The Changing Landscape Of Children's Services In California: The Challenges & Opportunities Presented By Katie A. & The Continuum Of Care Reform

The 2016 OPEN MINDS California Management Best Practices Institute
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Richard Louis, III, Senior Associate, OPEN MINDS
1. National Trends In Children’s Services
   a. Steve Hornberger, MSW, Director, Social Policy Institute, San Diego State University School of Social Work

2. Panelist Perspectives
   a. Richard S. Knecht, MS, Transformation Manager, California Department of Healthcare Services, Department of Social Services
   b. Judy Webber, LCSW, Deputy Director, Department of Children & Family Services, County of Ventura
   c. Briana Duffy, MBA, LSW, Senior Vice President, National Client Partnerships, Beacon Health Options

3. Questions & Discussion
National Trends In Children’s Services

- Greater use of managed care
- Increase in integration, care coordination, and systems of care
- More community-based care, less congregate care
Greater Use Of Managed Care

Increasing use of managed care financing and service delivery models

- Commercial
- Medicaid
- Medicare
- Dual eligible

New populations

- Complex disabilities
- Long-term care
- Foster care population
Managed Care Is Expanding & So Are The System Requirements

- Provider organizations need improved administrative capabilities for a managed care environment:
  - Marketing and contracting functions – payer contracting, referral development, and consumer choice
  - Systems to facilitate administrative processes of FFS managed care and value-based purchasing – preauthorization, continued stay review, documentation, performance measurement
  - Revenue cycle management – billing and collections for both payer and consumer
  - Development of services that are customer-preferred in terms of value – both payer and consumer

- Children’s Services organizations that don’t have solid competence in these four key areas will be at a competitive disadvantage
Increase In Integration, Care Coordination, & Systems Of Care

- Greater emphasis on care coordination and integrated care management is leading to better coordination of services for children in the foster care system

- About 20% of American children between the ages of three and seventeen years have a behavioral health disorder, including depression, autism, and drug and alcohol addictions

- Emerging models are attempting to create better systems of care
More Community-Based Care, Less Congregate Care

- The use of residential facilities to house children in the child welfare system has dropped continuously over the past decade due to a continued focus on keeping children with their families, the increased use of kinship care models, and the use of enhanced foster care models.

- In the future, only a small percentage of children will be placed in residential care and only for the purpose of either crisis stabilization or preparation for treatment in a community setting.

- Contract awards are going to the provider organizations that can demonstrate their ability to keep children in the community, achieve outcomes, and accept value-based reimbursement.
Richard S. Knecht, MS
Transformation Manager, California Department of Healthcare Services & Department of Social Services
Katie A. and Continuum of Care Reform: Building Shared Governance and Collaborative Mental Health Services for California’s Foster Children

Richard Knecht, M.S.  
Transformation Manager  
Departments of Health and Social Services
County Systems and State Departments are beginning to Share

- In various ways, local child and family services partnerships have collaborated for decades, but without consistent effectiveness.
- Integration is a far more complex journey, and requires observable and measurable structures and processes.
- Counties, in many cases, are now doing great collaborative work and in a few cases, are building integrated sustainable systems of three types:
  - Functional
  - Physical
  - Fiscal
“Isn’t the Katie A. Lawsuit over?”

Can your county child welfare and mental health team demonstrate that you are collaboratively delivering timely and effective mental health services to all eligible foster youth?

Can your county child welfare and mental health team assert that your practicing the elements of the *Pathways to Well Being Core Practice Model*?
Leading Up to Katie A.…

- Little Hoover Commissions— “collaborative and seamless services are needed”

- Judicial Council Blue Ribbon Commission— “Collaboration is key…”

- Department of Social Services Report to Legislature (Saenz)— “Fragmented services cause major challenges for California’s families…”
Pathways to Well Being Requires…

**County Collaborative**
- Program Enhancements for Children and Youth in Foster Care
  - Timely Screening for MH needs and services
  - Community Based Intensive Services
  - Child and Family Teaming
  - Therapeutic Foster Care (TFC)
  - Consistent Practices between Welfare and MH partners

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**State Departments**
- Joint Management Structure and Process
  - Mental Health/Substance Abuse and Child Welfare Authorities must collaborate
- Shared Accountabilities
  - Shared Data/Quality Improvement processes
  - Training and Technical Assistance
California’s Progress toward Collaborative Practice (2012-15)

- Pathways to Mental Health Core Practice Model dually approved (CPM) (2013)
- Memorandum of Agreement (December 2015)
- Semi Annual County Progress Reports
- Data and Information Sharing Agreement and Early Reporting (2015)
- Use of External Quality Review (EQRO) Containing County CPM Compliance Assessment (2015)
- Integrated Technical Assistance Calls (January 2016+)
What Does Shared Management Structure Look like?

- **Community Team**
  - Co-Chairs with “lived experience”
  - 24-person stakeholder conversation to guide state practice and instill genuine Shared Governance

- **Executive Team**
  - State Department Senior Staff

- **Transformation Manager**
  - Guides Shared Management Structure (SMS) Processes
  - Technical Assistance and Consultation to Departments

- **State Implementation Teams**
  - Execute the work of the SMS
  - County Support/Technical Assistance
  - Implementation of Service Delivery Action Plan/Sandbox Model
Community Team is a primary vehicle toward “Shared Management”

- Monthly 5 Hour Convenings
  - Oversee and support implementation of Integrated Practice from a Consumer-Centric View
  - Engage and Empower Youth and Parents
  - Connect Pathways to Well Being to other reform efforts underway
  - “Transform” two Departments
Key Questions at the state Level

- How will Community Team best support and challenge two state agencies to *evolve, adapt and transform*?
- Are we willing to challenge our own rules about how we’ve served families in the past?
- Is it possible and valuable to *let go of the control* and power that “the system” seems to demand from us?
- Are we willing to be “lead” by children, youth and their caregivers, who know and love them better than government can or will?
Children’s Services Sandbox—A conceptual/logic model.

1) **Shared Training**—Unified Technical Guidance and Content for all Counties and service Providers, regardless of their employer.

2) **Shared information and Data Management**—Provide access to relevant partner’s data for improved and unified performance and outcomes management.

3) **Shared Oversight and Compliance**—Integrated multi-system County Review, which will support county practice, reduce admin costs and close policy and practice “gaps”.

4) **Shared Core Practice Model**—One set of values, principles and behaviors for all child serving staff.
Sandbox Implementation Plan

- Pillar 1--Training and Technical Assistance
- Pillar 2--Information and Data Management
- Pillar 3--Oversight and Accountability
- Pillar 4--Core Practice Model

Engagement
Satisfaction
Appropriateness
Service Effectiveness
Access
Linkages
Cost Effectiveness
Shared Management Early Progress

- Dually authored letters
- Monthly Integrated Practice TA Calls and Bulletin
- Sharing Data via Claims Match and POS Systems
- Early Opportunities to Share Oversight and Compliance (EQRO and CSFR)
- Integrated Training Plan in Development
- Integrated Core Practice Model in Development/Revision
CCR is being implemented to improve California’s Group Home Structure and Outcomes.

- In September 2012, CDSS in partnership with CWDA, providers, State and County Mental Health partners, launched the CCR effort.

- Detailed action plan was developed and provided to the California Legislature in January of 2015. This action plan included information on current reform improvements made administratively and recommended revisions to improve the CCR through legislative action.
Vision

- All children live with a committed, permanent and nurturing family
- Services and supports should be individualized and coordinated
- System focus is on achieving a permanent family and preparation for successful adulthood
- When needed, congregate care is a short-term, high quality, intensive intervention that is just one part of a continuum of care available for children, youth and young adults
CCR Implementation Framework

State/County Implementation Team
CDSS, DHCS, CWDA, CPOC, CBHDA, CSAC
County Representatives

Stakeholder Implementation Advisory Committee
Providers, Youth, Caregivers, Tribes, Advocates, Counties, Legislative Staff and others

CCR Implementation Workgroups

- Program & Licensing
- Rate Structures
- Oversight Framework
- Resource Family Approval
- Training
- Mental Health
- Probation

Deliverables

Program Instructions
- Interim Standards
- Regulations
- ACLs/ACINs/CFLs
- Forms
- RFA Written Directives

Capacity Building Activities
- County and Provider Implementation Guides
- Training Gap analysis
- Training Curricula
- Child Welfare Assessment Tool

Accountability & Oversight
- Accreditation Process
- License application review process
- Oversight framework/measures
- Provider Performance dashboard
- Consumer Survey
Overarching Elements

- New provider rate structure:
  - Sunset RCL system (1-14)
  - Create new STRTP rate
  - Create tiered FFA rate structure

- Multi-year implementation:
  - New requirements take effect 1/1/2017
  - Provisions for extensions up to two years
  - Additional extensions for providers and longer for those serving probation youth

- STRRTC and FFA may be public or private
What’s next?

- State-county communication will be increasingly “Dually-Aauthored”
- Regional Information and Transformation Exchanges (RITE)
- Monthly “Child and Family Services Integrated Practices” Technical Assistance Calls
- Connecting State and Counties to Shared Data
- Expanding Roles for Youth and Parent Partners at State Level
- Assuring we don’t end up with Two Core Practice Models!
- Cross-walking State’s Oversight and Accountability Efforts to reduce redundancy and connect Child Welfare and Mental Health Efforts at County Level
Some Challenges Going Forward

- Continuum of Care and Therapeutic Foster Care efforts are large and complex.
- “Shared Management” must be authentically practiced at many levels.
- Additional sharing “champions” needed in both departments.
- 24 Community Team members have diverse interests and needs.
- Legal Youth Advocates anxious for more rapid change.
- State Departments are large, differ in structure.
- New Initiatives--Can the legislature and policy makers allow the departments to implement thoughtfully and without distractions?
- Money Troubles--How will we respond when the next fiscal crisis occurs?
- While the current approach may eventually yield aspects of a collaborative “functional” System of Care, structural changes would be needed to fully create a concrete, seamless and fully integrated system, if desired.
Judy Webber, LCSW
Deputy Director, Department of Children & Family Services
County of Ventura
System Change
Leadership and Implementation
Ventura County’s Experience

Judy Webber, LCSW
Deputy Director
Human Services Agency
August 23, 2016
Personal Profile

• Hope, Help & Opportunity
• Courageous * Passionate * Humble
• Lead with my Heart
• Use Intuition
• Strong Empathy
• Show vulnerability
• Always Learning
• Love to Laugh with Others
The Evolution of Child Welfare Services

• Continuum of Care Reform
  • Previously known as Congregate Care Reform
  • AB 403
  • Builds on Katie A.
  • Relies on CPM for foundational shift in how we work with families
• Family Based Care for all foster youth
  • Quality Parenting Initiative
  • Recruitment, Retention and Support
  • Resource Family Approval
• Integration of Mental Health Services & Supports
Continuum of Care Reform: Strategies

- Family Preservation
- Family Team Meetings
- Resource Family Approval
- Quality Parenting Initiative
- Katie A.
- Core Practice Model
- Safety Organized Practice
- Reform
Initiative Fatigue...

- Reactive vs. directionally driven
- Disconnect vs. Synergy
- Time telling vs. Clock Building (Built to Last)
- Classic Strategy vs. Adaptive Strategy
- Implementation vs. Sustainable Change
- **Legislation vs. Mission & Vision**
- A job vs. A calling
Leadership at Every Level

• Hiring the right people – at every level
• Professional Training and Experience
• High Expectations
• Focus on Retention
• Invest in Training
• **Attend to the parallel process** – hope, honesty and participation
• Invest in Technology
VC-CFS Foundational Work for CCR

- Majority of staff are Master Level Social Workers or equivalent
- Vision – “Protecting Children by Strengthening Families!”
- Belief Statements – created in collaboration with staff
- Safety Organized Practice – tools for meeting the expectations of the core practice model
- **Align Strategies, Services and Supports**
- Strategic Framework
Challenged to Align Goals and Efforts

- Linking quality care to new demands
- Whole Family Approach – Complicating Factors
- **Focus on quality practice, rather than compliance**
- Tap the operational level for innovation (PDSA)
- Coaching and Learning Circles
- **LEADERSHIP & PARTICIPATION AT EVERY LEVEL**
Engaging External Stakeholders

- Citizen Review Panel
  - Common Goals
  - Geo-mapping Data
  - Collective Impact vs. Parallel Efforts
- Board Involvement – recruitment, youth needs
- Substitute Care Providers – RFA
- A New Partnership – Quality Parenting Initiative
- Collaborative Training
Got Struggles?

• Change Management is never easy
• Walking the Talk
• Collaboration of two different cultures
• Bi-frocatated BH System
• Pace of Change
• Cross System’s Work/Shared Governance
• Measuring Our Success – Beliefs Dashboard
Balanced Perseverance

**Strengths**
- Committed staff and providers
- Structures in place
- Building on Successes

**Opportunities**
- Engage resource families more fully
- Maximize mental health funding and treatment services

**Risks**
- Number of resource families
- Managing/Sustaining system-wide change

**Expectations**
- Decrease children in care
- Increase reunification
- Decrease Congregate Care
System Change
Leadership & Implementation
NEVER GIVE UP!!
Briana Duffy, MBA, LSW
Senior Vice President, National Client Partnerships
Beacon Health Options
Mild-to-Moderate Medi-Cal Mental Health Services – Version 2.0

Experience Demands the Need to Expand the Pie and Workforce

Open Minds Conference
August 25, 2016
Who We Are

- A health improvement company that specializes in mental and emotional wellbeing and recovery
- A mission-driven company singularly focused on behavioral health
- Largest privately-held behavioral health company in the nation

We help people live their lives to the fullest potential.
Splitting Benefits on Functional Impairment is Difficult to Implement in a Person-Centered Way

Defining the “Bright Line” between Mild-to-Moderate vs. Significant impairments

To be eligible for County-funded mental health services, ALL of the following must be true:

1. **Diagnosis:** Must fall within one or more of the 18 specified diagnostic ranges

2. **Impairment:** Must result in one of the following:
   a. Significant impairment or probability of significant deterioration in an important area of life functioning
   b. For those under 21, a probability that the patient will not progress developmentally as appropriate, or when specialty mental health services are necessary to ameliorate the patient’s mental illness or condition

3. **Intervention:** Must address the impairment, be expected to significantly improve the condition, and the condition would not be responsive to physical health care-based treatment

*Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210*
Expected Penetration Rates in a Mature Market: Mild-to-Moderate

- Beacon has developed the following target penetration rates for the mild-to-moderate outpatient benefit:
  - Children (0-18): 2.5% - 4%
  - Adults (19+): 4.5% - 6.5%
- These targets are expected in a mature market—defined as three + years of operation
- They are based on a review of our experience in other states and California, national benchmark data, historical data on County mental health plan utilization, and the structure of the California delivery system
Providers are organized in response to different funding models.

- **Specialty MH Network**
  - County Directly Operated Clinics
  - County-Contracted Agencies

- **Mild-to-Moderate Network**
  - Federally Qualified Health Centers
  - Private Providers who take commercial AND some public insurance

- **Private Providers who take only commercial insurance**
- **Private Providers who take only cash only**
National Shortage of Child/Adolescent Psychiatrists

“The most common inquiry we receive at the Balanced Mind Foundation is where to find a child psychiatrist.” - Susan Resko, Executive Director The Balanced Mind Foundation
Widespread Mental Health Shortage in California

- There is a widespread shortage of psychiatrists and a maldistribution of other behavioral health providers in California
- Roughly 16% of Californians live in a federally designated mental health worker shortage area
- Most providers live in urban, wealthier areas
- Many providers are reluctant to accept Medi-Cal enrollees

Distribution of Providers Does Not Match Needs

Mild-to-Moderate—Varied Definitions across the State

There is an opportunity to improve care and strengthen the continuum

**Behavioral Health Severity**

**Mild**
- Many mild BH disorders are treated in PCP settings—goal is improve diagnosis and rapid care
- PCP clinical decision support including PDIP, PCP Toolkit, and Psychiatric Consultation
- Co-location of BH staff
- MH and SUD screenings including SBIRT and PHQ

**Moderate**
- Specialist referrals when indicated with eventual return to PCP setting
- Co-location of BH staff with training in EBPs for collaborative care
- Ensure rapid access for priority referrals
- Reimbursable collateral and care coordination, where appropriate
- Peer support services

**Severe**
- Alternative payment arrangements supported by ongoing technical assistance
- Use of rehab option, targeted case management, and array of community recovery services
- Collaborative care with medical services provided in community mental health center or other specialty BH setting

Often managed in primary care

Managed by County Mental Health System

Needs refinement and tailored services
One Solution: Telephonic Psychiatry Consultation

- Effective and safe way for PCPs to treat adults and children/adolescents with certain behavioral health conditions in primary care when supported by a psychiatrist
- Cost-effective way to promote the rational utilization of scarce psychiatric resources for individuals with moderate to serious mental illnesses
- Provides a virtual collaborative care model to support integrated care delivery
- Quick access (30 minutes or less) for PCPs to connect with a psychiatrist
Massachusetts Child Psychiatry Access Project

- Based on a University of Massachusetts Medical School pilot program
- Provides telephonic psychiatry consultation and coordination support to 98% of Massachusetts’ pediatric PCPs
- Meets psychiatric consultation needs of PCPs responsible for all 1.5 million children in Massachusetts
- Consists of six regional hubs—each one has one FTE child psychiatrist, licensed therapist, and care coordinator
- Helps pediatric PCPs build capacity to meet their patient’s behavioral health needs through:
  - Real-time telephonic consultation with Beacon child psychiatrists
  - Face-to-face appointments with a child psychiatrists, when indicated
  - Assistance in accessing community-based behavioral health services
MCPAP Results

- **6,695** children served in 2015
- **922** providers enrolled in MCPAP
- **44%** of all enrolled PCPs used MCPAP at least once in 2015
- **68%** of telephone consultations did not result in referral to psychiatry
- **PEDIATRICIAN UTILIZATION** of MCPAP is **57%**
- Over **60%** of children return to their PCPs to manage their BH/medication needs after a consult
- **30+** states developed child psychiatry consultation programs based on the MCPAP model
ACCESS Mental Health Connecticut

- Best replicates original MCPAP model

- Offers free, timely consultative services for pediatricians and other PCPs across Connecticut who provide behavioral health care to children and adolescents under age 19—irrespective of insurance coverage

- Includes phone and face-to-face consultations, as well as didactic learning sessions—both in the office and out in the region—on mental health disorders

- Three ACCESS Mental Health hubs cover the State—each team has one FTE board-certified child/adolescent psychiatrist, licensed behavioral health clinician, and program coordinator

- Unique program component—each team includes a Family Peer Specialist who engages, educates, and empowers youth and families to connect with support services, community resources, and advocacy assistance
ACCESS Mental Health Results

82% **Primary Care Practices** are enrolled

9,000+ **Consultations** provided

64% **Of Enrolled Practices** used the program at least once

2,000+ **Families** served

26% **Consultations Provided** by Family Peer Specialists
The Value of Peer Support Within a Workforce Continuum

- Persons with (or caring for a loved one with) mental health and substance use disorders benefit enormously from a relationship with someone who has:
  - Similar lived experience
  - A significant level of personal recovery
  - The insight and maturity to be a guide and mentor
  - A passion for advocacy and empowerment
  - The formal training to:
    - Work collaboratively with professional clinicians
    - Connect the individual with resources
    - Encourage a whole-person approach to wellbeing
Our Peer Support Specialists in Action

- In Connecticut, our Peer Support Specialists are assigned to any individual, of any age, who has an Autism Spectrum Disorder (ASD) diagnosis and their families to:
  - Help guide them through accessing ABA services
  - Connect them with resources in the community and access community supports
  - Gain access to augmenting services such as normative activities, social skills group, or other referrals

- In Illinois, our Peer and Family Support Specialists assist individuals and their family members in navigating the mental health system and also provide telephonic peer and family support via our Warm Line

- In Massachusetts, we use a person-centered approach that involves peer supports and contracts with peer-run organizations to:
  - Provide member satisfaction and other quality evaluation services
  - Conduct provider, peer, family, and staff training
  - Act as peer “bridgers” when transitioning from inpatient to community settings
  - Lead self-help regroups and other services
Peer and Family Support

The value of Peer and Family Support Specialists will only grow:

- Estimated 16 million new Medicaid members
- More than 3 million returning warriors, 10% of whom have PTSD
- Greater integration of mental health, substance abuse, and physical health

What we have learned—and continue to learn—about the indispensable role of peer support specialists will inform our work for years to come.

Thank You

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Questions & Discussion
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