

THE FUTURE OF CARE:

SURROUNDING CHILDREN AND
FAMILIES WITH COMMUNITY
SUPPORTS AND SERVICES
TO REDUCE OUT OF HOME
PLACEMENT



CBHNY

NY State Coalition for Children's Behavioral Health

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INTRODUCTION AND METHODS

New York State plans to comply with the federal Family First Preventive Services Act (FFPSA) by 2021, reducing reliance on congregate care from 16% to 12%. In general, the anticipated impact of the reform is to rely on the expanded use of evidenced based-preventive services to support reduced reliance on congregate care services. Another result of this transformation can be measured by the well-being gains of families and children who otherwise might be placed out of home. The purpose of this paper is to identify innovative treatment and supports for children in community-based placements and answer the question:

**WHAT MEDICAID OPPORTUNITIES
HAVE BEEN USED TO IMPROVE
CHILD HEALTH, SAFETY,
PERMANENCY AND WELL-BEING?**

New York is well ahead of all other states because stakeholders have identified that the key to a successful future is going to be growing a mix of effective, appropriate cross systems services within the child serving agencies. Some of the growing mix includes:

1. the early adoption of Evidenced Based Practices in the Metropolitan New York area;
2. the Children's Medicaid Redesign's belief that managed care will provide assurances that youth in foster care receive quality health and behavioral health services;
3. the addition of care management to the State Medicaid Plan in 2016; and
4. the expansion of an array of Waivered Home and Community Based Services (HCBS) available to a limited number of children and Child and Family Treatment and Support Services (CFTSS) as State Medicaid Plan services available to any Medicaid eligible child who needs them.

The methods of identifying the exemplary programs and services included surveying, interviewing, and meeting with Chief Executive Officers and senior program managers of 11 not-for-profit agencies certified and designated in New York State to provide both Medicaid mental health services and foster care services. In addition, two family focus groups were held, allowing access to the thoughts and experiences of 32 family members with experience as foster parents, adoptive parents of foster care youth, kinship caregivers or biological parents of children with severe emotional disturbance (SED). In addition, to collecting information from the field, the 11 not-for-profit agencies and 3 family representatives were asked to review and edit this report and verify the fiscal modeling of the selected services and programs.

The agency histories and practices that informed this work product exemplify the trend to reduce congregate care beds. The sample agencies reduced beds from 1,733 in 2002 to 604 beds in 2018, a reduction of 1,129 beds. More importantly the same agencies served the same number of children during the bed reduction time frame (2,314 children in 2008 and 2,297 children in 2018). Three agencies with the greatest change over a ten-year period included a single agency that reduced congregate by 508 beds; one agency that reduced beds by 284 beds; and one agency that reduced beds by 82 beds.

Overall, the bed reduction represented 40% of the 2002 capacity.

These agencies have a transformation story to tell and are clearly embracing and working in support of the research about child development and the value of positive connections to youth development.

The key to a successful future is going to be growing a mix of effective, appropriate cross systems services within the child serving agencies.

**WHY MENTAL HEALTH
SERVICES ARE
NECESSARY SUPPORTS
FOR FOSTER CARE
YOUTH IN COMMUNITY
PLACEMENTS**



Why are so many states turning to Medicaid funded services to stabilize the living situations of kids in care? The principal reason is because Title IV-E has been identified in the authorizing legislation as the “payer of last resort.” In the medical and mental health field, Medicaid is typically the payer of last resort after other forms of insurance have been exhausted. However, a review of the literature on the health and mental health needs of children in foster care, when compared with children not in foster care, gives another clear answer: the children need access to specialized services and without those services, the families and caregivers cannot maintain the children safely in the home and community setting.

As reported by the Children’s Hospital of Philadelphia Policy Lab after a recent meta-analysis, 39% of children less than seven years of age in foster or kinship have a developmental delay, with cognitive problems occurring in 23% and motor delay occurring in 16% (Vasiliev & Petermann, 2016). Yet few of these children have access to thorough developmental screenings on a regular basis, despite Early and Periodic Screening, Diagnosis and Treatment requirements for state Medicaid compliance standards. In New York, the new State Plan services, called Child and Family Treatment and Support Services (CFTSS) were added under the early and Periodic Screening, Diagnosis and Treatment benefit. However, both state and federal enforcement of access to the benefit needs improvement. New York will rely on Medicaid Managed Care Organizations to track access to the necessary screenings once the foster care population is added to Medicaid Managed Care on July 1, 2020. However, an October Government Accountability Office (GAO) report, entitled, *Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings* confirmed that not all children in Medicaid are getting required preventive screenings and CMS should set clear goals and performance targets for states and better monitor access to the screenings.

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The transition of foster care youth into Medicaid Managed Care sets the stage for better compliance with EPSDT standards, and will measure managed care plan performance against how many of their young covered lives (children) actually access services they have been identified as eligible for and are medically necessary.

In addition, children in foster care are disproportionately burdened by mental and behavioral health challenges (Turney & Wildeman, 2016). The most common diagnoses are oppositional defiant disorder, conduct disorder, reactive attachment disorder, adjustment disorder and mood disorder (Steele & Buchi, 2008). When compared with child not in foster care, children in placement are:

- 3 times as likely to be diagnosed with attention deficit disorder or attention hyperactive disorder;
- 5 times as likely to have anxiety;
- 6 times as likely to have behavioral health diagnoses; and
- 7 times a likely to have depression or depression symptoms (Turney & Wildeman, 2016).

As health care reform efforts integrate behavioral health, treatment, supports and screenings into mainstream health insurance coverage, New York will be ahead of the curve, once again. The transition of foster care youth into Medicaid Managed Care sets the stage for better compliance with EPSDT standards, and will measure managed care plan performance against how many of their young covered lives (children) actually access services they have been identified as eligible for and are medically necessary. Clearly, the literature confirms that access to innovative Medicaid-covered behavioral health services add value to the lives of kids in care – what else can it achieve?



IN THEIR OWN WORDS

Which services are valued most by parents, caregivers, family members and kin?

It is commonly expressed by families that they experience a substantial mismatch between their needs and what services are available or allowable. Our outreach and discussion with nearly 40 caregivers, grandparents, foster parents, adoptive parents and biological parents of children who have experienced residential placements was no different. We engaged three professional parent partners, those working in the field as family peer advocates, care managers or family peer supervisors but who have lived experience in the children's mental health or child welfare systems, to assemble two family focus groups. The events, held on September 30th and October 8th allowed parents, grandparents, and caregivers to be honest brokers describing their needs and the needs of the children in their care; what worked for their families; and from their perspective why the array of supports they deem necessary should drive the programs, supports and services delivered by providers.

Our goal was to have participants identify “what helped them most” in keeping their children out of residential, in their foster home, in their adoptive home, in their kinship placement or successfully returned home after residential placement. In their own voices, here are the most common programs, services and/or characteristics of care that our families identified as a benefit to their success:

Continuity of Workers “The hardest time is between programs, support us with a slow transition and what really worked for us is a worker who followed my child from program to program and really had a relationship with my son.”

Family Peer Support “Other parents are magical. Listening to parents is a first step and a peer sometimes can hear what is said no matter HOW it is said. It is good to talk to someone who is familiar; I need someone who knows what I need and what my kid needs and my family peer advocate is that person.”

Common Sense Parenting “I can’t tell you how often I went back to what I learned from that first service! It taught me how to make sure my caseworker back up my choices and preferences; It taught me how to be patient while my child communicated his frustrations; It was in a group, so I met other families and we all need friends so we don’t feel alone.”

Immediate Access to a Crisis or Respite Bed “When you need a break, you need a break. When your child is in a crisis, they need someone or someplace who knows them. There are just times when I need to replenish my energy and hope. Time for me and my child to get back to baseline and a familiar voice is calming.”

Group and a Peer Mentor for my Child “Kids don’t get relationship experiences because they don’t have the social skills or opportunities. Making the group opportunity happen (transportation) and keeping a few relationships stable helped my daughter trust others.”

Supervised Visitation Support/Skillbuilding “Help with planned activities and gave a place for all of us to practice the crisis or treatment plan; or in-home practice of the skill with someone who is witnessing the strengths and barriers to the transition/reunification. It helped if someone supported the role-play and responsibilities in the home – for meals, getting up for school, cooking, homework, laundry, personal hygiene, sibling support or other tricky times of the day or triggering situations.”

There are just times when I need to replenish my energy and hope. Time for me and my child to get back to baseline and a familiar voice is calming.

**IT IS COMMONLY
EXPRESSED BY FAMILIES
THAT THEY EXPERIENCE A
SUBSTANTIAL MISMATCH
BETWEEN THEIR NEEDS
AND WHAT SERVICES ARE
AVAILABLE OR ALLOWABLE.**



Not all the highly recommended services by family members fit into the service array under Medicaid managed care in New York. However, many of services are included as State Plan Services or HCBS and as we move through the case study segment, we will attempt to link the family recommendations to the service array.

A key to success and a service not robustly supported by Medicaid is transportation. Families uniformly mentioned transportation as necessary, no matter what service or program was identified. Many said that they have already experienced the loss of transportation because of changes to their Home and Community Based Services (HCBS) array. Others, without identifying how the transportation happened were grateful that transportation to group and therapy was part of the services they could access, with or without their child. In lieu of transportation, families would like to meet on phone or via telehealth with the many different workers in their and their children's lives.

The families expressed frustration and concern about worker turnover and said it is helpful to have someone who knows your family to call upon – not just anyone who can provide generic advice, but someone who is really ON YOUR TEAM. In the clearest terms, the relationships lost when workers turnover is a loss for the family, too. Families want worker turnover made easier on them by having provider plan ahead and make sure the staff is familiar with that family.

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With regard to managing their own care needs and their child's, most families identify the value-added by the concept of Health Home Care Management. Because of the potential complexity of their medical needs, children in the foster system require well-coordinated care and complete health information and accurate information relating to consent. While still a relatively new service, families are encouraged that care coordination is available for about 22,000 children in New York.

Many families expressed concern that crisis response was intimidating and worrisome and often resulted in police or emergency services being the resulting intervention instead of someone coming out to do an assessment and providing immediate feedback and planning for after crisis. Making crisis intervention more likely to be a face-to-face intervention with a trained professional and less likely to include law enforcement was the favored recommendation.

Overall, families want providers focus on improved parenting skills, reducing conflict and establishing environment that allows parents to fulfill responsibility to raise their children. Foster families and kinship family members were the most vocal in supporting access to mental health services for the children in their care and that providers “take down the walls between home/school” because there are very few issues that are “school issues” or “home issues”. Kinship family members and adoptive parents who had experience as certified foster homes said they were happier without the continued caseworker involvement.



INNOVATIVE CARE AND TREATMENT PROGRAMS AND AGENCIES

According to caregivers and providers, children who are at risk of losing placement and/or frequently in crisis, need services with a certain level of intensity. They need a program that will wrap around them and will work with the school, the parents, and provide the treatment in the community, in the settings where situations develop. Services that fit this description are being offered by four of our participating agencies.

THERAPEUTIC CRISIS RESPITE PROGRAM (TCRP)

This grant funded and community Medicaid funded services is being offered at an agency that closed all but 28 of its congregate care beds in the Central New York Region. This service focuses on patient engagement and continuing respite.

Model: Designed for youth who are experiencing a crisis requiring a need for temporary out of home stabilization with intensive family focused services interventions and delivery. “Crisis” may be defined individually, but generally youth present with behavioral needs, not meeting inpatient criteria, but presenting with a need for immediate support. Youth participate in respite, with intensive family engagement and involved for two-weeks. During the initial two weeks, the youth is rapidly evaluated and needs are assessed. The Treatment Team then matches services and supports to those needs. These could be clinical, medical, educational, social, etc. Family needs are assessed and addressed. Staff model coping skills with both the youth and the family. Following the two weeks, youth enter the aftercare phase. During this period, the team continues to work with the entire family on the skills learned during the respite phase. TCRP remains involved until the family either reaches stabilization or is admitted to another program or service as confirmed by the Treatment Team.

The fidelity is to the whole model, which establishes an intensive connection, rather than a less intensive planned respite model. TCRP is not appropriate to replace emergency care needs due to parental neglect or abuse. If CPS requires temporary relocation of a child, this is not the right service. This program is designed as voluntary to sustain a home or community based placement.

Outcomes: September 2019: 615 Referrals, 352 admissions. All “denials” are referred to alternative programs which would better meet family needs. Nearly 200 “declines” were youth or family refusing participation.

Most youth are Medicaid or MMC – Payor Mix includes commercial (9%), Tricare (14%), UHC (37%), Fidelis (6%) Straight Medicaid (25%) and BCBS (could be either) 10%.

Youth report 10% increase in self-esteem and 15% decrease in depression symptoms; 35% decrease in family difficulties, 20% improvement in self-concept, and 17% decrease in risky behavior. Approximately 80% of youth do not have a readmission into Emergency Department.

Annual Cost: \$1,200,000.00
Program Budget; Revenue generated through Medicaid Health Home Care Management when eligible; Medicaid Off-site clinic billing allowable when youth are in Medicaid Managed Care through the Licensed Behavioral Health Practitioner (LBHP) Benefit; CFTSS when Medicaid and medically necessary and through innovation grants of up to \$650,000.00

Staffing: 11 FTE Child Care Professionals (minimum, Bachelors Degree), 1 Care Coordinator, 1 FTE Clinician – 50% Clinical, 50% Administration; support staff from other Agency Programs (i.e., Education, Health Care, Recreation, Maintenance, Admin, etc.)

Capacity: Six youth at one time in respite beds

Geography: Must be centrally located within service area (no more than 90 mile radius) – this ensures connection to family, services, and education in district of residence without interruption.

Physical Plant of Respite Service: Home like setting with individual bedrooms or double occupancy on a campus to allow for respite visits where recreational and continuation with groups can occur during planned respite stays.

YOUTH ACT

Annual Operating Cost: \$1.6 million revenue generated by monthly Medicaid billing to 3 Medicaid Managed care companies; \$1.85 million revenue generated by monthly Local Department of Social Services rate for the 97 Youth ACT eligible youth. Additional revenue generated for non-Medicaid level of care youth.

Staffing: The ACT team can be staffed by employees or via contracted staffing, but must include a Clinical Coordinator, a Medical Team, a Behavioral Health Team, a Team Leaders, Care Coordinators (6 per 88 youth), Program Assistant, Transition/Employment Specialist and a Family Support Specialist. Optional staff can include Youth Peers and Paraprofessional staff.

Capacity: The Youth ACT fiscal model is based upon a total capped capacity of 175 youth. The capacity has sub capitation based on payer mixed with 97 youth full Medicaid ACT youth (88 allowed to be claimed to Medicaid in any month). This model supports a case mix of Medicaid/Preventive services youth, such that the highest risk youth with diagnoses received services paid by the Medicaid ACT rate (\$1466/month) PLUS and an Intensive local District of Social Services (IDSS) preventive services rate (\$1977/month). Youth just receiving the IDSS level of care and others receiving just a Step Down Level of Care do not bill Medicaid services under ACT monthly payments. The LDSS is involved in referring the youth to the Youth ACT program. To date, it has been used in Central New York for children returning from Juvenile Justice and Residential Treatment Centers to foster family, kinship and biological families to avoid recidivism or additional out-of-home placement.

Geography: Requires partnership with specific LDSS and serves youth living in that county.

This blended Medicaid/LDSS Preventive Services funded service is being offered at an agency that does not operate any congregate care beds in Central New York. The service focuses on individualized treatment needs and engagement with an average length of stay of 13 months.

Model: The Youth Assertive Community Treatment (ACT) team is a community-based program which provides or arranges for services, treatment and support to families with children at significant risk for out-of-home placement. ACT is an evidence-based practice (EBP). Currently, when youth are enrolled at the highest level that bundle Medicaid and LDSS funding, the provider is responsible for the first 60 days of placement out of the home. This risk-bearing model has much to offer providers that are being asked by payers to deliver Value Based Payment arrangements under Medicaid Managed Care plans.

The ACT team offers a point of responsibility for serving youth in the youth's home community, preserving family integrity and preventing unnecessary out-of-home placement. Success for youth requires both effective treatment and services that are flexible enough to meet families ever changing needs and include a strength-based care coordination model which is child centered and family focused, fundamental to enhancing resiliency, meeting the imperatives of developmental stages and promoting wellness for each child and family.

The Family Services Care Coordination model is used, with a case mix of 12 from any of the 3 levels of service. The team can arrange for or provide Medicaid services such as traditional mental health services at Article 31 or Article 32 clinics, the new CFTSS or Home and Community Based Waiver array: and the DSS paid services can include traditional preventive services like rise and shine, sibling services, group recreational services, and respite.

Outcomes: Since 2012, there has been a 99% engagement rate with only six of 512 youth served staying for less than 30 days in the program. There has been a 91% success rate in keeping children at home and out of institutional care (RTC, JJ, other) and a 26-point reduction on average in children's CAFAS score (A 20-point or greater reduction from intake to the last administration of the CAFAS represents a clinically meaningful reduction).

COMMUNITY BASED EVIDENCE BASED TREATMENT

This innovative approach has allowed a Metropolitan New York agency to close 284 of its 300 congregate care beds since 2010. The agency plans to close its remaining 16 congregate care beds soon by relying on a combination of offsite Article 31 mental health Clinic billing and local district funded Evidence Based Practice Prevention Services Funding.

Model: Grow the use Evidence Based Treatment (EBT) via home and community based delivery to provide families with the most effective and efficient services available. Service model focus began to change in 2007 and the use of offsite clinic billing for EBT's clinical services began in 2010.

Outcomes: 85% treatment completion and a 16% decrease in no-shows with a 161 day average length of stay.

Annual Cost: \$130,000,000 agency with Article 31 licensed mental health outpatient clinic

Staffing: 1 Physician, 11 Licensed Clinical Social Workers, 26 Licensed Mental Health Counselors, 45 Licensed Masters Social Workers, 2 Licensed Marriage and Family Therapists, and 49 staff with limited permits working under the supervision of licensed practitioners of the healing arts

Capacity: Provided 30,891 home visits between July 2018 and July 2019

Geography: 7,000 families served in the community.

Physical Plant of Respite Service: Home and Community Based

**KEY SERVICES WITH
CROSS-SYSTEMS,
MULTIPLE FUNDING
STREAMS: NEW SERVICES
AND EBT'S THAT
SUPPORT COMMUNITY
LIVING**



The acceleration of community-based foster placements is going to require maintaining more children in communities that are already taxed by a shortage of children's behavioral health care services and appropriate family support services. One approach, acknowledged both in the FFPSA and in the new Medicaid State Plan services is to offer the most effective care available, in the form of Evidence Based Practices (EBPs) and Evidence Informed Practices.

We support the provision of care through EBPs because it has a research base that shows proven effectiveness; because EBPs increase the probability of improving patient outcomes; because families deserve to receive the most effective care based on the best available evidence; and because EBPs are recognized to increase engagement. In addition, New York has already received approval from the Centers for Medicaid and Medicare to access Medicaid reimbursement for evidence-based treatment delivered as Child and Family Treatment and Support Services (CFTSS).

Total payment for CFTSS is likely to be less than offsite counseling services provided by Article 31 licensed clinic providers. However, the Other Licensed Practitioner (OLP) counseling and OLP Crisis offer stable reimbursement. In addition, the CFTSS services offer both flexibility and choice to youth and families trying to meet their behavioral health needs. Because many voluntary foster care agencies already provide follow-up and community supports that are equivalent to Psycho Social Rehabilitation (PSR), the addition of a new volume of billable Medicaid options is an attractive option for off-setting costs. What is unique and must remain a focus for the foster care population, is that the services can be provided in home setting or community setting means the setting in which children primarily reside or spend time, as long as it is not a hospital or nursing facility, such as an Intermediate Care Facility (ICF), or psychiatric nursing facility. Therefore the services, and practitioners, can follow children who move from setting to setting, providing continuity of relationships with supportive service providers.

Through "case examples" that demonstrate the use of EBPs, CFTSS and care coordination, this section highlights services that could be provided and paid for by either Medicaid or Prevention funding, or by blending funding to have Medicaid funding enhance an array of services for an individual youth and the possible reimbursement opportunities for that array. The uniform link is that the children are eligible for community Medicaid coverage, the unique characteristics of the child are what govern the services array.

Therefore the services, and practitioners, can follow children who move from setting to setting, providing continuity of relationships with supportive service providers.

OTHER LICENSED PROFESSIONAL, PSYCHO SOCIAL REHABILITATION, HOME & COMMUNITY BASED SUPPORTS AND CARE COORDINATION

Dora is an eight-year-old girl with autism in the custody of her 47-year-old grandmother who works and has few community supports. Grandmother is currently connected with a Parent Advocate, and also regularly looks to her church community for support. The Care Coordinator has mentioned connecting her with an Adult Health Home Care Manager for extra support, but Grandma doesn't feel it's needed at this time.

Dora is struggling with social skills and severe anxiety in public places, including school, and is beginning to show signs of self-destructive and impulse control behaviors exhibited by pulling out strands of her own hair (Trichotillomania). Dora is able to successfully get up each morning and get ready for school, but as soon as she attempts to get on the bus a meltdown occurs. This includes stressed/labored breathing, crying, and self-harm (such as biting her arms). Dora's treatment for anxiety in a formal clinic setting have not been helpful because of missed appointments, usually associated with transportation barriers. Grandma currently does not own a car and regularly takes the bus, which is difficult to bring Dora due to her social anxiety and safety concerns.

Dora's care coordinator regularly collaborates with Dora's school team and her Clinician. After several team meetings, it was decided that she needed additional supports and services to be successful. The care coordinator then made a referral to CFTSS services, and also did a CANS to determine her eligibility for HCBS. She is approved for both. Because she already has a diagnosis, a licensed clinical social worker (LCSW) meets with Dora and grandmother in the home to develop an assessment-based treatment plan. The treatment plan will address the child's anxiety, impulse control and psychosocial functioning in a group setting via CFTSS. Her care coordinator discusses additional service needs with the Grandmother and Dora, and they agree that her HCBS Plan of Care should include twice a month.

The CFTSS provider recommends daily 1-hour Psycho-Social Rehabilitation (PSR) to restore Dora's ability to focus on getting to school. This is aimed to help in reinforcing the cognitive behavioral therapy her LCSW is providing once a week in the home to address her anxiety symptoms and impulse control. Once the morning functioning is restored, the treatment plan will shift the use of PSR to the local playground twice a week, afterschool to restore appropriate social functioning and monitor impulse control in public settings.

The HCBS provider will arrange for 4 hours of respite every other Saturday so that Dora's Grandmother can get relief from her continued role as primary caregiver.

To ensure the highest level of continuity of care, the care coordinator will be regular phone/email communication with the CFTSS and HCBS providers (at least twice monthly) to assess and monitor progress and completion of goals. They will also join the family and care coordinator for a team meeting periodically to brainstorm around any barriers that may occur along the way. This will support all providers in being on the same page in regards to planning and working in the same direction.

Monthly revenue and expenses for Dora's plan of Care, include:

- OLP assessment one-time 1.5 hours = \$185.00
- OLP counseling 1 hour once a week @ \$141.00/hour
- PSR 1 hours 5 times per week @ \$60/hour
- HCBS Caregiver Support 2 hours once a month @ \$96.86/hour
- HCBS 4 hours of Planned Respite 2x per month @ per diem \$223.40
- Care Coordination \$185 CANS Assessment, Medium acuity monthly rate \$450

Total one-time revenue: \$462.50 (CANS and OLP assessments)

Total Revenue/month = \$2,854.52 Total Cost/month = \$2355.00

It would be possible to support a treatment plan like this through Medicaid HCBS funding and CFTSS funding.

CRISIS INTERVENTION, OTHER LICENSED PROFESSIONAL, AND COMMUNITY PSYCHIATRIC SUPPORT & TREATMENT

At the end of the school day, Priya, a nine-year-old girl in the care of a Putnam County foster family, exhibits aggressive behaviors including hitting and kicking peers, yelling profanities, and spitting at staff while boarding the school bus. School staff intervened to protect the health and safety of both Priya and her peers but are unable to de-escalate the situation every time it occurs and is often unable to calm down enough to maintain her own safety or the safety of others. School staff typically remove Priya from the situation by bringing her to the school social worker's office. The school social worker call the Crisis Intervention team in the area. The Crisis Intervention team, composed of a Licensed Psychologist and Family Peer Advocate met with Priya at the school. The Licensed Psychologist conducts an assessment to determine if Priya is at risk for harming self or others, while the family peer advocate met with Priya's family and the school social worker to discuss foster communication about ongoing options within CFTSS.

The school social worker and foster parent agree to an ongoing need and two additional CFTS services are recommended: Other Licensed Practitioner and Community Psychiatric Support and Treatment (CPST). The CFTSS sends a Licensed Mental Health Counselor to the home and provide psychotherapy to address Priya's oppositional defiance once a week for 1.5 hours. The school social worker and the OLP agree that the next time the staff is unable to de-escalate Priya's behavior, they will use telephonic crisis triage allowable through OLP, where the treating clinician will provide support to Priya to address her acute distress and behaviors requires additional immediate attention.

The CPST (BA-level worker) will assist the foster parent in understand their role in the treatment plan goal of keeping Priya in the public school by educating family members further about strategies or treatment options that minimize the environmental stressors that interfere with Priya's daily living. The same worker will assist the foster parent with strengths Based Service Planning to identify other natural supports that might be available in response to calls from school personnel.

Revenue Generated through Implementing this service plan:

- Crisis Intervention = 2 staff, 1 licensed for 2-hour session and evaluation = \$751.44
- OLP Counseling = at home \$159 per hour
- OLP Crisis Triage = via telephone \$174.44 per hour
- CPST = at home \$100.00 per hour

It is possible to support this treatment plan by using Medicaid reimbursement through CFTSS.

YOUTH ASSERTIVE COMMUNITY TREATMENT

Jada is a 12-year-old girl who was placed into a residential treatment center because her angry outbursts and were difficult to managed in the foster home settings available in her rural county. The county of residence was able to recruit a new home and established a unique discharge plan that relied upon the local Children's ACT Team.

Prior to discharge, Jada and her foster family are referred to the ACT Team in an effort to ensure a warm hand off to services. The family is assigned a Family Service Coordinator and a Family Peer Advocate to help them navigate and coordinate both traditional and non-traditional services upon discharge. The family, their assigned Service Coordinator, and Peer meet upon discharge to identify supports available both through the ACT team as well as natural supports in the community. With the ability of Youth Act to bundle care coordination, therapy, substance use counseling, skill building, therapeutic recreation, family support, crisis services and other services into a monthly rate the family has the chance to provide Jada with all the necessary supports to keep him on track. The family ultimately selects the following services to be a part of Jada's team:

- Behavior Management Services that acts as a liaison between the home and school to ensure Jada's transition back into her home school and is successful in following agreed upon behavioral plan.
- Mentoring services to focus on improved interpersonal and social skills.
- "Rise and Shine" skill building to assist the family in developing a successful morning routine that Henry can get ready for school and avoid conflict.
- The family decides to remain connected with the Article 31 clinic to maintain a continuity of clinical care even after the Youth ACT ends and to use the clinic brief crisis service
- Jada is also linked to individual and group AODA services at a local OASAS licensed outpatient program in her community who has a contract with the ACT team to address her need for these services.

All of these services are incorporated into a comprehensive Plan of Care that all team members contribute too and ultimately approve. Monthly team meetings are rotated between the family's home, her school, and Article 31 clinic to review Jada's progress and ensure the team is consistently on the same page.

Medicaid Youth ACT – monthly rate of \$1466
62-38% Prevention Grant from Local DSS – monthly rate of \$1977
Provider manages treatment plan and purchases or provides services as needed to implement.

FUNCTIONAL FAMILY THERAPY – THERAPEUTIC CASE MANAGEMENT THROUGH PREVENTIVE SERVICES, ARTICLE 31 CLINIC, CARE COORDINATION

Henry, a 14-year-old boy diagnosed with ADHD, and his biological mother are experiencing difficulties related to his “runaway” behavior and his truancy from school. CPS has removed Henry from the home because he has been consistently picked up by the city police when found wondering on the streets late at night and early into the morning hours. CPS has identified Kinship Placement with his paternal grandmother as the best option, but before that placement was completed, the Day Treatment provider recommended that Henry go to a Residential Treatment Facility for his mental health diagnosis.

At the RTF, Henry acknowledges he is using alcohol to slow down his thinking, but he realizes the medication management at the RTF is already helping more than the alcohol did. However, the time away from school and irregular sleep schedule resulting from his wondering has inhibited his daily functioning, personal growth, and interpersonal relationships.

Henry’s discharge plan from the RTF is return to his biological mother with intensive supports. Henry is admitted to the local Article 31 clinic for medication management and off-site counseling. The clinic identifies the need for Functional Family Therapy, including both the biological mother and the paternal Grandmother and Henry. FFT-Therapeutic Case Management (TCM) is an evidence-based practice that alters important risk and protective factors associated with problem behaviors by focusing on the function of behaviors within the context of family relationships. The first step in the therapy is to increase family members’ engagement and motivation to change by improving the functioning of families by focusing on their relationships and the context in which the behaviors are sustained. The clinic therapist arranges for home visits for FFT-TCM. The offsite clinic rate is charged for some of the required therapist visits and Henry is admitted to Health Home Care Management. Once, the 16-32 session FFT is completed, Henry is remains with the Article 31 clinic for medication monitoring.

The FFT-TCM therapist will have addressed behavioral changes that result in skill development to get to school on-time, identify life goals that include getting into the Summer Youth Employment program and understanding necessary pre-vocational skills, discusses the risks related to alcohol use, and control of his impulse to run away. He and his family have a crisis plan in case of runaway incidents that allow for brief crisis outreach from the clinic when necessary.

His Mother and Grandmother have access to the Family Peer Advocate who helps them maintain their FFT skills, determine when to call the clinic for brief crisis supports and helps them prepare for meetings with teachers, counselors and CPS personnel as needed.

Health Home Care Management = Medium acuity monthly rate \$450

Art 31 LBHP offsite clinical service for therapist involved in FFT = \$300.46 per hour for 20 hours = \$6,309.66

Art 31 Brief crisis = \$64.55 per 15 minutes when needed

Art 31 Medication Management = \$106.83 per 15 minutes

FFT – 62-38% Prevention services funding can pay for this Evidence Based Practice non-therapeutic sessions and contacts with the family.

YOUTH PEER SUPPORT TREATMENT

Jose is a high school junior diagnosed with SED, who struggles with verbal and physical aggression in school. He lives with his older sister in the Bronx, relies primarily on his IEP services to address his needs but is eligible for Child and Family Treatment and Support Services and has agreed to Youth Peer Support and Treatment services because he likes having weekly sessions with someone close in age. He has an upcoming Committee on Special Education (CSE) meeting. Although Jose is happy that he lives with his sister, instead of living in foster care, due to his mother's recurrent substance abuse and incarceration and his father's absence, Jose often views his sister as being too strict. Jose's sister is 21 years old. She graduated with her high school diploma at the age of 18 and works a full-time job at a fast food restaurant and a part-time job as a bartender to support the family. Jose does not believe his sister can relate to him because she did not have issues in school or any significant mental health. Jose finds it difficult to open up or seek advice from his sister, and he relies on his youth peer for advice.

Jose and his sister do not agree on the graduation goals set forth in the school plan. Jose wants to finish school with a certificate in one year and then pursue work as an auto mechanic. His sister believes he can get a diploma if he takes an extra year to meet the curriculum needs. He has invited his Youth Peer Advocate (YPA) to support him at the CSE meeting. The YPA works with Jose to know what to expect at the meeting, coaching him on appropriate attire and possible cues that will indicate the school staff wants to hear directly from Jose. His YPA also discusses Jose's personal goals and how what Jose asks for in the CSE can support those goals. Jose's YPA uses his own past personal experiences with an IEP to connect with Jose. This connection builds trust between Jose and his YPA. Jose and his YPA meet several times before the CSE meeting to discuss Jose's future plans to help Jose discern if they are reasonably attainable. The YPA also assists Jose in searching for alternative options. The YPA attends the CSE meeting with the sister and Jose to support and assist him in verbalizing his goals and practice self-advocacy skills that they have been working on. Jose, with his YPA sitting by his side, actively participates in the CSE meeting. At the end of the CSE meeting, the group, including Jose, decided Jose would complete this year of school. Next year, Jose will join the BOCES auto-mechanic trade school 2-year program. Jose and his YPA were able to review the benefits of enrolling in an alternative setting to meet Jose's goals. With the additional skills Jose would learn, Jose and his sister agree Jose is headed towards a positive career path.

To assist Jose in finishing the current school year, Jose's YPA and school counselor suggest he receive Psychosocial Rehabilitation (PSR) services in the CFTSS continuum of services. A PSR service provider meets with Jose after school in his home or the community and uses a pre-vocational plan of care to help Jose meet his life goals, regain interpersonal skills to manage his aggression through social stories and role-play scenarios. The PSR provider works with Jose for 2 hours each week on these skills. Jose uses these skills in the school setting on a regular basis, though it is not always easy for him. Jose completes the school year with a decrease in school suspensions and improved grades. Jose's YPA, PSR provider, and sister meet as a team to review Jose's progress and future goals once a quarter until Jose feels confident in his autonomy.

Medicaid Revenue generated in this example is insufficient to support the services long-term:

Weekly 1 hour YPST – Revenue: \$58.72/hour Cost: \$75.00/hour
(-\$16.28/week)

Weekly 2 hour PSR – Revenue: \$67.00/hour or \$134.00 total
Cost: \$77.00/hour (-\$20.00/week)

To support breakeven investment into Jose, this downstate agency will have to add Jose to either Fair Futures or use mentoring prevention resources to support the necessary interventions that keep Jose in placement with his sister. For an upstate agency, the worker trained to provide YPST and PSR could also be paid through county IV-E grants for mentoring services and only bill for the Medicaid services for the time he is specifically working with Jose on his treatment plan goals.

APPENDIX A

GLOSSARY AND SUMMARY OF FUNDING



ACRONYM	PROGRAM NAME	FUNDING SOURCE	STATEWIDE OR LOCAL
CFTSS	Child and Family Treatment and Support Services -6 separate services	Medicaid – State Plan Entitlement Services	Statewide
OLP	Other Licensed Practitioner	Medicaid – State Plan Entitlement Service	Statewide
CPST	Community Psychiatric Support and Treatment	Medicaid – State Plan Entitlement Service	Statewide
PSR	Pyscho-social Rehabilitation	Medicaid – State Plan Entitlement Service	Statewide
FPSS	Family Peer Support Service	Medicaid – State Plan Entitlement Service	Statewide
CI	Crisis Intervention	Medicaid – State Plan Entitlement Services	Statewide
YPST	Youth Peer Support and Training	Medicaid – State Plan Entitlement Service	Statewide
HHSC	Health Home Serving Children Care Coordination	Medicaid – State Plan Entitlement Service	Statewide
HCBS Array	Home and Community Based Services Array	Medicaid – Waiver Service (limited by stringent eligibility)	Statewide – capped number of slots
Article 31 Clinic	OMH Licensed Mental Health Clinics	Medicaid State Plan Service	Statewide
Youth ACT	Youth Assertive Community Treatment	Medicaid State Plan Service	Local prior to April 2020
TCRP	Therapeutic Crisis Respite Program	Base funding through grant with a combination of Medicaid, Private Insurance and 62-38% State/Local Prevention Funding added in based on eligibility	Local
FFT-TCM	Functional Family Therapy-Targeted Case Management	62-38% State/Local Prevention Evidence Based Treatment grants and Article 31 clinic claims	NYC ACS is currently the only region using IV-E funding for Evidence Based Practice reimbursement

Statewide Funding Streams that Support Services for Youth in the Community. The youth served by these programs could all benefit from Child and Family Treatment and Support Services if the children meet Medicaid eligibility Criteria and have behavioral health needs.

PROGRAM/STATE AGENCY	2019-20 LOCAL ASSISTANCE APPROPRIATION AMOUNT
Post Adoption Subsidies	\$10.6 million
62% State Share Preventive Services (38% local)	\$635 million
Flexible Fund for Family Services to counties (TANF purposes, including JD/PINS, Preventive Services)	\$964 million
Supervision and Treatment Services for Juveniles Program	\$8.4 million
Runaway and Homeless Youth Act	\$4.9 million
Youth Development Program	\$14.2 million
Community Optional Preventive Services	\$12.2 million
Healthy Families	\$26.1 million
Advantage After School	\$28 million
Summer Youth Employment Program	\$44 million

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