outpatient clinic allows ease of access to case management services during a pediatric visit.
- # **Community Collaborative Relationships.** The Center's collaborative relationships with community agencies foster increased coordination of services, increased visibility in the community, increased referrals, and a maximization of resources.
- # **Highly-Qualified Staff.** The Center's highly-trained case management staff are able to directly provide needed counseling and therapy services, which helps to circumvent the overloaded county system.
- # **Comprehensive, Long-Term Service Approach.** CVC's comprehensive, long-term service approach is beneficial to their high-risk clients who have a multitude of psychosocial risk factors and who need ongoing monitoring, counseling, and referrals.

The longevity of the CVC is a testament to the value of intensive care coordination services for high-risk families. The county's current efforts to use tobacco tax funds to promote integration of funding and service delivery for high-risk children will provide an opportunity for the Center to enhance its ability to coordinate with other service providers and to increase the range of services to which its clients have access.

Appendix A: Key Informants

Center for the Vulnerable Child

Key Informants

Children's Hospital Oakland

Cheryl Zlotnick, RN, DrPH

Denise Lowery, MSW

Ellen Eve Seligman, LCSW

Karen Kruger, MD

Diane Halberg, MD

California Children Services

Marge Deichman, MPA

Oakland Ready to Learn

Kate Dowling

Alameda Alliance for Health

Maureen Hanlon

Matt Snyder

Oakland Head Start

Bobbie Miller

Connie Chu

Alameda County Behavioral Health Care Services

Ellen Muir

Children's Village

A. Background and Introduction

Children's Village houses several service delivery agencies serving children with special health care needs (CSHCN). These agencies share resources, collaborate in the provision of care, and coordinate their individual efforts on behalf of children and families. The Village opened in October 1997. The building provides a central, child-friendly location for providing a wide range of services to CSHCN in the Yakima area. In addition to the main facility in Yakima, there is a second building in Sunnyside, Washington where services are also provided. Among the services available are family resource coordination, medical care, occupational and physical therapy, speech and language services, pediatric specialty clinics, mental health services, dental care, family support services, a health information center, child care, and education services.

The idea for Children's Village grew out of long-standing relationships between agencies serving CSHCN in Yakima County. These organizations came together to plan for a new building and a new way of delivering care for CSHCN. Three organizations were able to take the lead in planning the new building and became full-time providers within the Village. An additional 11 agencies serve as partners and provide services within the Village.

The primary funding for building Children's Village came from a capital campaign that drew on the resources of the local community. Yakima Valley Memorial Hospital has played a crucial role in bringing together the partners and ensuring that funding is available to cover the costs of operating the center. The hospital has also been able to utilize its fund-raising resources, including an affiliated foundation, to help provide the support that Children's Village needs to carry out its mission.

The agencies that founded Children's Village and have full-time service providers operating in the facility include the hospital; the Yakima Valley Farm Workers Clinic, which provides medical, dental, and social services in the Yakima Area and throughout central Washington and Oregon; and the Enterprise for Progress in the Community (EPIC), which provides a variety of services to young children and youth, including a Head Start Program. The other partners that provide services within Children's Village include community mental health providers, the Division of Developmental Disabilities, local school districts, a hearing and speech therapy provider, the local health department, the county department of community services, and Children's Hospital in Seattle.

A site visit was conducted to Children's Village in February 2001. Interviews were conducted with the director of Children's Village, administrators from Memorial Hospital, staff of the Memorial Foundation, administrators from the three founding agencies, and most of the partner agencies. Additional interviews were conducted with staff that provide services to children within Children's Village, including the mental health coordinator, occupational and physical therapist, speech and hearing therapist, care coordinators, public health nurses, and physicians. A meeting was held with the parent coordinator and a group of parents of CSHCN. Meetings were also held with a representative of the state Department of Health, the regional staff person for the state Department of Social and Health Services who is responsible for overseeing children's Medicaid, the director of the Yakima County Department of Community Services, and the state staff person who serves as liaison for the Department of Developmental Disabilities. A list of key informants is included here as Appendix A.

This report describes the findings of these case study interviews. In the following sections, we discuss the interagency relationships between the organizations involved in Children's Village, the Village's methods for identifying service needs, the services and providers coordinated through the Village, the financing structure, how families of CSHCN are involved in the Village's services, and plans for evaluation and monitoring. This report concludes with a section describing the major lessons learned from the experience of care providers in Yakima County.

B. The Program

1. Relationships with Other Programs and Agencies

The essence of Children's Village is the relationship among the agency partners in the Yakima Valley who are concerned with the physical and emotional/behavioral health of CSHCN. There are currently 14 agencies who provide services within the Children's Village framework. As mentioned previously, the three major partners in the Village are Yakima Valley Memorial Hospital, Yakima Valley Farm Workers Clinic, and the EPIC Program. Other service provider partners with either on-site staff or linked to the Village off-site include: Hearing and Speech Center; Yakima Pediatric Associates; Central Washington Comprehensive Mental Health; Yakima School District; Yakima County Community Services; Catholic Family and Child Services; the Division of Developmental Disabilities, which is part of the State Department of Social and Health Services (DSHS); Educational Service District #105, which covers the 13 school districts that serve Yakima County; the Yakima Health District; and Children's Hospital and Medical Center in Seattle. A major non-service-delivery partner is the Memorial Foundation, which is affiliated with Memorial Hospital. The foundation raises funds to support services and facilities.

Children's Village is not designed as a new organization but rather as a philosophical and physical entity where agencies caring for CSHCN can co-locate and collaborate in the planning and provision of comprehensive care. To facilitate this approach, each of the main partner agencies (Memorial Hospital, the Farm Workers Clinic, and EPIC) has space tailored to its particular needs within the Village. The other partners make use of areas designed to be used by part-time staff. The agencies with itinerant staff not only have areas in which to provide client services, but also have office space that provides access to information and communication systems. It is important to note that mental health staff are on-site full time, with two staff employed by the Yakima Valley Farm Workers Clinic providing therapy for clients and behavioral/mental health consultation to staff of many of the partner organizations. Space leasing agreements, as well as financial agreements, have been developed among these partners to support shared staffing in areas such as child care, program development, and reception. These fiscal arrangements are described in the section of the report focusing on financing of the project.

Children's Village partners stressed the importance of co-location as a means for staff from the various agencies not only to get to know each other but also to experience how their colleagues work. This

results in an increased understanding and respect for the expertise of others, creating high levels of trust and confidence and enabling staff to make referrals that are on target with the needs of clients and the agencies' strengths. In addition, individual staff members have the opportunity for professional development and cross-training, as their colleagues within the Village teach them new techniques for addressing the needs of their clients.

The working relationships among the on-site partners is supported by the philosophy that none of the agencies gives up anything, including their name, their culture, or their program autonomy, while at the same time each gains the opportunity to provide more comprehensive, effective services to their clients as a result of being a part of the Village. Other benefits described by participating agencies include the support of grant and other funding activities by their Village colleagues and the comfort of knowing that challenges faced individually or collectively can be addressed because the partners are already at the table providing a structure to create effective ways to handle emerging issues.

Strategies at both the leadership and service delivery levels have been established to sustain positive working relationships among agencies at the Village. Several Children's Village Committees meet on a regular basis; these committees are listed in the Table III-1 below.

Table III-1. Children's Village Committees		
Name	Schedule	Responsibility
Children's Village Trustees	Meets Quarterly	Policy Development and Financial Oversight
Management Team	Meets Monthly	Operational Coordination
Partnership Advisory Committee	Meets Quarterly	Coordination of Services
Medical Advisory Committee	Meets Quarterly	Medical Oversight

Each committee includes representatives from the partner agencies. The Village Trustees and Management Team consist of representatives of the three main partner agencies and the Memorial Foundation. The Chief Executive Officers of Memorial Hospital, the Farm Workers Clinic, the Memorial Foundation, and EPIC are all members of the Village Trustees. Individuals in these positions played a major role in creating the Village and it is important to its continued success that high-level

administrative officials remain involved. The Partnership Advisory Committee consists of representatives from all agencies that provide services at the Village. The Medical Advisory Committee is made up mostly of physicians and other medical providers who serve special needs children. This includes those providers who work in Children's Village and those who serve children in their offices in the community. Children's Village has been careful to build links with primary care physicians (PCPs). The Medical Advisory Committee at Children's Village works to educate physicians about the importance of early intervention and the resources that are available at Children's Village. Specialty staff make sure they consult with the PCP. These kind of relationships are seen as essential since Yakima is so far away from tertiary care centers and most of the child's care is going to be handled by the PCP. Parents are members of the Partnership Advisory Committee and a representative from the Indian Health Service is a member of the Medical Advisory Committee. The director of the Village serves on all the committees.

At the service delivery level, collaborative relationships are sustained through the sharing of a common mission focused on the well-being of children and families, weekly team meetings, and on-going efforts to strengthen the shared information system. A recurrent theme articulated by staff is their common mission of providing comprehensive care to children and families. This acts as a bond among the partners that facilitates problem solving rather than blame allocation. Staff cited the respect they share for the skills and experience of their colleagues as a major force in making team meetings child- and family-focused and goal oriented.

At Children's Village a common electronic chart is in place for each child using Village services, into which progress notes are entered and read by those providing services to the child and family. Parents can request and obtain a "lock-out" of staff to this system as they desire. Issues under discussion include the current practice of record duplication with documents kept at Children's Village and at the partners' home agencies. The goal of a revised system is to make information available within the Village while minimizing the requirements for duplicate entry and the risk of having two incomplete records because information is not entered at both sites.

In addition to the formal partners, several other organizations and agencies located in the Yakima Valley also work with the Village partners in the delivery of physical and mental health services to CSHCN.

The degree of collaboration varies in accordance with the mission and resources of the agencies. Of particular importance are the 13 school districts in the Valley, child protective services, and public health nurses employed by various community providers.

- # **Schools.** While each of the school systems has a relationship with the Children's Village, the nature of the relationship varies by school district. For example, the Yakima School District has a formal contract with Children's Village, while others may refer children to the Village as needed. Schools also vary in their approach to early intervention and mental health services and, thus, in their need for Children's Village services.
- # **Child Protective Services.** The child protective services system also intersects with the Village through some of the programs offered by EPIC and Catholic Child and Family Services.
- # **Public Health Nurses.** Public health nurses from the local health district, Providence Health Systems (the other hospital in town), Yakima Neighborhood Health Services (which operates a community health center), and the Yakama Indian Nation also work with families who are referred for services at the Village. In addition, the public health nurses provide coordination and follow-up services for families utilizing services at the Village.

2. Identification of Service Needs

Referrals to Children's Village come from a variety of sources, a number of which are described below.

- # **Physicians.** Pediatricians and other physicians who have concerns about a child's development are one of the most common referral sources.
- # **Indian Health Service.** The Yakama Nation has requested and received Bureau of Indian Affairs Funds to hire a public health nurse and family resource coordinator who works with the CSHCN population within the Nation. One of the roles of the public health nurse is to identify children with fetal alcohol syndrome and refer them for a full assessment.
- # **Child Protective Services.** Families that are identified by child protective services and then determined to be at risk for abuse and neglect are referred to a Yakima Health District public health nurse who works in the early intervention program. She assesses the children and refers to Children's Village when appropriate.
- # **First Steps Program.** Four agencies are contracted through the First Steps Program to provide Medicaid clients with maternity support services during pregnancy, and post-partum support for two months or up to one year for mothers with a high risk of a poor

pregnancy outcomes. The public health nurses from these agencies can refer a family to Children's Village.

- # **Specialty Clinics.** Children may come to the Village for services offered at one of the specialty clinics described below in the "Services and Providers" section. If it is determined that these children could benefit from other services offered at the Village, they may be referred at that point.

Once a child is referred, a triage coordinator at Children's Village responds to calls from parents and other individuals inquiring about services at the Village. The coordinator asks about the reasons for the call, whether the child has a diagnosis or medical condition, whether the child is on medication, whether the child has received mental health services, and whether the school district has identified the child as needing special education or early intervention services. If the primary problem identified is a behavioral or mental health problem, the case is transferred to the mental health coordinator. The triage coordinator may determine that the child would be better served outside of the Village, and may make referrals to other community services when appropriate.

When the primary problem is a behavioral health issue, the mental health coordinator will take the call. If the child has never visited or been diagnosed within the community mental health system, the mental health coordinator will refer the child out to that system. This procedure was developed as a result of Children's Village being overwhelmed by the number of behavioral and mental health referrals they were receiving. Behavioral and mental health referrals were accounting for approximately 40 percent of all referrals, and Children's Village could not afford to duplicate the functions of the existing children's mental health system. Children's Village responded to this problem by creating a Mental Health Task Force to define the types of mental health services that should be provided through the Village. The Task Force determined that services would be provided at the Village to children with "deficits in social-emotional functioning and at least one other developmental area (cognitive, motor, etc.)" (Children's Village Mental Health Task Force 2000). Behavioral and mental health services would be provided to these children and their families. However, if clients exhibit chronic mental health issues or require extended care to address acute problems, they will be referred to the community mental health system. The mental health coordinator position was created to serve as an entry point to services and to oversee the provision of mental health services within Children's Village.

If a referral is determined to be appropriate for Children's Village, a family resource coordinator is designated. There are six of these coordinators who are assigned particular geographic areas in the county so that they can build links with community resources and build working relationships with particular school districts. The family resource coordinator will make the initial contact and discuss the services that are available through Children's Village and the initial process of accessing those services. This meeting may take place at the Village, in the child's home, or at the primary care physician's office. Once it is decided that the child will receive services through Children's Village, the family resource coordinator gathers the child's medical records. Then there is a children's team meeting that discusses what service providers will need to see the child and how they will schedule and coordinate visits. If a mental health referral is accepted, the Behavioral Assessment Team will conduct a functional behavioral analysis. They will try to work with the family on a short-term basis, including modifying parental behavior when appropriate. They also review how care will be financed for the case. The goal is to find a financing source for the needed care, not to decide what care to offer based on what resources are immediately available. They set up an initial visit to conduct a full evaluation. This visit usually includes a conference with the family with the intent of involving them in creating a treatment plan and determining what the next steps will be. If the child is referred through the Early Intervention Program, the staff will develop an Individual Family Service Plan (IFSP) and in some cases work with the school system on an Individual Education Plan (IEP).

3. Services and Providers

A wide range of services is provided within Children's Village. Most of the services are provided by the three primary partners; however, additional services are provided by other agencies that serve CSHCN in Yakima County. Most services are focused on very young children, with the zero to three age group being a particular target. However, older children do receive services within the Village, though the school system tends to play a larger role as the children age. This section provides a description of the services provided within the Village.

- # **Resource Coordination.** Family resource coordinators serve as the first point of contact into the services offered in Children's Village and continue to provide service coordination after the intake period. Each family resource coordinator has a caseload of about 40 children under age three and between 50 and 125 children over age three. Caseloads differ because school systems play a larger role in serving children over age three, due to their responsibilities under the Individuals With Disabilities Act (IDEA) Part

B. While Children's Village does provide services to children over age three, they are less likely to handle assessments and take the lead in service planning, because the school districts are both legally and financially responsible for these services.

- # **Drop-In Child care.** Children's Village has a drop-in child care room for brothers and sisters of special needs children who are receiving services. There is no charge to parents for utilizing the child care room. While there was a great deal of debate as to whether this was a service that should be offered when the Village was being built, the parents of CSHCN stressed that the availability of this service made things much easier for them.
- # **Yakima Valley Farm Workers Clinic Services.** The Yakima Valley Farm Workers Clinic provides a variety of services within Children's Village. These include pediatric medical evaluations, nutritional assessments, and dental screenings and treatment. The Farm Workers Clinic has arranged a pediatric dental residency rotation with the University of Washington. The clinic space is also used by the behavioral assessment team and the specialty clinics that are described below.
- # **Early Intervention (Birth to Three) Services.** Memorial Hospital is the contractor for Part C early intervention services for children from birth to age three. Children eligible for services in Washington State under Part C are those with a documented developmental delay of 25 percent or more. The delay can be in the following domains: physical, cognitive, communication, socio-emotional, or adaptive. Seventeen types of services are required to be provided, including psychological services. While Part C is supposed to be the payer of last resort, the mental health system has very few services available for the birth to three population, so the issue has taken on greater importance within the early intervention system.

In Washington State, school districts are required to provide services for children older than three, but they may or may not provide services for the birth to three population. Four districts in Yakima County do provide some services for infants and very young children. The Yakima School District has a contract with Children's Village and refers all children identified through its birth to three program to Children's Village for a full assessment. One of the difficulties of serving these children occurs because of the way the state administrative code is written. School districts who do provide these services have to follow the rules under IDEA Part B. This means that Individual Education Plans (IEPs) have to be developed for anyone age zero to three who receives these services. Providers within Children's Village noted that this was a major burden and consumed extensive amounts of staff time and resources.

- # **Speech Services.** These services are provided primarily for children under age three who have been identified through the early intervention program. Memorial Hospital subcontracts with the Hearing and Speech Center to provide staff for three days at Children's Village. Children over age three are sometimes evaluated, but because of the lack of a funding source, treatment is usually not provided at Children's Village for them.

There is a serious shortage of speech pathologists, especially those able to work with Spanish-speaking children. In addition, the difficulty of funding services for children

over age three presents a challenge. Children's Village realizes that the shortage of speech therapists presents a serious problem and they are forming a task force to explore approaches to address the issue. One strategy they have been employing is to use speech pathologists for initial evaluations and consultations. The speech therapist then can train other staff who work with children, such as child care workers or occupational therapists, to pay attention to speech and hearing issues and use techniques that address the problems the children face. This is similar to the role the mental health coordinator is taking on. Cross-training staff in this way is made easier because of co-location and the level of trust that develops when the providers have an opportunity to observe each other's work. In addition, if a provider ever feels that a case requires intervention beyond their level of expertise, they can always consult with one of the specialists.

Pediatric Therapy Services. Occupational and physical therapists are available full-time at Children's Village. The therapists are employed by Memorial Hospital. There are three treatment rooms available, including an infant room, toddler room, and a big gym. There is an observation room that allows providers and families to view activities or evaluations in both the toddler room and the big gym. There is also a therapy pool available. This is the only therapy pool in central Washington State. There is some discussion about making the pool available for recreation purposes, because special needs children lack recreational facilities.

Therapeutic Child Care and Early Childhood Education. EPIC provides services for children involved with the child protective system and has an afternoon Head Start class located at the Village. The therapeutic development center has offered morning classes to children who are involved with the child protective services system. In addition, there is a crisis nursery for children when there is a family emergency that is also available for respite care. While many of these children fit the criteria to be served at the Village, there have been difficulties getting these children linked to the Village's services. Child protective services caseworkers have the ultimate authority over these cases and many of them have not sought to utilize the services offered at the Village even when staff who work there think it would be appropriate. This is an illustration of how difficult it sometimes is to work across systems. While co-location of the development center and the services offered through Children's Village presents opportunities, the full benefits have yet to be realized, because child protective services has failed to become a party to the interagency cooperation that makes the Village work. In recent months, the development center has been able to utilize a greater number of services than in the past. Staff at the Village have been called in to do developmental screenings and occupational therapy.

The therapeutic child care and crisis nurseries are soon going to be replaced by an Early Head Start Program. This is being done partly because of space reasons and partly because it is seen as an opportunity to serve children eligible for early intervention service under Part C through both Early Head Start and the other services available at the Village.

Specialty Clinics. The specialty clinics include fetal alcohol syndrome/fetal alcohol effects, neo-natal intensive care unit follow-up, cardiac consultation, neurology, orthopedic, endocrine, pulmonary, neurodevelopmental, physiatry (rehabilitation), and

craniofacial clinics. Most of these clinics involve visits from staff of the Children's Hospital and Regional Medical Center in Seattle. Previously, many of these services were available only in Seattle, over a two hour drive through the mountains. Parents of CSHCN indicated that the availability of these services in Yakima made their lives much easier.

A typical case involving the fetal alcohol syndrome/fetal alcohol effects clinic was described in detail. A public health nurse or family resource coordinator gathers a history of the child and family. The clinic brings together a team that typically includes psychologists, behavioral specialists, occupational and physical therapists, speech therapists, pediatricians, parent advocates, and a school psychologist. The evaluation usually takes all morning and includes a thorough physical. The child's guardian or, less typically, the parent will talk with the team about the child. After the evaluation, the team will discuss the case and consult with experts at Seattle Children's Hospital. The child's parent or legal guardian is brought in and the team discusses the findings and makes recommendations for services.

Department of Developmental Disabilities Services. The Washington State Department of Developmental Disabilities is responsible for providing family support services to help families of disabled children care for the child in their home. These services include respite care and transportation or reimbursement for transportation. The department has not had a physical presence at the Village. The parents of children who receive services at Children's Village indicate that they have had difficulty accessing services provided by the Department of Developmental Disabilities. They also reported that they are unclear as to what services they are eligible for and how to access them. There appear to be a number of reasons for this, including staffing shortages within the department. State funding for the Department of Developmental Disabilities has not been adequate to meet the needs of the numbers of families that are being referred to the Village. As a state agency, the department does not have the community ties that are characteristic of most of the agencies that provide services through the Village. There are ongoing attempts to establish more effective relations with the Department of Developmental Disabilities.

Mental Health Services. The role of mental health services within Children's Village is evolving. One of the goals of the mental health coordinator is to train staff to be comfortable making referrals for mental health services both for children and for families. In addition, the coordinator is training staff to use techniques that address behavioral issues they encounter in their own work. The mental health coordinator now has regular meetings with resource coordinators and with the staff that provide other services, such as occupational, speech, and hearing therapy. This creates an opportunity to confer about particular cases and to teach skills that are useful for addressing behavioral issues. The mental health coordinator has been able to help other professionals obtain better results from their therapeutic interventions. Some examples of what the behavioral health staff have been able to do are helping an occupational therapist develop techniques that succeeded in getting a hyperactive child to sit down so that occupational therapy could proceed, finding techniques that addressed the problems of a child who would regularly become non-responsive during occupational therapy, and observing a child with attention

deficit hyperactive disorder (ADHD) during the transition into middle school and developing recommendations for parents, teachers, and the school psychologist to ease the transition.

The direct services that are being stressed include short-term therapeutic interventions to address functional issues. The Behavioral Assessment Team teaches behavior modification skills to parents and other caregivers of special needs children. They will go to a classroom or home and draw up a treatment program based on their observations. In addition, the mental health providers at the Village are targeting particular interventions that are often needed with families of CSHCN. For example, they are addressing “grief-loss” issues that are likely to occur when a child is first diagnosed, family therapy, and parent support.

The availability of an on-site mental health coordinator in a center for CSHCN is reported to be extremely beneficial. Parents noted that the presence of mental health specialists within Children’s Village has encouraged them to raise issues regarding their child or family’s mental health that might not have come up or been addressed in a specialized health care setting. The presence of mental health specialists in the Village helps to prevent the intense physical needs of many of these children from overshadowing psychological or behavioral health issues that contribute extensively to the family’s quality of life.

4. Financing

Financing Children’s Village is an ongoing challenge. Raising the initial funds to build the Village was a tremendous accomplishment. However, the effort to keep the Village operating and delivering services is no less of a challenge. This section describes the initial capital campaign, how operating expenses are funded, and how services are funded.

a. The Capital Campaign

The initial funding for building Children's Village came from a capital campaign led by the Memorial Foundation. In March 1995, the Foundation authorized a capital campaign to purchase the land and build the facility. The campaign was able to raise \$4.1 million in 18 months, the majority coming from private sources (36 percent from corporations, 42 percent from individuals, and 22 percent from foundations). An additional \$400,000 grant was received from the Kresge Foundation to fund the multi-agency information system used in the Village. In addition to the funds from the campaign, in-kind contributions were made to provide for land, architectural fees, construction materials, and equipment. The building was opened in the fall of 1997.

This accomplishment is particularly impressive given the economic conditions in Yakima County. The median household income from the 1990 census was \$23,612, which was far below the median for the country (\$30,056) and for Washington State (\$31,183). The poverty rate for Yakima County in 1989 was 20.2 percent, once again well above both the national (13.1 percent) and Washington State (10.9 percent) rates. Initial fund raising efforts drew upon the reputation of the hospital, the partner agencies, and long-standing community efforts to address poverty and social ills in the Yakima Valley. The community began to mobilize in the 1980s to address issues of poverty, including poor health outcomes, that had become increasingly apparent. Various community agencies banded together to apply for grants that targeted communities with large at-risk populations, high teenage pregnancy, high rates of poor birth outcomes, high migrant populations and other indicators of community distress. The organization that won the grant would frequently subcontract with other community-based organizations in the county. This helped build relationships among organizations and fostered a collaborative climate. The fact that groups were able to work together to get things done has created a willingness among those in the community with resources to provide support when they are convinced of the need and merits of particular efforts.

The fund raising effort was designed with the intent of creating a building that would serve the needs of families of CSHCN and would be a source of pride for the community. The building was designed both to be child-friendly and to highlight the contributions that community donors made to the capital campaign. A decorative border at the entrance of the building lists donor names, and other names are engraved in ornamental stones and paving bricks. Along one of the main hallways in the building are

rustic wooden signs painted with the names of contributing businesses. The building has won architectural design awards and was built with the goal of making it easy to add on additional space if additional resources become available. The capital campaign represents an impressive effort to create a community resource and is one way in which agencies interested in fostering integration through co-location may be able to address the difficulty of getting grant funding for “bricks and mortar.”

b. Operating Expenses

A successful capital campaign was a major milestone in creating integrated services for CSHCN in Yakima County, but in order for Children’s Village to function, a plan had to be developed which provided ongoing funding for the operating expenses of the Village itself and for the integrated services that are provided for the clients. Agencies that have a full-time or a scheduled part-time presence at the village are charged rent based on the square feet their services occupy. These funds cover expenses for utilities, maintenance, and other common costs. In addition, an hourly utilization fee is charged based on the number of hours an agency provides services in the Village. The agencies are charged a per-computer cost for information systems expenses. Some of the part-time agencies share computers. Drop-in child care is billed on an hourly basis depending on which agencies’ services are being utilized during the time the child is in care. The main partners and the Memorial Foundation have combined to provide funding for a development specialist to focus on fund raising and a business staff person to work exclusively on Village finances.

The allocation of expenses is reviewed yearly and careful attention is devoted to issues of equity. Under the original billing system the partners were billed at the end of the year. This created uncertainty, because the final costs were unknown. Recently they have changed to projecting each partner’s expenses for the coming year.

Providing adequate funding for operating and common expenses has been challenging. Memorial Hospital has assumed a disproportionate share of the burden, but is hoping not to do so on a permanent basis. One of the goals is to try and minimize this by maximizing other funding sources. This is one of the reasons that the partners have funded a development specialist. The office is also exploring the possibility of opening the drop-in child care center to children of patients who utilize the cancer treatment center which is next door to the Village.

c. Financing Services

Children's Village makes use of a variety of State and grant-funded resources. Memorial Hospital receives four MCH Title V grants which are used for services at Children's Village. The total funds are \$111,000 for CSHCN, \$47,000 for cleft-lip palate, \$261,000 for early intervention services for children from birth to age three, and \$19,000 for neurodevelopment. The Yakima School District has a contract with Memorial Hospital to provide services under IDEA Part C. The family resource coordinators and the one person who handles intake calls are funded through MCH funds and through IDEA Part C.

The partners in the Village bill their various payers for the services they provide. During the planning stages for Children's Village there was some initial consideration given to creating a centralized billing system. However, it was determined that this would be costly, duplicate existing systems, and not meet the needs of the partners. Over 80 percent of clients who use the Village are on Medicaid. Children's Village has not been as aggressive as they could be in seeking to maximize Medicaid funding for the services they provide. For example, staff indicated that they have not been billing for the neonatology specialty clinic because the reimbursement level is so low. While it is understandable that there would be some resistance to dealing with the bureaucratic hassles of seeking Medicaid reimbursement, the Village may be depriving itself of needed funding by failing to seek maximum reimbursement from Medicaid. In addition to not seeking funding for services reimbursed at a low rate, they may not have fully explored whether certain services they are not currently billing Medicaid for are actually reimbursable.

Mental health services are paid for through the Regional Service Network (RSN). Washington State provides Medicaid mental health services through a managed care system that provides funding to a county or groups of counties that form a Regional Service Network (RSN). The RSNs are designated as "prepaid health plans" under the state's Medicaid waiver. There are 14 RSNs and they are allocated a fixed amount per Medicaid eligible resident. The RSNs are obligated to serve all Medicaid eligible persons who need services within the capitated funding amount. The advantage of this system is it provides a great deal of flexibility in determining what services to provide to particular clients. However, the funding was allocated to counties based on the previous geographic distribution of funds under the fee-for-service system and a study that estimated the prevalence of mental illness in each RSN (Joint Legislative Audit and Review Committee 2000). Staff and administrators in Yakima believed this

funding formula left Yakima County underfunded. The RSNs are receiving additional funding if they do not utilize all the state hospital beds they are allocated. However, at this point the RSN has been using this hospital diversion funding to provide funding for facilities that directly impact hospitalization, such as nursing homes for elderly patients who would otherwise go to the state hospital. The funding is not being used for preventive programs, though many of the providers who work with children in Yakima County think that it would be good policy to do so.

In Yakima the RSN is called Greater Columbia Behavioral Health and covers 11 counties. The county or consortium of counties contracts with providers for mental health services. There are three mental health contractors within Yakima County, including the Yakima Valley Farm Workers Clinic, Central Washington Comprehensive Mental Health, and Catholic Family and Child Services. All of these organizations have a presence at the Village, though only the Farm Workers Clinic is a full-time tenant.

5. Family Involvement

A recurring theme expressed in interviews with Children's Village partners is the child and family focus of the work. The attitude of "we will figure out how to make services happen for children and families" was expressed by partners at all levels of leadership and service delivery.

Families who were interviewed for the case study described their experiences with accessing services prior to the creation of the Children's Village. The parents described their frustrations in obtaining information about services and how to use them, problems related to traveling to Seattle to obtain care, and the lack of respect shown to them by several agencies. Parents described Children's Village as a place where the environment is welcoming to and supportive of children and families, and where the physical and behavioral needs of children are addressed in an interactive, integrated fashion. Families cited the presence of the child care room at the Village and the willingness of the staff to work together in an inter-disciplinary fashion as examples of the Village philosophy and stressed that they felt that families were seen as unique and as the primary decision makers for the care of their children. A number of parents stressed that their children enjoyed coming to the Village for therapy, which made the experience much easier for all concerned.

An important component of parent involvement is the Parent to Parent Program. This is an organization of parents helping parents care for their special needs child and their families. The most recently developed parent support program has the parent support staff visiting the Neonatal Intensive Care Unit to provide support and enabling services to parents with an infant who is likely to need the services available at Children's Village. Other services include parent support groups, a newsletter in English and Spanish, and several programs targeted to teens with special needs. These include: a mentoring program matching a typical teen with a special needs teen; Village Teens, a community program for teens with and without disabilities; Kids on the Blocks, a school-based educational program that uses puppets with disabilities to discuss issues of special needs children; and a program, Sib Shops, for the siblings of children with special needs to assist them in understanding the special needs of their brother or sister while having their own needs and feelings validated.

The Yakima Valley has a significant and growing Latino population which presents special issues for the planning and delivery of integrated services to Latino families with children who have disabilities or chronic health problems. Unfamiliarity with the health and social services systems, language and cultural differences, and a lack of comfort with the concept of advocating for services are frequent issues for Latino families. Parent to Parent is an especially important resource for Latino parents because the provider community in Yakima has a shortage of Latino staff. There is a bilingual parent to parent coordinator who can reach out to the Spanish-speaking community and connect parents and children to services available at Children's Village.

Overall, families see themselves and are seen by the Children's Village leadership and staff as critical partners in the design and delivery of services, as evidenced by their participation in leadership committees and the Parent to Parent Program, and the feeling expressed by families that "families are valued and respected."

6. Evaluation

Evaluation at the Village is focused in three areas: each of the partners conducts ongoing monitoring and evaluation as required by their individual funders; the leadership of the Children's Village has initiated a process to assess the level of integration achieved through the Children's Village structure; and the Yakima Farm Workers Clinic has launched an evaluation of three major service units at the Village site and is working with other Children's Village partners to broaden this evaluation to the entire Village.

Each of the partners is accountable to its funders and has instituted a variety of mechanisms to manage this. The leadership committees of the Village have established a strategy to assess both informal and formal services integration resulting from the institution of the Children's Village model. Areas of integration assessed include: information sharing and communication, cooperation and coordination, collaboration, consolidation, and integration. The group is using a self-assessment Community Services Integration Matrix as a tool to identify, examine, and discuss progress toward services integration and to compare the partners' success in these areas prior to the development of Children's Village with their current status. Thus far, the partners believe that they have made significant progress in partner/stakeholder relationships, shared goals and mission, relationships with state agencies, Children's Village governance, development of a service delivery model, financing and budgeting, and information management.

In addition, the Yakima Farm Workers Clinic is launching an evaluation of three service components (mental health, specialty clinics, and dental care) it offers at the Village and plans to link this evaluation to that of the entire Children's Village operation. Farm Worker's Clinic staff have met with the Children's Village strategic planning group to discuss an evaluation design and strategies to evaluate the overall effectiveness of integration of services at the Village. The Children's Village partners recognize the importance of and the need for more extensive evaluation of child and family health and well-being outcomes resulting from the integration of services.

C. Lessons Learned

Children's Village has succeeded in being a facility where CSHCN and their families can receive comprehensive and integrated services. Most of the families we spoke with brought up the difference

between services before Children's Village and after it was built. Children's Village has made it much easier to access services and has clearly improved the quality of their lives. This section describes the factors that have contributed to Children's Village's ability to create such a model, and the continuing challenges faced by the Village in providing and improving services to CSHCN and their families.

1. Factors Promoting Coordination, Collaboration, and Integration

There are a number of factors that have clearly contributed to Children's Village ability to create a new institution that has done such an outstanding job improving services.

- # **Leadership and a Willingness to Move Forward.** When Children's Village was in the planning stages, Memorial Hospital played a crucial leadership role in bringing the various agencies together. The original group consisted of about 20 agencies. As things moved forward, it became clear that 14 agencies wanted more direct involvement and the three main partners were the only ones who felt they could make a commitment to full partnership and full-time tenancy. The decision was made to move forward with these partners. Clearly, given the number of agencies unable to make a substantial financial commitment, the plan could have been discarded, but the key agencies decided to go forward in spite of a fair amount of risk. The leaders of the partner agencies have remained committed and Memorial Hospital has continued to back the Village by contributing a disproportionate share of operating expenses.
- # **The Commitment of the Community.** Children's Village was built on the foundation of community mobilization resulting from recognition of the serious problems that faced Yakima County. The commitment to tackling these types of problems extended beyond the community human service agencies, as was reflected in the success of the capital campaign. The Village was designed in a way that allowed the community to show off that commitment. The quality of the design and the effort to build in donor recognition provided an opportunity to display this commitment while furthering the goal of providing improved services.
- # **Creating a Strategy to Blend Funds.** In order for Children's Village to function, a strategy was needed for blending funds to pay for shared services, such as building maintenance, reception, information systems, and drop-in child care. The strategy that was developed combines rent payments from the main partners with billing for usage for certain services for those agencies without a full-time presence at the Village. While the Village is trying to find additional sources of funds to pay for some of these services, the strategy has enabled different agencies to combine funding in a manner that is fairly straightforward to implement.
- # **A Commitment to Maintaining and Improving the System.** Building Children's Village was quite an achievement; however, the purpose was not just to create a building but a new way of serving CSHCN. Those involved with Children's Village recognize that

taking advantage of the facility requires continual effort to maintain and improve relations among the providers. Administrators noted that there was a time when the Village risked becoming a place where separate providers were located in the same building. In order to avoid this, administrators and staff need to be regularly reminded of the goal of building an integrated care system. While attention has to be paid to financing, this has to be balanced with a willingness to allow collaborative efforts, even if it is not immediately apparent how they are going to be billed. Staff need to know that there is support at all levels for cooperative efforts.

As difficulties arise in implementing a model, action needs to be taken to address the problem and create solutions. Children's Village has done this on a number of issues. The best example is the creation of the mental health task force, to address the problem of behavioral and mental health referrals bypassing the existing system of care and coming instead to the Village. A task force was formed of Village providers and a parent representative, and surveys were conducted with Village staff, primary care physicians, and families to help determine what mental health services would be appropriate to provide in the Village. The task force developed specific recommendations that are in the process of being implemented. A similar strategy is being followed to address how to respond to the shortage of speech and hearing specialists. The strategy allows the professionals who are most affected by key service issues to come up with a plan to address problems that arise, empowering them to make decisions and making them pay careful attention to the potential consequences for themselves and the people they serve.

- # **Taking Advantage of Co-location Through Cross-Training.** Co-location creates tremendous opportunities for providing better services, but often these opportunities are not realized. Children's Village has succeeded in creating an environment where different types of providers learn from each other and, in the process, become better at their own specialty. The best examples involve the presence of mental health professionals at the Village. The behavioral health staff at the Village have been able to assist occupational/physical therapists in addressing the behavioral issues of their clients in a way that makes the therapy more effective. The mental health coordinator will observe other providers while they are doing therapy and make suggestions that help address behavioral issues. Other providers noted that the availability of mental health specialists at the Village have made it easy to consult and ask about problems they have observed. Parents also note a willingness to ask questions about behavioral health problems they or their children are experiencing. These types of relationships and consultations would be unlikely if they required a referral and a trip to another office.

- # **Family Involvement.** Children's Village has created mechanisms for regular family involvement and has consistently sought parent input into the provision of services. The development of a drop-in child care center at the Village was inspired by the input of parents of CSHCN. This is one of the features of the Village that parents praised effusively. The mental health task force obtained parental input by including a parent representative and by surveying parents. These mechanisms have allowed for the creation of services that directly address quality of life issues for families with CSHCN.

Parent to Parent has also provided a means for parents to provide support to one another. This has been especially important for Latino parents because of the severe shortage of bilingual providers in the community. The Village has created opportunities for children to have a good time and to address the stress associated with being a child who has special needs or the sibling of such a child. There have been social gatherings and opportunities for children who receive services at the Village to show off their physical abilities through exhibitions in the therapy gym. Parents indicated that the availability of such opportunities means a great deal to their children.

2. Ongoing Challenges

While Children's Village has had a great deal of success in improving services for CSHCN, there are a number of ongoing challenges that need continual attention. This section describes some of these key challenges.

- # **Funding Collaborative Family-Focused Services.** One of the key challenges is finding funding for the collaborative services that are offered through the Village. There are clear benefits when providers with different specialties work together to provide services. However, often these collaborations are not billable. For example, the occupational/physical therapist indicated that she can not bill consultations with the mental health coordinator. There are times when therapists need to visit a child's home or school in order to observe behavior, but the travel time is not billable. Many of the behavioral health interventions needed by CSHCN are not billable because they do not entail a mental health diagnosis.

Children's Village faces a constant struggle funding the services that are provided. There has been a great deal of difficulty obtaining funds for the Sunnyside site despite the fact that the county is large enough that a second site is an important service. Memorial Hospital and the Memorial Foundation do provide special funds when a payer cannot be found for needed services, but their ability to do so is limited. As noted in the "Financing Services" section of the report, Children's Village is not being particularly aggressive in seeking Medicaid reimbursements. Yet doing so might help fund some of these services. The challenge within an organization that seeks to develop integrated services is to find a way to bring similar creativity and energy that goes into serving children toward figuring out how to make the most use of financial resources available to fund these services.

- # **Setting Boundaries.** Children's Village serves children with special health care needs. Washington State has a broad definition of who is eligible for CSHCN services that encompasses most children who receive services through the state community mental health system (Children's Village Mental Health Task Force 2000; MCHB 2000). However, the Village was not set up to be a children's mental health provider, since there was an existing system designed to handle such cases. This issue presented problems when the Village began to get a large number of outside referrals for mental health services. One of the reasons for this was likely because the Village was a comprehensive

service provider and it did not carry the stigma of a mental health provider. The pediatricians interviewed in Yakima indicated that it is very common to make a mental health referral and then be notified that the family never shows up.

Though the ability to generate referrals for mental health may reflect its success in creating the image of a child friendly service center, the Village did not have the capacity to handle all these mental health referrals and did not want to be seen as usurping the role of the mental health providers who are also Children's Village partners. The Mental Health Task Force addressed this issue as described in the "Identification of Service Needs" section of this report.

Another boundary-setting issue involves services that are the responsibility of the schools. Many of the services offered through Children's Village focus on the zero to three population. The reason is that schools are responsible for providing services for children over age three. The quality of services provided through schools varies considerably by school district. The Village works closely with school districts in providing services to CSHCN. In addition, providers within the Village have helped parents become more effective advocates for services within the schools. However, there are important issues involving where to set this boundary, especially when the quality of services provided are an issue.

- # **Challenging Partners.** The Village has faced challenges in working with some partners. Working with school districts represents a challenge because there are so many in the area and their capacity to serve CSHCN varies. Community agencies throughout Yakima County have had difficulty developing a successful working relationship with Child Protective Services. This often results in problems getting children the services they need. In addition, funding may be available for children in the child protection system that is not getting utilized because linkages between agencies do not exist. The lack of involvement of the Department of Developmental Disabilities in the Village has meant that families face difficulties accessing needed services.

Children's Village providers continue to try and build relationships with some of these challenging partners. Until they are able to do so, some of the pieces of a comprehensive services system remain missing.

Children's Village has accomplished a great deal in improving services for CSHCN in Yakima County. The model provides useful lessons for any agency that wishes to provide more comprehensive care, including mental health care, for families of CSHCN.

Massachusetts Mental Health Services Program for Youth

A. Background and Introduction

The Massachusetts Mental Health Services Program for Youth (MHSPY) began in 1996 as a collaborative project of the Massachusetts Departments of Education (DOE), Mental Health (DMH), Social Services (DSS), and Youth Services (DYS), the Division of Medical Assistance (DMA), the school systems of Cambridge and Somerville, and Harvard Pilgrim Health Care (HPHC), a managed care organization. The project received its initial funding in 1997 through a one-year planning grant from The Robert Wood Johnson Foundation's Mental Health Services Program for Youth Replication grant program. The program's goal is to provide integrated medical, mental health, family support, and wrap-around services for children with severe emotional disturbance within a Medicaid managed care system.

The MHSPY program's administration is housed at Neighborhood Health Plan (NHP), a smaller health plan that primarily serves members of MassHealth, the state's Medicaid managed care program. During its design phase, the program was administered by Harvard Pilgrim Health Care (HCHP), a managed care organization that serves more than 100,000 enrollees in MassHealth. In 1999, HPHC enrolled all of its MassHealth members in NHP, which it had become formally affiliated, and NHP assumed responsibility for MHSPY. Although HPHC has administrative oversight over MHSPY, via NHP, medical care is provided through its former staff-model HMO providers who now form a separate medical group, Harvard Vanguard Medical Associates.

The project was originally conceived as an experiment, to be tested through comparison with a control group receiving traditional services. The program serves a total of 30 children at any one time and is currently operating only in the cities of Cambridge and Somerville. Children may be referred to the program by any of the participating agencies, but they must be eligible for MassHealth and must enroll

in Neighborhood Health Plan to receive services. The pilot's clinical eligibility criteria include clinical indicators consistent with serious emotional disturbance (SED), risk of out-of-home placement, and involvement with at least one of the partner agencies in addition to Medicaid.

The MHSPY pilot represents a creative attempt at integration of services at the administrative, supervisory, and client levels. Care managers with small caseloads work intensively with families to meet the full range of their needs, supervisors from the participating agencies meet regularly to discuss the administration and management of the program, and the leaders of these agencies have worked closely together to blend funding and continue to form the project's Steering Committee. The project's experience provides useful lessons in the challenges of service integration for children with mental health problems.

To explore the details of the MHSPY model, a site visit was conducted in January 2001. During this visit, researchers met with representatives of DOE, DMH, and DYS, as well as the Department of Public Health, the Parent Advocacy League (PAL) and the regional office of the Health Care Financing Administration (HCFA). In addition, interviews were conducted with the MHSPY program's medical director, clinical manager, two care managers, the parent coordinator, and a pediatrician who sees patients enrolled in the program. A list of key informants can be found in Appendix A. In addition to this site visit, in December of 2000 the research team attended a Contract Status Meeting of the program and met with the program administrator and medical director. A telephone interview was later conducted with an area representative from the Department of Social Services.

This report describes the findings of these case study interviews. In the following sections, we discuss the interagency relationships needed to operate the MHSPY program, the program's methods for identifying service needs, the services and providers coordinated through the program, the program's financing structure, its provisions for family involvement, and its evaluation and monitoring efforts. These are followed by a conclusion describing the major lessons learned from the MHSPY experience.

B. The Program

1. Interagency Relationships

The MHSPY program is built on the relationships among its partner agencies: DMA, DMH, DSS, DYS, and DOE. Historically divided by categorical definition, these agencies agreed to participate in an historic challenge posed to the state by Dr. Mary Jane England. Dr. England, then President of both the Washington Business Group on Health and the American Psychiatric Society, is a child psychiatrist who was also the former Commissioner of Social Services for Massachusetts and who has many friends in the provider community. She collaborated with Dr. Joseph Dorsey, then Medical Director of Harvard Pilgrim Health Care, the state's largest HMO, and Dr. Katherine Grimes, the director of child and adolescent services at HPHC, in 1994 to convene a meeting at HPHC of the state's child-serving agencies to discuss the changes in the state's social and health services systems as a result of the growth of managed care, and the need for public-private collaboration to confront these changes. The initial meetings included all of the program's current partner agencies as well as two who are not formally (or fiscally) involved in the pilot program, the Department of Mental Retardation and the Department of Public Health. This process was supported by HPHC and the Washington Business Group on Health. From these meetings emerged the original application, developed by the Department of Mental Health, for funding to be dedicated to the Division of Medical Assistance and passed through to Harvard Pilgrim Health Care. Thus, DMA received the grant, and although HPHC needed to be encouraged to take on the challenge, it did not have to bid on the MHSPY pilot contract. A project coordinator was hired by the Division of Medical Assistance funded out of the small planning grant from RWJ.

While the work of developing the interagency relationships had pre-dated the final awarding of the planning grant by three years, the efforts at the local level needed to implement the program only began with receipt of the grant. The development of the program's operations took the next 17 months, during which the partner agencies were required to negotiate agreements to blend funding for the project, request and receive approval from HCFA to claim Medicaid matching funds, develop formal service contracts with the agencies, and design a package of benefits that met the various agencies' diverse mandates and requirements. This last task was conducted by a design team made up of appointees of the assistant commissioners of the partner agencies, with family input contributed by four family representatives.

Finally, the HCFA regional office became involved in the design of the pilot three months before its implementation. The use of Medicaid funds (and the stipulation that enrolled children be Medicaid-eligible) required that HCFA approve HPHC's participation in the program; however, the use of what was essentially a sole-source contract to HPHC posed a potential obstacle. With the help of the HCFA regional office, the DMA's General Counsel provided justification for the sole-source contract: since no child was to be required to enroll in the program, MHSPY merely represented an optional benefit for children in Cambridge and Somerville enrolled in NHP. To gain approval, the state's general 1115 waiver, submitted in July 1997, was amended to include the pilot program.¹

The relationships among the MHSPY partner agencies continue at every level, based on the philosophy articulated by the project director as "continuity of intent;" that is, that collaboration and integration should be put into practice throughout the project. The mechanisms for this collaboration include:

- # **The Steering Committee.** The project Steering Committee is made up of the Assistant Commissioner-level representatives of each of the partner agencies who formed the original project design team. This group meets monthly and sets overall policy and reviews the performance of the program.
- # **The Area Level Operations Team (A LOT).** This is a group of mid-level representatives from each agency that includes those who supervise individual caseworkers. The group meets twice a month to set priorities among referrals based on needs and clinical issues and to discuss common problems that arise between care managers and agency caseworkers. The members of the team vary in their appraisal of its usefulness: from the perspective of DYS, which refers few children into the program, there is little purpose in attending if the agency has no cases to discuss. The A LOT representative from DSS, on the other hand, reported these meetings to be useful in resolving systemic issues; for example, the group has helped DSS to identify the most promising candidates for referral to MHSPY and has made helpful policy decisions (such as excluding children with an IQ below 70, as these children would be primarily involved with DMR, which does not participate in the program).
- # **Agency Liaisons.** In addition to their clinical responsibilities, the four MHSPY care managers each serves as a liaison to one of the four partner agencies. In this role, the care managers train staff of the agencies, identify how the program can help serve the agencies' needs, and encourage referrals. This role was instituted in 2000 in response to

¹ In theory, the program was to have been opened to other bidders after a specified period. Although that period has passed and this open competition has not occurred, no other plans have complained or expressed interest in sponsoring similar programs.

the evident need for ongoing contact and education of the partner agencies about the role and functions of the project.

Despite these many avenues for coordination and collaboration, program staff report that education of agency staff is a continuing need. Caseworkers in each agency often do not fully understand the nature and intent of the MHSPY program and may see it as only one of many treatment programs that may be purchased for their clients. Education of staff at all levels, particularly the caseworkers' supervisors, was reported to be essential in promoting the message of the MHSPY program as a comprehensive prevention and treatment program for children at high risk of out-of-home placement.

The continuing success of MHSPY depends on the ongoing commitment of the partner agencies. Several of the partner agencies, notably the Department of Social Services and the Department of Mental Health, express great enthusiasm about the program and have every intention of continuing to participate. Significantly, DSS, which provides the greatest number of the program's referrals, finds the program especially beneficial to their clients. Specifically, the DSS Area Manager reports that MHSPY's flexibility allows them to provide critical services to both the child and the family, and she expects the program to have long-term benefits for both, including a decline in substance abuse and greater self-sufficiency.

However, those agencies that are less closely involved with the program express some ambivalence about their ability to continue to invest in it. The state Department of Education, for example, supports its financial contribution from a fund earmarked for prevention of residential placement for children with special educational needs. However, as a statewide agency, it cannot indefinitely support a pilot that operates only in two cities, and the appropriation from which the MHSPY funding comes is ending. Therefore, the continuation of the pilot will require that the school districts of Cambridge and Somerville begin to contribute. However, the details of special education funding in Massachusetts make this an uncertainty. DMA pays a "bundled," or capitated, rate for each Medicaid-eligible child who uses special education services to cover a standard package of medical services and therapies; however, these payments are made to the municipality, not to the school system or the special education program. Therefore, any savings that MHSPY generates in special education expenditures are realized by the city or town, not by the school districts, limiting the districts' incentive to invest in preventive programs.

Similarly, the Department of Youth Services, which contributes financially at a much lower level, reports that although the MHSPY target population is likely to be involved with the juvenile court system, the MHSPY strength-based model, which requires the development of a team, does not fit well with the timelines and requirements of the courts. By the time a child reaches the DYS system, an offense has been committed that requires out-of-home placement. Therefore, DYS considers MHSPY to be a “prevention” program that, while perhaps a worthwhile investment, rarely serves their target population. While the agency plans to continue to contribute to the program, its officials do not feel that they are receiving the services their contribution pays for.

Another challenge for the program is gaining the support of agencies that do not currently contribute to MHSPY’s blended funding stream. As mentioned above, the Department of Public Health (DPH) has not contributed financially to the program, although the Commissioner of Family Health within DPH and her designee serve on the project’s Steering Committee. DPH’s rationale for its limited role is somewhat paradoxical: on one hand, the Department’s population-based public health orientation and emphasis on primary prevention create a bias against a financial investment in what it sees as a treatment program for a small number of children with primary mental health disorders. At the same time, if DPH were to contribute, funds would have to come from other programs that could potentially serve the MHSPY population; at present, the only such program under DPH’s oversight is substance abuse treatment for adolescents, and none of these funds can be spared. Thus, while the Department’s leadership decries the categorical limitations that make service integration so difficult, it is these limitations that define the Department’s participation in the program. In addition, DPH representatives take pains to point out that the Department leads and participates in a wide range of programs to improve the coordination of care for children with special health needs, including an assessment of the needs of children enrolled in both SSI and Early Intervention and a pilot project to provide case management to CSHCN through primary care providers’ offices. Moreover, the care coordination provided to all CSHCN functions as preventive mental health care by providing support to families of children at high risk. Thus, DPH feels that it contributes substantially to MHSPY’s mission even if it has not yet contributed to the program’s funding.

2. Identification of Service Needs

The process of assessing the needs and resources of a family begins when a child is referred to the MHSPY program. Children may be referred by any of the participating agencies. Of the 51 children who had ever been enrolled in the program through September 2000, 58 percent were referred by DSS, 20 percent by DMH, 12 percent by DYS, and 10 percent from the Cambridge or Somerville schools. One possible reason for the predominance of DSS referrals is the relationship between the agency and the MHSPY enrollment coordinator. Under the terms of the MHSPY contract, the enrollment coordinator must be a public employee, not an employee of HPHC. Although technically a shared employee of DMA and DSS, the coordinator was hired from within DSS and is stationed at the DSS regional office in Arlington. She visits the Cambridge/Somerville area DSS office to solicit referrals, but only does active outreach to the other agencies when referrals from DSS begin to flag. Of course, many DSS clients are ideally suited to the MHSPY program, further supporting the dominance of DSS in the program.

Once a child has been referred to MHSPY, the enrollment coordinator's first task is to determine his or her eligibility for the program. To be eligible, the child must:

- # Be eligible for MassHealth's managed care program;
- # Be receiving services from at least one of the other partner agencies;
- # Reside in Cambridge or Somerville;
- # Be between the ages of 3 and 18½;
- # Have a score of 40 or higher on the Child and Adolescent Functional Assessment Scale (CAFAS);
- # Have symptoms or functional impairments that have lasted at least six months and are expected to persist for at least one year;
- # Be "at risk of placement outside the home," or be ready to return home from such a placement; and
- # Have an adult who can be expected to participate in service planning.

Upon receiving a referral and confirming the child’s eligibility for MassHealth, the enrollment coordinator conducts a home visit to the family to describe the program and assess their initial interest in enrolling the child. Because a visit from a DSS employee is not always welcomed by families, and because it may be difficult to convince families that enrollment is indeed voluntary, these visits are followed by a visit from a MHSPY “parent partner” who can answer questions and reassure families about the intentions and goals of the program.

If the family agrees to participate, the enrollment coordinator begins the process of gaining releases from the agencies involved with the child to share their records. Once the records have been assembled, the coordinator begins the process of identifying the needs and goals of the child and family. This process includes the following forms:

- # **Referral/Intake Sheet.** This form includes basic information about the child and family, the other agencies involved with the family, the potential benefits of MHSPY to the child and family, and the major strengths that the family brings to the process. This form must be signed and approved by the parent or guardian and the referring party.
- # **MHSPY Intake Information Form.** Based on the home visit, the enrollment coordinator then fills out a form describing the kinds of help the family is seeking, what the child wants, how the family thinks this program can help, the treatment and medical history of the child (and family where appropriate), and the child’s history in school and involvement with the courts.
- # **Consent Forms.** Parental consent is required for information to be shared among the various services agencies that work with the child and family. The MHSPY Consent and Authorization for Release of Information form gives parental authorization for the release of medical records, mental health records, counseling records, school records, DSS service plans, DYS records, and MHSPY service records from the persons and agencies they list on the form, and, in turn, gives permission for the MHSPY enrollment coordinator to release this information to Neighborhood Health Plan and the MHSPY Care Manager. It also provides for ongoing authorization for the exchange of information to and among the Care Planning Team for two years, and includes a separate authorization for release of medical information and information that is sensitive or protected by law (such as information about abortion, substance abuse, mental health visits, and HIV/AIDS), if the parent or child chooses.

Because the MHSPY program is a research effort, a separate consent form must be signed by the parent or guardian (or by the child if he or she is older than 13) to participate in the project, which includes semi-annual interviews by DMA’s Enrollment Coordinator and health status questionnaires. The program uses the standard consent form used by the

University of Massachusetts Medical Center's Committee for the Protection of Human Subjects in Research.

Once all of the releases have been received, the enrollment coordinator administers the baseline CAFAS to determine clinical eligibility for the program. If the child is eligible, the forms and records are mailed to HPHC, the enrollment form is faxed to DMA, and all of the agency liaisons are sent a letter about the child's enrollment. In some cases, a family will get to this point and discover that there are no slots available in MHSPY; in these cases, they will go on a waiting list to be formally enrolled when a slot opens up. At present, there are no more than two or three families on the waiting list.

If a slot is available, the case is passed on to one of the care managers. The file that is passed on to the care managers includes all relevant documentation relating to the child's case, including the Individualized Education Plan (IEP) if the child receives special education services, the assessment forms, and the releases. The care managers aim to meet with the family within 72 hours of receiving the case. Each care manager is a master's-level clinician; most have MSWs, and one is an art therapist. With a caseload of up to eight families, the care managers work closely with the entire family to identify their needs, build on their strengths, and identify community resources to help them and their children. The care managers' low caseload is a hallmark of the program, and the care managers themselves as well as the program administrators emphasized the importance of the depth and intensity of their relationship with their clients. However, this is one of the most difficult aspects of the program to replicate, as it contributes greatly to the program's staff costs.

The care managers use a number of tools and worksheets:

- # **Initial Evaluation.** This form is used by the care manager to describe the immediate issues facing the child and family on admission into the program and the initial resources that are in place to address them.
- # **Crisis/Safety Plan.** This form lists the contact information for the child's parents or guardians; the names and phone numbers of up to six other key players in the child's life who can be reached in an emergency (such as family, neighbors, or care planning team members); the child's primary care provider, the child's diagnoses, medications, and dosages; current patient presentation and clinical concerns; pertinent clinical history information; and a crisis plan, including agencies or providers to notify, hospitalization or

placement alternatives, and family resources. The crisis plan is reviewed every week and updated as necessary.

- # **Comprehensive Assessment.** This more detailed form allows the care manager to document the range of providers, caseworkers, and agencies that have been or are now involved with the child; the child's and family's description of their current needs; the family's significant supports; the child's medical and psychological history; the social history of the family; and the child's current diagnoses.
- # **Life Domains Worksheet.** This form helps the care manager and family to identify their immediate support needs at the time of enrollment, such as housing, legal aid, emotional support, substance abuse treatment, educational services, and cultural and religious issues. For the many needs a family might name, the care managers work with the family to set priorities and develop concrete goals. The purpose of this process is to build the families' problem-solving skills, not to solve problems for them.
- # **Individual Care Plan.** This is the ongoing planning form which is used to document the goals of each family and their monthly progress toward them. For each goal, with the help of the family and the care planning team, the care manager describes the strengths and barriers faced by the family, the interventions used and progress toward the goals, and the person responsible for the interventions. The strengths can be identified using the **Family Strength Discovery Worksheet**, a matrix that arrays each family member's values and attitudes, skills and abilities, preferences, and features and attributes.
- # **Weekly Log.** On this form, the care manager documents all contacts with the family and the time devoted to each. The form is organized by the goals developed by the care planning team to assure that the care manager's work with the family is focused on the family's goals.
- # **Care Planning Team Meeting Evaluation.** Finally, after each of the care planning team's monthly meetings, the members of the team are asked to fill out an evaluation form ranking the meeting on a scale from 0 (least effective) to 9 (most effective).

The care managers' role spans that of family therapist and care coordinator; it is estimated that 50 percent of their time is devoted to the provision of direct therapy for their clients. While their primary role is to identify the family's needs and strengths and work with them to meet their goals, they report that they fill a wide range of roles for their families and that the level of support that families need can be intense.

3. Services and Providers

The MHSPY program's credo is to provide services based on the family's needs, not on a predetermined benefit package. Therefore, the benefit package is considered to be an expansive one. As the provider of Medicaid services for its clients, the MHSPY benefit package includes primary and specialty pediatric services, inpatient hospitalization, prescription drugs, and psychological and substance abuse treatment services, as well as "wraparound" services such as recreational activities, music lessons, and YMCA memberships. (These services are funded out of a special "flexible fund.") These "extras" are considered to be legitimate if the care manager can show that they help the child and family progress toward a goal; for example, if a child's goal is to attend therapy sessions regularly but he has no way to get there, the care manager can justify purchasing a bicycle. The flexibility of the benefit package was described as one of the program's major strengths.

MHSPY enrollees have access to the full provider network of Neighborhood Health Plan, which includes 225 primary care sites, 7,200 specialists, and 57 community and teaching hospitals throughout Massachusetts. In addition, if a child needs services, such as acupuncture, or a provider, such as a Spanish-speaking in-home family therapy team, the NHP network MHSPY can choose to pay for that service or provider based on the Care Planning Team's recommendation. Once enrolled, a child may continue to see his or her existing pediatrician (if the pediatrician is in the NHP network) or may switch to a pediatrician within Harvard Vanguard Medical Associates, the medical group that is formally affiliated with HPHC. Care managers report that communication, sharing of records, and coordination are simpler when the child is seen at Harvard Vanguard; because they are located in the same physical space, care managers and pediatricians can meet informally to discuss cases, and because they share administrative systems, the care managers can see patients' records easily and can send messages to their doctors promptly. Nonetheless, even the Harvard Vanguard pediatrician interviewed acknowledged that he does not have time to attend the care planning meetings and he does not find that he has, or needs, more information about MHSPY enrollees than about other children in his practice. Nonetheless, he appreciates it when care managers accompany MHSPY children to medical visits, as they can help to smooth the relationship between the pediatrician and the foster family and assure compliance with

appointments. In general, however, it was noted that the MHSPY enrollees' medical needs (beyond the pent-up needs often seen in new enrollees) are generally minor, and their medical care is not usually complex.

MHSPY enrollees have centralized medical and behavioral health records located within a locked are in the HPHC system. This combined record required a special contract provision, as physical and behavioral health records are generally separate in the Harvard Vanguard system due to confidentiality restrictions on access to mental health records for non-mental health providers.

The experience of the program in Fiscal Year 2000 has shown that approximately 59 percent of clinical expenditures are devoted to the salaries of the MHSPY clinical staff, including care managers, the parent coordinator, and the Medical Director. Clinical services represent 40 percent of expenditures, with most of these going to tracking, mentoring, and outreach (17 percent of total clinical expenditures). The other major categories are day treatment and after-school programs (15 percent), hospital care (13 percent), family support (11 percent), flexible funds, including respite, food, and activity therapy (9 percent), individual and group therapy (7 percent), transportation, pharmacy, pediatrics and family therapy (each at 5 percent), recreation (four percent), psychiatry and acute residential (2 percent each).

A critical element of the MHSPY benefit package is the work of the care managers. As was described above, the care coordination process is the joint responsibility of the family's care planning team, which meets monthly. The goal is that no more than 50 percent of this team be made up of professionals and at least 50 percent of non-professionals, including mentors, family members, or big brothers or sisters. The care managers report that it can be difficult to find the requisite number of such "natural resources," but that they are essential in assuring that the family has a support system to help them in meeting their goals.

While MHSPY maintains a strength-based, goal-oriented care plan, the care managers recognize that each agency with a legal responsibility toward the child, family, or community must also have its own planning document which may or may not fully coincide with the decisions made in the MHSPY team meeting. For example, children in the DYS system have parole agreements that delineate the conditions of a child's parole. These agreements may include participation in MHSPY, but the agreement is not

equivalent to the care plan. Similarly, the DSS service plan may include working with MHSPY as a task, and would attach the MHSPY plan. Nearly all MHSPY enrollees have IEPs, which also overlap with the MHSPY individual care plan; therefore, care managers need to be familiar with and integrate what is in the IEP as the care plan is created. While Massachusetts offers more special education services than any other state, officials note that schools are traditionally reluctant to find out too much about what services children need, lest they be required (based on their legal mandate to provide all educationally necessary services) to pay for them.

The development of consensus across these agencies with varying goals was described as one of the major challenges of the care managers' role. In addition to managing the variety of service plans and agreements that a child may have, the care manager must also coordinate with the other caseworkers responsible for the child through other agencies. In the case of DSS, the caseworkers are often accustomed to being their clients' primary case manager, so some may find it difficult to work with another care manager. DSS area supervisors have therefore learned to take the attitude of the caseworker into account when deciding which cases to refer to MHSPY, referring only those children whose caseworkers are known to be open to collaboration. From the perspective of DYS, their caseworkers tend to focus on areas in which the child is not in compliance with the probation agreement, not on their strengths, and they therefore find the care planning meetings frustrating. To address this challenge, the care managers and their supervisor recognize that they must acknowledge that the primary goal and responsibility of the other agencies may differ from that of MHSPY or of the family. This issue will be discussed further in section C below.

4. Financing

The project is financed through a blend of funds from the partner agencies as well as Medicaid matching funds from HCFA. The major elements of the project budget are:

- # The Departments of Education, Mental Health, and Social Services each contribute \$250,000, and the Department of Youth Services contributes \$64,000.
- # In addition, the Division of Medical Assistance contributes \$185,000. This includes a per-member-per-month (PMPM) capitation rate of \$541, approximately equaling the rate DMA pays managed care plans for children in Rating Category II, which includes children eligible for SSI. Although not all MHSPY children would qualify for this rating

category, a study of the cost of services used by the target population, including services provided through DMH and DSS, supported this higher rate for all MHSPY children.

NHP is then paid on a capitated basis for providing the full package of MHSPY-covered services. With all of the agencies' contributions included in this capitation rate, NHP receives a rate of \$3,283 PMPM for each enrolled child. This rate includes all medical, behavioral, and support services, but does not include residential treatment beyond 30 days (to include this would have produced a rate of over \$4,000 PMPM). After 30 days, if a child requires residential care, payment for that service is the responsibility of the referring agency, although the child may remain in MHSPY for another six months. (This is to make sure the child does not lose eligibility for the service during what may turn out to be a relatively brief placement.)

Included in this capitation rate is a subcapitation, provided to Harvard Vanguard Medical Associates, for medical and inpatient services. NHP then reconciles with HVMA regarding any unspent or overspent dollars and DMA reconciles with NHP. Presently, any savings obtained through the reconciliation are passed on to the general fund and are not returned to the purchasing agencies or the program.

The partner agencies' financial contributions to the program are passed to NHP through DMA. However, this pass-through does not necessarily allow DMA to draw down the Medicaid match (at Massachusetts' matching rate of 50 percent) for the full amount. To negotiate its initial "matchable percentage," DMA had to calculate the proportion of the capitation rates that would have been covered by Medicaid in the absence of MHSPY. This came to 23 percent of the total \$3,283 PMPM rate, and included all standard Medicaid services (as represented by DMA's \$541 PMPM contribution) as well as care coordination and additional services provided by the other agencies that could potentially have been reimbursable by Medicaid. However, some services, such as school-based and residential services, were excluded from the Medicaid match.

The difficulty in calculating this "matchable percentage" is that it was based on the array of services typically used by MHSPY-eligible children before the pilot began. If MHSPY is indeed able to reduce

the rate of residential placement for its enrolled children, then the program will be able to make the case that a larger percentage of the services provided were community-based, and therefore Medicaid-covered, so HCFA should match a larger percentage of the capitation rate. HCFA will allow DMA to recalculate this percentage once enough experience has been established and the data are available to do so.

Although the program receives matching funds for a portion (albeit a small one) of the financial contributions of the partner agencies (besides DMA), these agencies see no direct benefit from this match; the matching funds are transferred to the state General Fund. Therefore, the agencies have no particular incentive to maximize the “matchable percentage” of the program’s rate by assuring or encouraging the use of community-based, Medicaid-covered services. An example of the paradox this creates can be found in the case of school-based services. Because school-based IEP services are excluded from the MHSPY package, the Cambridge and Somerville school systems continue to provide services in accordance with their legal mandate and bill Medicaid for these services (although doing so may duplicate MHSPY services). In these cases, the school systems receive the Federal Medicaid match (of 50 percent of expenditures), while DOE would not directly benefit from the match if these services were provided through MHSPY. Thus, the school districts have no incentive to integrate IEP services into the MHSPY program, and on the state level, DOE has no incentive to encourage them to do so.

At the start, due to the lack of historical data for this program, both DMA and HPHC were wary of unforeseen risks and sought some risk protection. HPHC argued for a no-risk, FFS model; however, for HCFA to consider the contract between NHP and DMA to be a managed care contract, HPHC had to accept some level of risk. Therefore, the contract specifies that HPHC (now NHP) is at 1 percent risk for the costs of the program; that is, any losses beyond 1 percent of their budget will be restored by DMA. (Conversely, the plan cannot make more than 1 percent profit; revenues above that amount are returned to the state.) In practice, the plan has found that the costs of providing the MHSPY service package are well within the project budget. For the period of October 1999 through September 2000, the total PMPM expenditures for the program (including clinical and administrative expenses) were \$2913, well within the capitation rate. Moreover, the program has found that the average expenditure per child per month declines over time; that is, the longer an individual child is enrolled in the program, the lower the cost of his or her care.

5. Family Involvement

The MHSPY program not only allows for but actively encourages the close involvement of families both in the oversight of their children's care and in the administration of the program itself. The program employs a Parent Coordinator, who fills a number of roles: she works as a peer counselor directly with new families to explain and guide them through the program, and she serves as a coordinator of family activities for the program as a whole. In the first role, she acts as a support system to the parents, accompanying them to IEP meetings, for example, and ensuring that their voices are heard. This is reported to be a particularly useful service; by the time families are referred to MHSPY, multiple agencies have already intervened in their lives, often with little regard for their input or their need for support.

The parent coordinator also organizes regular activities for the MHSPY families. One of these is "family night," a monthly event in which families gather for pizza, arts and crafts activities for parents and children, and general socializing. This is generally a successful event with about 22 of the 30 families represented each month, often including fathers (who are generally much less involved in the children's lives than are the mothers) and the siblings of the MHSPY children. The coordinator also runs parent support groups every other week, but these are less well attended because they are generally held during the day and child care has not been possible in the current site. (The coordinator is currently surveying the families to identify the best time to hold the groups and new sites that are more "family friendly"). During these meetings the parents can discuss any issues that concern them; generally, shared concerns about the education system and medications and managing their child's behavior are frequent issues discussed at these meetings, which are generally attended by two to 10 family members.

The parent coordinator is supported by a small team of paid "parent partners," trained parents of children with complex mental health needs who work closely with individual MHSPY parents to set and attain functional goals for themselves and their children. The parent partners may have almost daily contact with their clients, and they meet regularly with the children's care managers to review and divide responsibility for common goals. The responsibilities of the parent partners are identified in the child's care plan. Currently, the program has three parent partners, including the parent coordinator, who has a caseload of six families.

The parent coordinator also works with the major organizations of families of CSHCN in the state, including the Federation of Families of Children with Special Health Care Needs (the state Family Voices chapter) and the Parent Professional Advocacy League (PAL, the state chapter of the Federation of Families for Children's Mental Health). According to the director of PAL, families particularly value the support of the parent partners, as they are often demoralized by social service systems and appreciate having someone on their team whom they know they can trust. The orientation of MHSPY toward the whole child and family is appreciated as well, as are the work and dedication of the care managers, and families find it empowering to be included in the care planning teams and appreciate the work and dedication of the care managers. MHSPY's focus on working with the child and the family to navigate complex systems has won over many parents who had become skeptical of the ability of the human services system to help them cope with their problems.

6. Evaluation and Monitoring

Because the program was originally conceived as a research project, evaluation and monitoring of outcomes are central to its design. The program's administrators have used three major assessment tools to measure the effect of the intervention on enrollees' functional status, as described below.

- # The major outcome measure used by the program is the CAFAS, an assessment tool that measures children's functional level in the domains of school, home, community, behavior to others, moods, self-harm, substance use, and thinking. In each area, children are scored on a scale of 0 (representing minimal or no impairment) to 30 (representing severe disruption or incapacitation), and these scores are summed to create a total functional score. The average baseline CAFAS score for MHSPY children at enrollment (based on the first 48 children enrolled) is 93.8, a score that reflects a need for intensive services and multiple resources; after six to 12 months of enrollment, the average score declines to 64.9 to 70, representing a potential need for intensive services; and after 18 months, the average score declines further to 53, still within the intensive range. Overall, this represents a 43 percent improvement in the CAFAS score.
- # Another measurement tool used is the Child Global Assessment Scale (CGAS), a measure of psychiatric functioning. On this tool, MHSPY children have shown an improvement in their psychiatric symptoms of 24 percent over 18 months, from "variable functioning with sporadic difficulties or symptoms in several but not all social areas" to "no more than a slight impairment in functioning."
- # A third instrument is the Patient Assessment Tool (PAT), which measures children's behavioral health in eight areas: substance abuse, duration of abstinence, severity of diagnosis, lethality, limitation of functioning, change in level of functioning, severity of

psychosocial stressors, and impairment of social support. MHSPY enrollees have shown improvements on all eight of these scales, ranging from a 64 percent improvement in substance abuse scores to a 9.8 percent improvement in severity of psychosocial stressors, over 18 months.

The positive results of these evaluations have prompted the Governor to include funding in his 2001 budget for the replication of MHSPY and the development of “MHSPY-like” programs in other areas of the state.

In addition to these functional assessments, MHSPY’s success is monitored through surveys of families, enrolled youth, and participating agencies about their satisfaction with the program. The families and the children themselves are asked to rate their satisfaction with their child’s care before MHSPY, the extent to which the Care Manager listens to them, how much they think “things are better” for the child and family, and their overall satisfaction with the help they got from the program. They are also asked what they would most like to change and what they would most like not to change about the MHSPY program and the Care Manager. Agencies are asked to rate the ease of coordinating services for children and families *before* MHSPY, and the effect of MHSPY on the amount of time spent coordinating services for MHSPY clients, on the quality of children’s medical and mental health care, and on the families’ ability to keep the child in the home. Agency representatives are also asked whether the MHSPY Care Manager listens to them and about their overall satisfaction with the program.

To fully evaluate the MHSPY intervention, functional, cost and satisfaction survey results must be compared to similar scores for a comparison group of children with similar diagnoses and needs who do not receive the services of the MHSPY program. Several approaches to the design of a comparison group were considered, including using children on the waiting list as comparison cases (complicated by the fact that the makeup of this group fluctuates over time), or using a pre-post comparison of the records of the enrolled children. However, a population of matched controls whose outcomes can be followed in the absence of the program may be critical to proving the value of the intervention to the partner agencies.² For example, DYS officials described a need to quantify the program’s success at

² The use of such a control group was part of the demonstration’s original design. However, HCFA felt that the experiment was so likely to yield advantages that the traditional service provided to this control population amounted to deprivation. Therefore, the control group was eliminated from the design.

keeping children out of the juvenile justice system and to compare the result to the value of the Department's investment in the program. To calculate this benefit would require that data be kept on a similar group of children through age 18 to monitor the services they use from all of the partner agencies.

C. Conclusion

The MHSPY program is currently at a crossroads as its leaders consider at once how to support and maintain the involvement of its partner agencies and how to expand the program into other areas of the state. These deliberations have led the program's administrators to identify what they see as the prerequisites for the design of an integrated model of mental health, physical health, and social support services for children and their families that replicates the MHSPY model. These include:

- # **Location in an MCO.** Respondents from a range of agencies agreed that housing the program in a managed care organization contributed to the integration of services. The advantages of this approach included the ability to contact providers, share records easily and assure that patients can be seen quickly, a feature most prominent in staff-model HMOs. In addition, there is a fiscal advantage to subcapitating an entity such as Harvard Vanguard for the costs of medical and inpatient hospital services, spreading the risk for costly services across a greater population than would be possible for an individual provider.

The major disadvantage noted for families was that requiring the MHSPY child to enroll in NHP sometimes meant that families would be split across different MassHealth plans; however, others reported that most families simply enrolled all of their children in NHP when one joined MHSPY. In addition, the widespread mistrust of MCOs in Massachusetts (and other states) can pose a significant challenge to the development of a managed care-based model.

- # **Authority of Care Managers.** Another benefit of locating the program within a managed care organization is that care managers can be given full authority to approve services, for which the MCO is then obligated to pay. Locating the case managers outside the plan would make it much more difficult for them to refer children to services efficiently.
- # **Interagency Relationships.** The key elements of the interagency relationships on which MHSPY is built include the involvement of people within each agency with the authority to commit funds and staff resources, leading ultimately to meaningful financial commitments on the part of the partner agencies. Without these investments, the agencies would not have been nearly as dedicated to the program.

- # **Monitoring and Evaluation.** For the MHSPY project to be truly successful—that is, for it to be replicated—it must be able to demonstrate its success in terms that are meaningful to policymakers. However, resources to do this are not provided within the capitation rate, nor are comparable data on elements significant to policy makers currently being captured outside the program. Ideally, funds would be identified so that the program would be evaluated using a valid research design with an appropriate comparison group, an infrastructure for data collection and analysis, as well as outcome measures that are specific to the goals of each participating agency.
- # **The Personality Factor.** A concern for several informants was the extent to which the success of the program to date has depended on the energy, commitment, and dedication of its founding Medical Director. A child psychiatrist and researcher with both a clinical and administrative role in the program, the director is passionately devoted to MHSPY and is available seemingly at all hours to clinical staff and agency officials alike to hear concerns and solve problems. Such a person is not likely to be available in every site, so it is important that the director’s job be one that can be done by a person of ordinary capacities.

Despite these positive attributes, the MHSPY program and others that attempt to replicate it face a number of significant policy and administrative challenges. The primary obstacles that another state or community might face in designing a similar program include the following:

- # **The Difficulty of Interagency Integration.** A central concern of the project is the clash of philosophies of the various participating agencies. While all of the partner agencies agree on the essential goal of the program—to integrate care for high-risk children in the hope of preventing future catastrophe—their perspectives on this goal can differ widely. For example, DYS considers the MHSPY model to be essentially preventive, and thus often irrelevant to the population for which they are responsible, while DPH sees MHSPY as providing a treatment service, and thus outside its mandate of population-based prevention. For these agencies, the result of these perceptions has been the relatively low fiscal contribution of DYS and a lack of funding from DPH.

A particular challenge in this area has been securing and maintaining the involvement of local school districts. Schools are essential players in an integrated system, as they are responsible for IEP services and teachers are well informed about children’s needs. Nonetheless, the traditional caution of school districts, combined with the lack of an incentive to collaborate, has hampered schools’ participation in the program.

- # **The Challenge of Evaluation.** Ultimately, each agency must feel that it is getting a reasonable return on its investment of funds. For DOE, this return might be defined as savings to the special education system; for DYS, savings in the cost of incarceration; for DSS, prevention of out-of-home placement or placement in less restrictive settings. If these benefits are to be realized by the agencies, they must be measured and evaluated in relation to outcomes in an appropriate comparison group. Currently, the project measures

its outcomes in functional terms, using the CAFAS and other similar tools. However, this measure alone is not meaningful to all of the partner agencies. Strategies are needed to measure educational outcomes, crime or delinquency prevention, and the cost of services for which each agency is responsible.

- # **Emphasis on Mental Health.** Although the service package offered by MHSPY is comprehensive, the program's emphasis is clearly on mental rather than physical health services, and few enrolled children have had chronic physical conditions. Thus, it remains to be seen how children with primary physical diagnoses, and associated mental health or behavioral problems, would fare under this model.
- # **The Complexity of Blending Funding.** One of the greatest obstacles to the program's initial implementation was the design of its financing structure. Identifying funding sources within each agency, reconciling differences in agencies' service definitions, and ultimately negotiating agreements that were acceptable to HCFA were time-consuming, complex processes. For such an effort to be successful, the participants from each agency must be open to cooperation and collaboration and must have the authority to commit funds, and the program's directors must design a financing structure that can maximize the participation of Medicaid.

Those interviewed agreed that the MHSPY program represents a clear attempt at integration of services; that is, the creation of an entirely new program using resources from across a range of agencies. Moreover, for the relatively small number of children it has served, respondents feel that the program has succeeded in improving the quality and coordination of services, and that the effects of these improvements can be seen in clear progress in children's school and social functioning and behavioral health. Families as well testified to the value of the care managers' effort and dedication to their children and their families as a whole. In addition, it is evident that, although the MHSPY model is might appear expensive to those used to seeing expenditures reported by agency rather than by child, its enrollees would be costly to the state in the absence of the program as well. The program still faces the challenge of demonstrating the long-term economic benefits of shared governance and integration of services.

The challenges to replicating this model are substantial: the program's administrative infrastructure is extensive and the financial commitment to the program would have to be high. Going to scale in Massachusetts—that is, providing MHSPY services to all children who qualify—is unlikely to be feasible unless some of the current barriers to integration (such as mutually exclusive eligibility criteria) are lifted. For another community or another state, the bureaucratic barriers and administrative costs

appear significant, so it remains to be seen whether the MHSPY model can be replicated.

Appendix A: Key Informants

MHSPY Project

Key Informants

Mental Health Services Program for Youth

Katherine Grimes, MD

Chip Wilder, MD

Mirta Ulivi

Mary Ann Orlando

Janet Peluso

Amy Corwin

Jeanette Adames

Harvard Vanguard Medical Associates

Tom Kruger, MD

Department of Medical Assistance

Emily Sherwood

Department of Mental Health

Joan Mikula

Department of Education

Marcia Mittnacht

Department of Public Health

Deborah Klein Walker

Brunilda Torres

Department of Social Services

CJ McConnell

Department of Youth Services

Scott Taberner

Andy Takki

Monica Coupal

Parents' Advocacy League

Donna Wells

Health Care Financing Administration, Region I

Ron Preston

Patricia Hitz McKnight

Dawn Project

A. Background and Introduction

The Dawn Project is an interagency initiative based in Marion County, Indiana to care for children with serious emotional disturbance in the community setting. The impetus for the creation of Dawn in the mid-1990s stemmed from a need in Marion County, as in other counties in the state, to control the spiraling costs of out-of-home and out-of-state placements for children with serious emotional and behavioral problems. State and county officials were also eager to improve their success at reunifying children with their families after residential treatment and to reduce the need for ongoing, often crisis-oriented intervention by social service and other agencies in the lives of children with serious emotional disturbance and their families.

These concerns spurred interagency efforts beginning in the late 1980s and extending into the 1990s to improve systems of care for children and their families and to reduce associated costs. Concurrently, the state legislature conducted a study exploring systems issues and found that the separate funding streams and administrative structures of the different state agencies serving children with serious emotional difficulties (education, child welfare, and mental health) made it very difficult for families to access services on behalf of their children and were likely to result in overlapping services and unnecessary expenditures.

The Dawn Project grew out of these early collaborative efforts and findings. With encouragement from the Robert Wood Johnson Foundation (RWJF), the state Division of Mental Health (DMH) applied for and received a Mental Health Services Program for Youth (MHSPY) Replication Grant to establish a pilot project in Marion County, the state's largest county, which includes the state capitol of

Indianapolis. The intent of this planning grant, which the RWJF awarded to twelve states (including Massachusetts, one of the other sites explored under this study), was to assist in the implementation of a family-focused, community-based, managed care system for children with severe emotional disturbance (SED). Indiana's grant was awarded in February 1996 to assist in the launch of the Indiana Cost Sharing Project, later renamed "The Dawn Project: A New Day, A New Beginning" (Dawn). DMH asked the Mental Health Association in Marion County to serve as the fiscal agent for the grant, reflecting the agency's commitment to involving an advocacy organization as a partner in Dawn's development and implementation.

Dawn has provided a vehicle for state and local agencies who provide services for children with SED to collectively envision, and then implement, a better way to address the needs of these children and their families. The core partners in Dawn are those state and county agencies who jointly fund the services provided to Dawn clients: the state Division of Mental Health (DMH), the state Department of Education/Division of Special Education (DOE), the Marion County Office of Family and Children (MCOFC, the county child welfare agency) and Juvenile Probation in Marion County. Together, these agencies pay a capitated rate to a non-profit managed care entity, Indiana Behavioral Health Choices ("Choices"), created by four Community Mental Health Centers in Marion County to serve Dawn clients.³ The capitated rate covers the costs of residential care for children who need this resource, as well as a range of wraparound services such as mentoring to support the care of children with SED at home or in other community-based settings. This capitated rate is enhanced by Medicaid, which is the primary payer of medical, behavioral health,⁴ and service coordination services for Dawn clients, 70 percent of whom are enrolled in Medicaid. For all clients, regardless of insurance status, Dawn uses an intensive service coordination model to link clients to services and community resources with the intent of moving families toward their identified goals. However, while physical health issues are routinely assessed and addressed as needed, the Dawn model of care for children with emotional disorders focuses largely on the mental health, educational, child welfare, and juvenile justice systems.

¹ Although Choices was initially created to serve Dawn clients, it now also operates several additional programs for youth, as well as a program based on the Dawn model for mentally ill homeless adults.

² Behavioral health services covered by Medicaid include therapy, day treatment, and acute hospitalization.

Since the first client was enrolled in May 1997, through January 2001, Dawn has served nearly 400 clients, with about 150 children enrolled at any one time. The project has shown promising results, including reductions in the length of stay of residential placements and the costs of residential care. The state is eager to translate the lessons from Dawn to other communities around the state; in July 2000, the Family and Social Services Administration's Division of Mental Health and Division of Family and Children came together to fund four replication sites around the state.

Dawn was selected as a case study site for this study because of its efforts to create a more integrated system of care for children with serious emotional disorders. The systems reform and service integration approaches implemented by the Dawn Project were explored through a series of key informant interviews conducted by telephone in February and March 2001. Using structured interview protocols, researchers interviewed representatives of DMH, DOE, MCOFC, the Indianapolis Public Schools, the Mental Health Association in Marion County, program administrators employed by Choices, service coordinators, a representative of the family support organization Families Reaching for Rainbows, and two types of providers (one residential treatment center and two hospital-based pediatric specialists). A list of key informants is included here as Appendix A. For additional contextual information about the state's systems of care for children with special health care needs (CSHCN), a representative of the Indiana State Department of Health's Title V/CSHCN Program was also interviewed.

This report describes the Dawn Project as reflected in the case study interviews and supporting program materials. In the following sections, we describe the interagency partnerships underlying the Dawn Project, strategies used to identify service needs, the services and providers utilized to address these needs, the program's financing structure, the role of families, and ongoing monitoring and evaluation activities. The final section draws some conclusions regarding the factors that promote and hinder service integration, including those specifically related to the integration of mental and physical health care.

B. The Program

1. Interagency Relationships

Interagency relationships are the foundation of the Dawn Project and are an intrinsic focal point in efforts to reform systems of care for children with emotional disturbance in Marion County. A variety of agencies and partners have been involved in the development and implementation of this innovative project.

The primary structure through which interagency relationships have been fostered has been the Dawn Project Consortium, which was formed in early 1996 to guide the implementation of the RWJF grant. This structure brought together multiple agencies and partners to collectively envision the possibilities that Dawn could help bring about, to implement the structures and processes to put this vision into practice, and to provide ongoing guidance over the course of this project.

The core of the Dawn Consortium is the group of state and local agencies that fund services for Dawn clients: DMH, DOE, MCOFC, and Juvenile Probation. Other partners in the Consortium, which has been expanded over the life of the project, include other state agencies such as the Department of Correction, the Mental Health Association in Marion County, Indianapolis Public Schools, psychiatric providers, and parents. Representatives of the Medicaid agency were initially involved but did not participate on an ongoing basis. Neither the state nor the local department of health have played a significant role in the Dawn Project or its Consortium.⁵

The Consortium serves as a cross-system governing and oversight body for the Dawn Project. Initially, Consortium activities focused on getting the project up and running. Several task forces, including representatives of the various partner agencies, providers, and parents, were set up to accomplish this goal, including:

- # The Provider Relations task force, which communicated with and recruited providers;

³ The Health and Hospital Corporation of Marion County (the county health department) is the fiscal agent that was identified by the mayor's office for the CMHS grant, which required that a government entity be the grantee. By virtue of this role, the President of the Health and Hospital Corporation has recently become a Consortium member.

- # The Clinical Operations task force, which identified criteria for eligibility and refined various aspects of the service delivery approach;
- # The Finance and Operations task force, which devised the financing arrangements;
- # The Management Information Systems task force, which identified a management information system that the project adopted initially (before developing its own); and
- # The Information and Training task force, which helped to shape the project's guiding principles and integrate this philosophy into project materials.

These interagency task forces provided a forum through which relationships between the different partners could develop, for the agencies to better understand each other's cultures, and for the Consortium to come to agreement around Dawn's mission and values, as well as the structures and processes through which the project would be implemented. These relationships have been further developed through monthly Consortium meetings, whose focus has evolved along with the project from implementation at the beginning to oversight once the project became operational. Interviewees noted the importance of these monthly meetings as a forum for ongoing communication and information exchange.

Problem solving is also a critical function of the Consortium. After the project had been running for two years the Consortium mobilized its attention to address outstanding challenges. Four workgroups, each including representatives of various agencies and perspectives, were created to address the main issue areas of policy governance; procedures and operations; education, training, and communication; and providers, services, and families. Some of the workgroups have disbanded since addressing their goals; others are still operating. This cross-system approach reportedly worked effectively not only to identify solutions to problems but also, through the process itself, to help promote education and resolve misunderstandings among the partners about their various mandates, roles, and perspectives. The importance of constantly providing opportunities like this for cross-system education and negotiation was stressed by the partners. Although the project has obtained the ongoing commitment and participation of high-level agency officials, whose ability to make and commit to important decisions

has been critical to the project's success, the time constraints of agency staff at all levels was noted as a major barrier to furthering cross-training goals.

Despite a need for more broad-based cross-training among agency staff, the core leaders of the project—the high-level representatives of the four funding agencies—have demonstrated a sharp ability to recognize and work around the cultural differences among the participating agencies. They have demonstrated the leadership to recognize that, while certain limitations of the participating agencies may make certain goals unreachable, at least at a given point in time, major strides can still be made in the desired direction. A key example of this ability was the group’s development of a shared financing structure (the details of which are discussed in the financing section). In agreeing to Dawn’s financing approach, the partners realized that, while it is not the ideal they hope one day to be able to reach, it represents a vast improvement over the usual way of doing business and is workable for their agencies; thus, it was important to move forward and adopt this approach. While the process has illustrated the difficulty of agencies’ turning over funds and power to another controlling entity, control issues did not prevent the group from moving forward toward their goals, and all partners remain financially committed to the project. The agency officials credit this success to their trust in one another and their commitment, established at the beginning of the project, to the shared philosophy that “our kids” can be better and more cost-effectively served through the reformed approach embodied in the Dawn Project.

An additional observation regarding the importance of interagency relationships in Dawn pertains to the particular role of the schools. While the State Department of Education’s Division of Special Education was integrally involved in Dawn since its outset, the local school districts in which Dawn was implemented were not brought into the Consortium until later in the process. Had the local schools been involved earlier, the project may have been able to facilitate the implementation of the Dawn philosophy and approach within the context of the local school environment, a process which has proven to be quite difficult. Notably, for the past year DOE has suspended new referrals to Dawn as a result of concerns raised by local school officials, for example, about the appropriateness of some services that Dawn has funded. Although both state and local officials expect that referrals will soon resume, this disruption in the project’s referral flow highlights the importance of local schools in efforts to address children’s needs within a community context. Schools play a central role in the lives of all children, especially for the 75 percent of Dawn clients receiving special education services, and their early involvement in planning, policy, and implementation decisions is important to facilitating the smooth operation of the project.

2. Identification of Service Needs

The Dawn project is designed to serve children with emotional and behavioral disabilities, specifically those children currently in residential placement or who are at risk of long-term inpatient psychiatric hospitalization or residential care. Referrals for the Dawn Project are made by juvenile probation, child welfare (MCOFC), and special education. Before making a referral for Dawn, these agencies must determine if a child meets the following list of eligibility criteria:

- # Has an impairment that impacts two or more functional areas: self-care, interpersonal relationships, self direction, or emotional adjustment;
- # Has a DSM-IV diagnosis and/or an impairment that has existed more than six months;
- # Is between the ages of five and 17;
- # Is at risk of separation from the family or is separated from the family;
- # Is currently (or was prior to placement) a resident of Marion County, Indiana, and living within Indianapolis or surrounding Marion County school districts;
- # Qualifies for services of two or more Consortium agencies; and
- # Is expected, as a result of services, to improve level of functioning, family satisfaction, and more cost-effective utilization of resources.

The process through which each of the referring agencies identifies eligible clients varies as follows:

- # **Child Welfare.** Referrals to Dawn from child welfare are made within the context of team meetings to identify and discuss arrangements to care for children needing residential placement services.
- # **Special Education.** A team approach is also used by special education programs to identify potential Dawn clients, although special education referrals may originate with any one of the 13 school districts in Marion County; thus, many people are involved in referral decisions. However, the state DOE has thus far required that the local school districts funnel their referrals through the state office, which makes the final determination of which students should be referred to Dawn.
- # **Juvenile Probation.** Decisions made by the juvenile court about which children to refer to Dawn are made by the Chief Probation Officer; thus, the referral process is a much more contained one than in the other agencies. Furthermore, while families referred by child welfare and special education are typically involved in the decision to participate in Dawn, the court often mandates participation by the children and families it refers. In

identifying clients who could benefit from participation in Dawn, the court typically selects children whose legal problems appear to be related to mental health issues and who have a history of out-of-home placement (especially in residential treatment facilities or psychiatric hospitals), and who may, in addition, have involvement with the special education system.

Given the range of people and various agencies involved in linking children to Dawn, the project faced the significant challenge of educating the various partners about which children are appropriately referred. At first, the Dawn coordinator attended placement meetings at the child welfare agency to educate staff about the project and to help identify appropriate referrals. This approach was also used with the schools, although, given the large number of school districts and people involved, cross-training of school personnel is quite challenging. One approach Dawn has used to educate school staff about the Dawn Project is to sponsor trainings in the school about various mental/behavioral health conditions and strategies for managing the behavior of children with such conditions within the school environment.

Dawn has also worked hard to cultivate a relationship with the Chief Probation Officer to facilitate referrals from juvenile probation to Dawn. For example, Dawn staff have undergone training by the courts so that they can better understand the juvenile court philosophies and processes. Several of the Dawn service coordinators were formerly probation officers, and Dawn has hired a consultant who was a former probation supervisor to act as a liaison between the court and the project, including by attending service coordination team meetings (described later). Such measures have helped to promote the level of trust and facilitate the working relationship that has evolved between Dawn and juvenile probation, such that the court now views Dawn as another partner that can assist in carrying out its responsibilities and also recognizes that there are various options for how these responsibilities can be met, namely by referring clients who meet the eligibility criteria to Dawn rather than to the Department of Correction.

The Dawn Project has a monthly administrative meeting to review new referrals. To date, all children referred to the project have been accepted, indicating a high degree of success in informing people about the project's target population. During the first three years of the project, child welfare referred 144 clients, juvenile court referred 100, and special education referred 55. (The relatively low number of clients from special education reflects their suspension of new Dawn referrals during the last year, a situation that is currently being addressed and is expected to be remedied in the near future.) There is no

cap on Dawn referrals, and administrators indicate that Choices could easily adapt to handle an increased caseload.

Once a new client is accepted into Dawn, the project assigns a service coordinator to the child and family. Within 72 hours of referral, the service coordinator meets with the family, usually at their home, to listen to the family's story, obtain consent for release of records from providers and agencies serving the child, and begin the process of identifying their strengths and needs, a process which is continued on an ongoing basis by the service coordination team.

The process Dawn employs to identify clients' needs, and subsequently develop a care plan, is one that builds on the strengths and needs of the family in twelve life domains: daily living, psychological/emotional, legal, educational/vocational, family/relationship, home/a place to live, social/recreational, safety/crisis, cultural/spiritual, financial, substance abuse, and health/medical. The approach reflects Dawn's philosophy that all families have strengths and resources in each of these areas and that, by building on these strengths in addressing their needs, families can enhance their ability to function self-sufficiently during and beyond the time that the child is enrolled in Dawn. Identified needs within each of the life domains are addressed in the service coordination plan.

In light of the focus of this study on the relationship between physical and mental health systems of care, researchers inquired in particular about the types of health/medical issues that typically arise for Dawn clients. Informants reported that the presenting problems of Dawn clients, whose eligibility for the project is linked to their emotional disturbance, often also include a physical component. These conditions have included, for example, seizures, brain injuries, eating disorders, and genetic disorders with serious physical and behavioral components, such as Prader-Willi Syndrome, which is characterized by compulsive eating and morbid obesity. For children with these types of chronic conditions, ongoing medical treatment is clearly an important component of their care plan. However, the importance of medical care is also recognized for children without obvious physical problems, not only with regard to their need for regular checkups but also because of the possibility that a physical health problem may underlie the child's emotional or behavioral challenges. For example, the project had a case in which a child's behavioral and learning problems were found to be largely the result of an

undiagnosed visual impairment; once the problem was diagnosed and treated, the child showed tremendous improvement in both his behavior and his school performance.

Thus, in inquiring about a client's medical and health issues, service coordinators routinely ask if the child has a regular source of medical care. Children who do not have a primary care physician are linked with one, although service coordinators report that most clients already have a physician, especially given that 70 percent of clients are on Medicaid. Of the remaining 30 percent, most are uninsured; some Dawn clients have private insurance but have often reached caps on mental health or other benefits. All clients are encouraged to receive an annual physical, eye exam, dental exam, and nutritional assessment (although family representatives report that annual exams are often not a high priority of families given the more pressing problems they are facing). While children with insurance are referred to their primary care providers, children without insurance maybe referred to a local health clinic, but no formal relationships exist with the local health agency to provide medical care to Dawn clients.

A frequent concern identified by families related to their children's medical care is transportation to appointments. In addition, service coordinators often find that families need help in learning how to communicate better with their children's doctors, for example, about concerns related to recommended treatment approaches. These are among the many needs addressed by the Dawn project.

Dawn's process for identifying needs results in the development of a service coordination plan, which outlines the child's needs, the services or interventions to address these needs, and the outcomes which the interventions are designed to achieve. The types of services included in the care plans are described in the following section.

3. Services and Providers

The services provided by the Dawn Project are aimed at promoting and facilitating community-based alternatives to residential placement for children with SED. As indicated above, decisions about the services included in each client's plan are made within the context of the service coordination process.

Service coordination is a core component of the Dawn model. There are four service coordination teams located at Choices to serve Dawn clients. Each of these teams is employed by one of the four CMHCs that formed Choices and includes a supervisor who manages the teams, five service coordinators, and one to three case managers who assist the service coordinators. Service coordinators typically have a master's or bachelor's degree in social work or other social sciences, as well as experience in serving a similar population. Each manages a caseload of eight to ten families. Service coordinators, who are the family's main contact with Dawn, take the lead in assembling and heading a team (usually referred to as a "Child and Family Team") to work with each family; these teams typically include a representative of the referring agency, the Dawn client and his/her family, and other support persons such as relatives, neighbors, and clergy. Through ongoing contacts with the family—which typically occur weekly by at least one member of the team and monthly with the whole team—the Child and Family Team works to identify the family's strengths and needs, to provide ongoing support to the family, and to review and revise the service coordination plan each month. Ultimate responsibility for authorizing services in the care plan, however, rests with the service coordinators. Dawn's placement of this central clinical and fiscal management function with service coordinators, the staff with the most direct and ongoing experience with the family, is a hallmark of the Dawn approach and one which clearly distinguishes it from most other managed care plans that rely on people to authorize services who do not have direct client contact.

In determining how to address clients' needs, Dawn relies heavily on the philosophy that families do not always want or need the intense level of services that is often routinely provided and that families' self-sufficiency can be enhanced, and costs kept in check, by tapping resources within their own communities. The project's inclusion of community members and relatives on the Child and Family Team and in other roles that support the family is an important reflection of this philosophy, as is the project's efforts to keep children at home or in other community-based settings (such as group homes) rather than in costly residential treatment centers. Service coordination plans reflect the project's reliance on community resources as well as its focus on outcomes, as each service or intervention included in a service coordination plan must be tied to an identified outcome for the family.

There are seven major categories of services provided by Dawn:

- # **Placement.** This category includes residential treatment and psychiatric hospitalization for children who need those services, as well as community-based alternatives to these institutions, including group homes, foster care, and crisis residential placements.
- # **Mentoring.** Dawn links many of its clients with mentors, who may focus on fostering success in school, independent living skills, or in other areas of the child's life.
- # **Behavioral Health.** Behavioral health services include day treatment, family and individual therapy, substance abuse therapy, and crisis intervention.
- # **Respite Care.** Respite care, a service used extensively by Dawn clients, includes planned respite as well as that provided in crisis situations.
- # **Service coordination.** A core service for all Dawn clients is service coordination, which includes such activities as team meetings, care planning, and contacts with the family.
- # **Discretionary services.** The flexibility built into Dawn's service delivery approach, and motto of doing "whatever it takes," is reflected in the project's coverage of discretionary services which, like other services, are authorized by the service coordinators. These may include, for example, clothing, transportation, legal assistance, equipment to allow parents to constantly monitor their children, and education expenses, among others.
- # **Medical care.** Medical services paid for by Dawn for clients without another source of reimbursement such as Medicaid include doctors' visits, hospitalizations, nursing services, and medication checks.

Under the model developed by the Consortium, Choices may not provide these services directly,⁶ but must instead contract with community providers. Choices reimburses those providers who bill the project for services not covered by Medicaid or private insurance out of its capitated rate. The flexibility afforded by the capitated rate allows Choices to craft a service coordination plan that responds to the unique needs of each child.

Dawn has reimbursed 550 individuals and agencies for services provided to Dawn clients. These providers include CMHCs, residential treatment centers, foster care providers, group homes, therapists, community hospitals, families, and faith-based providers, among others. The involvement of faith-based

⁴ This prohibition refers to the managed care entity only, not to the four CMHCs that created Choices, which are the providers of service coordination.

organizations, which provide services such as mentoring, respite, and after-school care, responds to the need for culturally appropriate services for Dawn's largely African-American clientele.

Choices has placed a high priority on strengthening the capacity of providers who serve its clients to operate in line with the Dawn model. For example, the plan employs a Community Resources Manager whose responsibilities include meeting regularly with providers and conducting provider satisfaction surveys. The Community Resources Manager has also played an important role in helping to develop the cadre of individuals and agencies from the community who serve as mentors to Dawn clients by educating these providers about the Dawn model and working with them to define the role of mentors in helping families to achieve their goals.

Dawn staff also work intensively with key providers, namely residential treatment facilities that provide Dawn's costliest services, to assess and change their approaches to promote Dawn's goals of community-based, family-centered care. For example, Dawn collaborated with one of the residential treatment centers in Marion County to establish a new family and community unit in the center to serve Dawn clients. As described by the center's director, the unit has helped the center to model a new way, based on the Dawn philosophy, to provide care in a much more flexible, family-centered, and cost-efficient manner that has resulted in a reduced length of stay for Dawn clients; the center hopes in time to expand this model to its other units. Other Dawn providers, including a hospital and foster care agency, while acknowledging the difficulty that instituting change involves, have also credited the project with promoting changes which they feel have resulted in a higher quality of care for their clients.

The average length of enrollment in Dawn is 13 months. Generally, clients are disenrolled when the service delivery team agrees that the family has achieved its goals. Services may be ended abruptly, however, for children involved in the juvenile courts, because once a judge closes a case for a child who was referred from the court, the child is no longer eligible for Dawn. Dawn is working with the courts to identify ways that court-involved clients can be more smoothly transitioned out of the program.

4. Financing

As indicated earlier, the initial funding for Dawn was provided through a grant from the RWJF. This grant, which was awarded in February 1996 in the amount of \$75,000, provided funding for a project coordinator,⁷ her travel to MHSPY grantee meetings, and the services of a local consultant who worked with the Consortium to develop the financing structure. After the grant ended, several of the Consortium agencies came together to provide continued support for the project coordinator position.

The goals of the RWJF grant included the creation of capitated managed care arrangements to support the delivery of children's services. In line with this goal, Dawn's financing structure involves the payment of a capitated payment to Choices, the non-profit managed care organization created to serve Dawn clients. The funding partners of Dawn believe that payment of a capitated rate is a critical component of the project's success, as it allows Choices to offer a flexible menu of services in accordance with each child's needs.

The capitated payment agreed to by the funding agencies is \$4,130/month. This rate was chosen based on their determination of the average cost of services for children in residential treatment in Marion County prior to Dawn's implementation. To come up with this cost estimate, the group looked at the number of children in residential treatment being paid for by MCOFC on July 1, 1995 and determined their use of residential treatment services in the six months before and after that point. This process allowed them to estimate the average length of stay and average monthly cost for children in residential treatment, which came to about \$5,500/month.⁸ They also compared this estimate to the expenditures of different agencies and states serving children with similar needs. In light of Dawn's goals of reducing the use of residential treatment in favor of community-based alternatives, the group felt that the average costs for Dawn clients would be less than this estimate, although they weren't sure by how much. As one informant described it, "everybody held hands and jumped over the cliff" in agreeing to the \$4,130 rate, their best guess as to what the expected average costs would be for Dawn clients. The project has

⁵ Dawn has employed the same person in the coordinator position since the RWJ grant. She was hired in July 1996.

⁶ The \$5,500 figure was based on 1995 data. More recent figures put this estimate at approximately \$5,900/month.

been very successful in keeping expenditures in line with this rate, which has been in place since Dawn's inception; calculations done at the end of Dawn's second year showed the average cost per child to be within a few dollars of the capitated payment rate. Administrators of Choices, which is at full risk for any costs that exceed this rate, note that the project's reliance on the Dawn model, which emphasizes the use of community resources, has been key to their success in keeping costs within budget. The supplementation of the capitated rate by Medicaid, as discussed below, is another critical factor.

Thus, for each child referred to Dawn, Choices receives a monthly capitated payment of \$4,130. However, the source of funds for each child's payment is largely dependent on which agency made the initial referral, according to the following structure:

- # DMH pays \$166/month for all Dawn clients;
- # DOE pays \$3,964/month for each client referred from the school districts and approved by DOE; and
- # MCOFC pays \$3,964/month for each client referred from child welfare or juvenile probation.⁹

Under this structure, DMH is the only agency that contributes to the monthly capitation rate for all Dawn clients, regardless of the referring agency. DOE and MCOFC, the agencies that pay the bulk of the capitated rates, only pay for children referred by their own agencies. Thus, rather than truly blending funds from the different agencies, they may more accurately be described as "braided," a term used by one of the key informants to describe the way that the funding flows together without losing its distinct ties to, and identification with, the source agency. While the agency partners indicate that a truly blended pool of funds is a goal they would ultimately like to achieve, they feel that this "braided" arrangement represents major progress toward that ideal, especially because it provides Choices with the flexibility to tailor services to each child's needs.

As noted above, while DMH is the only agency to contribute to the cost of care for all Dawn clients, the amount of this payment is much less than that contributed by the other agencies for the clients they refer.

⁹ In Indiana, child welfare and juvenile probation services are both funded out of county property tax dollars. Funds for juvenile probation services flow through MCOFC.

The stark contrast in these amounts reflects the project's use of existing funds for residential treatment; that is, because DOE and MCOFC were the primary existing payers of residential treatment for children in Marion County,¹⁰ they remain the primary funders of Dawn. DMH's funds have been traditionally directed to the care of mentally ill adults; however, it does contract with providers for the care of SED children, and DMH contributes to Dawn at the same rate that the agency pays these providers. The inequity in funding levels has been a source of tension among the Dawn partners, with concern over the fact that Dawn rewards, rather than remedies, DMH's traditional lack of focus on children by maintaining the status quo. Again, however, while DMH's contribution may be small, it is notable that DMH is the only agency that has taken the necessary step toward truly blending funds by making its contribution for all Dawn clients regardless of referral source.

While the capitated rate is substantial, this rate is supplemented by another source of funds—Medicaid. Over Dawn's first three years, Medicaid has funded nearly \$3 million in services for Dawn clients, 70 percent of whom are eligible for the program. The project has accomplished this through its use of two main strategies:

- # Through a partnership with the county's Community Mental Health Centers (CMHCs), Dawn benefits from the status of CMHCs as the only entities in the State of Indiana that are allowed to bill through Medicaid's rehabilitation billing option. Under this arrangement, the CMHCs employ Dawn's service coordinators, who are located at Choices and provide service coordination to all Dawn clients. The CMHCs bill Medicaid, through the rehabilitation option, for the costs of service coordination for Dawn clients on Medicaid, an arrangement which has drawn down roughly \$1.875 million in Medicaid funds.¹¹
- # Dawn also refers its Medicaid-eligible clients to Medicaid providers in the community for therapy, day treatment, acute hospitalization, and medical care so that these services can also be billed directly to Medicaid. Medicaid has reimbursed providers approximately \$1 million for delivering these types of services to Dawn clients.

⁸ In Indiana, residential treatment services for children in the child welfare and juvenile justice systems are paid for by county property tax funds. Residential treatment for children in special education needing these services is paid for by the State Department of Education; no local school funds are used for this purpose.

⁹ The CMHCs bills Choices for service coordination for non-Medicaid-eligible Dawn clients. Choices pays the CMHCs \$600/month for each child receiving service coordination.

In addition, although Dawn pays for residential treatment for all clients who need this service out of its capitated rate,¹² Medicaid coverage of psychiatric treatment services for children in at least one residential treatment center used by Dawn clients is subsidizing the per diem rate paid by Dawn. As explained by the director of a primary residential treatment facility used by Dawn clients, their relationship with a community hospital that provides and is reimbursed for psychiatric services to its Medicaid clients has allowed the facility to charge Dawn \$180/day, about half as much as they would have to charge in the absence of this arrangement to benefit from Medicaid financing.

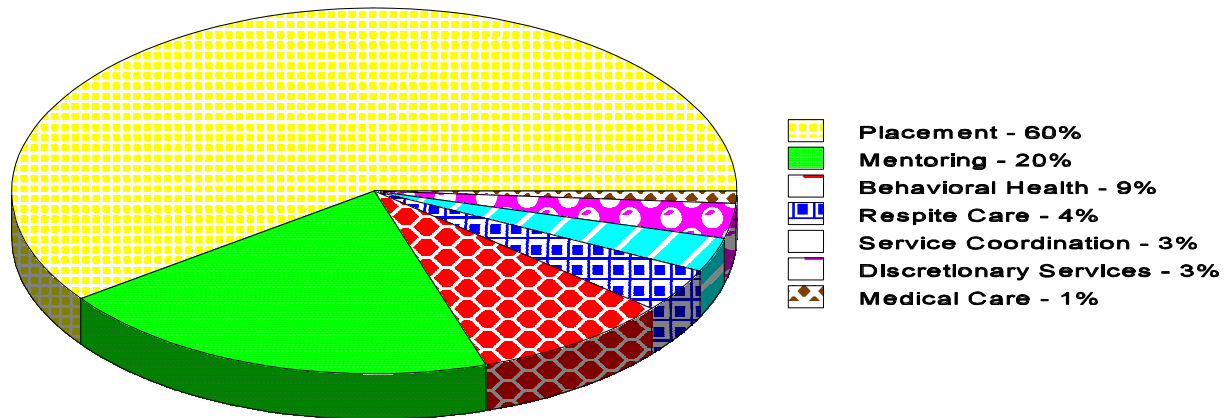
As Choices administrators point out, by not having to pay for these services out of the capitated rate, the managed care organization has significantly stretched the resources provided by the funding agencies in meeting Dawn clients' needs. The degree of creativity needed by administrators to get Medicaid reimbursement, however, is worthy of note.

Over the project's first three years, Dawn spent \$16 million in provider reimbursements for the seven categories of services. As shown below in Figure 1, the largest portion of project expenditures (60 percent) have been spent on residential treatment services, which have been used by approximately 30 percent of Dawn clients at the cost of \$8,000/month. The second largest category of expenditures is accounted for by mentoring services, which are used extensively by the project and, in some cases, can be quite costly, as in the use of full-time mentors to accompany students in school who would otherwise be banned from participating due to behavioral problems.

Also shown in the chart is the relatively small portion of expenditures on such services as respite care, which accounted for four percent of expenditures. However, because respite services are relatively inexpensive, this figure masks the widespread use of this service among Dawn clients and families. In fact, respite services have been provided to half of Dawn clients.

¹⁰ Residential treatment services are not covered by Medicaid or other insurance plans.

Figure 1.
Dawn Project Three-Year Expenditures



The relatively small costs incurred for behavioral health, service coordination and, in particular, medical care reflect the role of Medicaid reimbursement in paying for these services. Grants have also played a significant role in expanding Dawn's funding capacity. In addition to obtaining initial funding from the RWJF to launch the project, in October of 1999 Dawn was awarded a six-year \$6 million grant from the Federal Center for Mental Health Services (CMHS) to enhance its efforts in Marion County. The focus of the grant is to support the community's efforts to build an integrated system of care for children with serious emotional disturbances and their families. The funds will allow the project to expand the population it serves as well as its efforts in a variety of other areas, including evaluation.

5. Family Involvement

Family involvement is integral to the Dawn Project, as families are at the center of the Dawn model. One of several core values developed by the Consortium states that "services must be child centered and family focused, with needs of the child and family the most important factors in deciding the types of services provided." The mission statement, furthermore, notes that Dawn is "founded on the belief that children and their families are remarkably resilient and capable of positive development when provided with community-centered support, truly defined by what is in the best interest of the child." Dawn's service coordination process, which focuses on identifying families' strengths and includes families as

essential partners in the process, is an extension of this philosophy. So is Dawn's focus on helping providers and agencies to listen to and focus on families as they have not done before.

In working with families that have a child with SED, Dawn has found it is not unusual for the biological parents to be either unable or unwilling to provide a stable home. In these cases, the project has worked hard, and been quite successful, at locating relative and kinship placements for Dawn children. This approach reflects Dawn's recognition that "family" is a term that may be defined in many different ways.

Parents also play an important role in the administration, operation, and policy decisions of Dawn. Parents are important members of the Consortium and its workgroups, and they represent the project at conferences and meetings. Dawn also employs several parents as mentors to other families in the project. In addition, the administrator of Choices meets with parent representatives on a monthly basis to obtain their input and feedback.

Fostering the formation of a parent support organization was an early goal of the Dawn Project, and one which has been successfully achieved. The Mental Health Association in Marion County, as part of its role under the RWJF grant, spearheaded the development of a local chapter of the Federation of Families for Children's Mental Health in September 1998 as a source of education, support, and fellowship for families with children in Dawn. Parents have since assumed the role of leading this chapter, which is named "Families Reaching for Rainbows" and which now also includes families with seriously emotionally disturbed children who are not in the Dawn Project. The organization has also taken on an advocacy role, providing ongoing input not just to Choices but also to the agencies that are responsible for serving SED children in Marion County.

Thus, through the implementation of a family-driven model and the development of a parent support and advocacy organization, Dawn has facilitated the empowerment of families with children with emotional and behavioral disabilities in Marion County. Of similar import, Dawn has also focused providers' attention on the importance of listening to and responding to families' needs and priorities. Because this process necessarily involves an increase in families' level of control in deciding their children's care, it has not surprisingly entailed some degree of tension between families empowered by Dawn and the agencies and providers serving their children. Service coordinators, while serving as advocates and

coaches to their clients, also work to mediate these relationships and help all parties come to agreement about the best approach to caring for the children involved.

6. Evaluation and Monitoring

The Dawn Project carries out its activities with an outcomes-oriented focus. As one of its initial activities, the Consortium identified six broad goals for Dawn—two related to the child and family (client level), and four related to the broader system of care (systems level). Dawn’s client-level goals include, for example, “to provide high-quality care which results in improved outcomes for the child and family.” One of Dawn’s system-level goals is to “decrease the cost of serving children/youth with the most disturbed and disturbing conditions in Marion County.” For each of the six goals, the group also identified several desired outcomes, with accompanying measures, to monitor the progress of the project. To help collect data for outcomes monitoring, as well as to facilitate effective day-to-day management of the project, Dawn implemented a sophisticated online management information system called “The Client Manager” (TCM). This system, developed in the mid-1990s for a MHSPY project in Wisconsin¹³ and used in only a few sites around the country, allows service coordinators to input data about their clients in a central place and for the team to obtain real-time information including assessment results, the services authorized in the service coordination plan, and the costs of these services. As described by Choices officials, this system uses technology to improve the capacity for effective and efficient clinical and fiscal management, including monitoring of progress toward desired outcomes. The data from this system are not only being used internally, but also are being shared with the partner organizations to inform them about the return they are getting for their investments. In addition, the data are being used to educate agencies including Medicaid about the service utilization and cost patterns for children with SED.

One of the important system goals identified for the project that is not measured by TCM is replication of the Dawn Project in other Indiana communities. As noted earlier in this report, the state mental health agency is funding four sites around the state to replicate the Dawn Project. In addition, the state legislature is currently considering funding for additional replication sites. Replication of the Dawn

¹¹ Choices’ CEO, who worked with the Wisconsin project prior to coming to Dawn, was involved in TCM’s development.

model has also been accomplished within Choices, which now operates a similar program for homeless mentally ill adults.

Dawn's award of the CMHS grant will allow the project to significantly expand its evaluation activities. The evaluation study will focus on six major areas of study, including profile and outcomes of Dawn Project participants, patterns of service use, dynamics of service coordination teams, effectiveness, the Families Reaching for Rainbows family advocacy organization, and system-level functioning. While major evaluation activities are still at their beginning stages, preliminary analyses of data from the project's early years indicate that the model is proving successful. For example, preliminary analysis of Child and Adolescent Functional Assessment Scales (CAFAS) data suggest that the project is improving the overall clinical functioning of Dawn clients. Dawn has also reduced the length of stay in residential treatment for project participants to 101 days on average, as compared to the 120 day average length of stay for non-Dawn clients in Marion County. In addition, analysis of cost data shows that the Dawn model of care is less costly than the standard treatment of care for children with emotional disturbance in Marion County, likely due to the shorter average length of stay for Dawn clients as compared to those not participating in Dawn. The evaluation study will further explore these and other important issues.

C. Conclusion

As described in this case study, the Dawn Project has implemented a collaborative multi-agency model of care for children with emotional and behavioral problems in Marion County, Indiana. This experience has elucidated numerous factors that promote and hinder the holistic approach to service delivery embodied in the Dawn model, including those that relate specifically to the integration of physical and mental health care and systems. These are discussed by major topic area below.

Dawn's experience suggests that the following factors promote cross-system integration:

- # **Commitment to Interagency Collaboration.** Several factors have fostered the interagency relationships that provide the foundation of the Dawn Project. The recognition among Dawn's partner agencies that they are, to a large degree, serving the same clients was a powerful force in bringing the agencies together to figure out a better and more cost-efficient way of serving their shared client population. This recognition, as well as their belief in the vision and mission of Dawn developed jointly at the outset of the initiative, has sustained the group through the challenges of this multi-agency effort. The commitment of time and resources by high-level officials to envision, implement, fund, monitor, and solve problems on an ongoing basis is another critical factor in the project's success.
- # **Leadership to Move Ahead Despite Obstacles.** The Dawn Project has benefitted from the ability of its leadership to identify and implement ways of keeping the project moving toward its goals, even when the envisioned ideal remains out of reach. This quality was demonstrated in particular during the project's development of its financing approach. When a fully blended funding approach was determined not to be feasible, the leaders identified an alternative approach that still uses funds from separate agencies to finance a capitated payment to Choices. Second, when the project found that Medicaid had decided not to be a funding partner due to its conclusion that the data did not support this level of involvement, an alternative arrangement was devised to draw down Medicaid funds through a partnership with Community Mental Health Centers.
- # **Utilization of Managed Care Principles.** The Dawn Project's use of managed care principles has been an important factor in its ability to improve service integration for Dawn clients. In particular, three managed care principles were identified by informants as critical to facilitating this goal:
 - < **Capitated Payment.** The payment of a capitated rate by Dawn's partner agencies has allowed Choices to individualize care to fit the particular needs of each child. With the flexibility to use funds as it sees fit, Choices is able to offer traditional services like individual and group therapy, less traditional services like mentoring, and a range of gap-filling services such as payment for recreational activities, transportation, and clothing. In essence, the flexibility afforded by capitation provides Choices with the opportunity to implement the "whatever it takes" philosophy of this ambitious project.
 - < **Role of Service Coordinators in Authorizing Services.** Unlike most managed care plans (but like the Massachusetts MHSPY project also explored under this study), Choices places the locus of responsibility for authorizing services that the plan will pay for with the service coordinators. This decision supports Choices' view that the staff with the most contact with and, therefore, best understanding of the family's needs are the most appropriate ones to determine the services and interventions that will best address those needs.

< **Accountability.** In their role in authorizing services for Dawn clients, service coordinators are also responsible for ensuring that each authorized service is linked with an outcome, so that the plan is only paying for interventions that the service coordination teams believe will move families closer to achieving their identified goals. Similarly, in contracting with community providers to serve Dawn clients, Choices expects that providers will work in accordance with Dawn's community-based, family-driven model. The project has also demanded that providers, namely the residential treatment centers, work to reduce costs while improving outcomes, as illustrated by its efforts with one residential treatment center to adopt an entirely new approach to serving Dawn clients and families.

Holistic Service Coordination Approach. Dawn's model for working with families is a holistic one that recognizes the many dimensions of a family's life that impinge on their overall functioning. In identifying families' strengths and needs, Dawn service coordination teams help families to assess their needs and goals related to medical care, school, home, emotional well-being, and recreation, among other areas. In taking this comprehensive approach, Dawn minimizes the fragmentation that families with children with SED often experience in piecing services together from different agencies, each focused on only one particular area of their lives. Its focus on the goals identified by families also helps to ensure that expenditures are driven by children's needs rather than by the priorities of the different funding agencies.

Dawn's experiences have also indicated that the following factors hinder the delivery of integrated services for children with SED:

Conflicting cultures and priorities of partner agencies. While Dawn has succeeded in bringing together a variety of different agencies to improve the care of children with SED, it has also highlighted the challenges inherent in an interagency effort of this nature. Despite agreement on the project's overarching goals, each agency must still adhere to its own policies and mandates in carrying out its responsibilities. For example, local schools initially challenged whether mentors accompanying Dawn clients met the requirements that the school must adhere to for school-based staff. In addition, the courts have stressed the need for Dawn to help ensure that their mutual clients be held accountable for the consequences of their actions, such as violation of probation. While Dawn has made progress in finding common ground with these agencies to further common goals, these examples point to the need for ongoing cross-training efforts to facilitate the identification of strategies that meet the needs of all parties.

Lack of reimbursement for activities and services that facilitate integration. For the majority of its clients, Dawn relies on Medicaid to reimburse providers for the cost of medical care. Therefore, to the degree that the project hopes to involve medical providers in Dawn's collaborative approach, the project also relies on Medicaid. However, like other insurance programs, Medicaid does not reimburse providers for the time involved in

activities that support integration, such as attending Dawn service coordination meetings or speaking with schools about IEPs. These reimbursement policies limit the degree to which medical providers are, and can be expected to be, involved in activities that support the more integrated delivery of care to their patients. To address the barrier that lack of reimbursement presents to coordination, Dawn will reimburse providers for the time spent in service coordination meetings out of its capitated rate; however, while this approach has been successfully used to facilitate the involvement of mental health providers, the project has found that medical providers are too busy to attend, even if the time to participate is reimbursed. Service coordinators typically communicate with medical providers by phone or by accompanying clients to appointments, and then share information back with the team.

In addition to the lack of reimbursement for activities that support integration, providers report that obtaining reimbursement for services that recognize the link between physical and mental health is also extremely difficult. For example, although counseling could help a diabetic child with depression adhere to recommended diet and exercise routines and, therefore, avoid severe and costly medical complications, insurers typically refuse to reimburse for counseling services, while rarely questioning the costs of expensive hospital care.

- # **Inadequate training of providers in recognizing and addressing the varied needs of children with mental and physical health problems.** Informants for this study reported that providers often do not recognize the need for behavioral counseling in treatment plans for children with chronic physical conditions. Similarly, mental health providers are often not trained in caring for children with chronic physical conditions. Such reports point to the need for more cross-training of both physical and mental health providers in how to address the needs of children with these types of problems.
- # **Lack of formal ties with health agencies.** Dawn was launched to create a more integrated system of care for children with SED and their families in Marion County, and interviews with key informants point to the project's success in this important goal. However, it appears that the project could be further strengthened by broadening the interagency focus to include health agencies. For example, local health departments could be an important source of medical care for Dawn clients without health insurance. Furthermore, more formal relationships with medical institutions such as the state's children's hospital, a source of care for some Dawn clients, could help to raise providers' awareness of Dawn and its family-centered philosophy of care and also potentially identify more children in need.

In recent years, spurred by Indiana's implementation of its State Child Health Insurance Program, interagency relationships at the state level have been greatly strengthened through a statewide emphasis on improving collaboration among child-serving agencies. Within this context, the state mental health agency and the state health department have begun to identify areas of common concern that can be jointly addressed. For example, the state mental health agency is funding a program by the state's Title V/Maternal and Child Program in the health department to prevent substance abuse in pregnant women.

Several partners noted that, in the context of the recent Surgeon General's Report on Mental Health, perhaps the time is right to strengthen such relationships at the local level, as well. The involvement of the Health and Hospital Corporation of Marion County in Dawn as the fiscal agent for the CMHS grant is an important step in this direction.

In sum, the Dawn Project has made great strides in building bridges between many important agencies and providers serving children with SED and their families in Marion County. The model has introduced a more holistic and family-centered way of serving this vulnerable population. It will be interesting to see, in light of the project's recent infusion of Federal funds and the effort to replicate the model around the state, how the Dawn model will continue to grow and evolve.

Appendix A: Key Informants

Dawn Project

Key Informants

State Division of Mental Health

Janet Corson, Director

State Department of Education

Robert A. Marra, Director, Division of Special Education

Indianapolis Public Schools

Mary Jo Dare, Director, Special Education/Student Services

Mental Health Association in Marion County

Marge Towell, Executive Director

Marion County Office of Family and Children

Ann Jefferson, Division Manager

Indiana Behavioral Health Choices

Janet McIntyre, Dawn Project Systems Coordinator

Knute Rotto, CEO

Community Mental Health Centers

Sophie Belleau, Service Coordinator

Rebecca Buhner, Service Coordinator

Mary Fran Crowley, Service Coordinator

Beverly Musseter, Service Coordinator

Joan Wyatt, Service Coordinator

Families Reaching for Rainbows

Betty Bledsoe, President

Lutherwood (Residential Treatment Facility)

Jim Dalton, Director

Riley Children's Hospital

Brian Hainline, Pediatric Subspecialist

William Kronenberger, Clinical Director, Pediatric Psychiatry Consultation-Liaison Service

Indiana State Department of Health

Wendy Gettelfinger, Title V/CSHCN Director

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