



Choices®



Fiscal and Clinical Models of Choices

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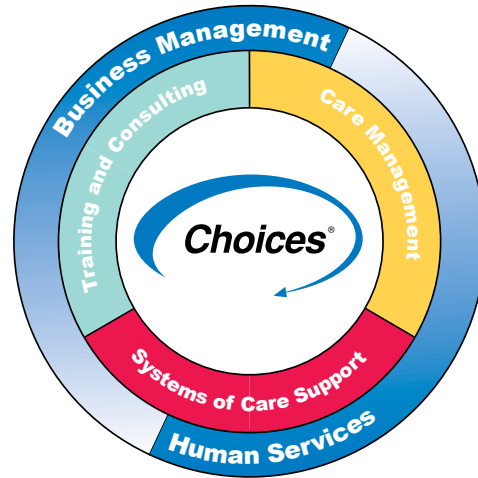
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Executive Summary

Choices, Inc., a nonprofit 501(c)3 incorporated in Indiana in 1997, is a Care Management Organization (CMO) that specializes in cross-system care coordination within a system of care framework for at-risk children and youth. Choices was created when a group of government officials, including former Juvenile Judge James Payne, asked for a nonprofit, non-provider entity to be developed to manage the clinical and fiscal operations of their project in Indianapolis, Indiana. Choices coordinates care, individualizes the needs

of its clients, *reorganizes sustainable funding structures to maximize tax dollars*, and builds accountability into delivery systems through community-based provider networks. Choices employs 150 staff nationwide and serves approximately 1250 children and families annually. Choices is governed by a 13-member volunteer Board of Directors consisting of community members and system partners, including consumers/family leaders.



Choices' main office is in Indianapolis, Indiana. It is the parent company of three wholly-owned subsidiaries: *Ohio Choices, LLC* serving Hamilton County (Cincinnati), Ohio; *Maryland Choices, LLC* serving the counties of Allegany, Baltimore, Carroll, Frederick, Garrett, Harford, Howard, Montgomery and Washington; and *DC Choices* serving Washington, DC. Like Choices, *each subsidiary operates as a CMO in its respective community*, serving at-risk children and families referred from child welfare, juvenile justice, education, mental health and developmental disability systems. Unlike many other agencies that provide both care management and clinical services, the *only business* of Choices is the coordinated management of care for at-risk children and their families.

The primary purpose of this document is to describe the breadth of funding models under which Choices' CMOs manage. Choices operates multiple funding models – each with its own attributes – because each *Choices community* tailors a funding model for its system of care that best meets its needs and desires. However, *irrespective of the funding model, Choices' philosophy of care and its clinical operations are consistent across programs* - focusing on individualized, team based and family-driven care.

Philosophy of Care

Choices' approach is based on the belief that children and youth should remain with biological parent(s), caring and supportive relatives, foster parents, and other community-based settings rather than in congregate care settings.¹ Therefore, our cross-system, collaborative approach is built upon the nationally recognized systems of care^{2,3} framework, using high-fidelity wraparound⁴ as the comprehensive approach to care. Studies using the Wraparound Fidelity Index (WFI)⁵ have shown that systems with higher levels of fidelity to wraparound achieve better outcomes for the children and families they serve than systems of care with lower levels of fidelity.^{6,7,8} Choices delivers high fidelity wrap in all of its sites. The values and principles central to a system of care^{9,10,11} include the tenets that services should be family-driven, youth-guided, community-based, culturally competent, individualized, provided in the least restrictive environment, and coordinated among child serving agencies. Choices focuses on what works for specific families and engages family members upfront, including relatives and friends, as a way of reducing families' dependence on paid or "formal" social services.

When Choices is invited into a community to develop or help further its system of care, *its goal is to quickly become part of the fabric of the community and grow organically*. All local staff positions are hired locally, so from the beginning, Choices' staff are part of the community that they serve. Inherent in this model is that *virtually all local money stays in that community*. With great intentionality, *Choices is not a service provider*; therefore, a vast network of service providers is needed to ensure a full complement of culturally and linguistically competent providers is readily available in the community to provide any services needed by a youth and his/her family. Choices

assists its service providers in developing and implementing high fidelity wrap services through training and consultation. Several research studies have found that youth receiving wraparound have better outcomes than youth receiving traditional services.^{12,13,14} Others have identified wraparound as a promising approach in child welfare.¹⁵

Did You Know?

Choices contracts with more than 400 agencies and individuals in Indiana to serve youth and their families.

Choices is committed to a strength-based approach in all aspects of services. This approach relies on the ability of direct care staff to work with families to effectively identify the inherent strengths that all families have and to use those strengths to design innovative approaches to intervention. This approach is driven by core values that state services, resources and supports must:

- Be child-centered and family-focused.
- Be community-based, building on the strengths, natural supports and resources of the family.
- Respect and respond to the unique culture (such as racial, religious, ethnic, socio-economic) of each family.
- Be designed to help families develop positive pathways to their own independence.
- Be committed to helping families change and sustain those changes that promote safe, stable and healthy families. Choices clearly understands that demanding compliance seldom leads to the kind of change needed to provide the outcomes desired.

Clinical Operations

Many similarities exist among the families served by Choices, yet a few striking differences have been found as revealed in the table below, developed from treatment plans and the Child and Adolescent Needs and Strengths (CANS) tool.¹ Although this is interesting information which drives the focus of developing service provider options a bit differently in each jurisdiction, on a youth-by-youth, family-by-family level, it has little bearing on the service provided because everything – from the time and location of child and family team (CFT) meetings, to members of the team, to which needs are most critical to address, to how those needs are addressed – is *individualized by the team for the youth and his/her family*.

Wraparound Process

Choices' care coordinators engage families and youth assigned in the wraparound process as defined by the National Wraparound Initiative (NWI).¹⁶ According to the NWI, the wraparound process consists of ten principles and a series of activities organized within four phases: engagement and team preparation, initial plan development, implementation, and transition.¹⁷ The following discussion illustrates key elements of Choices' practice model within these four phases.

Engagement and Team Preparation

The activities within this phase include orienting the family to wraparound; exploring the family's strengths, needs, culture and vision; and engaging members of the child and family team. Over the first thirty days of a family's enrollment with Choices, the care coordinator meets with them often in order to complete a strengths-based discovery process. This discovery process consists of: 1) a face-to-face meeting with the parent/caregiver and children (as appropriate) discussing strengths and concerns in 12 life domains (i.e., Home/Place to Live; Substance Use; Educational/Vocational; Psychological/Emotional; Health/Medical; Safety/Crisis; Legal; Family/Relationships; Social/Recreational; Cultural/Spiritual; Daily Living; and Financial); 2) completion of appropriate needs and strength assessment tools, the CANS and other funder-requested tools, if any; 3) articulation of a family mission and vision; 4) document review; 5) gathering of family history, and 6) collateral contacts made with providers and other professionals involved with the family.

After the strengths-based discovery process, the care coordinator helps the family identify and engage members of their CFT. CFTs include the child(ren)/youth, the primary caregiver, other family members, and formal and informal resources that comprise the youth/family's support network. The care coordinator gives and reviews with the family the *Child and Family Team Handbook* that outlines the responsibilities of all involved – care coordinator, family, and team members, both professional and natural supports. This helps the family prepare for what to expect at the first team meeting and also helps them speak to other team members about the obligations and expectations of serving on the child and family team. When the care coordinator contacts potential team members, he/she also prepares them for what to expect when they agree to participate. To facilitate full participation, all barriers that prevent parent involvement at CFT meetings, including transportation, time of day, childcare, and conflicts with work are removed prior to the first team meeting. Team minutes are distributed after each meeting and always include the assigned tasks for each person that are to be completed by the next team meeting.

Initial Plan Development

Activities are focused on developing a cohesive CFT with a shared mission, creating an initial plan of care, and developing a crisis plan. The care coordinator facilitates initial meetings of the CFT to ensure that a high-quality team is developed and that the strengths, concerns, and needs of the family are shared effectively with the other team members.

¹ Specifically, the percent of youth who had a rating indicative of a strength that needed to be developed and an actionable need at the time of enrollment was calculated. This statistic represents the number of youth that had a functional impairment requiring an intervention in each dimension.

The care coordinator assists the CFT in developing and implementing specific emergency/ crisis safety plans to teach dedicated adult(s), child(ren), provider(s), and others how to respond in specific crisis situations to avoid high risk behaviors and/or out of home placements. The plan outlines previous history of crises, types of crises, what has worked well, who to contact, placement options, and procedures to follow during a crisis.¹⁸ The comprehensive community-based crisis plan includes interventions built upon the strengths and natural supports of the child, family, and team as well as crisis services that are accessible 24 hours a day. The crisis plan is reviewed at each CFT meeting and updated as needed.

Implementation

The primary purpose of the CFT is to develop, implement and monitor the effectiveness of the plan of care. Daily we advance the practice and belief that “Families don’t fail, plans do.” Care coordinators look for strengths and are trained to build upon the strengths to meet the identified needs. This constant focus on strengths and the belief that youth and families are resilient ground this work and energize the staff to ensure that family-driven, strengths-based planning is implemented through the child and family teams.

Whenever existing strategies are found to be ineffective, the CFT identifies new strategies and assigns the action steps necessary to achieve desired outcomes. Because the family is an active participant in the CFT process, along with individuals they identify to be on the team, the CFT is able to ensure that care is being delivered in a manner consistent with strengths-based, family-driven, and culturally sensitive values. Although each plan of care is individualized, all include 1) the needs and strengths identified during the strengths-based discovery process, 2) desired outcomes and goals established with the family related to needs currently being addressed on the plan of care, 3) strengths-based strategies and approaches (i.e., interventions) used to address identified needs, and

4) authorizations for services that specify the providers, units, frequency, duration and cost of services. At a minimum the care coordinator has weekly contact with the family.

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Transition

Care coordinators help CFT members think and plan proactively about case closure and the transition from formal services and supports to natural supports and services that can be sustained in the community. Discussion about case closure begins during the initial team meeting and involves the entire child and family team. The team understands that the individualized plan of care includes closure planning and must take into consideration resources that will be available after closure to ensure child safety, stability, well-being, and permanency.

Provider Network

The *only business* of Choices is care management. Choices has more than 13 years of experience in developing and managing community-based provider networks, across 3 states and Washington, DC, that offer families and teams services that 1) are individualized, 2) provide immediate access to quality local providers, 3) ensure that quality improvement and assurance processes are “real-time” and responsive, and 4) built upon local resources that will be sustained after the client and family have completed their intensive care with Choices.

Choices attributes much of its success in helping families meet their goals to its ability and willingness to find the right provider for the right family at the right time. In all served communities, Choices has developed rich provider networks offering a full spectrum of services and resources that can be customized to meet the individual needs for every child and family. In each community, Choices hires a provider relations manager whose job is to grow and nurture this rich network. The provider relations manager's job includes finding community-based, natural supports for families that help them sustain success after transitioning from formal system involvement. *Choices holds contracts with 100 to 250 core agencies in each community – from large multi-million dollar public and private agencies, to single proprietorships and small faith- and community-based organizations.*

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Many of Choices' providers use evidence-based practices and promising approaches, so a cadre of providers offering best practice options is available in every Choices provider network. Providers are embedded in neighborhoods throughout the service delivery area and offer families immediate access to individualized, diverse, culturally competent providers in their neighborhoods that will be available after the family has completed their plan of care. Choices structures provider networks to reflect the families served and includes providers from faith-based organizations, eligible to bill Medicaid and/or insurance, of various ethnic and linguistic backgrounds, and specialize in serving families with diverse clinical and social needs. Providers in existing Choices networks include those who offer gender-specific programming/intervention, gay-lesbian-bisexual-transgender services, specific faith- and culturally/linguistically-based services, and a multitude of other population-specific focuses.

Choices seeks to ensure that its provider networks are able to serve all the families in culturally and linguistically competent ways that best meet their needs. As service gaps are identified in a community, Choices works with community agencies to develop the appropriate service. The array of services that can be provided by Choices' provider network is delineated in the table on the following page. In addition to the 100-250 core agencies in each provider network, *Choices develops client-specific contracts when necessary to ensure that every family receives the most appropriate service by the most appropriate provider.* Examples of client-specific contracts include a recent contract with a retired neighbor who stayed at the home of a single mother so her elementary age children could go to bed in their own beds each night while the mother worked a swing shift schedule and a contract with a cleaning service to thoroughly clean the home of a grandparent whose home needed such attention after the death of his spouse and a recent surgery. After the home was cleaned, the grandchildren could be placed in his home as opposed to foster care. *In a recent year in Marion County, Choices had more than 450 client-specific contracts that served fewer than 300 children.*

Provider Service Array

Placement

Acute hospitalization
Foster care
Therapeutic foster care
Group home care
Relative placement
Shelter care
Crisis residential
Supported independent living

Respite

Crisis respite
Planned respite
Residential respite

Mentor

Community case management/case aide
Clinical mentor
Educational mentor
Life coach/independent living skills mentor
Parent and family mentor
Recreational/social mentor
Supported work environment
Tutor
Community supervision

Behavioral Health

Behavior management
Crisis intervention
Day treatment
Evaluation
Family assessment
Family preservation
Family therapy
Group therapy
Individual therapy
Parenting/family skills training
Substance abuse, individual/group therapy
Special therapy

Psychiatric

Assessment
Medication follow-up/psychiatric review
Nursing services

Care Coordination

Case management
Care coordination
Intensive case management

Discretionary

Activities
Automobile Repair
Childcare/supervision
Clothing
Educational expenses
Furnishings/appliances
Housing (rent, security, deposits)
Medical
Monitoring equipment
Supplies/groceries
Utilities

Other

Camp
Team meeting
Specialty consultation
After school programming
Transportation
Interpretive services

In 2010, Ohio Choices made more than 700 authorizations to providers who use evidence-based practices and/or clinical best practices.

Choices Financial Models

Children's services are funded in a variety of ways, and Choices has worked within several different funding structures. We seek to be exceptionally flexible in terms of how the money flows into our system, the risk structures associated with the funding, and how a variety of funding streams may be blended together. We seek financial structures that support individualized, family-driven, strength-based and culturally competent care. We know the importance of having a funding structure that allows for the child and family team to make service and purchasing decisions – to drive their plan of care. Ultimately, care is better and more sustainable because purchasing and decision-making is in the hands of the people who know the family best. In Choices' model, care coordinators have ultimate fiduciary responsibility. This is one of our first focuses as we begin to serve a new community.

Several funding structure elements can and do differ among Choices' sites. At the highest level, several differences exist in terms of how state, county, and local government's fund children's services. In some states, individual state agencies control all of the dollars; in others multiple agencies have combined dollars that are managed in aggregate. In yet others, all decisions are made at a county level. In some contracts, funds are appropriated for youth who meet certain eligibility criteria, often as a result of a lawsuit. In other contracts, funds are part of general funds with no criteria attached. All of these structural elements can impact the financial model that is chosen and the manner in which the funding flows to Choices and, ultimately, the youth and families. One funding component present in most of Choices' contracts is the case rate; however, even case rates do not look the same. In the Indiana projects, a single case rate pays for everything – care coordination, administration, services (including placement), and discretionary funds. In Ohio, the case rate pays only for services. In Maryland, the case rate in some contracts pays for care coordination and administration, and in others the case rate only pays for care coordination. The simple concept of a case rate can be modified to fit the

funding climate, the funder needs, the chosen risk structure, and the program goals. So many variables are involved with case rate development that it is not good practice to compare rates across environments.

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Another important difference between funding models is the risk structures associated with them. Risk structure simply refers to which entity carries the risk – the funder or Choices – or the model may employ a shared risk structure. It is important to understand that no structure is better or worse than another, they are just different. It is equally important that all involved understand who bears the risk in any particular situation and that measures are taken to ensure that the one bearing risk is fully equipped to deal with it. A funder might question why it should ever want to assume the risk. As will be evident from the following discussion, often the entity that assumes the most risk also has the most control.

The Indiana funding models are high risk for Choices and very low risk for the funder. The model is good for the funder because it has fixed costs, any overages are the responsibility of Choices, the funder can quickly scale the project up or down to meet its needs, and it knows Choices has an incentive to keep costs low. On the other hand, Choices has all of the control to operate as it sees fit and it keeps any profits. As a result, this structure provides good growth opportunities for Choices. Perhaps the biggest down side to this model is that the funder can bankrupt the project by simply cost

shifting or starving the program with a lack of referrals. Whenever Choices enters this type of risk structure agreement, we have to feel comfortable that the funder has the right intentions.

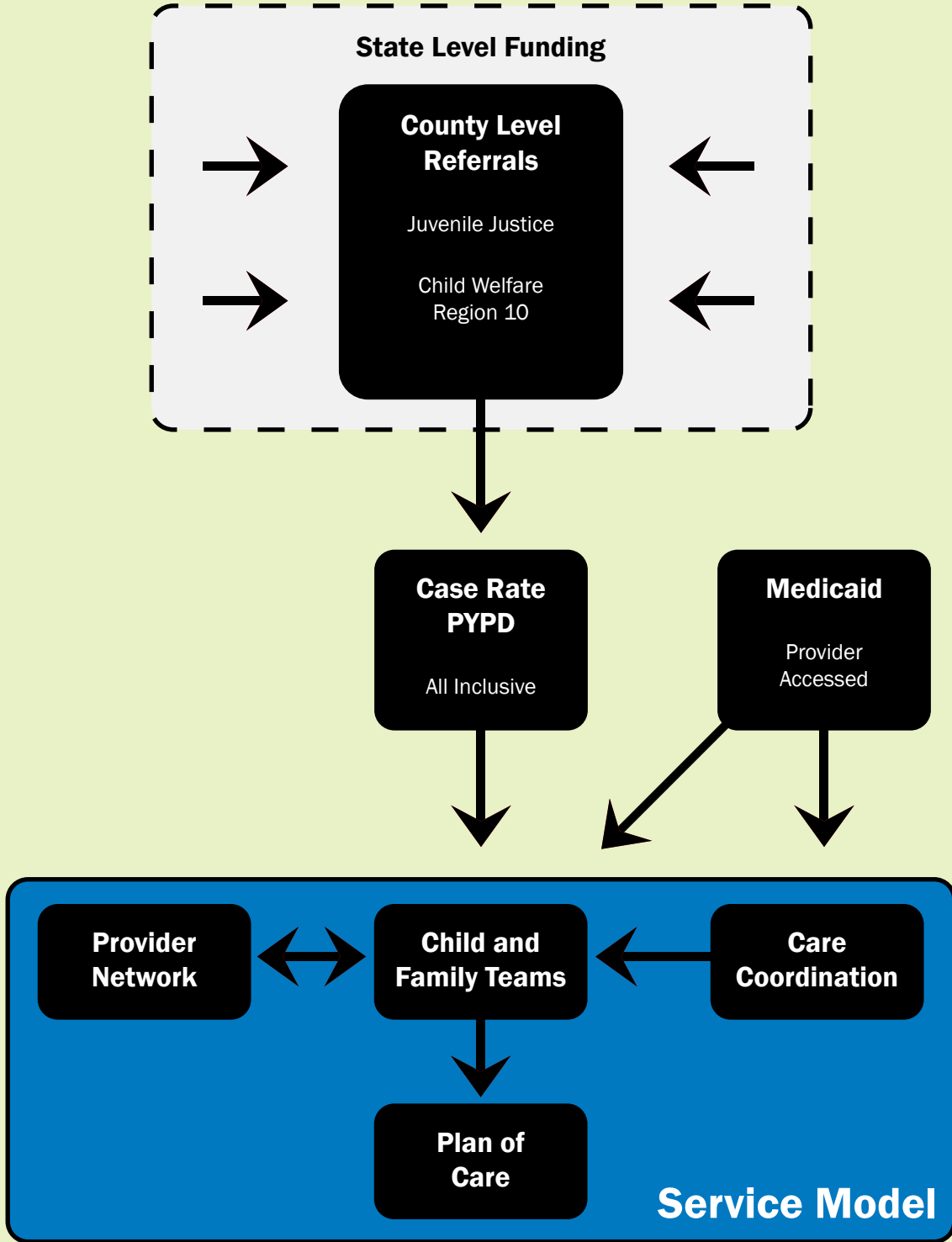


Shared risk models like those in Maryland and Ohio are exactly that, shared risk. This is arguably the most fair model, as it ensures equal interest in success for both parties. In Ohio the funder pays for some basic structure; therefore, it is incentivized to use that structure ensuring Choices a certain amount of business over time. Choices receives a case rate to pay for services; therefore, we have an incentive to keep service costs low. The Maryland model is still shared risk, but in the opposite direction. The funders reimburse dollar for dollar on service costs; therefore, they have to deal with the budgeting for fluctuating service costs. Choices has a case rate to pay for care coordination (and in one contract also administration); as a consequence, Choices has to manage a fluctuating census and work to keep care coordination and administration costs low. One of the drawbacks to this type of a structure is that it can be more rigid. It can be harder to scale these models up and down and they provide limited growth opportunities.

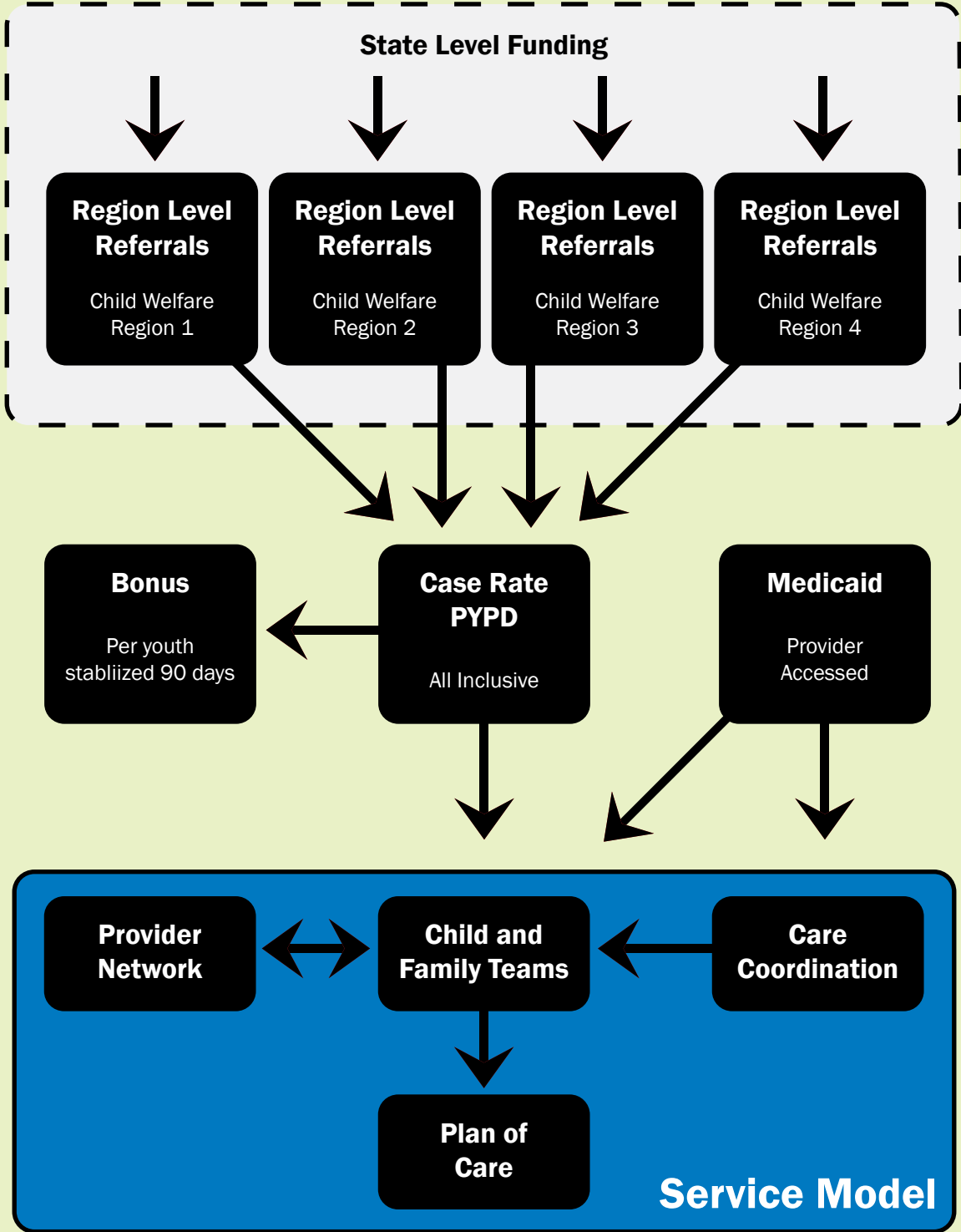
High funder risk and low Choices risk models are like those we have in Washington, DC. These are often fixed annual budget contracts (i.e., Choices is

paid 1/12th of the value of an approved budget every month) or cost reimbursement contracts (i.e., Choices is reimbursed for approved costs after the expenditure is made). Choices assumes little risk in these models as we have a fixed stable cost. Although the funders must react to changing costs, they also have greater control over how the money is being spent by requiring and approving budgets and reviewing expense reports. These funders know precisely how and why their money is being spent. Sometimes funders prefer to take the risk knowing that they have this kind of control.

Financing Structure



Financing Structure



Indiana Projects

Choices operates two system of care programs in Indiana, both of which receive state funding through the Indiana Department of Child Services.

The Dawn Project

The Dawn Project is Choices' system of care in Marion County, Indianapolis, Indiana that has been in operation for 13 years. It serves youth with emotional difficulties and/or disabilities who are referred by the child welfare or juvenile court systems. Dawn serves the typical referred youth for 10-13 months, with an average length of stay over the last fiscal year of 12 months. The goal of the Dawn Project is to develop and implement a single plan of care that will enable the youth to return to and/or remain in his/her home with natural or otherwise sustainable support for the youth and the family with the ultimate goal of ending system involvement.

The Dawn Project receives its funding in the form of a case rate that is paid by the referring agency. In other words, if child welfare refers a youth then child welfare pays the per youth per month case rate. A case rate works like an insurance premium. The referring agency pays a fixed amount per youth per month and the Dawn Project provides any services the youth requires. In some instances, we spend more than the case rate on a youth and in other instances we spend less. The goal is to balance out in the end.

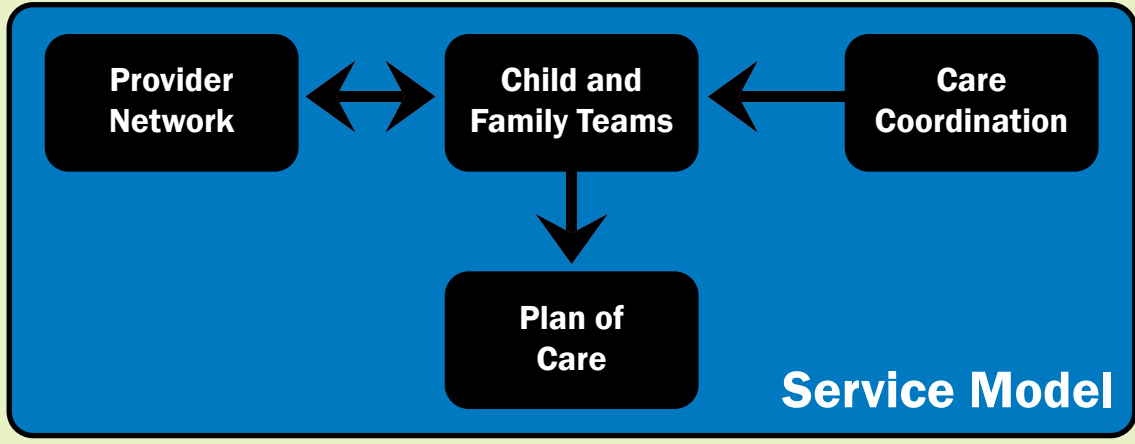
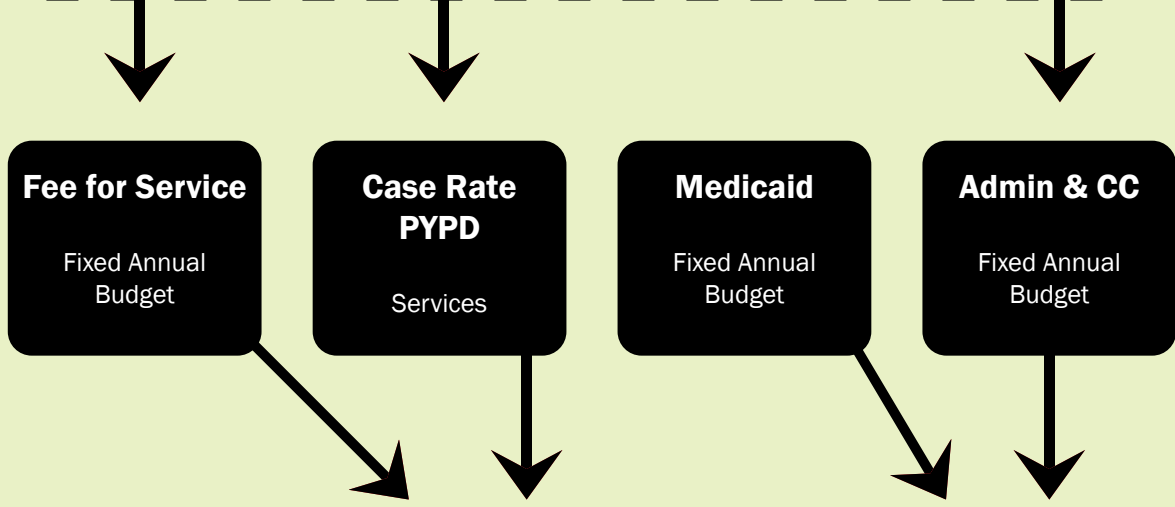
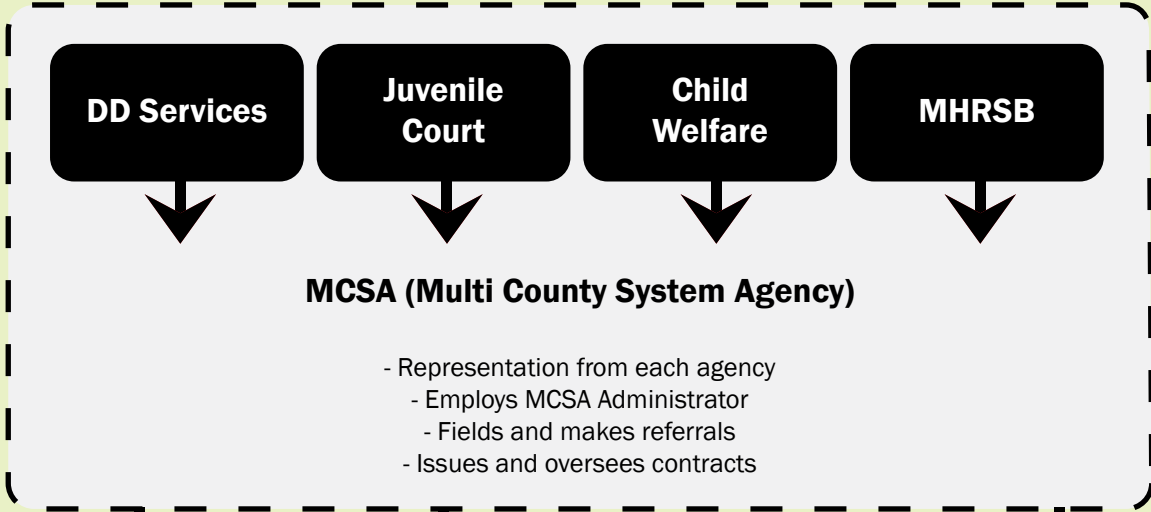
The case rate for Dawn is an all-inclusive rate – it covers care coordination, administration, out of home placements, services, and discretionary expenses. No other funding for Dawn exists outside of the case rate; however, Dawn does use Medicaid when possible by referring to providers who can bill Medicaid for the services they provide to youth or their families. For the Dawn Project tiered case rate determination, Choices enlisted the help of Anthony Broskowski to develop a cost model to aid in case rate setting decisions. Broskowski's methodology of setting up a shared risk arrangement for child welfare departments continues to be used nationally in Florida, Nebraska, Ohio, and Washington state.¹⁹

Northern Indiana Team Choices (NITCH)

This project began in September 2010. NITCH serves Indiana Department of Child Services (DCS) Regions 1-4, 20 counties in Northern Indiana. NITCH's primary office is in Merrillville and satellite offices are operated in South Bend and Fort Wayne. NITCH serves only youth residing in residential treatment facilities or group homes. The purpose of this project is to move youth to less restrictive placements based on DCS data that youth are "over placed" in these regions. Youth are referred by DCS in large cohorts for a six month length of service. NITCH receives its funding as a per youth per day case rate that includes care coordination, administration, services, and out-of-home placement. Choices also receives a bonus payment for each youth stabilized for a minimum of 90 days in a less restrictive placement.



Financing Structure



Ohio Choices

Ohio Choices is the system of care site in Hamilton County, Cincinnati, Ohio which has operated for 9 years. It serves youth involved in developmental disability, juvenile justice, child welfare, and mental health systems. Like the Dawn Project, the purpose of this project is to develop and implement a single plan of care that will enable the youth to return to and/or remain in his/her home with natural or otherwise sustainable support for the youth and the family with the goal of ending system involvement.

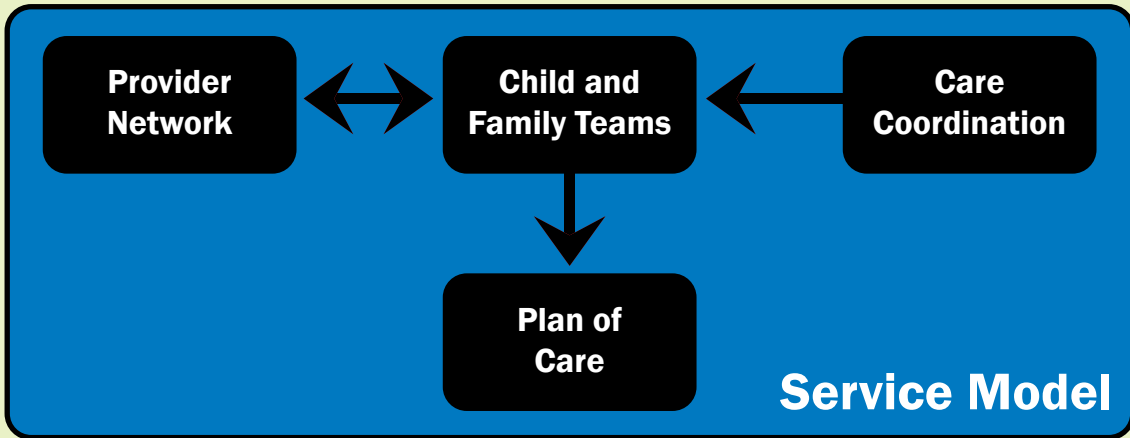
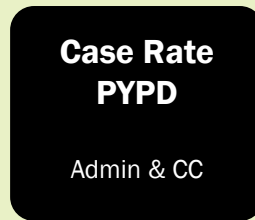
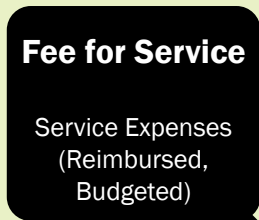
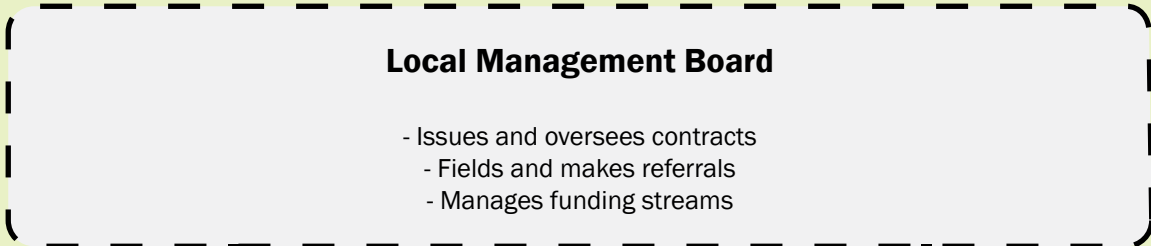
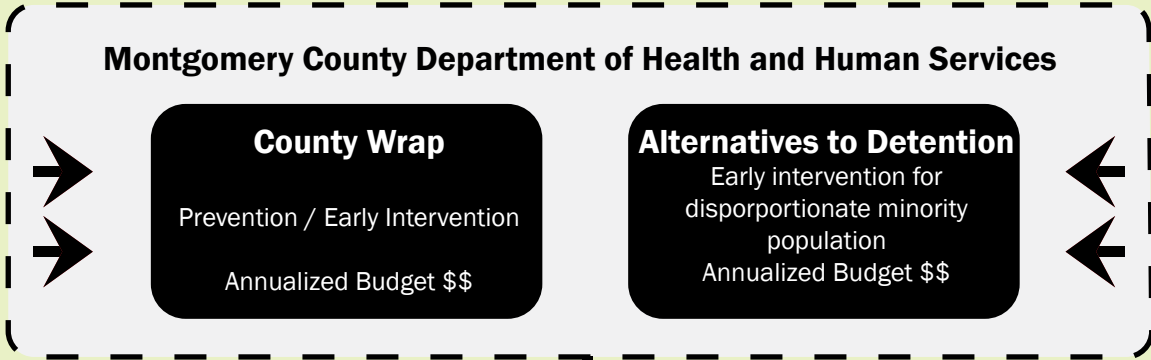
Ohio Choices' funding structure is one of pooled funding. The four child serving agencies contribute funds into a pool of money to serve youth through the system of care. An organizing body was created in order to manage that pooled money, the Multi County System Agencies (MCSA). The MCSA is made up of a representative from each of the contributing agencies. It is staffed by an administrator that was hired by the child serving agency representatives to the MCSA. The purpose of the MCSA is to field and make referrals from each of the contributing agencies as well as issue and oversee contracts.

Ohio Choices operates under a case rate funding structure, but it is not all-inclusive. In this instance, the case rate only pays for service expenditures. Ohio Choices has a separate fixed budget for care coordination and administration which is paid irrespective of the number of youth served. Ohio Choices also has a fixed budget for Medicaid that flows through mental health and can be used to help pay for care coordination or services. The Medicaid portion of the budget is a fixed amount because of the local match requirement. In addition, Ohio Choices has a fee-for-service funding stream that is used for inordinately expensive youth with little hope of stepping down in severity. These are often youth with developmental disabilities that need extended, on-going support until they transition to the adult service system. The MCSA along with Ohio Choices reviews and agrees upon which youth will pull from that funding stream.

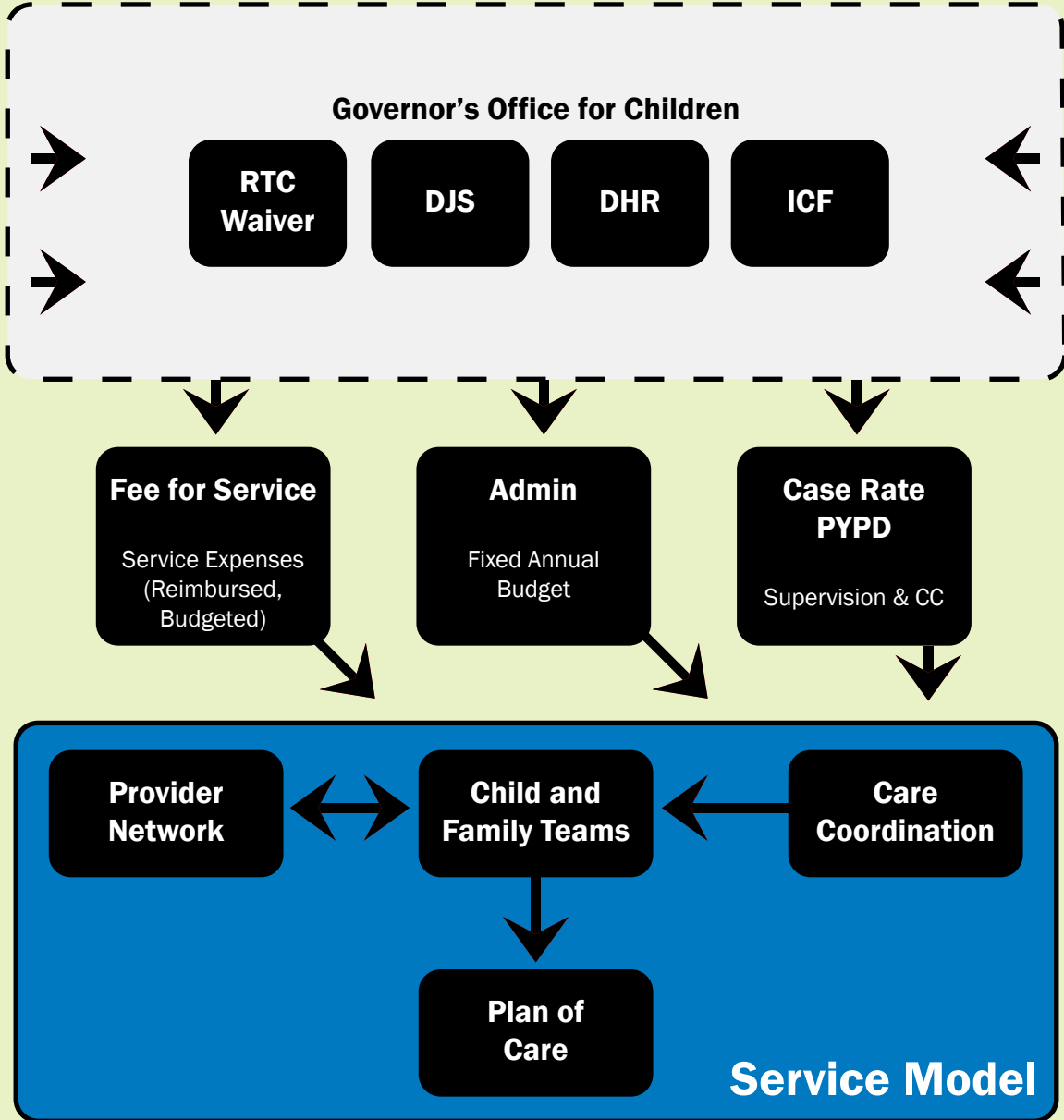


The populations served by Choices are as diverse as the funding models used to serve them.

Financing Structure



Financing Structure



Maryland Choices

Maryland Choices is the system of care using the wraparound service delivery model serving the northeastern region of Maryland, a nine county area of the state. It is funded both by the Governor's Office for Children and through county contracts from Montgomery and Baltimore Counties. Like the Dawn Project and Ohio Choices, the purpose of this project is to develop and implement a single plan of care that will enable the youth to return to and/or remain in his/her home with natural or otherwise sustainable support for the youth and the family with the goal of ending system involvement.

Although this model looks similar to Ohio Choice's structure, a crucial difference exists – the funds are not pooled. Each funding stream is kept separate. Each has its own eligibility criteria, and each has its own contract (reporting) requirements.

State Agency Funding

Maryland Choices has a contract with the Governor's Office for Children to serve youth in nine (9) counties, Allegany, Baltimore, Carroll, Frederick, Garrett, Harford, Howard, and Montgomery. This funding is provided through the Maryland Children's Cabinet. The intent of this funding is to serve youth through the RTC Waiver to return and divert youth with serious mental health needs from Residential Treatment placements, as well as to return and divert youth involved with the Department of Juvenile Services and the Department of Human Resources from group home placements. Each funding stream is managed separately to ensure accountability to each agency involved.

In this particular model, Choices has a case rate that includes care coordination and administration. Services are paid on a reimbursement basis.

County Funding

Maryland Choices has local funding in both Montgomery and Baltimore Counties.

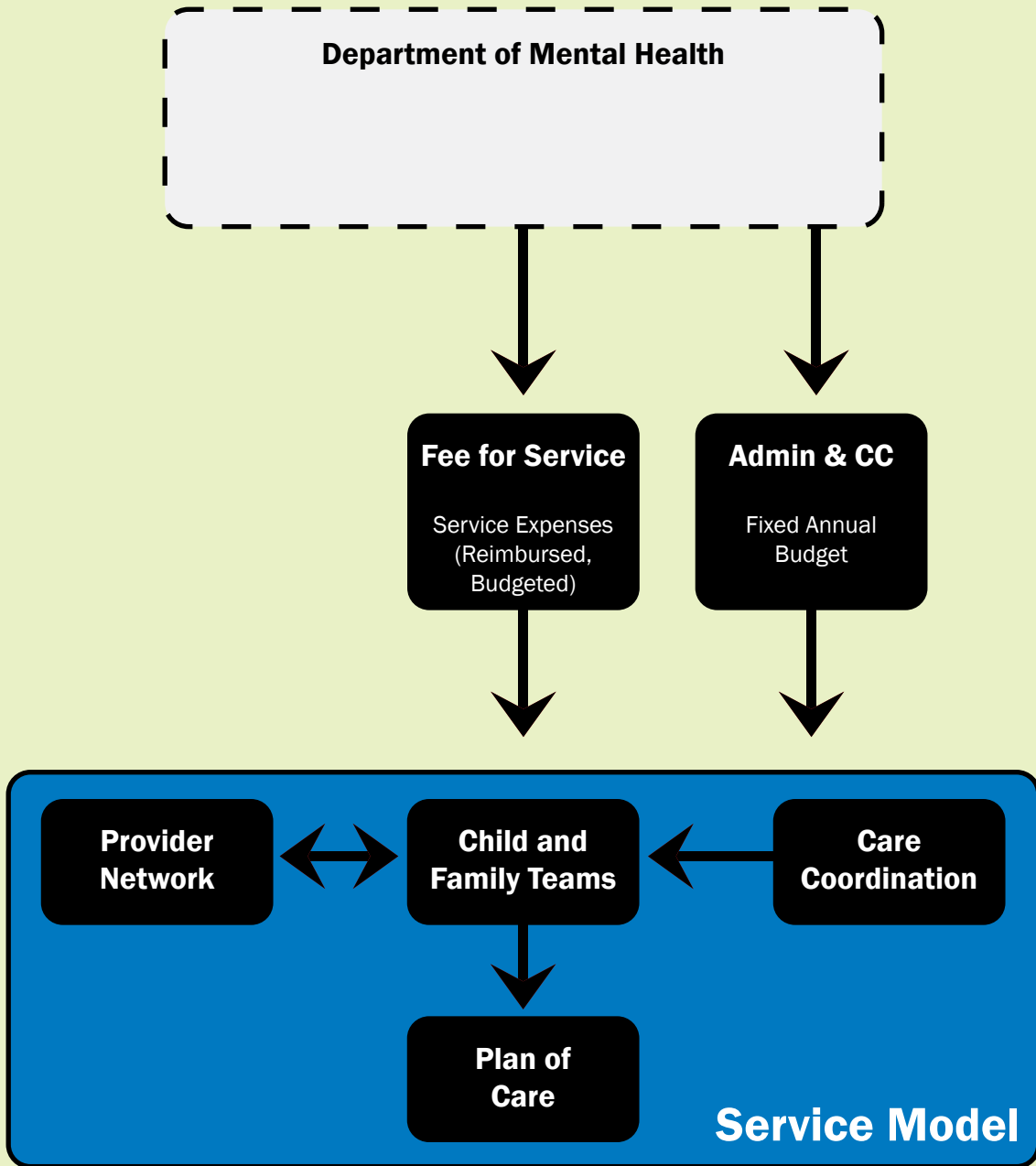
Baltimore County is locally funded through the Local Management Board and allows Maryland Choices serve youth in a Voluntary Placement

Diversions program. The purpose of this program is to prevent parents from having to relinquish custody of their youth to the Department of Social Services in order to get services to address the young person's needs. This program allows families to remain intact by preventing out of home placement and custody relinquishment. In this model, Choices has a case rate that includes care coordination and administration. Services are paid on a reimbursement basis.

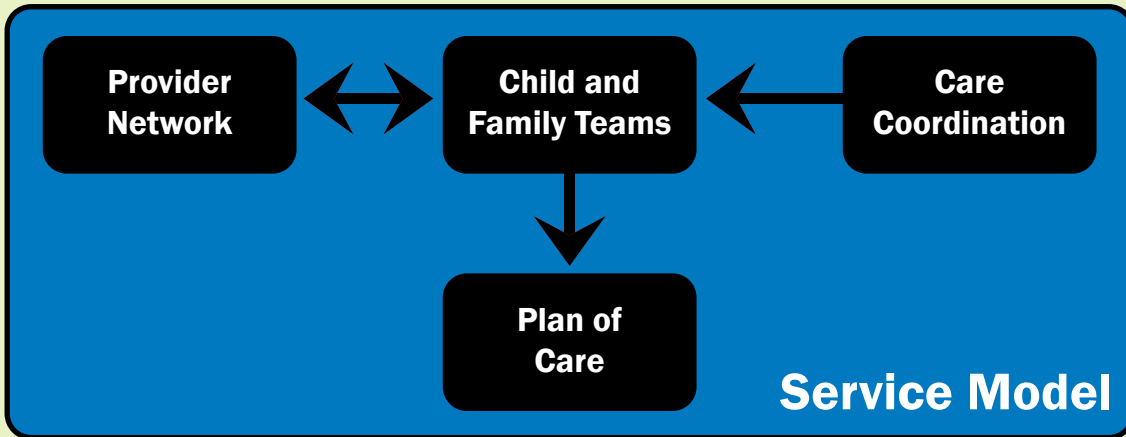
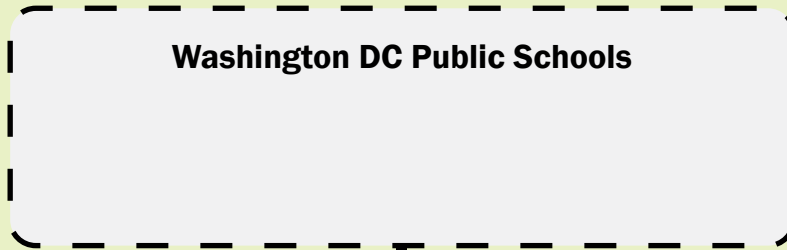
Montgomery County is locally funded by both the Collaboration Council and Montgomery County Department of Health and Human Services – Child Welfare Services. The Collaboration Council receives funding from the Montgomery County DHHS and the Governor's Office for Crime Control Prevention (GOCCP). These contracts are referred to as County Wrap and the Alternatives to Detention. The goal of both of these programs is to prevent youth and families from seeing higher levels of care to manage their youth's behaviors and mental health needs. Additionally, Alternatives to Detention focuses on addressing the issues surrounding disproportionate minority youth contact with the juvenile justice system. In this model, Choices has a case rate that includes administration, care coordination and service dollars.

Additionally, Maryland Choices has a direct contract with Montgomery County DHHS to serve as their Interagency Family Preservation Services provider. This program is an intensive 14 week model where we use the principles of systems of care and the structure of the wraparound child and family team build individual service plans with parents and youth to meet their needs. This intensive model uses the providers in our provider network to quickly and intensively respond to the needs identified by the team and stabilize the family to prevent further Child Welfare involvement or out of home placement. In this model, Choices has a case rate that includes care coordination and administration. Services are paid on a reimbursement basis.

Financing Structure



Financing Structure



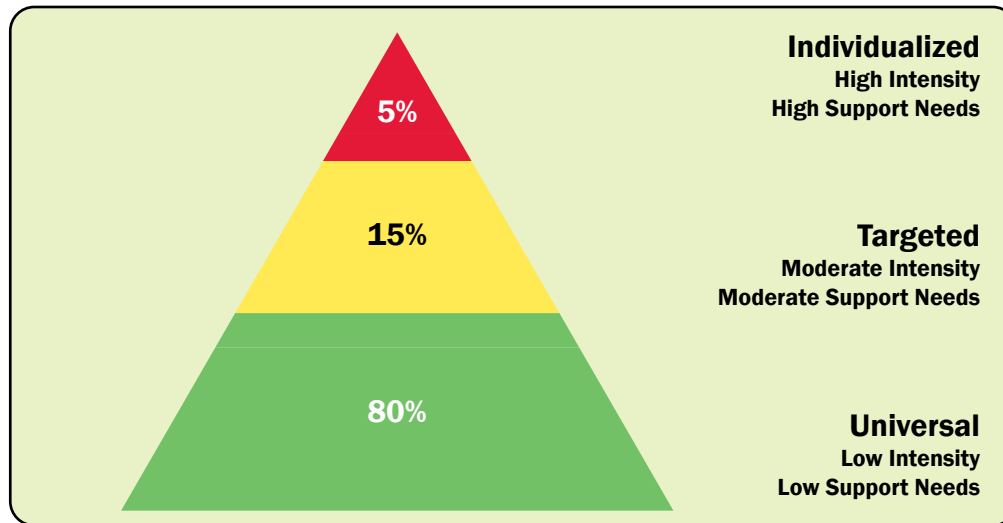
DC Choices

Choices' program in the District of Columbia includes two separate funding streams: the Department of Mental Health (DMH) and DC Public Schools (DCPS). The purpose of the DMH project is to develop and implement a single plan of care that will enable the youth to return to and/or remain in his/her home with natural or otherwise sustainable support for the youth and the family with the goal of ending system involvement. Like the Maryland Choices' contract, an annualized budget for care coordination and administration is paid monthly in one-twelfth increments and service expenses are reimbursed.

The purpose of the DCPS project is to provide school based wraparound to youth at risk of expulsion and/or suspension in the schools. This contract is full reimbursement of staff and administrative expenditures with a pool of discretionary funds available for services not Medicaid eligible.



Local Decisions



Because funding structures associated with a case rate can look quite different, we have provided a description of how Choices helped Marion County, Indiana, work through a recent decision to develop and adopt a multiple case rate funding structure for the Dawn Project. Choices uses the thought process found in *Good to Great* by Jim Collins, “First Who, Then What.”

First Who

When a community is tasked with determining the right case rate structure for them, they must first answer the question “Who?” – Who do we want to serve? In what age range, in what geographical area, with what needs? It is important to define the population to be served as specifically as possible.

The triangle above represents all youth in any community – your community included. The majority of youth, about 80%, have low levels of need. They may or may not be considered at risk, but they are the least costly to serve. There is a smaller population of youth, approximately 15%, who have moderate levels of need. These youth would cost more to serve than the prevention youth, but less than the intensive youth. Finally, an even smaller population of youth, approximately 5%, who have high levels of need. These youth are the most costly and most complex youth to serve. Even though this represents the smallest portion of youth, the

majority of the service dollars would be directed to these youth.

Originally, the Dawn Project was geared toward these high need/high cost youth. If the majority of the resources are going to these youth, it makes sense that the community would try to figure out how to serve these youth better. The impetus for the recent case rate revision came from Marion County discussions focused on how to more effectively serve system-involved youth. “How can we take what has proven to work with Dawn to other populations?” was the question posed by Marion County Department of Child Services and Marion Superior Court Juvenile Division. The targeted youth have typically been in the child welfare or juvenile justice system for two years or more and have proved challenging for the system to serve through traditional services and support; however, they have not yet risen to the level of intervention for which the Dawn Project was created.

Choices has long been a proponent of using the Dawn model to intervene with youth earlier in their time of system involvement. Researchers have found that the earlier youth participate in wraparound, the more likely they are to meet their treatment goals.²⁰ Choices staff believe that for many youth and families, implementing this model of care earlier in their system involvement could prevent further

involvement with child-serving systems. After hours of conversations, brainstorming sessions, and planning meetings with our referring agencies, it was decided that all system-involved youth should have access to the services of Dawn in order to prevent deeper penetration into the system. Thus, the “Who” question was answered.

Then What

Managed care literature²¹ identifies three things that need to be known or estimated in order to set and manage a case rate: how many youth will use services, how many units of services each youth will use, and how much does one unit of service cost. For the Dawn Project, the next questions that needed to be answered by the funder included, “What do we want a case rate to include? What services do we want to provide? What do we want to pay for aside from the case rate? What level of risk are we willing to share with the care management entity?”

Some or all of the following can become part of a case rate: care coordination, administration, placements, services, and discretionary dollars. If not paid via a case rate, some of these expenditures will need to be paid via a cost reimbursement, such as care coordination and administration. A community may decide that other costs will be restricted to some specific amount, such as specific services, and some may not be available at all, such as discretionary dollars. The community may wish to pay for some items, such as placement, outside of the contract altogether.

In the Dawn Project, it was determined that all of the items above would be included in the case rate, with different service tiers. Because Dawn already served youth who could logically be divided into two tiers – residential treatment and intensive (at risk for residential treatment) – it seemed logical that a third tier could be *early intervention* and a fourth *prevention*.

Then, a method for effectively assigning youth to tiers was needed. The collaborating partners decided to use the CANS Assessment²² as a central component of this assessment. With CANS data already collected on youth served by the Dawn Project, as well as readily available service and cost data, Choices identified variables most associated with higher costs of care and that information was used to identify services that youth in each tier might require.

Clearly, many decisions are inherent in the development of a case rate. Choices has proven experience in this area which, when coupled with our flexible funding structure and our strong clinical model, will enable Choices to effectively serve the at-risk youth and the systems entrusted with their care.

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