

Meeting the Needs of High Needs Children in the Texas Child Welfare System

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CONTENTS

Executive Summary	6
1. TSG Approach and Methodology	9
Scope of this Analysis	9
Approach	9
2. Overview	11
Defining the Population of High Needs Children	11
Data on High Needs Children	11
Number of High Needs Children Statewide and in the Regions	14
Children with Intellectual and Developmental Disabilities	14
Total High Needs Population	16
Data on High Needs Population Over Time	16
Outcomes for High Needs Children	17
3. Current Response to Meeting Needs of These “High Needs” Children	23
What high needs children require from the child welfare system	23
Current System’s Approach to Meeting the Needs of High Needs Children	23
Child Protective Services (CPS)	24
Child Placing Agency	27
STAR Health	28
Local Mental Health Authorities (LMHAs)	31
IDD Services and Supports	32
4. Gaps in Policy and Practice	34
Lack of accountability to ensure provision of case management and care coordination	34
Many entities perform case management functions	34
Case management functions are not coordinated by an accountable entity	39
Available behavioral health Medicaid services not being fully utilized	40
Limited number of CPAs provide TCM and behavioral health rehabilitative services	41
Difficulties for Foster Youth in Accessing Services	42
No Standard Indicator(s) to identify high needs children and ensure consistent process is followed	43
Data-related gaps	43

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Lack of an automatic identifying mechanism.....	44
Process and Organizational Challenges in How CPS Works with These Children.....	45
Texas Comprehensive Child and Adolescent Needs and Strengths Assessment	45
Accessing Assistance from Subject Matter Experts	46
Accessing STAR Health Services.....	47
Caregiver knowledge gaps.....	48
Communication between CPS, CPAs, and STAR Health	48
Escalation of High Needs Cases	49
Gaps in Preventing and Addressing Trauma	50
Child Welfare System Issues	52
Placement and Service Capacity Issues	54
Capacity to serve the high needs children varies across the state.....	54
Barriers to building capacity exist	55
Barriers to placement exist even when capacity exists.....	55
Lack of capacity results in a number of negative outcomes	56
There is a critical lack of wraparound services needed to support children transitioning out of more restrictive settings and to prevent placements in restrictive settings.....	57
CPS efforts to address capacity.....	57
5. Case Studies	59
6. Best Practices	65
Texas Examples	65
Foster Care Redesign – a Continuum of Care	65
Turning Point Diversion Program.....	65
Building Local Continuum of Care.....	65
Improving Reintegration of Foster Youth.....	66
Preventing Placement Breakdowns.....	66
Permanency.....	66
Other State Examples.....	67
Virginia	67
Louisiana: Coordinated System of Care (CSoC).....	67

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California: Medi-Cal Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members.....	69
Wisconsin: Care4Kids	69
Wisconsin: Therapeutic Foster Care (called Treatment Foster Care).....	70
Illinois: The Department of Children and Family Services (DCFS) System of Care.....	70
Florida: Use of Targeted Case Management	72
7. Recommendations.....	73
Build on what is working.....	73
Fill in the gaps.....	74
1. Develop a uniform standard definition of children with “High Needs.”	74
2. Identification of identifying mechanisms for specific interventions	75
3. Build an integrated and accountable case management system and process that results in an integrated model of care that holds CPAs responsible for connecting case management functions and ensuring behavioral health needs are met	76
4. Use prevention strategies to stabilize high needs children who are not yet in crisis situations	79
5. CPS should focus on effective organizational improvements that will ensure quality outcomes when working with this high needs population	79
6. Improve caregiver training and outreach	81
7. Focus on high intensity in-home supports that provide the continuity for essential services to reduce the risk of recidivism.....	81
8. Continue with Starfish process as a way to evaluate system reforms and identify continued gaps in process	82
Action Strategy	82
Appendix A – Required Notifications	84
Appendix B – Additional Other State Best Practices in Care Coordination and Specialized Services for High Needs Children	87
Arizona, Massachusetts, Michigan, New Jersey.....	87
Medicaid Financing	87
Eligibility, Enrollment, and Access	87
Screening and Early Intervention.....	87
Covered Services	88

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Medicaid Providers 88

Performance and Outcome Measurement 88

Case Studies: Making Medicaid work for the Child Welfare Population 89

Hawaii, Maine, Maryland, Michigan, New Jersey, North Carolina, Oklahoma, Rhode Island 91

 Maine 92

 Michigan 92

 New Jersey 92

 North Carolina 92

 Oklahoma 92

 Rhode Island 92

Training 93

EXECUTIVE SUMMARY

The current Texas Child Welfare system is not providing the most effective statewide case management and response to addressing the needs of children with the highest of needs. The structure for these children is disjointed and often requires them to move through numerous systems of care that results in an inefficient, expensive service delivery system that does not meet their needs in many cases. This represents an opportunity to improve the quality of outcomes among this group and to deliver services in a more cost-effective manner.

The Stephen Group (TSG) conducted an assessment of the status, policies and practices that currently exist between Texas Child Protective Services (CPS) and Child Placing Agencies (CPA) in providing behavioral health case management services to children with the highest needs, and was asked to make recommendations on improving the performance of care based on our findings. The review also considered the intersection of responsibilities among STAR Health Medicaid services and the Local Mental Health Authorities (LMHA) as well.

The first fundamental concern is the lack of a clear standard for what “high needs” means within the child welfare system. While it is a best practice across health care and human services to develop specialized care management tools for those cases with significant costs and service needs, that currently does not exist among these children, partly because there is no one definition of the category of conditions and needed services. Thus, these high needs children often are treated the same as other children in the system.

The special needs for the children in this review have specific needs that range from emotional, medical, and intellectual/developmental disability. The number of children across the state that are identified as fitting these criteria is over 5,000.

It is important to note that there is not a lack of data to determine these needs. A robust amount of information on these children currently exists through IMPACT, STAR Health and other sources. The challenge is integrating this information and settling on a clear understanding of those who currently demand a high service level, as well as those who are at high risk of needing these intensive services, and how the system(s) of care wrap around these children at the right time and in the right setting.

TSG’s review also found there is a lack of accountability as these children move through the various systems of care, whether health care, mental health, developmental disability or other services. CPS caseworkers and contractors cannot be expected to understand the intricacies of each of these systems, and access to subject matter experts is not readily available. Thus, case management becomes disorganized and confounds the implementation of best practices.

Some of these concerns are a result of gaps in training, process and organization within CPS to deal specifically with these high needs children. These gaps are exacerbated among CPS contractors who provide critical foster care services to this group of children and are unaware of the best way to utilize the systems of care to ensure that each child gets the right care at the right setting at the right time.

In addition, there are limitations on specialized training needed to provide essential behavioral health services, and underutilization of appropriate services, Targeted Case Management that is a covered Medicaid benefit under STAR Health. An appropriate utilization of these services could work to reduce future expenses by avoiding hospitalization or placement in an institutional setting, which are highly expensive and undermine quality outcomes.

The goal for children with high needs should involve providing safe environments where they can develop that is appropriate based upon their needs and strengths. They should have a system of care that is coordinated around them to meet their needs and the plan of care should move seamlessly from one system of care (such as medical, mental health or disability) to another. The placement of these children should match the child's needs with a caregiver who is trained in the appropriate area(s).

This means much better coordination among groups such as CPS, CPAs, STAR Health, LMHAs and other providers to ensure the care for that child is well understood by all agencies that might come in contact with each high needs child. This should include greater stability to encourage consistency among providers to have a strong, ongoing relationship with the child, by working to keep these children in the smallest number of settings possible, and in a similar geographic area.

Accordingly, TSG makes the following recommendations to improve the quality and efficiency of care delivery for high needs children in the Child Welfare system:

- **Develop a uniform, standard definition of Children with “High Needs”** – Many emotional and medical issues do not represent “high needs” and should not be included for intensive management. Those that do, particularly those with co-occurring disorders, should be identified clearly and early.
- **Identify a clearly defined mechanism(s) and map them to specific interventions that meet the particular child's needs and ensure the correct process is followed in every child's case** – Using the definition of high needs child, identify clear indicators/events (i.e., hospitalization or institutionalization) and map them to specific interventions. The interventions would not be the same for every child; but a consistent process would be followed to ensure the child's individualized needs were met. Also, work to reduce the risk of escalation.
- **Build an accountable case management process in an integrated model of care** – Ultimately, one entity should be responsible for the outcome of each high needs child, regardless of where that child receives care. This entity will then work to ensure that the care is coordinated around the child to produce the best result. The model for

reimbursement must be built around successful outcomes, not services delivered. These successful outcomes must involve meeting essential health and well-being performance measures as well as the goal of achieve timely permanency.

- **Use prevention strategies to stabilize high needs children who are not in crisis situations** – Building best practices to identify those high needs children who are not yet in a crisis environment is critical to effective case management and getting better outcomes. This will shorten the time to permanency, which is good for the child and less expensive for the State.
- **Establish process and organizational improvements for how CPS works with this population** – CPS should continue to improve training, building best practice models and working to build community-based infrastructure to ensure that appropriate support exists to transition to a high needs management model will be successful.
- **Focus on high intensity in-home supports that provide the continuity for essential services to reduce the risk of recurrence** – When high needs children have had a significant intervention, getting the right support in the care setting is critical to reducing the possibility of a repeating situation. This also should include the continuity of support once permanency is achieved

1. TSG APPROACH AND METHODOLOGY

The Department of Family and Protective Services (DFPS) and Health and Human Services Commission (HHSC) directed The Stephen Group (TSG) to perform a comprehensive assessment of how the Texas child welfare system serves children with high needs outside foster care redesign areas.¹ DFPS directed TSG to identify gaps in policy, process, and knowledge that result in poor outcomes for these children, and outline a solution to improve how the child welfare system cares for them.

Scope of this Analysis

DFPS directed TSG to explore issues affecting high needs children across Child Protective Services (CPS) programs, out of recognition that children in investigations and family based safety services could eventually come into DFPS care. However, the focus of this assessment was on high needs children in DFPS conservatorship. TSG focused primarily on how CPS and Child Placing Agencies (CPAs) work with high needs children, support the placement process, and coordinate services. Given the interconnection of the different actors in the Texas child welfare system, this analysis also includes additional findings and recommendations for entities in addition to CPS and the CPAs.

Approach

TSG sought to define this population of children, understand how the current system should work, the roles and responsibilities of all the parties within the system, and identify the gaps in this system, in order to offer concrete recommendations. To do so, TSG employed several research methodologies.

TSG conducted analysis of data on children and youth in conservatorship to identify special needs children and understand more about them collectively. This included placement location, their regions of origin, co-occurring conditions/characteristics, and their authorized level of care.

TSG interviewed several State Office staff including:

- Director of Permanency
 - Director of Policy/Family and Youth Services
 - Director of Placement, Capacity Building Specialist

¹ TSG was directed to focus on foster care youth outside of foster care redesign catchment areas, and thus, did not examine outcomes in the foster care redesign areas for high needs children as part of this assessment.

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- Director of Foster Care Redesign
- Permanency Division Administrator, Program Specialist
- Director of Medical Services Team
- Director of Investigations and Family Based Safety Services (FBSS)
 - Division Administrator for Investigations and Alternative Response
 - Division Administrator for Child Safety and FBSS
 - Program Specialist
- Division Administrator of Excellence in Practice
 - Practice Model Specialist
 - Mental Health Specialist

TSG interviewed over one dozen directors of Child Placing Agencies (CPAs) and Residential Treatment Centers (RTCs).

CPS leadership also directed TSG to conduct fieldwork in four regions thought to have strong/best practices in this area, including Regions 2, 3, 7 and 10. TSG interviewed conservatorship management staff (program administrators, program directors, and supervisors) and specialists (Developmental Disability Specialists, Well-being Specialists, Nurses, and Special Immigrant Juvenile Specialists). TSG conducted in-depth research on several case study examples to illustrate the strengths and gaps in the current child welfare system.

Finally, TSG also spoke with a number of child welfare mental health subject matter experts from other states as well as researching best practice examples from other states.

2. OVERVIEW

Defining the Population of High Needs Children

There are multiple ways to define high needs children in the context of the child welfare system and the term means something different to different groups of program staff. Some identify this as the population with behavioral health diagnoses. Others take a broader approach to include those with behavioral health or physical health issues. To some, the population includes children and youth with the “intensive” or “specialized” authorized levels of care (ALOC) which dictate the amount of foster care payments. Others consider it a practical issue of placement and define high needs children as anyone with challenging diagnoses, behaviors, and other characteristics whose placements break down frequently and require new placements frequently. Another perspective is to define high needs children as those who drive foster care and health costs.

These children consume a large amount of human resources in CPS, and in the therapeutic and medical community. Depending on the definition one uses, the composition and size of the high needs population varies significantly. Coming to a common understanding of the definition of this population is important in the design of solutions to improve the provision of care.

While the scope of this analysis includes all children in the child welfare system with high needs, the focus is on those in DFPS conservatorship. Identifying children in open investigations or family based safety services stages is difficult because no data element in IMPACT captures whether they have special needs. Documentation in the case files from teachers, physicians, parents, and other key contacts may indicate that a child has certain characteristics or needs but that data cannot be captured readily for analysis. The investigations and family based safety services stages are important, but the information is not available to quantify and address the issues with the children in these stages of service.

Data on High Needs Children

There were 28,031 children in DFPS conservatorship as of August 2015. There is no one source of information at this time that can identify the number of high needs children.

Caseworkers capture a number of child characteristics in IMPACT and this information is helpful to begin the process of identifying children with high needs. While there are dozens of individual indicators, over time, DFPS Management Reporting and Statistics has created certain composite indicators that group together related characteristics to facilitate easier reporting. One indicator is also used in identifying eligibility for adoption assistance. These indicators include emotional, learning, medical, physical, and special needs. Some individual characteristics are included in multiple composite indicators (i.e., a child with bipolar disorder would have both the

“emotional” and “special needs” indicators). The listing of individual characteristics mapped to the composite indicators is shown below.

Characteristics comprising Key Indicators

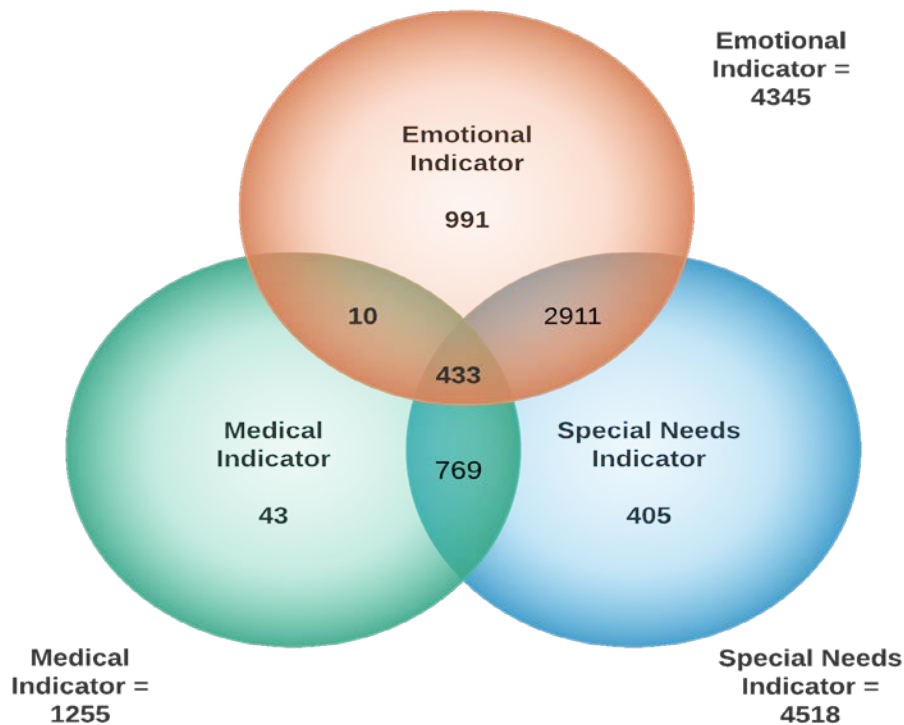
Emotional	Learning	Medical	Physical Needs	Special Needs*
	ADD/ADHD			
	Autism			
	Developmental Delay			
	Developmental Disability			Developmental Disability
				Down Syndrome
Animal Cruelty				
Assaultive Behavior				
Reactive Attachment Disorder				Reactive Attachment Disorder
Bipolar				Bipolar
Depression				Depression
Eating Disorder				
Emotionally Disturbed – DSM				Emotionally Disturbed – DSM
		Enuresis/encopresis		Enuresis/encopresis
		Failure to Thrive		Failure to Thrive
Fire Setting Hx				
Gang Activity/Affiliation				
		Medically Complex		Medically Complex
		Hearing impaired		Hearing impaired
		HIV positive/AIDS		HIV positive/AIDS
	Learning Disabled			
		Medically Fragile		Medically Fragile
	Intellectual and Developmental Disability			Intellectual and Developmental Disability
			Mobility Impaired	Mobility Impaired
Oppositional Defiant Disorder				Oppositional Defiant Disorder
			Physically Disabled	Physically Disabled
Post-Traumatic Stress Syndrome				Post-Traumatic Stress Syndrome
Psychotic Disorder				Psychotic Disorder
Runaway				
Self-Abuse				
Sexually Acting Out				
		Sexually Transmitted Disease		
	Speech Disabled			
			Spinal Bifida	
		Terminal Illness		Terminal Illness
		Traumatic Brain Injury		
Other Behavior Problem		Visual Impairment	Visual Impairment	

Note: A child is “special needs” if they are part of a sibling group, are white and over age 6, are non-white and over age 2, and have any of the characteristics shown.

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No one category is a perfect encapsulation of the high needs population. The groups of population of children closest to the high needs children reviewed by TSG are likely to fall into the following three categories: (1) Emotional; (2) Medical; and, (3) Special Needs. The special needs category includes some behavioral and physical health indicators, as well as captures most children in foster care with Intellectual and Developmental Disabilities (IDD).

There is some overlap in these groups. Some children may have multiple characteristics that would result in their categorization in multiple groups. Other children may have characteristics that map to multiple indicators. The Venn Diagram illustrates the overlapping population with one or more of the emotional, medical, and special needs indicators. While there are 4345 people with the emotional indicator, 1255 with the medical indicator, and 4518 with the special needs indicator, the total unduplicated count across these indicators is 5,562. There are 433 foster children that have characteristics that would result in their categorization in all three groups. The diagram below illustrates the areas where the overlap occurs (again, noting most IDD cases are captured in special needs).



Number of High Needs Children Statewide and in the Regions

The figure below provides the number of children in each region and statewide with each of these indicators. The unduplicated count of children across these categories is also provided. Regions 3, 6, 7, and 8 have the greatest unduplicated total number of children with these characteristics; Regions 10, 6, 2, and 9 have the greatest percent of high needs children.

Children in Care, with Certain Characteristics, by Region

	Total Children in DFPS Conservatorship	Emotional	Medical	Special Needs	Unduplicated	Unduplicated % of Total Caseload
1	1613	239	55	238	298	18.5%
2	897	166	50	177	216	24.1%
3	5972	838	228	831	1056	17.7%
4	2005	298	77	306	377	18.8%
5	985	136	59	167	192	19.5%
6	4953	921	314	1003	1241	25.1%
7	3659	491	156	530	639	17.5%
8	4347	661	162	668	810	18.6%
9	1019	167	45	175	211	20.7%
10	381	87	14	87	102	26.8%
11	2200	341	95	336	420	19.1%
Total	28031	4345	1255	4518	5562	19.8%

Source: August 2015 CVS Big Data File.

Children with Intellectual and Developmental Disabilities

Children with IDD are a portion of the high needs population. CPS defines the population of children in foster care with IDD as having one of five characteristics: intellectual and developmental disability, developmental disability, autism, Down Syndrome, and Spinal Bifida. In the count of special needs children above, children with both intellectual and developmental disability and individuals with developmental disability only are included, however, none of the indicators above capture all of these children.

TSG looked at the individual indicators in IMPACT for these five characteristics. The regional total number of children with each of these characteristics as captured in IMPACT is shown below. That totals reflect children for which the characteristic is both diagnosed and suspected.

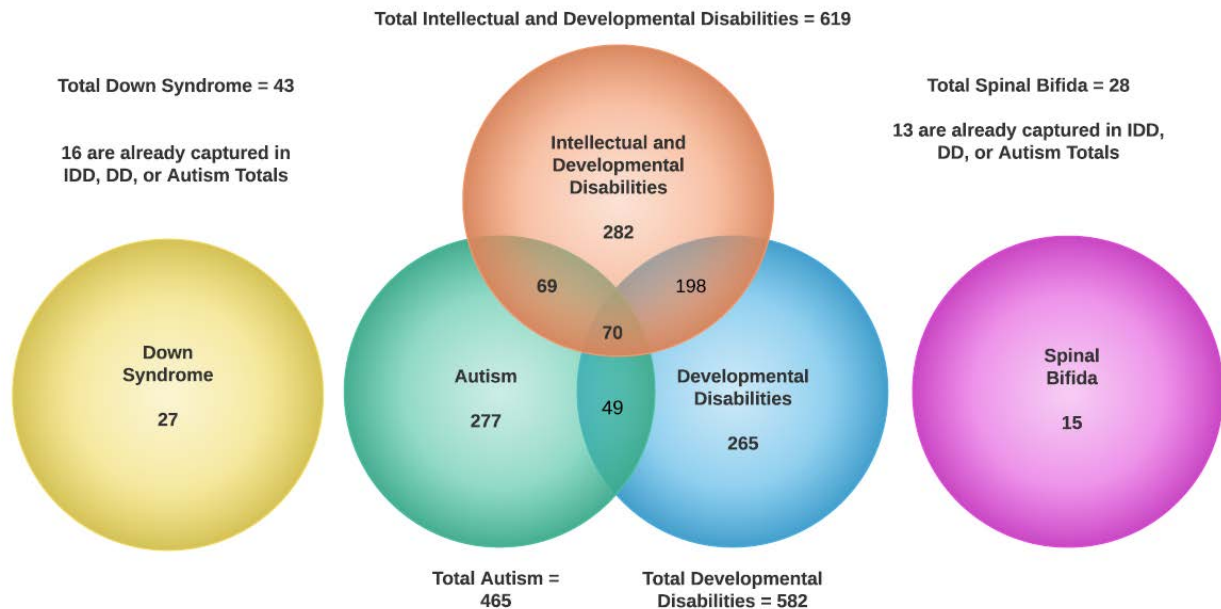
Children in Foster Care with Intellectual and Developmental Disabilities, as of August 2015

	Developmental Disability	IDD	Autism	Spinal Bifida	Down Syndrome	Total
1	45	43	17	1	1	107
2	10	27	20	2	1	60
3	100	93	104	5	11	313
4	51	48	36	0	2	137
5	48	32	22	0	2	104
6	90	111	70	3	8	282
7	101	92	66	3	5	267
8	71	81	68	10	6	236
9	23	40	18	1	2	84
10	9	11	10	1	0	31
11	34	41	34	2	5	116
Total	582	619	465	28	43	1737

Note: August 2015 CVS Big data file. Total is duplicated count.

The duplicated count of these children is 1,737, however because several of them have co-occurring conditions, the unduplicated count of children in foster care with IDD is estimated to be 1,252. As shown in the figure below, TSG analyzed the three most common conditions (IDD, DD, and autism). 70 foster children have all three. 316 children had two of those conditions. 824 have one (282 have IDD, 265 have DD, 277 have autism). There are a small number of children in foster care with Down Syndrome and Spinal Bifida who are not captured in the IDD, DD, and autism count and should be included in order to make the count complete.

Unduplicated Count of Children in Foster Care with IDD, August 2015



Source: August 2015 CVS Big Data File.

Total High Needs Population

There is no single indicator that encapsulates all high needs children in foster care. Using several indicators, it is possible to get a composite of what the high needs population in foster care might be but it is important to note that it is only an estimate. TSG estimates that there are approximately 5,900 high needs children in DFPS conservatorship. This total includes the 5,562 children above with the special needs, emotional, and medical indicators. This total also includes part of the IDD population (those with IDD, DD because those characteristics are mapped to the special needs indicator). If one wanted to include the entire IDD population in this high needs count, one would add an additional 292 children with IDD. These children have autism only and Spinal Bifida, and are not otherwise captured in the total.

Data on High Needs Population Over Time

Data on the change in the high needs population over time, as defined in these parameters, are not readily available. CPS Permanency Division staff indicated this population has not grown over time. Anecdotally, regional staff indicated they think the population of high needs children, especially those with co-occurring conditions, is growing, but several acknowledged that they do not have the data to support this. One factor that could be contributing to this feeling is that

foster youth do not have to age out at age 18; youth can now remain in extended care until age 22.

At TSG’s request, Region 2 staff conducted a deeper dive into their high needs population. Of their children with emotional issues in September 2015, they found the greatest diagnoses were ADHD, assaultive behavior, bipolar, and conduct disorder. The analysis indicated an overall decrease in the number of children with emotional issues, but an increase in the occurrence of some serious behavioral issues (i.e., assaultive behavior and conduct) which could also be contributing to the perception that this problem is growing over time.

Outcomes for High Needs Children

They are not all in crisis

Although there are approximately 5,900 children that could be classified as high needs based on the above data, but it must be recognized that they have varying levels of need. Some are in crisis but others comprise a pool of children who could be at risk of crisis. One can understand this point when analyzing the levels of care of children with these indicators. The authorized level of care (ALOC) is based on a third-party assessment of the child's needs and is used as a basis for billing (higher payment for higher intensity).

The ALOC varies from specialized (most severe) to basic (least severe). Below, the ALOC of all children in DFPS conservatorship in August 2015 is shown (by far, most of these children are at a basic and moderate level of care).

Authorized Level of Care, all Children in DFPS Conservatorship, August 2015

	Total	%
Intense	522	1.9%
Specialized	2909	10.4%
Moderate	3315	11.8%
Basic	16453	58.7%
Psychiatric Transition	32	0.1%
NA	4800	17.1%
Grand Total	28031	

Source: August 2015 CVS Big Data File.

High needs children considered in this analysis have varying ALOCs. Generally, they are more likely to have higher levels of care than the average foster child population. However, this data is instructive for two reasons.

First, children where these indicators are present and the ALOCs are specialized and intense are likely to be the highest of the high needs children in care – those in crisis or potentially in need of significant services and supports.

Second, the fact that a significant number (approximately half) of the children with these indicators are at moderate or basic levels of need suggest that mere existence of one of these indicators does not equate to a crisis situation.

This supports the argument that these children are at risk of becoming part of that highest needs group, but that with the right supports, can remain stable. The strategies used to manage the care of those at lower levels of care could prove instructive for a longer-term prevention strategy.

Note that the counts below are duplicated.

Authorized Levels of Care, High Needs Children

Emotional	Count	Medical	Count	Special Needs	Count
Intense	339	Intense	113	Intense	380
Specialized	1548	Specialized	461	Specialized	1604
Moderate	1465	Moderate	282	Moderate	1357
Basic	915	Basic	314	Basic	1002
Psychiatric Transition	25			Psychiatric Transition	25
NA	53	NA	85	NA	150
Grand Total	4345	Grand Total	1255	Grand Total	4518

Source: August 2015 CVS Big Data File.

Despite the fact that not all of these high needs children are at high levels of need currently, a review of the outcomes for this group as provided in the Overview section of this report indicates that, as a group, they tend to have worse outcomes than their peers in the foster care system.

High needs children have more placements

For all of the children in care as of August 2015, the average number of placements they have experienced at this point is 2.7. For children with high needs characteristics, that number is much greater. For example, for children with the emotional indicator, the average is 5.7 placements. The following figure compares the number of placements for children with and without these indicators. Children without these indicators tend to have fewer than the statewide average of 2.7. Children with these characteristics have a much larger number. Note that per CPS staff, hospitalizations and psychiatric hospitalizations are not counted in the number of placements.

Statewide Average Placements, for Children with and without Select Characteristics

Emotional	Average Number of Placements	Medical	Average Number of Placements	Special Needs	Average Number of Placements
No	2.2	No	2.7	No	2.3
Yes	5.7	Yes	4.1	Yes	5.0
All Children in Care	2.7	All Children in Care	2.7	All Children in Care	2.7

Source: August 2015 CVS Big Data.

Children with high needs are over-represented among those with the greatest number of placements. The following chart shows the count of children by number of placements per region. Out of the 28,301 children in care as of August 2015, 990 have had 10 or more placements (3.4%).

Number of placements, all children in DFPS conservatorship as of August 2015

# Placements	Regions											Total
	1	2	3	4	5	6	7	8	9	10	11	
1	515	333	2325	911	437	1900	1795	1576	374	136	788	11090
2	445	266	1845	599	295	1194	940	1067	274	81	561	7567
3	240	114	771	205	106	646	402	599	125	52	308	3568
4	127	70	351	90	56	333	184	325	75	30	172	1813
5	78	22	176	57	29	213	91	213	48	18	105	1050
6	37	16	130	37	17	162	67	172	36	14	79	767
7	37	14	79	27	12	104	44	87	25	9	41	479
8	21	18	65	17	8	87	34	61	15	7	42	375
9	20	12	38	11	10	49	18	43	16	8	25	250
10	19	6	40	12	2	49	20	32	8	7	7	202
11	15	7	27	11	1	34	11	26	4	9	12	157
12	12	5	24	10	6	31	6	23	4	2	13	136
13	6	3	26	4	1	31	11	18	5	1	11	117
14	10	2	8	2		15	3	15	3	3	6	67
15	4	2	4	2	1	13	3	11	1		7	48
16	7	2	8	1	1	13	6	14	2	1	3	58
17	3	2	7	2		14	5	8		1	4	46
18	2		6			6	2	6	2		4	28
19	1		2		1	11	5	5	1		3	29
20	1		9			6	4	4				24
21	2		1		1	7	2	5			2	20
22	1		1	1		2	1	3		1	4	14
23	2		2	1		2		4				11
24	1	1	1			2	1	2				8
25	1		2			3		2				8
26						2		1				3
27						1		3				4

28	1		1			2			1			5
30											1	1
31			1									1
33			1									1
34			1									1
37										1		1
Total	1613	897	5972	2005	985	4953	3659	4347	1019	381	2200	28031

Source: August 2015 CVS Big Data.

Note: Excludes children with 0 placements at the point in time the file was created (this could be because the child just came into care and the worker had not yet entered the placement into IMPACT).

Of the 990 children with 10 or more placements:

- 71.8% have a characteristic that would lead to their classification under the emotional indicator
- 60.1% have a characteristic that would lead to their classification under the special needs indicator
- 11.4% have a condition that would lead to their classification under the medical needs indicator

High needs children have longer average stays in foster care

Children with high needs have a longer average stay in care than the average foster child. The average child in foster care in August 2015 had been in care for 1.93 years. If a child does not have an emotional, medical, or special needs indicator, their average stay is less than 1.93 years. Specifically, it is 1.57 years among those without an emotional indicator, 1.84 years for those without a medical indicator, and 1.59 years for those without the special needs indicator. If they have the emotional indicator, they average 3.91 years in care. If they have a medical indicator, they average 3.98 years in care and, with a special needs indicator, they average 3.72 years in care.

Average Time in Care (in Years) for Children in Care in August 2015

Average all Children	Emotional		Medical		Special Needs	
	No	Yes	No	Yes	No	Yes
1.93	1.57	3.91	1.84	3.98	1.59	3.72

Source: August 2015 CVS Big Data File.

High needs children reside in certain settings more than the average children in foster care

Children in foster care most often reside in foster family homes (DFPS or contracted) or kinship homes. Children with the special needs or emotional indicators are less likely to reside in foster family homes and significantly less likely to reside in kinship homes. They are about four times more likely to reside in residential treatment. Children with the medical indicator are more likely than the average child in conservatorship to reside in a foster family home, but much less likely to be placed with kin.

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Compared to all children in DFPS conservatorship, those with the medical indicator are twice as likely to reside in residential treatment.

Comparison of Placement Types

Setting	All Kids in DFPS Conservatorship		Special Needs		Medical		Emotional	
Contracted or DFPS Foster Family Home	11261	40.2%	1594	35.3%	581	46.3%	1296	29.8%
Kinship Home	10425	37.2%	546	12.1%	208	16.6%	402	9.3%
Residential Treatment	1672	6.0%	999	22.1%	154	12.3%	1153	26.5%
Contracted or DFPS Foster Group Home	1586	5.7%	441	9.8%	110	8.8%	502	11.6%
Emergency (Shelter Services)	608	2.2%	147	3.3%	24	1.9%	163	3.8%
FC Other Foster Care	440	1.6%	301	6.7%	79	6.3%	257	5.9%
Private or FPS Adoptive Home	682	2.4%	125	2.8%	44	3.5%	106	2.4%
GRO Child Care Only	737	2.6%	191	4.2%	33	2.6%	231	5.3%
Independent Living	27	0.1%	7	0.2%	2	0.2%	8	0.2%
Other	502	1.8%	128	2.8%	17	1.4%	172	4.0%
SIL Youth	91	0.3%	39	0.9%	3	0.2%	55	1.3%
Total	28031	1	4518		1255		4345	

Source: August 2015 CVS Big Data Set.

These children have less desirable permanency outcomes

A number of factors may make it difficult for these children to achieve permanency. They may have co-occurring issues for which adoptive homes feel ill equipped to address. Frequent moves may make it difficult for them to address their underlying trauma and issues that impede achievement of permanency. They are less likely to be placed with relatives or to remain with relatives, so have a reduced likelihood of achieving permanency with relatives. They may have outstanding immigration issues, which limit their ability to access Medicaid services including waiver programs that provide a structure of support after they leave CPS conservatorship.

Some regions have strong Permanent Managing Conservatorship (PMC) units and the efforts to help youth achieve permanency discussed in the best practices section of this report.

3. CURRENT RESPONSE TO MEETING NEEDS OF THESE “HIGH NEEDS” CHILDREN

What high needs children require from the child welfare system

With this understanding of who high needs children are, TSG met with State Office staff to understand what they needed from the child welfare system. According to CPS, these needs include:

- Safe, nurturing environments, ranging from foster homes to group homes to RTCs to hospitals depending on their level of need at the time.
- Seamless, rapid movement from one placement to the next as they step down their level of care. More support in making their moderate needs placements work.
- Medical and psychiatric services, delivered primarily in the home environment through well-trained providers.
- More medical training and support for the entities CPS contracts with (child placing agencies) and foster families in dealing with the special issues these kids have.
- Coordination across all the entities involved in meeting the needs of these children to share historical information and maintain continuity of care.
- Stability of location across placements so they can continue with their same therapist, school, friends, and family connections. Greater capacity everywhere in Texas to keep these kids local.
- A responsible agency or party that is willing to assure capacity, coordination and delivery of all essential mental health services for the child throughout non-foster care redesign regions, and help to minimize placement disruption, achieve quality outcomes of normalcy and well-being and work towards achieving permanency for these children

Current System’s Approach to Meeting the Needs of High Needs Children

Meeting the needs of children with high needs is a collaborative effort involving CPS and many external partners, as outlined below.

Entities involved in Meeting Needs of High Needs Children

Entity	Role
CPS	Legal responsibility for children in conservatorship, coordinating and arranging for placement and care while in state’s conservatorship. CPS “acts as the parent” when dealing with medical issues and shares information with providers and caregivers to allow them to meet the child’s needs.
<p>Child Placing Agency</p> <p>CPAs contract with various placement settings including foster homes, therapeutic foster homes, group homes, and Residential Treatment Centers.</p>	<p>Contracts with DFPS; places children in a variety of settings (contracting with homes and providers); responsible for care delivery to the children under their agency’s placement; responsible for the majority of children in DFPS conservatorship.</p> <p>Each child has a case manager.</p>
STAR Health (Superior HealthPlan)	Medicaid managed care program for children in foster care. Vendor provides primary, behavioral, dental, and vision care by contracting with a network of providers across the state. STAR Health Liaisons, 7 regionally located, designated MCO staff, serve as the point-of-contact to answer questions and resolve issues with DFPS regarding STAR Health.
Local Mental Health Authority (LMHA)	Local government entity that contracts with the Department of State Health Services to provide community-based mental health services to indigent persons. In the context of foster children, LMHAs act as contracted Medicaid providers of targeted case management and other rehabilitative services.

Child Protective Services (CPS)

CPS staff spoke about their responsibility to act as a foster child’s “parent.”

The CVS caseworker has primary responsibility for the child while they are in DFPS care and for ensuring their needs are met. The caseworker coordinates placement, services for a child in foster care, and engages in permanency planning for the child. If a placement is found out of region or state, the worker brings the child to the placement. If staff cannot find a placement, the worker spends the night with the child in the office.

The worker makes monthly face-to-face contact with the child (or uses an ISY worker if the child is placed out of region). The worker is accountable (publicly) in court for all the decisions made in a case. The worker ideally facilitates the sharing of information between placements, therapists, medical staff and caregivers to allow better treatment of the child. This can include anything from successful ways to calm a child down to familiar bedtime routines. The worker also briefs medical staff, much as a parent would, on the child's history.

When a worker has a high needs child on their caseload, arranging for placement (especially out of region placement), arranging for services, and complying with the dozens of notification requirements in policy (see Appendix A), can be very challenging. Because of these difficulties and the specialized knowledge required to navigate different systems and services on behalf of high needs children, CPS has created different subject matter expert positions over time that together, work as a team with the caseworker to meet these children's needs. These positions are summarized below.

Select CPS Roles and Responsibilities

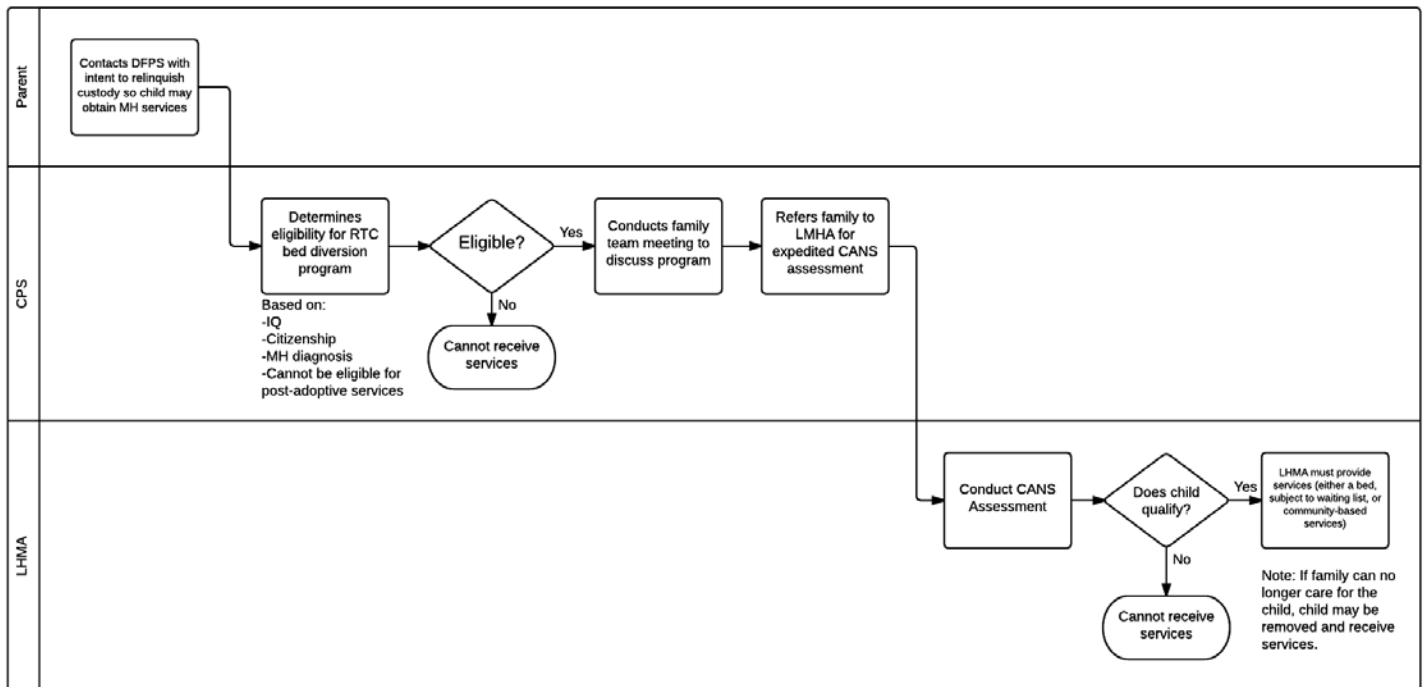
Position	Number of Staff	Role
ISeeYou Specialist	81	Secondary caseworkers for children placed out of region. Responsible for monthly face-to-face visits.
Central Placement Unit (CPU) Coordinating Specialist	44	Locate placements for children. State Office reports finding placements may often require literally hundreds of telephone calls.
Well-being Specialist	7	CPS staff liaisons to the STAR Health primary care and behavioral health vendor (Superior HealthPlan and provide caseworkers with subject matter expertise in meeting the needs of youth with specialized needs.
Developmental Disability Specialist	12	Assist caseworker in understanding needs of child with developmental disabilities and making placements. Assigned secondary on cases where primary worker is out of region and conduct face-to-face visits of children in institutions. Make referrals to local authority and Department of Aging and Disability Services programs.
Nurse	6.5	Assist caseworker by providing medical subject matter consultation, training, and technical services. They review medical documentation, communicate with providers. They act as regional liaison with STAR Health, Psychotropic Medication Utilization Parameter Reviews (PMUR), Forensic Assessment Center Network (FACN), and Sexual Assault Response Team (SART).
Special Immigrant Juvenile Specialist	3	Provide subject matter expertise in cases involving children in care who are non-citizens and who are eligible to receive the benefits of becoming a U.S. Permanent Resident. These

		individuals visit with the child, get documentation as permissible, try to apply for a green card for the children, coordinate with consulate, and work with lawyers.
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Source: DFPS, Active Position Report, October 23, 2015.

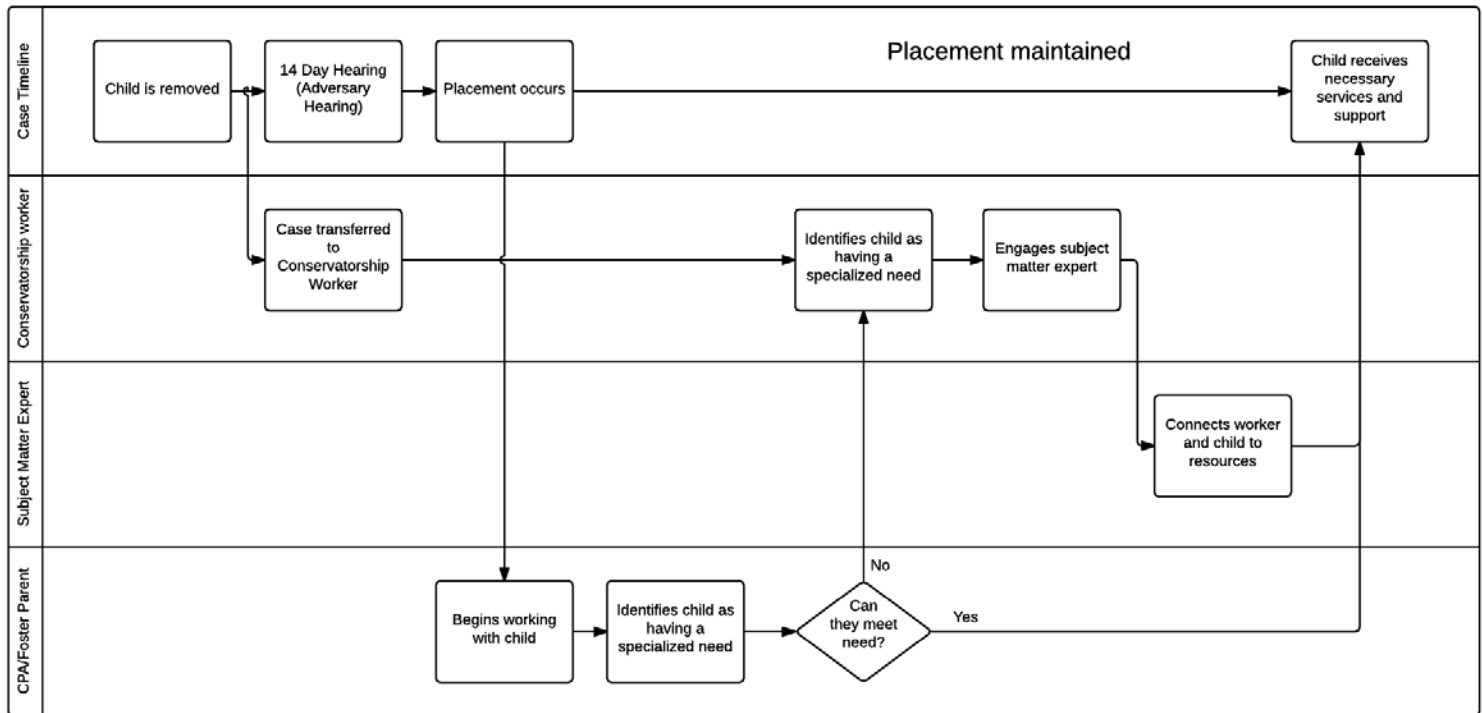
Given this approach to concentrating knowledge among a relatively small number of specialists, the following process maps illustrate how the current process is supposed to work in an ideal situation when a child presents with a specialized need.

In the first scenario, the parents approach DFPS about relinquishing custody so that their child may obtain behavioral health services. CPS determines if the child is eligible for the bed diversion program and if so, refers the family to the local mental health authority for an expedited CANS assessment. The LMHA conducts the assessment and if the child qualifies, must provide services (either a bed, subject to a waiting list, or community-based services). This process was established as a result of SB 44, Eighty-third Legislature. The Department of State Health Services (DSHS) has 30 diversion beds and may provide intensive community services for children who qualify. In this scenario, the investigations worker engages the Mental Health Specialist, who connects the child to DSHS and if found to be eligible, the child can receive supports.



In the second scenario, the child presents as a typical abuse/neglect case. The Investigator handles the initial removal and may identify a specialized need based on observation, information from the caregiver or collateral, or on review of documentation (such as a prior psychological). The CVS worker, once they become involved, knows which subject matter

expertise to tap into and together, the team works to get the child the necessary supports and services. A variant in this model is that the CPA/foster parent identifies a need and either tries to resolve it within their span of control and resources, or reaches out to the worker for support. Again, the worker supports them and maintains the placement.



Complete information may not be available at the time of the removal. Commonly, a child deteriorates while in care and requires different supports. The worker may not know who to reach out to for support on the case. It may not be clear whether the behavior is a result of the recent trauma of removal or a deeper issue. The placement might not be appropriate and might not be able to withstand the crisis. It may be difficult to find a placement. A placement might submit notice that the child needs to be removed before the stabilizing services and supports can be provided. There might not be good communication between the worker and the CPA or the foster home and the CPA. The subsequent sections of this report analyze these gaps in more detail.

Child Placing Agency

CPS contracts with Child Placing Agencies to provide placement and services for foster children. CPAs sub-contract with foster homes, therapeutic foster homes, and group homes. Some also have Residential Treatment Centers (RTCs). CPAs serve the majority of foster children in Texas.

As a result, DFPS/CPS does not have a direct contractual relationship with the caregivers for the majority of Texas foster children.

CPAs make the decision of whether or not to accept placement of a foster child. Once accepted, CPS contractually requires the CPA to manage the case of each child placed in their care, including developing and updating service plans, maintaining the case of the child by updating the service plan, making monthly direct contact with the child, and performing any additional case management services needed. CPAs must also recruit and train foster homes and provide supports to the foster parents.

CPAs have the contractual ability to submit notice on any child within their care to request a transfer of that child out of their care. A particular contractual provision allows them to submit notice within 24 hours on admission to a psychiatric hospital.

Minimum licensing standards and the contract contain numerous requirements for CPAs. Numerous requirements pertain to the initial assessment of children. Specific admissions criteria exist for children with specialized needs (i.e., emotional disturbances, intellectual and developmental disabilities, primary medical needs). There are detailed requirements for service planning including what must be in the plan and who must be involved in the plan.

STAR Health

STAR Health is the Medicaid managed care program for foster youth. In the request for proposal for the current STAR Health contract, HHSC stated its intent for this program is to ensure continuous delivery of integrated and behavioral health services for children in foster care, to ensure they have a consistent source of healthcare through a medical home, and to improve their health care outcomes.

The STAR Health vendor receives a capitated, per member, per month rate to ensure the statewide availability of and to administer the following benefits:

Summary of STAR Health Benefits

Physical Health Benefits	Behavioral Health Benefits
Medical	Inpatient Services
Dental	Outpatient therapy
Vision	Partial Hospitalization
Prescriptions	Intensive outpatient
Hearing exams/aides	Day treatment
Durable medical equipment	Observation
Hospital care	Rehabilitation
Emergency Rom	Telemedicine
Inpatient	Disease management (IDD)
Physical therapy	Complex case management
X-rays	

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Transplants	
Family planning	
Disease management (asthma, diabetes)	

Source: Superior HealthPlan

Specialized programs include:

- 24/7 Nurse line
- Service management – Telephone-based assistance in finding doctors/specialists, scheduling appointments, education on conditions like asthma, depression, obesity, participating in hospitalizations/discharge planning, providing health information for legal reviews.
- Physical and behavioral health complex case management
- The Transitioning Youth Program
- Trauma Informed Care Training for providers
- Start Smart for Your Baby OB case management program
- Transplant Case Management Program
- Diabetes (dual case management by behavioral and physical health team)
- Personal care services (PCS)
- a2A Program – Support for adolescents 18-21 who are about to age out of care to prepare them to take responsibility for their health.
- The health passport - Allows the medical consentor, providers, and CPS Caseworkers in a child’s case to access electronic health information about a child including prescriptions, primary care providers, lab results, immunizations, allergies, and visit history.
- Behavioral Health 7 Follow-Up program – Incentive program for members who attend 7-day follow-up appointment after hospital discharge.
- New support services available for members with certain needs (i.e., trauma informed peer support, DME when placement changes)

The STAR Health Contract requires that children be seen by a primary care doctor within 30 days of enrollment (per the state’s Early and Periodic Screening, Diagnosis, and Treatment program known as Texas Health Steps) so that the child can be referred for any specialty care needed.

Resources available in some parts of the state (not yet statewide):

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- Mobile Crisis Outreach Teams – This service operates in Houston, Dallas, San Antonio, Lubbock, and Corpus Christi for children served by Pathways and Covenant Kids (statewide teams available through local mental health authorities).
- Psychiatric Hospital Diversion Program – Currently in Tarrant County, expanding to Houston, San Antonio, and one site in Regions 2 or 9.

Included in the capitated rate that the state already pays the STAR Health vendor are some specific services for children with behavioral health needs. The STAR Health vendor has a contractual responsibility per the RFP, 8-88, sec. 8.1.17.8, to provide mental health rehabilitation services and mental health targeted case management services as part of the service array.

Per the STAR Health Contract, “these are services designed to assist Members with gaining access to needed medical, social, educational, and other services and supports. These services are furnished to Members who have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.” The MCO must ensure that it coordinates with providers of TCM to ensure integration of behavioral and physical health needs of members. STAR Health credentials and contracts with providers of TCM.

In addition to TCM, the rehabilitative services included in the STAR Health program and as defined in sec. 8.1.17.8 include:

- Skills training and development – skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers, and teachers.
- Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms to prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting
- Crisis intervention – intensive community-based one-to-one service provided to Members who require services in order to control acute symptoms that place the Member at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting.
- Psychosocial rehabilitation services – social, educational, vocational, behavioral, or cognitive interventions to improve the Member’s potential for social relationships, occupational or educational achievement, and living skills development.
- Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the Member in understanding the nature of his or her mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community

Foster children are also eligible for the Medical Transportation Program, which may pay for child and caregiver/medical consentor travel to a medical appointment. This service is provided outside the STAR Health capitated rate.

Local Mental Health Authorities (LMHAs)

Local mental health authorities (LMHAs) are units of local government that contract with the Department of State Health Services (DSHS) to administer community-based mental health services to adults and children. Thirty-nine community centers provide services across Texas. Per Chapter 534.053 of the Texas Health and Safety Code, these entities use a combination of state and local funds to provide at a minimum, the following local mental health services:

- 24-hour emergency screening and rapid crisis stabilization services,
- Community-based crisis residential services or hospitalization,
- Community-based assessments including the development of interdisciplinary treatment plans and diagnosis and evaluation services,
- Medication-related services, and
- Psychosocial rehabilitation programs.

Section 545.053(c) specifies that to the extent that resources are available, the department (DSHS) shall:

- (1) Ensure that the services listed in this section are available for children, including adolescents, as well as adults, in each service area;
- (2) Emphasize early intervention services for children, including adolescents, who meet the department's definition of being at high risk of developing several emotional disturbances or mental illnesses.

Another program administered through the LMHA system is the Youth Empowerment Services (YES) Medicaid home and community-based services waiver program. The YES program provides comprehensive home and community-based services to youth between the ages of 3-18 (up to age 19) who have serious emotional disturbances. In this program, a wraparound approach to service delivery is used and LMHAs provide Targeted Case Management (TCM). Services include:

- Adaptive aids and supports
- Community living supports
- Employment Assistance
- Family Supports
- Minor home modifications
- Non-medical transportation
- Paraprofessional services

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- Pre-engagement service (for non-Medicaid applicants)
- Respite (in and out of home)
- Specialized therapies – animal-assisted therapy, art therapy, music therapy, nutritional counseling, recreational therapy
- Supportive employment
- Supportive family-based alternatives
- Transitional services

Previously, YES was a pilot in select areas of Texas. It is now a statewide program. Foster youth had previously been ineligible for these services; next year, they will be eligible to enroll, as slots are available.

LMHAs operate outside the foster care system, serving children and adults. LMHAs are also providers of services to foster children. State and local-funded community services can be provided to children connected to the CPS system (potentially in an open investigations or family based safety services stage). They may also bill Medicaid for services provided to foster children that are available under the STAR Health program (i.e., TCM and other services).

IDD Services and Supports

Foster children with IDD can receive certain services offered by other health and human services agencies including those accessed through local authorities and Medicaid services, assuming that they meet all of the eligibility criteria for these programs or that services are available.

Local Intellectual and Developmental Disability Authority Services

Local intellectual and developmental disability authorities (local IDD authorities) provide community-based services and supports for persons with intellectual and developmental disabilities using a combination of state and local funds. Local authorities are the “front door” to accessing public programs for persons with intellectual and developmental disabilities operated by the Department of Aging and Disability Services (DADS) and HHSC. They also perform case management for persons in certain programs.

In the context of foster children, there are some important functions they provide. They can assess a child and establish the institutional level of need required to access certain programs. They can help the child get on a waiting list for a DADS Medicaid waiver program or access a waiver slot if they are one of the populations that qualify for diversion slots.

They can also provide services, which can support children in their placements. Per Section Texas Health and Safety Code, as amended by Senate Bill 219, Eighty-fourth Legislature, they must offer:

- Community-based assessments, including diagnosis and evaluation services

- Respite care
- Case management services

The ability to access these and additional services (i.e., respite, day habilitation, supportive employment, therapies) varies statewide based on the availability of funds and demand for services. Some local authorities have waiting lists for services.

Home and Community-based Services Waiver

The Home and Community-based Services (HCS) waiver is a Medicaid 1915(c) waiver that provides services and supports to persons with intellectual disabilities who reside in their own homes, family homes, and group homes (alternative to institutional care). HCS provides a continuum of benefits that a person with IDD across his or her lifetime, as their needs change. Youth and adults are eligible to receive services. The waiver includes a residential component, as well as nursing, therapies (physical, occupational, speech/language pathology), day habilitation, dental care, dietary, audiology, cognitive rehabilitation therapy, behavioral support, supportive employment and employment assistance, respite, and adaptive aids and minor home modifications.

Because the HCS waiver is not an entitlement program, access to HCS depends on the availability of funding. DADS operates an interest list for HCS services and services are available on a first-come, first-served basis. Under the Promoting Independence initiative, the Texas Legislature has funded “slots,” or capacity, for HCS youth aging out of foster care and to help children in certain DFPS facilities (Hope Esperanza and Mission Road) to move into less restrictive, more integrated community settings. These slots allow some foster children to bypass the interest list. Not all foster children with IDD currently receive waiver services. According to CPS staff, there are 250 aging out slots and 25 facility slots for the FY2016-17 biennium.

Community First Choice

Texas amended its Medicaid state plan to establish the Community First Choice program, effective June 1, 2015. There is no interest list; Texas must serve all eligible persons who present. If a child in foster care has an IDD diagnosis as confirmed through a local authority (such that the child would meet the institutional level of care for an Intermediate Care Facility), is on a DADS interest list for a Medicaid waiver program (such as HCS), is Medicaid eligible and meets other eligibility criteria, they can receive personal attendant services, habilitation, and emergency response services through the STAR Health managed care model.

4. GAPS IN POLICY AND PRACTICE

TSG found evidence of multiple gaps in policy and practice for the child welfare system in its care of high needs children. Primary gaps include the following areas, with numerous other gaps (which are not listed in this summary) contributing to the problem:

- Case management functions are not coordinated by an accountable entity
- Data indicates that available behavioral health Medicaid services are not being fully utilized
- There is no data point or standard indicator to identify high needs children and ensure consistent process is followed upon identification
- There are several placement and service capacity-related gaps.
- There are process and organizational challenges in how CPS works with these children.

Lack of accountability to ensure provision of case management and care coordination

Many entities perform case management functions.

The term “case management” has different connotations depending on its use across the medical community and the child welfare system. There are many related terms, such as “service coordination,” “service management,” “care coordination,” and “targeted case management.”

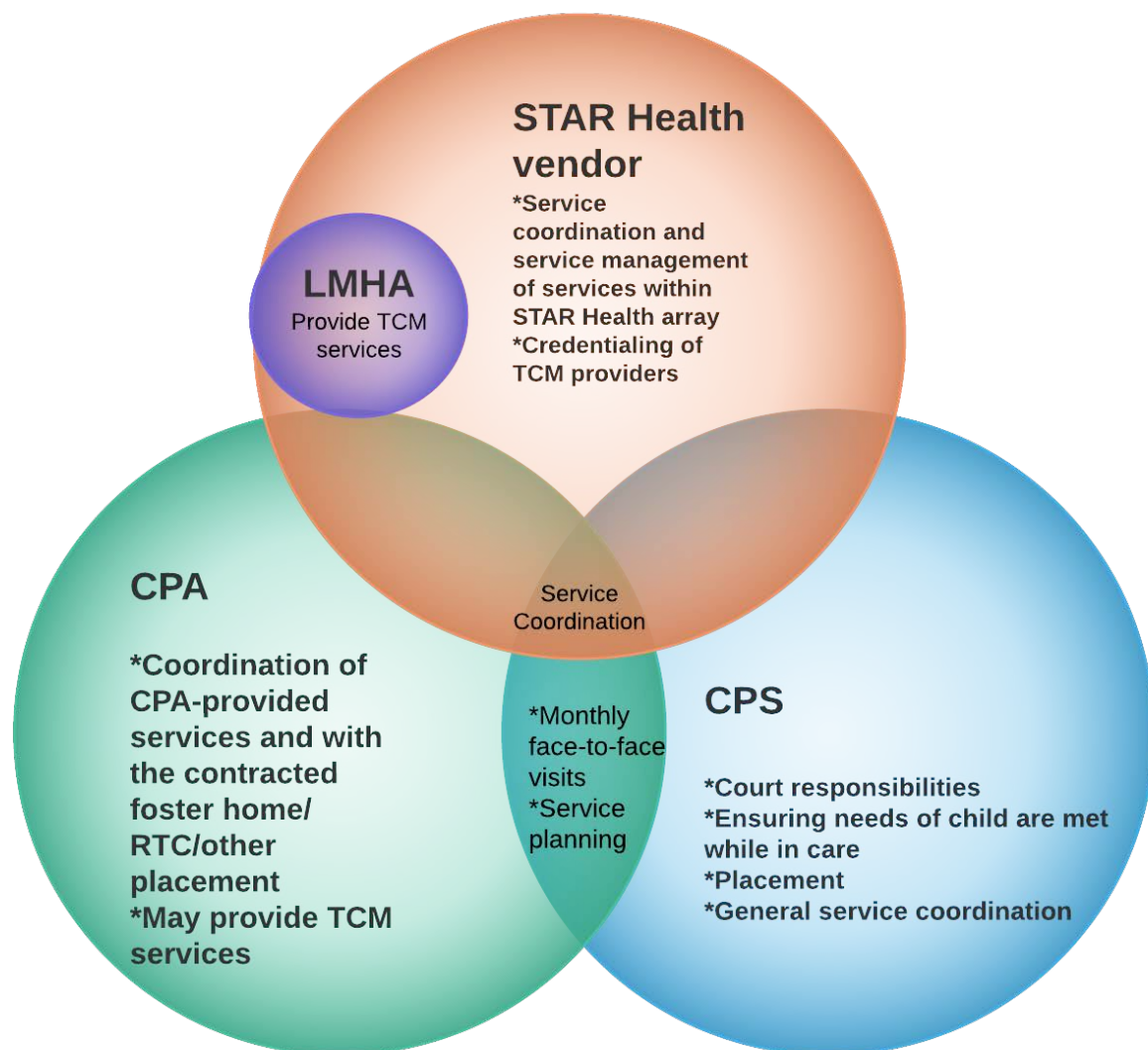
The question of who has case management responsibility for foster children and in particular, high needs children is complicated. Different contractual and legal requirements apply to the various entities in the child welfare system. These entities receive compensation from HHSC/DFPS to perform their responsibilities. It is critical that no overlap exists to ensure clear accountability for these children and prevent the state from over-paying for these services.

Summary of responsibilities for case management and related services

CPS	CPA	STAR Health	LMHA
Court/Legal responsibilities			
Ensuring needs of children are met while in care			
Placement			
Monthly face-to-face child visits	Monthly face-to-face child visits		
Service planning (child and family)	Service planning (child)		
General service coordination	Coordination of CPA-provided services	Coordination of medical, behavioral, dental, vision, pharmacy and other services covered in STAR Health Medicaid benefit (this includes any services provided by a LMHA) Service coordination and service management)	Provision behavioral health services
	Medicaid provider of Targeted Case Management for complex behavioral health cases	Credentialing of providers to provide TCM and reimbursement for TCM (carved-in to rate)	Medicaid provider of Targeted Case Management for complex behavioral health cases

These responsibilities are also shown graphically below.

Case Management and Related Roles of CPS, CPA, STAR Health vendor, and LMHA



Source: TSG.

Role of the Caseworker

According to DFPS legal staff, there is no statutory requirement that caseworkers perform case management. However, multiple places in the law indicate a requirement that DFPS/CPS meet the child's needs – whatever they are (Texas Family Code Section 153.371 and required state plan assurances in 42 USC 622, 671, and definitions in 42 USC 675). Case management is a function traditionally thought to belong to the CPS worker.

Chapter 264.106 of the Texas Family Code defines case management services as:

- (A) Developing and revising the child and family case plan, using family group decision-making in appropriate cases,
- (B) Coordinating and monitoring permanency services needed by the child and family to ensure that the child is progressing toward permanency within state and federal mandates; and,
- (C) Assisting the department in a suit affecting the parent-child relationship commenced by the department.

The RFP for the current STAR Health contract defines some functions of case management that are performed by CPS and its contractors (CPAs) accordingly:

member (child) visits, family visits, the convening of Family Group Conferences, the development and revision of the Case Plan, the coordination and monitoring of services needed by the member and family, and the assumption of court-related duties, including preparing court reports, attending judicial hearings and permanency hearings, and ensuring that the member is progressing toward permanency within state and federal mandates.

Child Placing Agencies and General Residential Operations

CPS contracts with the CPA to provide an array of services, including certain case management functions. Minimum standards for CPAs and General Residential Operations include dozens of provisions that could pertain to the area of case management, including many specific requirements depending on the needs of specific children who present. Some important requirements to highlight include:

40 TAC §§749.663 (Minimum Standards for Child Placing Agencies)

- a) Child placement staff providing foster care services are responsible for:
 - (1) Deciding whether to admit a child for placement, including completion of an admission assessment and any other evaluation of a child for placement;
 - (2) Placing a child into a foster home or other substitute living arrangement;
 - (3) Managing the case of a child, including:
 - A) Developing and updating of service plans;
 - B) Stewarding direct contact with the child and the foster parents or other caregivers; and
 - C) Performing any additional case management activities;
 - (4) Orientation, assessment, and verification of foster parents; and
 - (5) Monitoring and providing support services to foster parents, including the initiation of development plans, corrective actions, or adverse actions.
- (b) Child placement staff providing adoption services is responsible for:
 - (1) Deciding whether to admit a child for placement;

- (2) Placing a child into a foster home, adoptive home, or other substitute living arrangement;
 - (3) Managing the case of a child, including:
 - A) Developing and updating of service plans;
 - B) Stewarding direct contact with the child and the foster parents, adoptive parents, or other caregivers; and
 - C) Performing any additional case management activities;
 - (4) Case management and service delivery to birth parents; and
 - (5) Orientation, assessment, and approval of adoptive parents.
- (c) Child placement management staff may directly perform any of these responsibilities.

40 TAC §§748.561 (Minimum Standards for General Residential Operations)

A professional level service provider must perform the following functions:

- (1) Completing an admission assessment or any other evaluation of a child for placement;
- (2) Developing, reviewing, and updating of service plans for a child in care;
- (3) Completing a discharge or transfer summary for a child;
- (4) Approving any restrictions that will be imposed on a child for more than seven days that have not been reviewed and approved by the treatment director or service planning team, and any monthly re-evaluations of restrictions that continue for more than 30 days;
- (5) Approving any restrictions to communication and visitation with the child's family that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team, including monthly re-evaluations of restrictions that continue for more than 30 days; and
- (6) Approving any restrictions to a particular room or building for more than 24 hours that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team.

DFPS and CPAs contract with general residential operations, such as residential treatment centers. These providers, due to the nature of the services they provide, also have contractual requirements related to case management. There are detailed service plan requirements for the initial service plan and updates. In addition, residential providers are required to ensure the case manager is available 24/7 to the child's caregiver and prevents the sub-contracting of this function.

STAR Health vendor

HHSC contracts with the STAR Health vendor to manage the medical and behavioral health care of foster youth. Per the contract terms, two levels of management are required, beyond the initial

telephone screening they provide for every member and outreach around scheduling the first well-check exam (EPSDT/Texas Health Steps requirement):

- **Service coordination:** This is the next level of management provided by STAR Health. As defined in the contract, this is an administrative service to coordinate services and information, such as medical information for court hearings, at the request of a Medical Consenter, Caregiver, Member, DFPS Staff, SSCC staff, or PCP and to coordinate non-capitated Services.
- **Service management:** This is a more intensive level of management. The contract defines this term as the “Clinical service performed by the MCO to facilitate development of a Healthcare Service Plan and coordination of clinical services among a Member’s primary care provider and specialty providers to ensure Members with Special Health care needs have access to, and appropriately utilize, Medically Necessary Covered Services.” This includes complex case management, which is provided to a smaller number of children in specific instances, often surrounding defined episodes (i.e., pregnancy).

LMHAs

DFPS does not have a direct contractual relationship with LMHAs to provide services to foster children. LMHAs may perform TCM and other behavioral health services as a billable Medicaid service, as discussed previously.

Case management functions are not coordinated by an accountable entity

Multiple entities share responsibilities for case management functions, but a lack of coordination by any one accountable entity is a major concern. Children with less complex needs may not experience any challenges in having their needs met by this system, but high need children are more at risk of having poor outcomes. Several gaps contribute to this greater problem.

- The multiple responsibilities create confusion about who is ultimately responsible and how these case management functions work together.
- Existing case management functions are performed by the various responsible parties within the context of their own roles and contracts. There is an absence of a more comprehensive level of coordination across all of the CPS, STAR Health, CPA, and LMHA systems. No one entity has been held responsible for coordination at this higher level.
- The CPS worker, although generally responsible for the child, lacks time, data/other information and leverage to manage these high needs cases. It can be difficult for the worker to understand what CPAs and the STAR Health vendor are contractually required to provide. The worker may not have access to the right data to hold them responsible for managing these cases.
- A related issue is that no one accountable entity is conducting data analysis at the system level to know when there are problems with under-utilization of behavioral health

services by high needs children or other concerns. STAR Health has daily dashboards that tell the vendor about significant utilization issues statewide and down to the local level. CPS has monthly dashboards with certain child welfare system indicators. No one is putting this data together. The current system is not set up for the worker to spot these trends. For example, a caseworker might know that an individual child is not receiving the care she or he needs, but that child might be part of a larger trend that all the children placed with a certain CPA are having the same issues.

- Also lacking are key performance measures that would hold CPAs accountable for outcomes. CPAs are regulated under a compliance framework not a performance framework. They are not required, for example, to ensure the child meets all of their HEDIS measures, behavioral health-specific measures, or any measures related to permanency.
- Data and authority are not aligned. The STAR Health vendor has aggregate data that could be used to analyze CPA performance (i.e., HEDIS measures for the children served by each CPA) but does not have contractual relationship with CPAs. Note that the STAR Health data does not group children by CPA so some analysis would be required. DFPS/CPS has the contract with CPAs but does not have ready access to data it needs to hold CPAs accountable for whether the children they receive are accessing the needed STAR Health services. The STAR Health vendor reports on several key performance indicators to HHSC program staff, but those reports are not currently being used by DFPS and CPS staff. If CPS had a “real time” breakdown of each CPA and how the children were doing in terms of their HEDIS measures or perhaps an array of behavioral health measures, they would be able to work with CPAs to improve outcomes.

Available behavioral health Medicaid services not being fully utilized

In discussion with regional staff and other research, TSG identified a gap that foster children have low utilization of Targeted Case Management (TCM) and other essential behavioral health rehabilitative services. Low utilization may suggest that high needs children have difficulty getting connected to services they need. Several factors may contribute to this gap.

One major factor is a lack of knowledge on the part of CPS caseworkers about what benefits are available under STAR Health (also applies to services available through LMHAs and Local IDD Authorities). Another related factor is a lack of knowledge among CPS contracted foster parents and kinship caregivers about what benefits are available under STAR Health (and through LMHAs and Local IDD Authorities). These knowledge gaps are examined in greater detail in the CPS gaps section below.

Other factors that have limited access to services include the limited number of CPAs that are credentialed TCM providers and some barriers to accessing LMHA services.

Limited number of CPAs provide TCM and behavioral health rehabilitative services

Historically, LMHAs have been the only providers capable of providing these services. Some have argued that they did not have the capacity to address the true need among the foster population. Senate bill 58, Eighty-third Legislature, carved mental health rehabilitation services and TCM into the capitated Medicaid managed care rates and enabled providers, in addition to LMHAs, to become credentialed through STAR Health as providers of these services.

Despite SB 58, some factors have limited expansion of the number of providers, like training, on-going coaching and provider credentialing. The credentialing process to become a Medicaid provider (and receive payment under STAR Health) can be a lengthy and complex process. According to CPS Placement staff, this can take 6-8 months. Even when a provider has interest in offering behavior health services, it can take time to bring their capacity on-line.

There are currently a small number of CPAs that have completed the extensive training and certification required to provide TCM and other behavioral health services (two of the CPAs have a number of trained staff already providing these services). However, a number of CPAs have indicated they are interested in the training and are waiting to see how the credentialing process through STAR Health will work before committing time and resources to this effort.

Per the HHSC Uniform Managed Care Manual, a provider must undergo training in the following areas in order to be credentialed as a TCM provider:

- Administering the CANS assessment
- Social Skills and Aggression Replacement Techniques (START)
- Preparing Adolescents for Young Adulthood (PAYA)
- Seeking Safety
- Nurturing Parenting Program
- Barkley's Defiant Child/Defiant Teen
- Wraparound Planning Process

Some of these training components are available online. However, the Texas Department of State Health Services has mandated that the National Wraparound Implementation Center's training program is required for organizations to be able to provide TCM. The Texas Institute for Excellence in Mental Health (at the University of Texas) is the entity that provides this training and coaching in this model for Texas providers. This training is offered a limited number of times per year, and with a limited number of open slots. In the past, the majority of slots typically go to LMHA staff and this has restricted availability to CPAs.

Outside those who want to be certified, some CPAs do not want to or are not aware that they are able to become providers. Because they would have to become certified to provide an array of services – they cannot “cherry pick” to provide only TCM – some may opt not to go through

with the training due to the volume required, the financial implications, and the complexity of navigating the training requirements.

Some providers may not be aware that they can become TCM providers given requirements in place prior to SB 58. TSG is not aware of any significant outreach to CPAs statewide on how to access this training and certification from HHSC or STAR Health; however, HHSC staff has been discussing this issue in certain parts of the state as it engages local systems of care.

Difficulties for Foster Youth in Accessing Services

Despite this statutory authority, historically, there have been gaps in foster children's ability to access these services. These gaps may be due to several factors.

- The degree of LMHAs-CPS collaboration varies statewide and even in areas where it is strong today, historically, that has not been the case.
- LMHAs have historically lacked pediatric services.
- LMHAs may have perceived foster youth to be outside their priority population since DFPS appropriations provide for their care.
- CPS caseworkers may be reluctant to refer CPAs or DFPS foster parents to their LMHA for services because they do not have an understanding of what services are available, whether the child is eligible, or because they think there is a waiting list for services. Increased appropriations since Senate Bill 58's adoption (Eighty-third Legislature) have reduced this issue, but perceptions remain.
- There have been challenges in developing LMHA/CPA collaboration.
 - LMHAs and CPAs provide some of the same services (therapy etc.) and are competitors. Some LMHAs have required persons to receive all of their services in addition to TCM through the center, which CPAs have not wanted to occur.
 - CPAs have indicated that LMHAs do not understand the needs of foster youth in the same way they do. Providers have indicated LMHA services are "hard to access" and that service quality is "inconsistent." Another provider identified a number of staffing issues, stating that LMHA staff "are poorly trained, have high turnover, won't go into (foster) homes, and the service coordinator changes from meeting to meeting." The issue of LMHAs not providing in-home services may be a particularly significant factor contributing to low usage of their services by foster children.

HHSC is attempting to address the lack of collaboration between CPS, CPAs, and LMHAs at the local level by facilitating meetings to discuss local systems of care. HHSC staff, including staff with expertise in Medicaid and LMHA issues, has convened meetings with CPS, CPAs, LMHAs, and other key entities to begin to tackle local problems with communication and capacity. El Paso was the first site where HHSC leadership began to engage local partners to improve how

the system serves high needs children. More about the collaboration in El Paso is featured under the Best Practices section of this report.

No Standard Indicator(s) to identify high needs children and ensure consistent process is followed

As illustrated in a review of the data on high needs children, there is no singular data point to define who these children are. Absence of data and a lack of consensus of who high needs children are has contributed to the fact that there is no automatic indicator or mechanism such that once a high needs child is identified, (either as they come into care or as their needs change while in care) the ideal process(es) can be followed in 100% of cases.

It is possible for high needs children to have his or her needs met in the system, but the success of the case often depends on how the CPS caseworker and other elements of the child welfare system converge to meet that child's needs. As will be discussed in subsequent sections, TSG found evidence of numerous gaps to suggest why this is problematic.

Data-related gaps

There are some important issues to acknowledge when using the IMPACT child characteristics data. These issues also contribute to other gaps.

First, there is some concern about the accuracy of the child characteristics data in IMPACT. Thousands of caseworkers must identify the needs of children in DFPS conservatorship and update IMPACT to capture that information in order for this data to be accurate.

It is likely that existing data are incomplete and contain errors. For example, when CPS staff did in-depth analysis of one indicator (girls pregnant in care), there were a number of problems with data accuracy. For example, there were boys inaccurately flagged as being pregnant. There were also instances of girls who were pregnant at two points in time over 9 months apart, suggesting that even if the girl was pregnant initially, the worker did not remember to uncheck the box after the pregnancy ended. This is only one indicator, but it illustrates the potential for inaccuracy in this pool. Going forward, if this data is to be used in establishing any sort of identifying mechanism for this population, there needs to be a concerted effort to shore up its accuracy.

Setting aside accuracy, another important finding is that there is no precise way to define or identify these children in the data. This reflects the underlying issue that there is no common understanding of who these high needs children by all entities involved in serving them.

There are multiple ways to define high needs children and multiple data sources that can be used, resulting in each entity approaching the population differently. For example, CPS staff could be

using the child indicator data. STAR Health is using its own service management process including a telephonic screening as well, as claims data to profile who they think high-risk children are.

Identifying children in care whose needs are changing (making them of higher risk) might be even more difficult. This is particularly a risk when it comes to high needs children with the indicators TSG identified but who are at lower ALOCs. They may be stable now, but are at risk of crisis. CPS said they can usually identify high needs children generally, but it may be difficult to connect the disparate data points early enough to prevent a true crisis. There is no prompt or automatic mechanism to show a worker that a child's needs are escalating.

Data sharing issues contribute to these challenges. No one entity has the full picture of the high needs child population or has the responsibility to analyze how the high risk populations as defined by STAR Health and CPS compare. STAR Health has powerful analytics to monitor utilization and uses a risk-based approach to identify children who might need certain medical interventions, which prompts staff to provide outreach. However, despite the fact that the vendor gets a daily file of children coming into care and placement changes, they lack access to other data in IMPACT that could help them create a more complete profile of children at risk.

CPS and CPA staff (depending on who the medical consentor is) have access to the health passport to obtain certain medical information, but usage data suggest they are not considering this information routinely or uniformly. In addition, this data is on the individual child level; CPS does not know at the population level who STAR Health thinks are most at risk and how that aligns to their understanding.

Lack of an automatic identifying mechanism

Several CPS staff zeroed-in on the lack of an automatic identifying mechanism to flag a high needs child and ensure the correct process is followed in 100% of cases as a significant gap in the current process. There is no automatic notification of the worker or any of the specialists that a high needs child has been identified. While some specialists can run reports to identify potential children (such as with the intellectual disability indicator), it can be more difficult for other specialists to know when they need to get involved.

It is possible for high needs children to have his or her needs met in the system, but it is also possible for children to slip through the cracks. The consequence of this lack of mechanism is that it depends on the CPS caseworker and other elements of the child welfare system converging to meet the child's needs. As will be discussed in subsequent sections, TSG found evidence of numerous gaps to suggest why reliance on the CPS worker and the other entities in the system to come together is problematic.

Process and Organizational Challenges in How CPS Works with These Children

Workers have limited classroom and field-based training on how to identify high-needs children. There are some webinars on mental health issues (i.e., Mental and Emotional Disorders in Maltreated Children parts 1 and 2 and Parents with Mental illness) but usage statistics from the DFPS Center for Learning and Organizational Excellence indicates between 20-30 users have accessed these trainings in the last year. Most of the training is about how to access subject-matter experts who have specialized knowledge about navigating these cases. The new training model includes field-based seminars from these subject-matter experts.

These experts act as resources or escalation points when a worker needs assistance. Regional interviews uncovered several examples of how the process has worked when the subject matter experts are properly engaged. Field interviews and interviews with state office experts indicated that caseworkers do not have difficulty identifying children with high needs.

In practice, this might occur numerous ways. The worker might get information from the investigations/family based safety services worker. She or he might observe the behavior first-hand or hear from a caregiver. The worker might be reviewing diagnostic information or therapy notes.

Texas Comprehensive Child and Adolescent Needs and Strengths Assessment

In the future, caseworkers will have even better information about the needs of the children due to implementation of the Texas Comprehensive Child and Adolescent Needs and Strengths Assessment (CANS). Senate Bill 125 (Eighty-fourth Legislature) mandates that all children in foster care receive an evidence-based, developmentally appropriate comprehensive assessment within the first 45 days in DFPS conservatorship and again every 12 months forward.

DFPS is working with DSHS to design the new tool. It is based on the CANS assessment that has already been in use by LMHAs. DFPS worked to add a child welfare module that includes trauma-informed questions, caregiver questions, and other appropriate questions for this population.

When completed, a single, comprehensive CANS will be used statewide. For foster youth, STAR Health providers will administer the CANS in every region except Region 6A (Harris County), where CPS staff will administer it. The CANS will provide a uniform tool to evaluate the needs of children in foster care and will identify when and if additional screenings for IDD, behavioral health, or other issues are appropriate. CPS is working with a vendor to design the tool and the output of the tool (what information the caseworker will receive) so that the worker can use the tool findings to inform next steps in the case. Final decisions have not yet been made on what form the output of the tool will take. CPS anticipates needing to train staff and CPAs on how to use the CANS assessment to inform service planning.

Consensus from field and state office staff was that assessment was not the issue; the gap falls between the caseworker's assessment of the need and their ability to access assistance or services on behalf of the child.

Accessing Assistance from Subject Matter Experts

There is no single indicator or mechanism to ensure that a child needing specialized care is flagged for assistance and that a specific protocol is followed in 100% of cases. This is not to suggest the interventions for children with the same needs should all be the same; the process should be consistent but the interventions would be tailored to the child's circumstances. The success of the process CPS has established to concentrate knowledge in certain workers depends on a worker's ability to navigate the system and seek assistance at the right time from the right supports. There are numerous gaps in this area.

The subject matter experts we interviewed discussed how they advertise their services. They attend unit meetings, hold periodic trainings, conduct seminars for new workers, and even send newsletters. They also run reports in IMPACT to try to identify cases where they should be involved based on certain child characteristics (i.e., child has IDD) and reach out to caseworkers. These methods are imperfect but they do result in many cases coming their way.

The SMEs are busy day-to-day in providing assistance on the cases where workers seek out their help. However, they agreed that there is no failsafe way to ensure that they are getting involved in all of the cases that they should and that there may be cases slipping through the cracks.

A variety of factors has limited involvement of the subject matter expert, including:

- Workers have so much information to absorb during training that they may not recall this information later when they have a high needs child on their caseload.
- Visibility of SMEs varies. SMEs are not housed in every region and every office. Some regions share SMEs (for example, the 6.5 nurses covering 12 regions). Field interviews suggest usage of the SMEs is highest in the area where the SME is located.
- SMEs do not get an automatic notification when they should be involved in a case. This goes back to the fact that there is no singular way in IMPACT to identify a high needs child.
- The child characteristics data in IMPACT is not always complete or accurate so it is difficult for the SMEs to identify cases where they should be involved, even when they proactively run reports to identify potential cases.

Accessing STAR Health Services

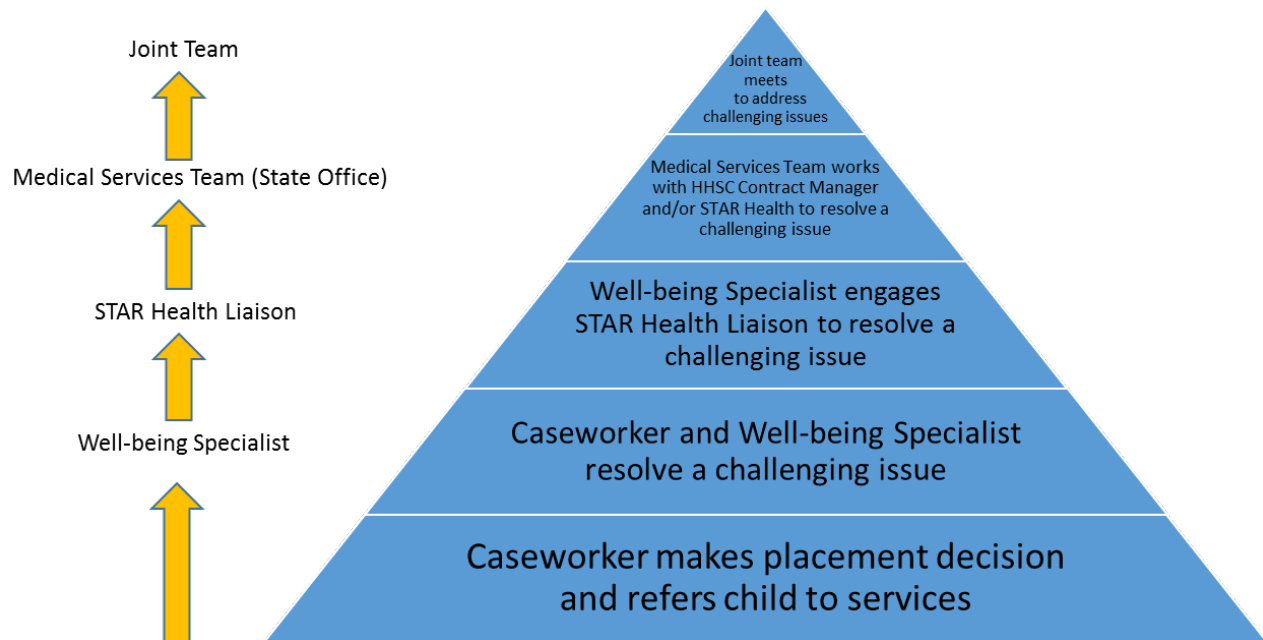
Caseworkers have significant knowledge gaps about the STAR Health benefits available to high needs children.

Caseworker knowledge about STAR Health benefits, including the enhancements, is limited. Although an information blitz occurred with the STAR Health rollout, there has not been an effort to keep workers informed since. Webinars have been available, but not mandatory. Given high historical caseworker turnover, there has been no mechanism to educate new workers.

The escalation process does not always work as intended.

The CPS Well-being specialist exists to support the CVS caseworker in navigating the STAR Health system. The CPS Well-being Specialist is the escalation point for a caseworker. They work closely with the STAR Health Liaisons, regionally located vendor staff who serve as the subject matter experts for the STAR Health contract and services. The following figure illustrates how the Well-being specialist helps the worker to resolve an issue, in the best practice scenario. The STAR Health Liaison helps the worker to escalate an issue. If it cannot be resolved, the issue is escalated to the CPS Medical Services Team. The Team works with the HHSC Contract Manager and STAR Health to address the issue. If the issue remains unresolved, a joint team consisting of CPS, HHSC, and STAR Health staff meet to address the issue.

Escalation Process, Using Well-Being Specialist



Source: Child Protective Services.

Caseworker knowledge about the role of the Well-being specialist varies. Well-being specialists have not done a lot of general education of workers about their roles. Individual Well-being

specialists have been busy day-to-day consulting on cases, but they cannot be sure they are getting all the right cases. They may have been utilized by staff co-located in the same area, but under-utilized by other staff. TSG also found in a prior assessment of the use of specialized positions that regional leadership were unsure of the role of these specialists.

Since summer 2015, the CPS Medical Services Team, which includes the Well-being Specialists, has taken steps to increase its visibility. In addition, the Medical Services Team in partnership with STAR Health has implemented a communication plan to inform workers on what was in the base STAR Health contract as well as the new enhancements effective in FY 2016.

State Office staff recognizes the need for ongoing, annual refresher training on STAR Health going forward. In addition, the Team has created a joint monthly meeting with STAR Health, the DFPS Physician, and the Placement Team in order for those parties to stay coordinated and to provide a forum to address issues.

One other factor to take into account going forward is that the CPS Medical Services division is undergoing some change that will affect the responsibilities of Well-being Specialists and Nurses. As part of the effort to review specialist positions and maximize their utilization, CPS will shift to a model where every region has either a Well-being Specialist or a Nurse over time, using attrition (no positions will be eliminated). The impact this will have on the job functions of both positions has not yet been determined.

Caregiver knowledge gaps

In addition to the caseworker knowledge gaps, there are gaps in caregiver knowledge which may contribute to low utilization of services. If the caseworker is unaware of existing services foster children can access, s/he cannot advise caregivers on how to access them. This may be of particular concern for the 37.2% of children placed in kinship homes (note: this statistic refer to the percent of all children in kinship homes but not all of them have high needs). Per CPS, there has been no education/outreach on STAR Health benefits for these caregivers. There have been online resources for them to access but they extent to which they have used these materials is unknown.

In addition to lacking general knowledge about STAR Health, it is likely that gaps exist in awareness of some of the specialized programs STAR Health maintains such as TCM and rehab services or programs for children with chronic conditions such as dual case management for children with diabetes.

Communication between CPS, CPAs, and STAR Health

CPAs and CPS engage in separate case planning for children and families in most areas of the state. CPAs have indicated that their plans are more detailed and specific to the needs of the child's treatment because they work with the child on a day-to-day basis. Separate case planning risks inconsistent plans and results in significant duplication of effort. CPAs may be working

with multiple siblings but may not be able to access the information they need about the parents to comprehensively address the needs of the whole family.

The Comprehensive Case Plan (formerly known as Single Child Plan) Transformation initiative sought to change the practice of separate case planning and bring all parties together to develop one plan for the child. An extension of this initiative is to develop one plan for the family.

Regions where foster care redesign existed previously (Region 2) had a lot of the infrastructure in place for this initiative to work well. However, the challenges experienced in other regions illustrate ongoing communication issues between CPS and CPAs. In some parts of the state, CPA reluctance to participate in this initiative is evidence of historical poor communication and lack of trust between CPS and CPAs. Other barriers to collaboration between CPS and CPA staff are confidentiality requirements that prevent sharing of certain caregiver information and the weak contractual requirements requiring that CPAs to participate in joint planning with CPS.

Other factors contributing to poor communication are the gaps between CPA contract expectations and performance, as reported by field staff. CPS staff report a lack of responsiveness from some CPAs after hours. CPS staff report difficulty placing certain high needs children with CPAs, due to the CPA's fear of the risk to their other children and organization.

In addition to communication issues between CPS and CPAs, there are also gaps between CPS and STAR Health. For example, STAR Health is not always notified immediately when placement changes are made. STAR Health staff indicated that knowing about placement disruptions sooner would be helpful.

Some CPS regional staff discussed the difficulties they encountered in trying to resolve issues through STAR Health. There may be gaps in contract expectations and performance. Staff indicated that sometimes staff or families are directed by STAR Health staff to webpages to search for providers themselves. In other cases, they did not think the staff they were referred to were as invested in resolution of the issue as CPS was or as willing to take the extra step to ensure follow-through of an issue. When speaking with STAR Health, however, they indicated a willingness to immediately respond to and address any of these types of communication issues and fully recognized their role in providing service coordination.

Escalation of High Needs Cases

Regional staff mentioned that typically, most of the issues raised by high needs children's cases are addressed at the regional level. In some instances, SMEs may engage their counterparts or management chain at State Office for assistance. Generally, regional staff works with State Office the most when a child is having a placement crisis.

Starfish Staffing Process

DFPS created the Starfish Staffing process in 2014 as an escalation process for high needs cases. The process brings together a group of DFPS/CPS State Office experts, the STAR Health vendor, representatives from other health and human services agencies, and representatives from some of the state's CPAs. This group brings experience, cross-program knowledge, and fresh eyes to the case and offers a forum to identify a new placement and solve some of the barriers that have presented in the case. Each week, approximately four cases have a Starfish staffing. CPS Placement staff selects these cases from the pool of children without a placement. Regions mentioned the ability to request a similar (internal) staffing process for a case not selected for Starfish.

This process is viewed by CPS State Office staff, other HHS enterprise staff, and CPA participants as very positive. Not only has it allowed for resolution of barriers in individual cases, but it has allowed CPS to identify broader system issues that affect many additional children (i.e., placement issues). It has also fostered collaboration among DFPS and other state agencies, CPAs, the STAR Health vendor, which has many spillover benefits into other areas.

According to statistics kept by the CPS Placement staff, a low percentage of placements were found during a Starfish meeting. However, these statistics do not capture the CPAs who might have accepted a child at some point after the staffing, nor do they capture the system-wide benefit of bringing these important components of care together.

The Starfish process could be more effective earlier in the process.

Some feedback about the Starfish process is that it happens too late for a child – it happens when there is a placement crisis. Some have argued that the Starfish process could be more effective earlier in a case to put together the team and package of services needed to prevent a child from entering a crisis.

Gaps in Preventing and Addressing Trauma

The preceding sections outline different gaps in the child welfare system in working with high needs children. Although there are many systems issues that are detailed in this analysis, gaps in how caseworkers work with these children are important. As one State Office official indicated, “we need to be looking at ourselves.”

One cannot discount the importance of child welfare practice. Deficits in child welfare practice contribute to the difficulty of managing high needs cases. Generally, gaps exist in how workers engage children and families and these gaps make it difficult for foster children to address the trauma they have already experienced or may experience while in DFPS conservatorship.

Examples of these practice gaps that could cause trauma or make it difficult for children to address the trauma they have already experienced include:

- Workers may not consider permanency and well-being at the front end of a case. This can result in parents and children who become more and more detached during a case (making reunification unlikely).
- Workers may not ensure children understand why they are in care and why they are separated from their families.
- Workers may not ensure that opportunities exist for the parents to maintain their parenting role while the child is in care. Staff do not always connect birth parents and foster parents to maintain continuity for the child, to ensure the parent can receive updates and stay connected to the child, and so the parent can give the child emotional permission to connect to another family.
- Adoptive placements can be rushed and can break down. Children may not be ready to be adopted or need to start with a more distanced relationship.
- The provider system and CPS do not work closely enough in working with children and families. Typically, CPAs and CPS have their own child and family plans and do not always coordinate their approach.
- Workers may not do effective and rigorous safety planning which could allow children to stay in the home and keep them with their families.
- Workers may not engage other adults to help ensure a child's safety so the child can return quicker or stay in the home initially.
- Investigations workers can be very task-oriented and have not been taught how to get people mobilized in ensuring safety.
- Workers may struggle with how to help placements when they are about to break down. Workers are often "reactive." Workers do not know what to do or how to partner with placements.

Existing worker development does not provide workers with the skills to handle these situations and system factors like turnover may make it difficult for workers to learn to do these things well. The CPS Excellence Practice Division focuses on improving child welfare practice.

The CPS Practice Model provides the framework and the Signs of Safety model provides practical tools to improve practice across all stages of service. Many of the gaps identified above are intended to be addressed through Signs of Safety and the new Structured Decision Making tools. These approaches represent a significant practice shift for CPS.

Staff expects Signs of Safety to help the Conservatorship stage of service in particular in the following ways:

- Improve staff critical thinking to think about the long-term trajectory for each child.
- Should expect to see fewer removals and increased reunification when Signs of Safety is rolled out to Conservatorship. Signs of Safety results in expedited time to reunification

and lowered recidivism by bringing together networks of relatives to ensure the child's safety.

- Should improve placement stabilization.
- Increases involvement of children in their case.

These tools and approaches are not a “silver bullet.” Their rollout will take several years, depending on the scenario adopted by DFPS/CPS and they represent a significant cultural shift for CPS.

In the interim, CPS is working to make practice model tools and components of the Signs of Safety model accessible to workers. Several subject matter experts are making resource guides for staff to help in areas like substance abuse, mental health, and domestic violence. One gap is that the designated mental health subject matter expert is primarily involved in implementation of SB 44. The division does not have the resources to support other mental health related caseworker questions and to focus attention on high needs children in DFPS conservatorship.

Child Welfare System Issues

These gaps in knowledge and policy are exacerbated by several child welfare system issues. Turnover is a problem that worsens many of the gaps previously discussed. Turnover has resulted in a loss of knowledge in the workforce about how to deal with high needs cases, whom to engage, how to navigate the STAR Health/LMHA systems, and how to engage families effectively. Given high turnover rates in some programs and regions, any solution for improving the care of high needs children must take into account the need for refresher training to replace the knowledge loss.

The crisis-focused nature of the work often prevents caseworkers and others from intervening in a high needs child's case early enough. Generally, workers and management focus their attention on cases that are in the greatest crisis on any one given day. This mindset makes it difficult to focus on prevention.

As illustrated in this analysis, there is a larger pool of children for whom the characteristics of “high needs” are present but who are not currently in crisis. They may be in “basic” or “moderate” levels of care. However, these children have the potential to become the “intense” and “specialized” cases. Some high needs children may need more supports than they are currently receiving, but it is often recognized only when the placement breaks down that attention is drawn to the case.

Alternatively, a worker may know they need to engage a SME on a particular case, but they may not engage them early enough in the case to make a difference. For example, one DD specialist noted that often the children with IDD who are in institutional placements languish in institutions

because their placements are stable. The worker might not be thinking about all the ways they could better coordinate services for this child because of pressing issues on their workload.

Another system issue that affects the care of high needs children is the role of the judicial system. Regional interviews identified examples of judges who order children placed within their region, with certain caregivers, or kept in the office until an in-region placement is found.

One example that is featured in the case studies section involved a case where the court made several quick placement decisions with relatives that were not prepared to care for the youth and before CPS could put necessary supports in place for the placements. These placements all eventually broke down. These are just a few examples of how judicial decisions can tie CPS' hands in caring for high needs children and compound some of the gaps already discussed (i.e., placement capacity).

Another issue is the incompatibility of the medical model in instances where CPS is acting as the child's parent, a gap identified by State Office staff. When a child is taken into DFPS conservatorship, the caseworker acts as the child's parent.

According to CPS, responsibility and accountability rests with the worker. Even though there are many other subject matter experts, internal and external to CPS, involved in a case, the worker is ultimately responsible for the child, as a parent would be. The worker must advocate for the child, coordinate services and ensure that every other part of the child welfare system is working correctly and meeting the needs of the child.

However, a worker also differs in some key ways from a parent. The worker does not reside with the child. The worker does not have perfect information about all aspects of a child's history including the medical history. The worker may not be able to provide physicians with information about a child's history. CPS staff indicated that some of these high needs cases illustrate the difficulty in translating the child welfare model to the medical model.

Placement and Service Capacity Issues

CPS seeks to place foster children and youth in their communities and in the least restrictive (most home-like) setting possible. However, sufficient capacity to achieve these goals does not exist statewide. As illustrated in the introduction, high needs children have more placements than other children in care; the frequency of their placement disruptions suggests existing placements and supporting services are not meeting their needs. It is important to note that these capacity gaps are reflective of non-foster care redesign areas, which were outside the scope of this analysis.

Capacity to serve the high needs children varies across the state

Generally, there are issues with the adequacy of capacity in terms of the availability of placements in all areas of the state. Staff identified capacity issues for groups such as teenagers, those with high needs including behavioral and physical health needs, and children with diabetes. The following figure shows licensed foster homes and their capacity by region and county (including DFPS and contracted homes):

Licensed Texas Foster Home Capacity, as of 9/30/15

Region	Homes	Total Capacity
1	469	1434
2	307	1037
3	2299	7208
4	426	1394
5	298	1086
6	1943	6093
7	1212	3629
8	1248	3904
9	201	570
10	164	498
11	670	2669
Total	9237	29522

Source: DFPS Data Warehouse, report # lic_40slx.asp, Data as of 10/7/15.

While on the surface, it may appear the availability of foster homes is sufficient to meet the need, the numbers overstate the reality. The total number of homes and capacity is approximately 5% more than the number of children in care as of August 2015. However, the capacity number appears higher than it really is.

Homes can be licensed to serve more children than they will accept or they may prefer to accept children in a certain age range. In addition, the regional balance is important to keep kids near their biological parents, their prior school, their friends, and a host of other local connections. The licensed capacity, compared to children in care, by region, shows shortages in Regions 1, 4, 7, 8, and 9. Region 9 needs 44% more foster homes than their current licensed capacity. Region 4 needs

an additional 30% -- just to meet their needs on paper. These numbers do not reflect the reality that not every family is a perfect match for every child or youth and, therefore, greater capacity is actually needed. When considering homes trained and capable of working with high needs children, especially high needs children with co-occurring conditions such as a behavioral health condition and an intellectual disability or a behavioral health condition and a physical condition such as diabetes, effective capacity is further reduced.

Availability of Residential Treatment Centers (RTCs) also varies across the state. Of the 76 licensed RTCs in Texas as of 9/30/15, 69% can be found in Regions 6, 7 and 8 (note that not all RTC's contract with the department).

Licensed RTC Capacity, by Region, as of 9/30/15

	1	2	3	4	5	6	7	8	9	10	11	Total
Number of RTCs	3		7	3	1	34	13	13		1	1	76
Total Capacity	108		148	126	35	1234	1014	800		84	20	3569

Source: DFPS Data Warehouse, lic_42slx.asp, Data as of 10/7/15.

According to the CPS Permanency Division, RTC capacity issues are exacerbated by the fact that CPS has closed off access to some capacity by placing CPAs on placement holds due to safety issues. This has prevented youth in RTCs who were ready to leave from stepping-down to other services; they have remained in the RTC, preventing other youth who need RTC services from accessing them.

Barriers to building capacity exist

Some of the barriers for providers contracting with CPS include:

- Some providers do not want to contract with DFPS/State of Texas. They may consider reimbursement rates too low. They may not want to deal with the paperwork and administrative burdens of state contracting. They may not want to attend court.
- Existing contracts exclude out of state placements. This requires the department to pursue individual contracts for children needing these services.

Barriers to placement exist even when capacity exists

Even when capacity exists, there are a number of reasons a provider may be unwilling to take a high needs child. According to State Office Placement Staff, providers may disagree that the level of care (which affects the payment level) is sufficient. Often a child or youth may be served in a more restrictive setting at a higher level of care. When the child is stabilized, their level of care may drop but the provider may disagree that the payment is sufficient to maintain the child at a stable level.

Providers may not want to take on the liability of caring for the child due to the behavioral or medical acuity. Some children may require a greater level of supervision than the placement's staffing level allows. Liability issues may be real or perceived; children with psychiatric

hospitalizations or certain conditions can be stigmatized and considered too difficult for placement even when they no longer display certain behaviors.

Another barrier is that service availability differs across the state with some areas having access to additional supports and resources for high needs children. Without knowing where the placement is located, it may not be possible to determine what services are available but some placements may want to know what supports the child will receive prior to accepting the child.

Lack of capacity results in a number of negative outcomes

A difficulty in finding placements for high needs children can result in out of region, and even out of state, placements. When this occurs, it can be harmful to the child for a variety of reasons including destroying connections to family and friends (which may affect their permanency outcome), causing disruptions in their education and therapy.

It can also make it difficult for their primary caseworker to get to know the child and monitor progress. They have to rely on the ISeeYou worker to do the monthly visits and provide documentation on the child's progress. Regional interviews indicate that this sometimes works well but in other instances documentation was sparse and not timely.

This situation can be even more difficult if a new caseworker is assigned to the case while the child is placed out of region. Interviews with regional CVS management indicated that when this occurs, they are more likely to approve out of region travel for their caseworkers; typically, however, that does not occur.

Capacity limitations also inhibit transition planning which could make a new placement more successful. Often placements are located at the last minute. This limits the time to prepare a new placement to meet the needs of the child and to prepare the child for the change.

Staff mentioned concerns about transition planning on several levels. Not enough transition planning occurs when children leave a psychiatric facility and move into a placement. Because many high needs children may move between placements across regions, this also inhibits planning and communication between providers. Regional staff indicated it is often not possible for staff at one RTC to meet with the child or caregivers at an RTC in another region prior to taking the child.

Another issue is that the child may have to remain in a more restrictive facility longer than it is medically or therapeutically necessary. Regional interviews identified numerous instances of individuals in psychiatric and medical hospitals longer than necessary because CPS did not have a placement option. In addition, some children may remain in an RTC longer than needed because a placement in their community is not available. This reduces RTC capacity for those in the community who need those services.

Another consequence of capacity issues is that in some circumstances, children and youth may have to spend the night at a CPS office with staff in between placements. Aside from the negative effects of this situation on the children, this also creates numerous challenges and risks for staff.

According to interviews with regional management staff, they think caseworkers are ill equipped to stay in the office, often alone, with some of these children. The children may have aggressive behavior or require medical care/administration of medications. Management is concerned that staff has not been trained for these situations and do not think the staffing ratio employed is adequate to ensure their safety or the safety of the children.

There is a critical lack of wraparound services needed to support children transitioning out of more restrictive settings and to prevent placements in restrictive settings

Interviews with CPS staff, CPA/RTC staff, and review of some case study examples revealed that some children do well in the RTC setting. These children may achieve some stability in placement while in the RTC and make progress in reaching their therapeutic goals. When this occurs, their level of care may drop and CPS looks for a new placement in a less restrictive setting. This is in line with both state and federal policy about serving foster youth in their communities, in less restrictive settings.

However, because supply of “step-down” settings with the comprehensive wraparound supports they need is scarce, many of these youth have unsuccessful transitions to their next placement. The “step-down” they are asked to make is too great. The change in their rate may prevent provision of the additional services that might preserve the placement.

The same intensive wraparound services that are lacking for youth stepping down from facilities are lacking for foster children who are being served in the community (foster homes, therapeutic foster homes, etc.). The services do not exist to support these community placements, prevent them from breaking down, and prevent the need for more restrictive placements such as in psychiatric hospitals.

One other issue is that the rate structure does not reward a provider for stabilizing a child to the point that his or her LOC drops. A reduced LOC reduces payment to the provider.

CPS efforts to address capacity

It is important to acknowledge CPS efforts to address capacity concerns; CPS has dedicated staff to this purpose. Priority areas include:

- Replication of the provider networks under foster care redesign by improving collaboration among providers in a local system.
- Engagement of the DFPS Center for Policy, Innovation and Program Coordination to conduct a review of the placement process in in order to identify best practices and efficiencies. This analysis is due in November 2015.

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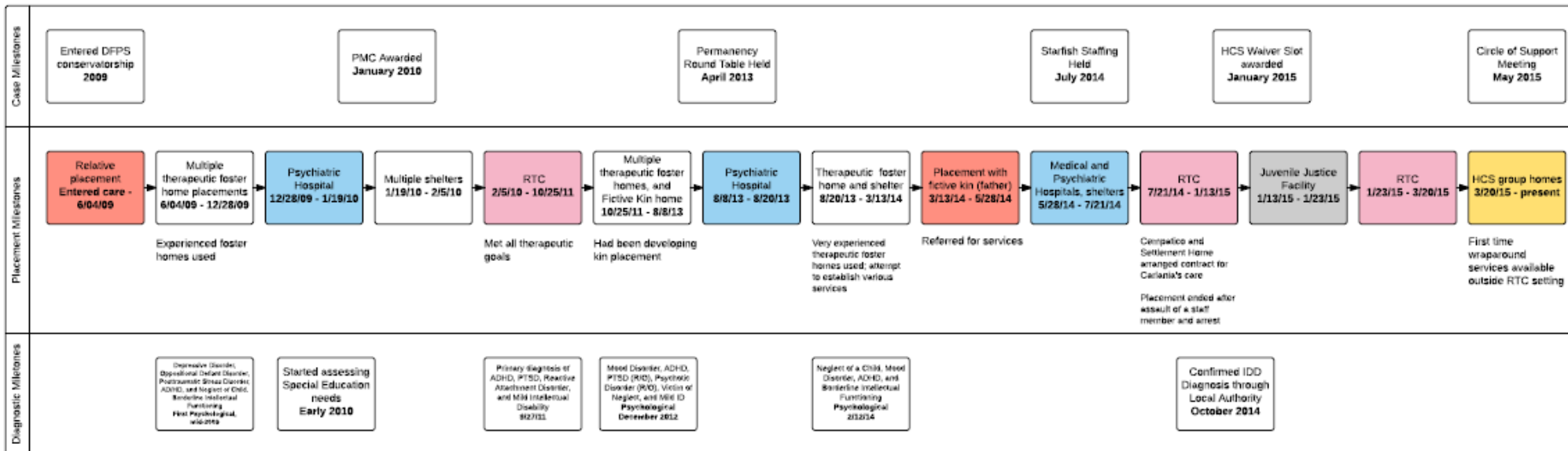
- Revision of the Common Application. Most CPAs use this tool to make placement decisions. This form has not been revised since the 1980s. CPS staff is leading a work group to review and modify this document.
- Exploration of other placement tools (similar to what FCR areas use) that could aid in matching children with placements. These have GIS mapping capabilities and other enhancements. No funding exists for this purpose.
- Facilitation of contracting with neighboring states. There are out of state placements that are closer to certain CPS regions than instate placements. For example, there is no state-contracted RTC in Region 10 but there is one in New Mexico. In the status quo, the closest RTC is in Lubbock, but the New Mexico facility is 20 minutes from El Paso. This requires that CPS modify its contracts to include other states.
- Building capacity for sub-acute care. CPS Placement is working on an RFP to contract for these step-down services.
- Working to improve communication and referrals to LMHAs. Some regions have better partnerships with their LMHAs than others do.

5. CASE STUDIES

At A Glance:

- Time in Care: 2009 - present (6.5 years)
- Age when came into care: 10 years of age
- Current Permanency Goal: Adoption
- Current Placement: HCS Group Home
- Total Placements: 24
- Total Caseworkers: 2 (since rights were terminated)

Case Example #1



This case illustrates several of the gaps discussed in the preceding sections, as well as several areas of strong practice.

- A child came into care at 10 years of age. Since then, the child has had 24 placements, suggesting that it was very difficult for CPS to find a placement that met her needs. She had several out of region placements, institutional stays, and RTC placements. However, notes reveal that the department used some of its strongest therapeutic foster homes to try to meet her needs and that several settings were attempted before her first RTC placement in 2010.

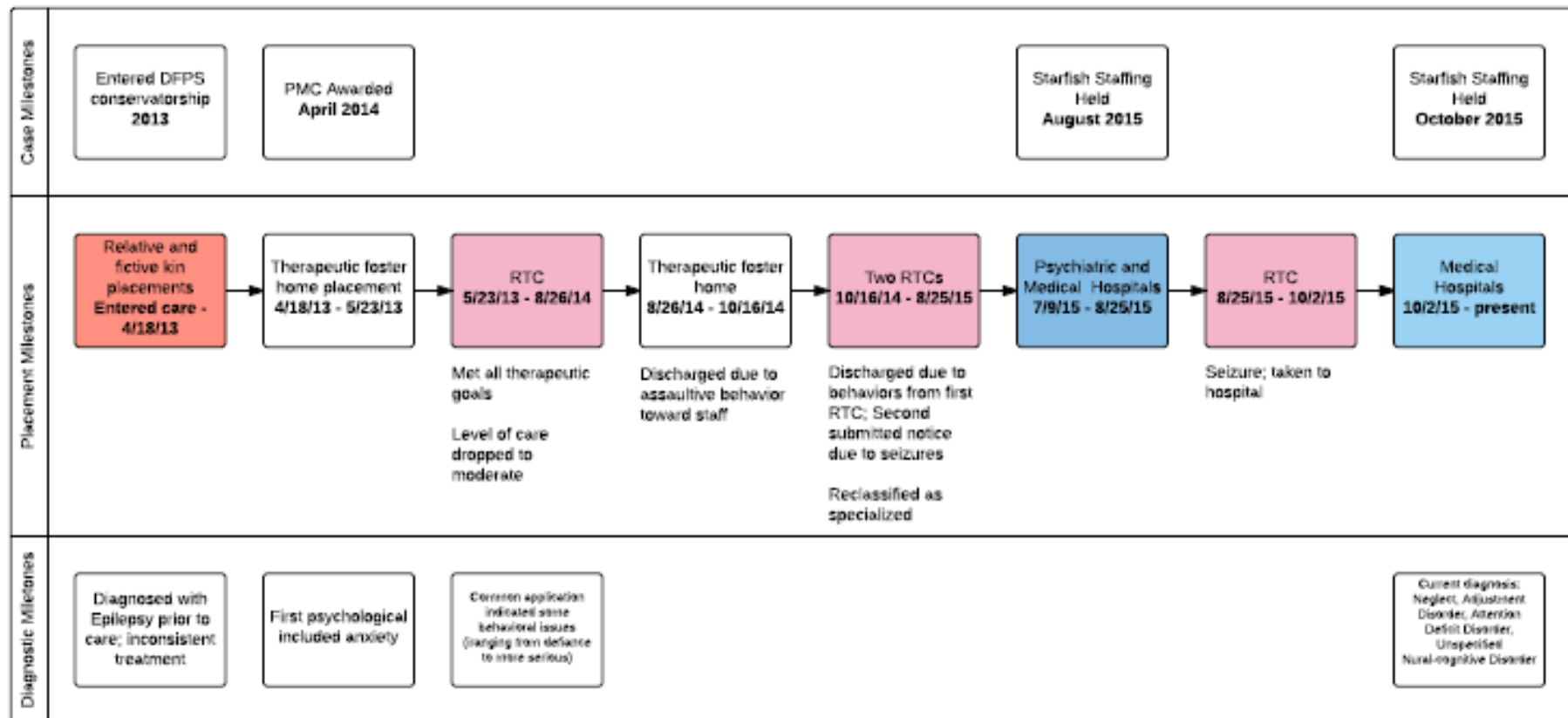
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- This case is an example of a provider working with STAR Health to create an individual contract that would enable the RTC to care for this youth. This financial support enabled the RTC to accept her placement at a time when no other placement could be identified.
- The child had several placements break down because true wraparound supports were not available. It was not until she received her DADS HCS slot that regional staff considered her to have the supports she needed.
- The child was very successful in an RTC setting. When “stepping down” from an RTC, she did not get the needed supports to remain successful in those placements.
- The child had several placements break down because of limited transition planning. Some of the least successful placements were court ordered placements with relatives or fictive kin, where almost no preparation was possible to increase the likelihood of success.
- The child had multiple complex diagnoses. For several years, borderline intellectual disability diagnoses were discussed but it was not until 2013 that she was diagnosed through a local authority, which was critical to her receipt of a DADS waiver slot.
- Although she has not yet reached permanency, her case reflects creative and persistent attempts to consider different relatives for permanency. For example, she was placed with her father after rights were terminated. Even though it broke down, staff stand by the decision to try to make that work.

At A Glance:

- Time in Care: 2013 - present (2.75 years)
- Age when came into care: 12 years old
- Total Placements: 8
- Current Placement: N/A (hospital)
- Total Caseworkers: 1 (since rights were terminated)

Case Study #2, Region 2



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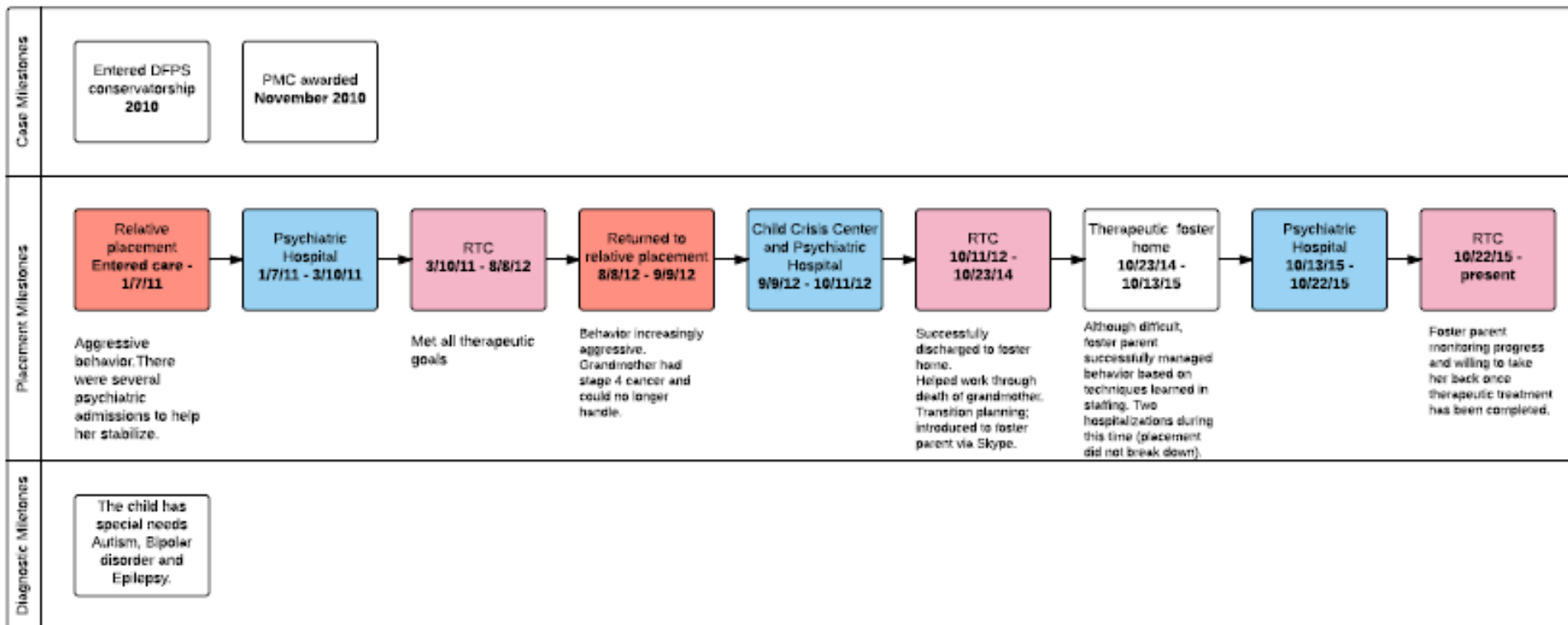
This child's case illustrates several of the gaps discussed in the preceding sections.

- The child came into care at age 12 and has been in care for over 2 years. The child has had 8 placements.
- The child had co-occurring behavioral and physical health issues. CPS struggled to find a placement that could meet his needs. His epilepsy proved to be most difficult in terms of placement. Many providers expressed concerns in taking on the liability of his case due to his seizures despite the fact that physicians indicated he did not require hospital care.
- Additional difficulty occurred in finding caregivers willing to administer his anti-seizure medication (suppository).
- His case remains an ongoing challenge. He is still in a hospital awaiting placement. He had a second Starfish staffing to assist with this effort.

At A Glance:

- Time in Care: 2010 - present (5.75 years)
- Age when came into care:
- Current Permanency Goal: Relative placement (about to change to adoption, DFPS to pursue TPR)
- Current Placement: RTC
- Total Placements: 7
- Total Caseworkers: 5

Case Study #3, Region 10



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- This child has been in care for over 5 years. She has special needs including autism, epilepsy, and bi-polar disorder.
- This child has moved between a variety of settings including RTCs, psychiatric hospitals, and foster homes.
- This case illustrates several best practices.
- The providers and CPS worked together to create some continuity for the child. The transition from RTC to therapeutic home was managed well and the foster parent was prepared to manage the child's behaviors. In addition, her foster home did not submit notice when she required hospitalization; they accepted her back. In addition, the foster home is maintaining contact while she is currently being served in the RTC setting and has indicated they will accept her back. She has been able to transition between settings as her needs have dictated, with the support of her providers.

6. BEST PRACTICES

Texas Examples

Regional interviews with staff in Regions 2, 3, 7, and 10 yielded best practices in the area of supporting high needs youth.

Foster Care Redesign – a Continuum of Care

One of the primary purposes of foster care redesign is to try to serve youth in their communities. Now operational in part of Region 3, foster care redesign has resulted in creation of a continuum of care in the catchment area. The single source continuum contractor (SSCC) has worked to build a network of providers such that sufficient capacity exists within the catchment area regardless of a child's level of care. The SSCC also has access to some capacity in the area immediately surrounding the catchment area. The SSCC has been successful at placing children within the catchment area.

Other features of foster care redesign have also helped in the area of high needs children. The SSCC has a no reject/no eject policy for the children placed and is responsible to find the most appropriate setting for the child. Foster care redesign results in joint case planning on the part of the worker and the CPA.

The comprehensive case plan initiative was born out of foster care redesign because of how they were able to work together. At present, foster care redesign operates in one catchment area (Region 3) and the Eighty-fourth legislature has directed expansion into one additional area during the FY2016-17 biennium (Region 2).

Turning Point Diversion Program

STAR Health piloted the Turning Point program in the Fort Worth area. It has recently been included in the new contract as an enhancement after demonstrating strong outcomes. The program has diverted more than 100 children who reside in foster homes from the psychiatric hospital setting.

There are three components: the mobile crisis team, use of a psychiatrist to oversee the clinical work, and respite for a few days to stabilize (if needed). The program will expand to Bexar County on December 1, 2015, Harris County on April 1, 2016, and to an additional site in Regions 2 or 9 by July 1, 2016.

Building Local Continuum of Care

Region 10 has sought to build a continuum of care locally with providers in the community including CPAs and the LMHA. Because of its geographic isolation and lack of providers

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(shortage of some kinds of providers, no RTC serves this region), the region has to send children requiring certain services out of region for care. HHSC initially facilitated a meeting locally and the group has continued to work together. A number of efforts have been occurring at the local level, including:

- Efforts to build local capacity
- Taking inventory of local resources
- Creating a local Starfish-like process

Improving Reintegration of Foster Youth

The Child Protective Services Reintegration Project is a program housed and funded by Travis County. Casey Family Programs had previously provided funding and evaluation for the project.

This project provides support to reunify children with emotional and behavioral disorders who reside in therapeutic foster care or RTCs. The project provides support the 60-90 day period before a child leaves their care setting and extensive wraparound services post release so that the child's reintegration is successful. This involves meeting with the family/caregivers and working to building their capacity, and engaging the child.

Cases are identified as potentially eligible by the CPS Risk Manager and staffed with the project to determine if this is appropriate. Region 7 staff is very enthusiastic about the program. Anecdotally, staff indicated that when, after engaging the family, the Reintegration Project staff thinks the family is ready for the child to be reunified, and they have been successful.

Preventing Placement Breakdowns

Region 7 is in the process of implementing an initiative to stabilize placements at risk of breaking down. If a provider gives notice, regional staff will activate a team to hold a Placement Stabilization Meeting to work through the issues involved and identify what is needed to preserve the placement. This includes the Family Group Conference Team. The region is still designing this process and will be monitoring its effectiveness.

Permanency

Several regions TSG interviewed used Permanent Managing Conservatorship (PMC) units or workers for cases once parents' rights have been terminated. High needs children, especially adolescents, are frequently part of the workload of these units and workers. Some have developed significant expertise in working with these children over time and in helping them achieve permanency.

For example, in Region 10, the PMC unit has renamed itself "STITCH," to reflect that they are stitching together all the work everyone has done across stages of service for a child. The unit has had what the supervisor calls, "a complete mind shift" to orient their work toward permanency as part of the broader CPS Permanency initiative. They have really focused on

preventing youth from aging out of care and have seen success. Their caseloads, were previously as high as 35 per worker and currently are approximately 19 per worker. This reflects the work the unit has done to help these youth achieve permanency. They have seen several successful adoptions, returning children to their parents post-termination, and having people assume PMC of these children.

Other State Examples

Virginia

Virginia uses Intensive Care Coordination (ICC) and the High Fidelity Wraparound (HFW) Model for youth with challenging behavioral health issues and who are at risk of out-of-home placement. The HFW is based on the following principles:

- Individualized and family and youth driven services
- Strengths-based practice
- Reliance on natural supports and building self-efficacy
- Team-based practice
- Outcomes-based service planning
- Cultural and linguistic competence

The model uses a short-term crisis stabilization plan and then more long-term planning based on an assessment of the child's strengths and needs. ICC/HFW is a team-oriented approach that seeks to engage the youth, build on family strengths, and integrate planning. That differs from both a traditional clinical service and traditional case management.

External evaluation has validated the efficacy of this model. Evaluation of a similar wraparound system in Maine has found as many as 82% were able to move to less restrictive environments after 18 months compared to 38% of the comparison group.

Louisiana: Coordinated System of Care (CSoC)

The Coordinated System of Care (CSoC) was developed for Louisiana's children and youth with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement. CSoC is included as part of the Louisiana Behavioral Health Partnership (LBHP), a comprehensive system for behavioral health services, led by executives of the Department of Children and Family Services, the Department of Education, the Office of Juvenile Justice and the Department of Health and Hospitals.

LBHP offers an array of Medicaid State Plan and Home and Community-Based waiver services to all children and youth in need of mental health and substance abuse care and with significant

behavioral health challenges or co-occurring disorders. The Coordinated System of Care is managed by Magellan Health Services.

CsoC is an evidence-based approach with the goal of reducing the number of targeted children and youth in detention and residential settings, reducing state costs, increasing the array of home and community-based services, and improving overall outcomes, through Medicaid and specialized treatment planning and services. Eligible out-of-home placements include Foster Care, Therapeutic Foster Care, as well as several other Psychiatric, group and alternative placements.

A large component of the CSoC initiative is to support the development of regional Wraparound Agencies (WAA) and Family Support Organizations statewide. CSoC started with a pilot in five regions, serving approximately 1,200 children and families, and was expanded statewide in September 2014 to serve approximately 2,400 children.

Magellan determines clinical eligibility (behavioral health diagnosis, ages: birth – 21, exhibiting high-risk behavior, in or at risk of out-of-home care). Children not eligible for Medicaid are also eligible for CSoC services. In these cases, another funding source must be identified, which may include the referring agency.

Services are provided under a Wraparound model by nine regional Wraparound Agencies (WAA) and guided by the Wraparound Facilitator. Wraparound Agencies and Family Support Organizations must be contracted with Magellan and participate in required training. The Office of Behavioral Health contracted for 3 years with University of Maryland to offer workforce development and technical assistance on the implementation of wraparound in accordance with the standards established by the National Wraparound Initiative (NWI).

NWI Wraparound training was provided to Wraparound Facilitators and Supervisors. Wraparound Facilitators and Supervisors are employees of the contracted Wraparound Agencies. Supervisors who receive additional training can become trainers or coaches to provide sustainability in the workforce.

A statewide team consisting of representative from the Departments of Children and Family Services, Education, Juvenile Probation and Office of Behavioral Health serve as liaisons to their agencies to make sure they understand Wraparound and Coordinated System of Care and how they are beneficial to the youth served.

The child and family team also includes the Wraparound Facilitator, staff from agencies involved with the child, mental health and other providers. The Wraparound process is for planning, not directly for clinical intervention.

According to one state official, some of the challenges in working with this model include:

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- Helping stakeholders and families understand what it is and is not. Wraparound is a planning process guided by values, not a therapeutic intervention.
- Successful Wraparound implementation depends on a healthy System of Care.
- Implementation requires a cultural shift for everyone involved.
- Building a sustainable training and coaching workforce.

California: Medi-Cal Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members

This model is based on a Core Practice Model (CPM) for an all-inclusive approach for service planning and delivery. Intensive Care Coordination (ICC) is similar to Targeted Case Management to facilitate implementation of cross-system/multi-agency collaborative services, but must use a Child and Family Team (CFT) as the primary service delivery vehicle. ICC uses different service and procedure code than TCM, but is reimbursed by Medi-Cal at the same rate as TCM.

Intensive Home Based Services are targeted at the Katie A. subclass (“Katie A” is a California Federal Court Settlement Agreement designed to improve CW mental health services) and expected to be more intensive than traditional Specialty Mental Health Services. This service is billed using different procedure and service function codes but is reimbursed by Medi-Cal at same rate as Mental Health Services. CFT includes at least a coordinator and a family support partner or family specialist for youth. The coordinator can be a mental health provider, social worker or probation officer.

Wisconsin: Care4Kids

Care4Kids is a Medicaid benefit that provides a medical home team for each child to coordinate physical, mental and dental health. The State Plan Amendment was approved by CMS and is a joint effort by Department of Children and Families, Department of Health Services and Children’s Hospital of Wisconsin; it is billed through the Children’s Community Health Plan. It was initially rolled out in six counties and targeted for children entering out-of-home care; children already in care will be phased in later.

The benefit is facilitated by Health Care Coordinator (RN or APSW), who has experience with children with special needs or in out-of-home care. The coordinator oversees and ensures access to medical services. They also develop the Comprehensive Health Care Plan within 60 days of entering OHC; and monitors status and coordinates revisions.

The plan includes an action plan for behavioral health management, if appropriate. Other functions performed include collection of available medical history and distribution to medical provider, along with health screening findings, collaboration with child welfare workers, and assistance with location of providers and scheduling appointments timely. Outreach Coordinators assist the coordinator with duties related to service coordination, such as scheduling

appointments. The broader care team includes child welfare caseworkers, health care professionals (primary care providers trained in the needs of children in out-of-home care), out-of-home care providers, family and other important adults in child's life.

Services include an initial screening within 2 days of entering care, a comprehensive health assessment within 30 days, and mental health evaluation if needed. Children can receive all Medicaid-covered benefits, dental and vision care, and ongoing routine checkups. The Comprehensive Health Care plan tailored to child's individual health needs. Ongoing Health Care is provided for 12 months after discharge from out-of-home care.

Wisconsin: Therapeutic Foster Care (called Treatment Foster Care)

Wisconsin offers Treatment Foster Care (TFC), which is home-based care for Level 3-4 Foster Care Services. Foster parents can get 24-hour support from a Mobile Urgent Transport Team, in addition to monthly face-to-face meetings with caseworkers.

Title IV-E reimbursement payments to Treatment Foster Families are based on the Uniform Foster Care Rate, plus a Supplemental Rate based on the child's CANS rating and Child LON/Provider LOC. An additional Exceptional Rate may be paid for extreme needs above and beyond what is covered by the Basic and Supplemental Rate, for a total reimbursement not to exceed \$2,000/month. Additional payments are not IV-E reimbursable.

Provider example and services include: Family and Children's Center (FCC), a private non-profit agency, provides trauma-informed care with a multi-disciplinary team approach including in-house social workers, therapists, a clinical supervisor and a child psychiatrist to provide intensive, specialized support and advocacy for each treatment foster care family and child in placement in a 6-county area. The FCC has 24/7 on call social workers available for any emergencies with TFC youth or for referrals for respite services.

Home visits to each treatment home occur monthly and telephone contact occurs weekly. They feature highly trained and experienced treatment level foster parents all residing within one hour of La Crosse. Services include family integration through co-parenting and mentoring between TFC parents and birth or adoptive parents. This includes individual and family therapy and independent living skills training.

Illinois: The Department of Children and Family Services (DCFS) System of Care

The Care Coordination Pilot was implemented in 2014 in four counties targeting children in psychiatric hospitals, residential treatment, specialized foster care and entry-level foster care if they already showed signs of instability. (The existing Illinois Medicaid Care Coordination Entity Program for Children with Complex Medical Needs, approved by the CMS, governed by a lead entity and receiving a care coordination payment, excludes Department of Child and Family Services Foster Children.)

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The pilot serves approximately 200 children in child welfare, with 800-1000 children expected at full rollout. Rollout to statewide implementation will be strategic and regional over the next couple of years.

In the pilot, DCFS contracts all care coordination for high needs children with Choices, an outside vendor specializing in Systems of Care and Care Coordination for children in the child welfare system. The cost of services are offset, because children are stabilized in less restrictive placements or stepped down from psych hospitals and residential placements, resulting in an overall decrease in costs for care.

Choices uses Systems of Care principles in a Case Management Entity Approach. Choices provides Care Coordination Services and Child and Family Team services as a neutral party, as well as having access to a wider provider network than with which DCFS contracts.

Services authorized by Choices Child and Family Teams include many services not available through Medicaid, including specialized therapies (art, play therapy), intensive in-home support, social/ educational/clinical mentoring, supervision, and transportation. Flexible spending to purchase those services is overseen by Choices, ensuring accountability.

DCFS pays Choices with General Revenue funds for services authorized by Choices and provided to the child. If the child has access to Medicaid, eligible services are billed directly to Medicaid. Care coordination services provided by Choices are currently paid by General Revenue funds, but Illinois is working on an amendment to include those services under Targeted Case Management, to allow billing to Medicaid and make the program more affordable to the state in the future. DCFS Caseworkers received an initial in-service training to understand the care coordination system. DCFS is currently developing training for Care Coordinators to understand better the child welfare side, as well as additional in-service training for child welfare workers.

The model was implemented successfully in several states including New Jersey, Louisiana, Ohio, Wisconsin, Washington DC, and Indiana. After 18 months of piloting, they are seeing the desired outcomes, including:

- Establishment of care coordination / managed care benefit that is specific to needs of child welfare population and children with complex behavioral health needs.
- Increased availability and coordination of home and community based services to stabilize wards in the least restrictive placement possible.
- Increased communication and collaboration between child-serving state agencies.
- The anticipated loss in Medicaid match is offset by being able to authorize and reimburse providers for a broader and more flexible array of services individualized to the child's specific needs, thereby incentivizing providers to broaden their services, and leading to savings when children are stabilized in less restrictive settings.

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Florida: Use of Targeted Case Management

Florida has outsourced case management of foster youth. For high needs children, TCM provides additional support. For foster children with a severe mental health issue requiring a high level of care, such as a hospitalization, he or she is assigned a targeted case manager, and the manager becomes part of a team that monitors the child's progress. TCM services are dependent on MH diagnosis or condition. There is a mechanism in the assessment or if a significant event occurs, such as a hospitalization.

The targeted case manager conducts service planning, provides services or coordinates service provision, and conducts permanency planning for the child. The position also monitors utilization data to ensure under-utilization of services is not occurring. The focus is to try to resolve the issue while maintaining the child in a home-like setting.

Also part of the team is the primary caseworker and other specialists. The role of the primary caseworker is that of "connector." Previously, other approaches have been used, such as creating specialized units to work these cases but that was not effective and could not be sustained. Another member of the team is the mental health specialist (similar to the Well-being specialist role in Texas).

7. RECOMMENDATIONS

Build on what is working

In conducting a comprehensive assessment of the Texas child welfare system, TSG uncovered several STAR Health design features that make Texas a national leader, best practices already in place in some regions of the state, and areas where CPS is aware of gaps and is taking steps to address them. TSG notes these throughout the preceding sections of this report and summarizes them below to show that Texas has all of the elements to create the improved, integrated system TSG recommends.

- Elevation of Mental Health Policy – The Texas Legislature created a position at the Health and Human Services Commission to oversee and coordinate mental health policy and programs among health and human services agencies. This office has championed local collaboration among all the entities involved in caring for the behavioral health needs of foster children.
- Elevation of the specialized needs of foster children – DFPS and other health and human services agencies created the Starfish process to bring attention to the specialized needs of children in care. Not only has it allowed for resolution of barriers in individual cases, but it has allowed CPS to identify broader system issues that affect many additional children. It provided the impetus for more in-depth research and problem solving in the area of meeting the needs of high needs foster children. It has also fostered collaboration among DFPS and other state agencies, CPAs, the STAR Health vendor which has many spillover benefits into other areas.
- STAR Health design – Texas is a national leader in terms of the healthcare program available to foster children. In addition to the previous benefit structure, many new enhancements were added to the most recent contract that will provide substantial benefits for foster children, especially those with high needs. Texas has significant experience with Medicaid managed care, including contract oversight. Texas foster children have had the benefit of service coordination and service management through STAR Health, while many other states continue to use fee-for-service for the foster child population. The STAR Health vendor is held accountable for healthcare access statewide. There are TCM and rehabilitative service providers in every CPS region.
- Texas System of Care – Texas uses a national best practice training as provided through the University of Texas for its providers of TCM and rehabilitative services. Legislative authority exists for CPAs to move forward in becoming providers and being trained under this best practice model.
- Best practices – Several localities in Texas have demonstrated use of best practices related to psychiatric hospital diversion, how to support placements, and reintegrating

youth after they have received more intensive interventions. These practices can be replicated in more parts of the state.

- Collaboration with STAR Health to increase CPS caseworker awareness about STAR Health benefits.
- Concentrated knowledge in a number of subject matter experts across the CPS system. Well-being specialists, nurses, developmental disability specialists, and special immigrant juvenile specialists have been able to make the difference in supporting caseworkers and helping high needs children when engaged in the process.
- Efforts to build provider capacity – CPS is aware of its capacity challenges and is working to address many of them.
- Robust data – STAR Health and child welfare data is already available to inform and support a more accountable system.

Fill in the gaps

Despite these system strengths, TSG also identified a number of gaps (identified above) that should be immediately addressed to meet the needs of these children. TSG offers the following eight recommendations that provide a way to meet the needs of the highest needs children in foster care, and to prevent others from joining this group:

1. Develop a uniform standard definition of children with “High Needs.”
2. Identify a clear identifying mechanism for specific interventions to ensure the correct process is followed while a child is in care.
3. Build an integrated and accountable case management system and process that results in an integrated model of care that holds a single entity responsible for connecting case management functions and ensuring behavioral health needs are met.
4. Use prevention strategies to stabilize high needs children who are not yet in crisis situations.
5. CPS organizational improvements that will ensure quality outcomes when working with this high needs population.
6. Improve caregiver training and outreach.
7. Focus on high intensity in-home supports that provide the continuity for essential services to reduce the risk of recidivism.
8. Continue with Starfish process as a way to evaluate system reforms and identify continued gaps in process.

1. Develop a uniform standard definition of children with “High Needs.”

Texas CPS needs to develop a standard definition of children with high needs. This definition could build on the functional definition TSG developed but should be reviewed for consistency

with federal measures already captured in IMPACT and cross-walked with Administration for Children and Families AFCARS measures. Development of such a definition will allow CPS to identify both the highest needs group (in crisis) and the broader at-risk population (to enable targeting of preventative, lower-cost services).

2. Identification of identifying mechanisms for specific interventions

In addition to establishing and agreeing on a more standard definition of a “high needs” child, it is critical that CPS consider multiple condition variables that are factors of an effective standard definition and develop a system that can determine children with a high probability of being high needs upon entry into the CPS system so that care planning and preventive services and supports can begin as quickly as possible. Towards that end, CPS should create an automatic identifying mechanism to identify these high needs children and initiate specific protocols. This method would use objective criteria to activate certain interventions and take some of the variability out of the current process of working with these children.

This could include the integration of IMPACT data (such as child characteristics, number of placements) with STAR Health claims data (i.e., based on identified diagnoses, psychiatric hospitalizations, events such as missed a follow-up appointment or has not refilled prescription medication, and time factors) to form a profile of a youth at risk. The STAR Health vendor already has a risk profile process; CPS should work with the STAR Health vendor in designing a predictive analytic model that provides “real time” data on risk indicators readily available to the CPS caseworker and the child’s case manager.

The indicators would be used to link the highest needs children with Targeted Case Management and the wraparound services they need and ensure that the right prevention strategies are used to prevent crisis situations for the population at risk. In addition, CPS could use the data and indicators internally in a variety of ways to ensure that case involved staff collaborate as intended, SMEs are involved, and children get the support they need. Indicators should also be available to CPAs when they take the child and STAR Health when enrolled or, as quickly this type of data would be available.

The data would also be used to inform CPS of who is at risk of becoming a “high needs” child (the broader high needs population). An initial identifying mechanism for children coming into care should be integrated into the CANS rollout, which would occur at the earliest in March 2016. Given the potential of the CANS to help the child welfare system better meet the needs of high needs children, TSG encourages CPS to take whatever action is needed to ensure an expedited rollout of the assessment. CPS is in the process of working with STAR Health to design the CANS tool and the output of the tool. A unique window exists to influence how this tool is structured and in what format the information will be provided. CPS should consider how

to flag the different populations of high needs children using this tool so the output can feed into a specific process.

3. Build an integrated and accountable case management system and process that results in an integrated model of care that holds CPAs responsible for connecting case management functions and ensuring behavioral health needs are met

DFPS should work to build an integrated and accountable case management system with one entity (CPAs) assuming responsibility for the outcome of each high needs child, regardless of where that child receives care. The designated CPA will then work to ensure that the care is coordinated around the child to produce the best result. The model for reimbursement must be built around successful outcomes, not services delivered. These successful outcomes must involve meeting essential health and well-being performance measures as well as the goal of achieve timely permanency. CPS should immediately begin formulating a plan for a pilot to test this approach that is based on the following specific action items:

- Establish an integrated model of care to be used in the pilot, including use of TCM and wraparound services for a clearly defined group of high needs children (potentially those with the indicators discussed and with the highest ALOCs). These would be the sub-set of high needs children who are in crisis. “Wraparound” refers to a specific approach to care planning that engages key family and community supports and mobilizes local resources. This approach includes four phases (Engagement/Team Preparation; Initial Plan Development; Plan Implementation; and Transition) and has empirical success with placement stability.
- Identify a geographic area to conduct the pilot. The pilot would be for all foster children who meet the criteria of high needs within the area.
- CPS should conduct outreach to external stakeholders, including the courts, to educate them about the pilot, the broader initiative of improving the child welfare system’s treatment of high needs children in foster care, to identify how they can support this work, and to prevent them from ordering that children in areas outside the pilot area participate.
- Amend the CPA contract to strengthen the CPA role regarding high-needs children in the pilot area. Added duties would include placement decisions and the expectation that the CPA would have a high-level case management responsibility for these children. This case management responsibility would not be confined to just services provided by the CPA. The CPA would be responsible for managing the high needs child’s care across the child welfare system, including STAR Health and LMHA services for that individual child.

- CPAs would assume risk for high needs children (with a no reject/no eject policy) they agree to serve.
- CPAs assume responsibility that each high needs child accesses all of the services that are clinically appropriate, including TCM. It is the provider of TCM that would be responsible for monitoring the day-to-day situation, such that if the child was experiencing decline, this person would be responsible for identifying it.
- The CPA could become credentialed to provide TCM or sub-contract with an LMHA or another CPA to provide TCM and other behavioral health services if the organization does not want to be certified. Ultimately, however, the CPA contracting with CPS will be responsible for ensuring that these essential services are provided and meeting quality outcomes.
- HHSC should work with DSHS and the University of Texas to ensure that any willing provider of TCM services is able to access needed training. STAR Health should continue to do whatever possible to address any remaining barriers to credentialing.
- HHSC, in partnership with the STAR Health vendor, should conduct an education and outreach campaign for CPAs. This should include the requirements and process to become credentialed to provide TCM and rehabilitative services and focus on what the CPA needs to do today to provide the services they are already required to provide.
- The CPAs would need to be compensated for taking on additional case management duties. Consider use of different compensation strategies including payment based on level of need and use of incentives to reward excellent providers for their performance in these key areas. Consider use of a “hold-back” provision such as that used by other health and human agencies in rewarding the best providers.
- Require CPAs to increase communication with the STAR Health vendor to ensure timely notification of placement changes.
- Establish key measures for the CPA to reinforce accountability and encourage excellence. These measures could track how quickly case management activities occur, whether foster children complete a package of behavioral health milestones (could be modeled after well-check and immunization requirements that STAR Health must meet with regard to Texas Health Steps requirements), demonstrate that the provider has done everything to prevent placement breakdown, and outcome-oriented measures surrounding permanency.
- Hold CPAs accountable for outcomes around children leaving psychiatric hospitals and close contractual and process gaps to reduce the number of placement challenges at this critical point.
- Hold CPAs accountable for providing sufficient services to children leaving RTCs to increase the likelihood the next placement will be successful.

In this pilot, responsibilities for case management and related functions would shift as is shown below.

Recommended case management responsibilities, high needs children

CPS	CPA	STAR Health	LMHA
Court/Legal responsibilities			
Ensuring needs of children are met while in care			
	Placement		
Monthly face-to-face child visits	Monthly face-to-face child visits		
Joint service planning (child and family)	Lead on service planning but joint service planning (child and family)		
Monitoring that service coordination is occurring	Total coordination of CPA-provided services, medical services, behavioral health services	Coordination of medical, behavioral, dental, vision, pharmacy and other services covered in STAR Health Medicaid benefit (this includes any services provided by a LMHA) Service coordination and service management)	Provision behavioral health services
	Responsible for ensuring provision of Targeted Case	Credentialing of providers to provide TCM and	Provision of Targeted Case Management for complex behavioral

	Management for complex behavioral health cases – may provide or contract with LMHAs/other CPAs	reimbursement for TCM (carved-in to rate)	health cases
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4. Use prevention strategies to stabilize high needs children who are not yet in crisis situations

CPS, HHSC, the STAR Health vendor, providers, and advocates should work together to identify mental health and substance abuse prevention strategies that specifically address the conditions of high needs Child Welfare children such as Resilient Peer Treatment for post-traumatic stress (could be school-based), Child Centered Therapy for post-traumatic Stress (CCT), and Family Therapy for post-traumatic Stress and develop a plan of development, implementation, and timeline.

5. CPS should focus on effective organizational improvements that will ensure quality outcomes when working with this high needs population

The CPA pilot with the highest needs children will shift some responsibilities from the CPS worker to the CPA. The intent is for the CPA to take the lead responsibility in case management for the highest needs children (i.e., in the pilot), which will free up the worker so that s/he can take the lead on doing the prevention and placement stabilization work with the population of children who share many of the same characteristics as the highest needs children, but who are currently stable in their placements.

Conduct rigorous, standard, independent utilization review of STAR Health data

Assign an accountable role within CPS to assume this function. This role should develop internal capacity to analyze and review information from the STAR Health vendor and to combine it with child welfare data. CPS would have more capacity to know the children then think are at risk are getting needed services and to identify where the gaps exist.

Use data to hold CPAs accountable

Improving internal familiarity with this claims data is also going to be important in holding the STAR Health vendor and CPAs accountable for the outcomes CPS wants to see with high needs children.

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Continue capacity building work

This should include a focus on the step-down services from residential settings. CPS is working on a procurement for sub-acute care. Conduct rigorous outreach to ensure every region has supply of these services. Determine how they can provide support for the step-down and prevent the full step-up for children.

Regions should continue to facilitate their discussions with local partners about building a continuum of services, with support from HHSC and CPS state office.

Identify expectations for protocols that are to be followed when specific events occur

This involves formalizing involvement of subject matter experts and when to hold the Starfish staffing (perhaps opportunities other than placement crises are appropriate for that forum), among other key decisions.

Conduct training and communicate changes with CPS staff

There are several areas where more training for caseworkers is needed:

- How to identify high needs children
- What protocols to follow when high needs children are identified
- What services are available for high needs children (STAR Health, LMHA, and Local Authority)
- How to engage the right subject matter experts
- How to engage providers and caregiver to prevent placements from breaking down (see Region 7 best practice under development)
- How to prepare children and caregivers in situations when a child is returning home from a more restrictive setting

Generally, CPS should also use this opportunity to refresh staff on STAR Health benefits and how to use the Health Passport. CPS should continue with its plan to conduct rigorous annual communication around STAR Health. CPS should ensure workers understand the interventions available for high needs children. In particular, workers need to understand what TCM is and the rehabilitative services that are available. Workers in areas that have the mobile crisis outreach teams and psychiatric hospital diversion programs need to understand how to access those services.

This training should be coordinated with training for other upcoming initiatives (i.e., CANS in Spring 2016, new SDM tools in FY2016) to reduce the burden on the worker to attend so many days of training. It is anticipated several trainings may occur in Spring 2016; CPS may want to consolidate some of them.

Ensure Children in DFPS Foster Homes and Kinship Placements Receive Services

For high needs children in DFPS foster homes or kinship placements that meet the criteria of children in the CPA pilot, CPS should identify a responsible entity to assume their case management. One option would be to contract with CPAs to perform this service. This would ensure a consistent approach to meeting the needs of these children. One concern is that CPAs have not traditionally provided any services to these placement types. Another option would be to entrust CPS staff with the responsibility. Staff would need to be trained on the additional expectations to ensure those children receive the same level of cross program support as those served by CPAs. Workers would need to understand that they are responsible for case management across the child welfare, STAR Health, LMHAs, and Local IDD Authority systems as needed, and in particular, for referring the children to TCM and rehab service providers in their areas (LMHAs) so that they can benefit from the integrated model of care.

6. Improve caregiver training and outreach

CPS and CPAs should conduct education for their contracted caregivers (foster parents, kinship caregivers). As indicated in the data analysis section, about 45% of children with the special needs indicator, 55% of children with the medical indicator, and 41% of children with the emotional indicator are placed in contracted or DFPS foster family or foster group homes. Specific areas of education should occur in the following areas to increase service utilization and avoid placement breakdown:

- STAR Health benefits – This includes how to access the nurse line and the different service coordination/management services offered, TCM and enhanced rehabilitative services for children with behavioral health needs, and some of the specialized services in certain areas of the state (i.e., psychiatric hospital diversion).
- Caring for children with chronic health conditions – CPS specialists in particular (Well-being specialists and nurses) should work with STAR Health to increase caregiver training and education in caring for children with chronic health conditions (i.e., diabetes and epilepsy).
- LMHA and Local IDD Authority services and how to access them.

7. Focus on high intensity in-home supports that provide the continuity for essential services to reduce the risk of recidivism

CPS should also develop a plan to ensure that, when needed, high intensity in-home supports follow the child when the child goes home or if the child is adopted. Achieving permanency for these children is as important a goal as any child in foster care. Once a child is returned home or is adopted, the child may still need intensive behavioral health services, but the STAR Health benefits may no longer be available. Continuity of services here is critical.

Although this particular issue was out of scope for this review, TSG heard from many of the individuals we interviewed that there exists a critical need here for in-home supports to follow many of these children once they reach permanency in order to reduce the risk of recidivism. In future procurements of STAR Health contract, DFPS may want to carve in medical services for adopted children to ensure better continuity in their medical and behavioral health care. In the status quo, these children are eligible for Medicaid if the adoptive parents elect coverage, but they move out of the STAR Health program once they are out of DFPS conservatorship and depending on their location in the state, may be served by a different MCO with a different network of primary care and specialist physicians.

While developing its response to meeting the needs of these children, CPS should also consider the continuity of these essential behavioral health services once a child is no longer in foster care. For example, CPS should look to Multi-Dimensional Foster Care, the KEEP program (designed for foster care parents), and Multi-Systemic Family Therapy as evidence based practices that can be designed and implemented in a wraparound model to support stable home placements along a continuum of a child's needs over time.

8. Continue with Starfish process as a way to evaluate system reforms and identify continued gaps in process

The Starfish process brought attention to the specialized needs of foster children, created a forum to trouble-shoot barriers to serving high needs foster youth, and fostered collaboration among the HHS enterprise agencies, CPAs, and the STAR Health vendor. The meetings have been effective because of the participation of key state leaders and stakeholders, with decision making authority for their respective organizations. Given the composition of the group, TSG recommends that the Starfish meetings be used in a new capacity during the pilot. The meetings can be used to evaluate system reforms, resolve barriers or issues that emerge during the pilot, and continue to identify gaps in meeting the needs of high needs children. At a recent meeting, participants discussed trends over the last quarter of Starfish reviews. TSG recommends a continuation of this type of system analysis and discussion.

Action Strategy

To proceed with the recommendations outlined here, TSG recommends that CPS pursue the following “action strategy” approach:

- Form an internal working group to come to consensus around the gaps and solution (session planned for November 9).

- Identify the specific indicators to be used and corresponding interventions. Work with the STAR Health vendor to examine sources of data that could be used to flag children in crisis and at risk of crisis.
- Develop the business case for the pilot and key recommendations to develop an automatic identifying mechanism for high needs children, including determining the ideal pilot size in order to achieve cost neutrality. It is anticipated that the data analysis and development of the methodology to identify high needs foster children and to predict when children are experiencing decline will have a cost. It is anticipated savings from avoided institutionalizations/psychiatric hospital admissions and from reduced time in foster care due to better permanency, outcomes would offset the one-time data costs and ongoing costs from increased service utilization. Included in the business case would be reinvestment strategies for savings, should the pilot savings exceed costs.
- Work with STAR Health vendor to establish utilization review protocol and closely monitor utilization for pilot participants, to ensure children receive the appropriate level of services (avoiding over and under-utilization).
- Define the criteria for participation in the pilot.
- Determine if contractual changes are required for implementation of the pilot.
- In collaboration with CPAs, define the performance measures to be used in the pilot.
- In collaboration with STAR Health vendor, define any additional performance measures that should be included in the STAR Health contract.
- Develop the protocols that should be followed when high needs children are identified to prevent them from declining and experiencing crisis.
- Develop the training needed for CPS staff and caregivers. Determine a rollout plan that coordinates rollout with the CANS implementation.

Work on all of these action items can begin immediately (prior to the CANS rollout) so that the pilot launch and rollout of training can be done at or after CANS implementation.

APPENDIX A – REQUIRED NOTIFICATIONS

Policy #	Description	Notify
4112	30 days prior to a planned move	Current caregiver
4113.4	Planned move--send request to move and notify	AAL, GAL, CASA
4113.4 & 4153.2	Emergency move--within 3 days after the move notify	AAL, GAL, CASA
4121	48 hours advance notice prior to move if not already informed of the placement selection	AAL, GAL, CASA
4623.8	Conclusion of RCCL investigation CPS worker notifies	Parents, AAL, GAL, CASA
4625.31	Extension in emergency shelter--written notice before the 15 th day	Emergency Shelter
4711	Authorized independent living arrangements	AAL and Court
4712	Unauthorized living arrangements	LE, AAL
4712	Unauthorized living arrangements --must keep the following parties informed ongoing during youth's absence	Court, parents, authorized caregiver, DFPS attorney, AAL, and all other parties to the case
Appendix 4623	Placement change to ensure safety	Supervisor, PD, and PA
5225	General notice about CPS hearings	Parents and children
5231.2, 5231.4, 5231.41	Cooperating with AAL, GAL, CASA--shares information on regular basis; keeps informed about case developments and hearings; reports progress or changes related to the CPOS; meetings, events; critical events	ALL, GAL, CASA
5332.1, 5332.2, 5332.3, 5332.4, 5223.5	Notify the court--child may be harmed; without placement; change in jurisdiction; removal from return & monitor; medical consent	Court
5353.11	Making OAG aware of issues that could affect child support collection	OAG's office
5354.1	Child support and dismissal orders--must notify caregiver that DFPS will not assist in child support collection	Caregiver
5354.3	Helping caretaker obtain child support	Caregiver
5432.5	Ed decision maker and surrogate parent	Court
5534	Permanency Hearing notification	Child, caregiver, parents parent's attorney, CPA, AAL, GAL, CASA
5622.2	Review hearing for extended foster care notification	Young adult, caregiver, parents, CPA, AAL, GAL, CASA
5622.6	Start of trial independence period	Attorney representing DFPS
5632.2	Return from trial independence to foster care	Attorney representing DFPS
5642.5	Withdraw of consent for extended jurisdiction	Court
5830	Foreign born children in foster care	Foreign consulate, attorney representing DFPS
5831,		

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5831.1		
5851	Appointment of DFPS as GAL of child in conservatorship	Regional managing attorney
6123	Locating relatives and providing notice of removal & ongoing effort to locate and notify	Paternal & maternal relatives, all person's parent indicated on the 2625, adult relatives of the alleged father,
6XXX--not yet published but law	<p>Caseworkers are required to keep parties informed of significant events that occur while a child is in the conservatorship of the department. Such as:</p> <ul style="list-style-type: none"> • a placement change, including failure by the department to locate an appropriate placement for at least one night; • a significant change in medical condition; • an initial prescription of a psychotropic medication or a change in dosage of a psychotropic medication; • a major change in school performance or a serious disciplinary event at school; • or any event determined to be significant under department rule. 	<ul style="list-style-type: none"> • Parents, • AAL, GAL, CASA, • Licensed Administrator of the child-placing agency or their designee, • caregiver, • prospective adoption parent, • director of the group home or GRO where the child is residing, • any other person determined by the court to have an interest in the child's welfare
6XXX	<p>Within 24 hours, PARENTS must be notified of:</p> <ul style="list-style-type: none"> • an initial prescription of a psychotropic medication; • a significant change in medical condition of the child; • the enrollment or participation of the child in a drug research program. 	Parents
6XXX	<p>No later than 48 hours before the department changes the residential child-care facility of a child in conservatorship, the caseworker must notify:</p>	<ul style="list-style-type: none"> • Parents, • AAL, GAL, CASA, • Licensed Administrator of the child-placing agency or their designee, • caregiver,

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		<ul style="list-style-type: none"> • prospective adoption parent, • director of the group home or GRO where the child is residing, • any other person determined by the court to have an interest in the child's welfare
6252	Participation in development of CPOS	Parents, parents' attorneys, child, caregiver, AAL, GAL, CASA, any relative that has expressed interest
6264	Developing FPOS	Each parent
6272	Administrative Case Review	All principles
6273	Notice of PPM	Child, caretaker, parents, parents' attorney, AAL, GAL, CASA
6274	Permanency planning youth over 14	Parents, family, fictive kin, CASA, AAL, GAL
6314.1	Minor child missing for foster care placement	LE, court, AAL, GAL, parents
6314.2	Missing child returns to care	LE, AAL, GAL, Court, Parents
6329	Child travels out of state	Court
6412	Family services (FRE goal)--notify of all meetings convened by DFPS about case	Parents, Parents' attorneys
6412.4	Initiate reunification process	Court
6415.4	Keep parents informed--notify of case plan reviews, meetings, court hearings, child's situation	Parents
6417	Military families--certificate of service	Attorney representing DFPS
6420	Services to caretaker--notification of court hearings, PPMs	Caregiver
6512	Death of child in care	Court, AAL, GAL, CASA, attorney representing DFPS, Regional Attorney, Parents' attorney, parents
6521	Reporting juvenile offences	LE
6524.4	Youth in TJJD permanency hearing notification	TJJD caseworker, TJJD administrator
6530	Foreign Custody order/Abduction Suit Hague--notify	Parents and relatives
6723	International placement	All parties, court, AAL, GAL, CASA, foster family or facility, consulate
6930	Selecting adoptive family--home study review	CASA
6932	Adoption by FP--plan for FP to adopt is approved	Foster Parents
6938	Meeting--review and discuss adoptive home studies	CASA, caretaker, therapist
11152	Notifying Parents about the Use of Psychotropic Meds--within 24 hours; initial prescription, change in medical condition; enrollment in drug research program	Parent

APPENDIX B – ADDITIONAL OTHER STATE BEST PRACTICES IN CARE COORDINATION AND SPECIALIZED SERVICES FOR HIGH NEEDS CHILDREN

Arizona, Massachusetts, Michigan, New Jersey

Making Medicaid Work for Children in Child Welfare: Examples from the Field, S. Pires and B. Stroul, Annie E. Casey Foundation, June 2013, outlines key Medicaid strategies for the child welfare population, including, state program descriptions and advice to other states (http://www.chcs.org/media/Making_Medicaid_Work.pdf)

Key Medicaid Strategies include:

Medicaid Financing

Use of child welfare general revenue as Medicaid match to expand home- and community-based services: Arizona and Michigan contributed child welfare funds to the behavioral health system to provide additional services under the 1915(c) waiver. New Jersey identified additional services that could be incorporated into the state's Medicaid plan.

Risk-adjusted rates and incentive payments to guard against under-service and encourage evidence-informed practices: Arizona's risk adjusted behavioral health capitation rates paid to providers average 29% higher than for non-welfare involved children. Michigan pays incentive payments above the capitation rates for Medicaid children targeted at children with serious mental health conditions who are in foster care or involved with child protective services.

Eligibility, Enrollment, and Access

- Presumptive Medicaid eligibility for children in child welfare to ensure immediate access to screening and services (Michigan, Massachusetts).
- Co-location and Medicaid financing of health and behavioral health liaisons in child welfare offices to assist with eligibility, screening, access, linkage, consultation, and crisis intervention (Michigan, New Jersey).

Screening and Early Intervention

- Timeframes for physical, behavioral, and dental health screens through EPSDT for children entering care: Arizona requires a behavioral health assessment within 72 hours of entering foster care. Michigan, Massachusetts, and New Jersey require a comprehensive assessment within 30 days of entering state custody. In New Jersey, Child Health Units visit each child in out-of-home care within two weeks and regularly thereafter to ensure children receive ongoing assessments and follow-up care.
- Use of standardized screening tools.

Covered Services

- Robust Medicaid benefit covering home- and community-based services including such services as family peer support, mobile crisis response and stabilization services, therapeutic foster care, and intensive in-home services: These services are provided by adding services to the state's Medicaid plan, revising service definitions, and using Rehabilitation Services Option and Targeted Case Management. New Jersey provides flexible state funds to pay for services that are part of the individualized service plan but not covered by Medicaid.
- Coverage of Evidence-Based Practices such as Trauma-Focused Cognitive Behavioral Therapy under separate or existing codes: In Michigan, evidence based practices are covered under Medicaid when delivered by a certified clinician and covered under billable service codes such as home-based therapy or individual therapy. New Jersey also offers supported training in various evidence-based treatments.
- Individualized Service Planning and Intensive Care Coordination: Massachusetts Community Service Agencies and New Jersey Care Management Organizations provide intensive care coordination financed by Targeted Case Management using a Wraparound model.
- Coverage of Wraparound practice model to support individualized care planning (Arizona, Massachusetts, Michigan, New Jersey).
- Coverage of intensive care coordination at low care coordinator to child ratios (e.g., 1:8-10) for children with complex needs.

Medicaid Providers

Inclusion of skilled child welfare providers and specialists in Medicaid networks: Arizona mandated that child welfare contracted providers become certified as Medicaid providers and be included in regional provider networks. Massachusetts provider networks are required to include expertise in trauma-informed care and an advanced study certification program was established at a college. Michigan agencies may seek out specialty providers that are "out of network."

Practice guidelines and protocols for Medicaid providers.

Ongoing training on the unique needs of the child welfare population and effective practices: Arizona behavioral health providers and Michigan community mental health agencies receive training on the unique needs of the child welfare population. Training is also provided to child welfare staff on behavioral health services and evidence-based practices. New Jersey provides training for working with high needs population through the Child Welfare Training Academy and the Behavioral Health Research and Training Institute.

Performance and Outcome Measurement

- Performance expectations specific to the child welfare population for Medicaid managed care entities and providers and monitoring of quality of implementation.

- Tracking of performance, service utilization, expenditures, and outcomes specific to child welfare population.
- Cross-agency data sharing agreements and use of data to identify areas needing improvement and to show results.

Case Studies: Making Medicaid work for the Child Welfare Population

Arizona

- Medicaid is the platform for a single behavioral health delivery system (behavioral health carve-out) with attention to the needs of children in child welfare
- Enrollment of children in foster care in a single health plan for medical and dental care
- Risk-adjusted rates
- Using child welfare funds to draw down additional federal Medicaid match to expand behavioral health resources
- Practice guidelines and protocols for Medicaid providers related to the child welfare population
- Co-location of behavioral health staff in child welfare offices
- Broad medical and behavioral health benefit, including support services like respite and family peer support
- Urgent response required by Medicaid behavioral health plans when child enters care; screens within 72 hours
- Mandated Wraparound approach to service planning and delivery, funded by case management and family support billing codes
- Use of Therapeutic foster care
- Attention to appropriate use of psychotropic medications
- Specialty providers knowledgeable about the child welfare population
- Provider training on needs specific to child welfare population
- Tracking service utilization of the child welfare population Massachusetts

Massachusetts

- Mandated behavioral health screening as part of EPSDT screens
- Coverage of broad array of home- and community-based services
- Use of Targeted Case Management to support an intensive care coordination approach using high quality Wraparound
- Coverage of family peer support
- Coverage of mobile crisis intervention model that allows longer-term involvement of crisis team with the child and caregivers
- Continuity of providers between community and residential placements
- Coverage of youth in foster care to age 25

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- Presumptive Medicaid eligibility for children in foster care
- *Michigan*
- Home and Community-Based Services Waiver
- Incentive payments to providers
- Use of child welfare general revenue as Medicaid match to expand resources
- Presumptive eligibility for children entering care
- Health liaisons and mental health specialists in local child welfare offices
- Timeframes for physical, behavioral and dental health screens through EPSDT for children entering care and use of Pediatric Symptoms Checklist and Ages and Stages Questionnaire
- Broad coverage of home- and community-based services, including evidence-based practices Targeted Case Management, and intensive in-home services
- Coverage of family and youth peer partners with lived experience
- Coverage of Wraparound approach to service planning
- Red flags and consultation to prescribers for psychotropic medications
- Performance monitoring unique to child welfare population and use of data to show results

New Jersey

- Customized child behavioral health carve-out using blended funds, Medicaid as administrative single payer system and DCF with management oversight
- Coverage of intensive care coordination at low ratios using high-quality Wraparound and care management organizations for children with complex behavioral health needs, financed through Targeted Case Management
- Payment for family and youth peer support using Medicaid administrative dollars
- Coverage of broad array of home- and community-based services using the Rehab Services Option, including treatment homes/therapeutic foster care and mobile response and stabilization services
- Maximization of Medicaid by using child welfare, behavioral health and Medicaid dollars to expand federal match
- Health units in child welfare financed with Medicaid administrative dollars
- Requirement for designated care coordinators in Medicaid HMOs as liaisons to child welfare
- Payment for behavioral health clinical consultation to local child welfare offices
- Enhanced Medicaid rate for physical and behavioral screens within 30 days of placement
- Training of Medicaid providers in evidence-based practices and in the child welfare population
- Tracking data indicators specific to the child welfare population

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- Tracking and review of psychotropic medications through data sharing between child welfare and Medicaid

Cross-State lessons learned:

- Understand the unique needs of children and families involved with child welfare
- Recognize the importance of relationships and collaboration
- Create multiple strategies
- Incorporate a robust Medicaid benefit
- Adopt an individualized approach to services using the wraparound process
- Create financing vehicles to maximize resources and flexibility
- Understand the mandates, goals, and cultures of partner agencies
- Ensure solid implementation and monitoring of new strategies
- Implement sustainability strategies for each provision

Hawaii, Maine, Maryland, Michigan, New Jersey, North Carolina, Oklahoma, Rhode Island

Effective Strategies for Expanding the Systems of Care Approach, Beth A. Stroul, Robert M. Friedman, SAMSHA, September 2011.

The 2009 study focused on diverse states that had made significant progress toward expansion of the systems of care approach: Arizona, Hawaii, Maine, Maryland, Michigan, New Jersey, North Carolina, Oklahoma, Rhode Island. See:

<http://gucchdtacenter.georgetown.edu/publications/SOC%20Expansion%20Study%20Report%20Final.pdf>

The most significant and effective strategies for expanding the System of Care approach included:

Incorporating requirements in RFPs, contracts, and regulations

Creating or assigning state and local focal points of management and accountability

Providing training and TA on the system of care approach

Expanding the array of services and supports

Expanding an individualized, wraparound approach to service planning and delivery

Expanding family and youth involvement in services

Creating strong family organizations

Increasing the use of Medicaid financing

Success in expanding system of care were attributed in large part to the Children's Mental Health Initiative (CMHI) system of care grants and SAMHSA's System of Care Expansion Planning Grant Program that allowed them to build infrastructure, test new approaches, collect effectiveness data, strengthen family and youth organizations and provide training and technical assistance.

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Maine

In partnership with the child welfare system, Maine has implemented Wraparound Maine to serve children in the child welfare system who have intensive service needs. In addition, significant investment was made in implementing evidence-based trauma-focused care. Although the grant program Thrive only provided direct service to three counties, it provided statewide training and technical assistance.

Michigan

The new expansion strategy was implemented because of a 2006 lawsuit filed on behalf of children in the child welfare system. A strategic decision was made to capitalize on federal training and technical assistance related to systems of care. In 2011, a 1915(c) pilot was underway for children with serious emotional disturbance.

New Jersey

Children's behavioral health system is a single statewide-integrated system for children and adolescents with emotional and behavioral disorders who depend on public systems across all child-serving agencies.

North Carolina

Originally a response to a lawsuit in 1979, the system of care has been expanded for all youth with serious mental health challenges, with a particular focus on case management and wraparound and strong state-level interagency collaboration. Grants were used to provide training and technical assistance; assist in state planning; demonstrate the application of system of care values, principles, and practices; and provide outcome data.

Oklahoma

System of care grants provided state-level infrastructure and helped fund local coalitions. Statewide expansion was supported by an RFP process to provide about \$140,000 in state funding to counties, with direct services financed by Medicaid, including wraparound facilitation, family support providers and behavioral health aides. Expansion efforts were aided by strong partnerships among mental health, Medicaid, juvenile justice and child welfare agencies; extensive training and technical assistance provided by the state; a strong focus on the wraparound process; and strategic planning at the state and county levels.

Rhode Island

System of care strategy was established by legislation, including blended funding, requirements to collaborate between DCF and Medicaid, practice standards (e.g., wraparound), provider contract requirements, and establishment of training at Rhode Island College.

Training

Providing Training, TA, and Coaching on Systems of Care was found to be both one of the most effective strategies. However, providing training, TA, and coaching on evidence-informed, practice-based and promising practices was found to be one of the most underutilized strategies.

Training was provided by bringing in consultants with expertise (Arizona), contracting/collaboration with universities (Hawaii, Maryland, North Carolina), a system of care grant community (Maine, Michigan, North Carolina, Oklahoma), statewide wraparound training and certification programs (Maryland, Michigan, New Jersey, Oklahoma, Rhode Island), and an annual conference or institute (Maryland, Michigan)

In addition, statewide training in Michigan is provided by a full-time, state-employed wraparound trainer.

Capacity for ongoing training is key to expansion and continued development of staff, given turnover among administrators and providers. Maryland and New Jersey have established centers at universities that provide ongoing training; Michigan, Maine and Oklahoma have created local system of care sites and provider agencies.

Maryland's Innovations Institute at the University of Maryland, community agencies in Michigan, and Maine provide training on evidence-informed practices as part of a statewide strategy to support system of care expansion. In the other states, training on evidence-based practices were generally not used as a system-wide strategy to support system of care expansion.