RECOMMENDATIONS

FOR SYSTEM REFORMS

FOR THE DELIVERY OF

CHILD WELFARE SERVICES

COLORADO DEPARTMENT OF HUMAN SERVICES

DECEMBER 2000

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INTRODUCTION

The purpose of this report is to communicate recommendations for system reforms for the delivery of child welfare services consistent with 26-5-105.5(3.5)(b), C.R.S.

26-5-105.5(3.5)(b), C.R.S. reads as follows:

> The state department, with input from the counties, shall develop recommendations for statewide implementation of system reforms for the delivery of child welfare services. The plan shall be submitted to the general assembly and the chief justice of the supreme court no later than December 1, 2000.

Invitation for counties to provide input was extended to County Commissioners (through Colorado Counties, Inc.), county directors and other county staff from managed care and non-managed care counties. Three meetings were held through September and October and a list of individuals who participated in each meeting is available on request from the Department.

This report presents information about pilot counties which have operated under agreements with the State for at least two years. Information about counties who are currently negotiating agreements with the State or who have entered into agreements since July 1, 2000 is not included.

The first annual Child Welfare managed care evaluation is titled Colorado Child Welfare Evaluation, Interim

Implementation Status Report. The report is dated June 30,2000, was prepared by William Mercer, Inc. and is available on-line at **www:state.co.us/cyf/cwelfare/interi11.pdf**

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BACKGROUND INFORMATION

In Colorado's Child Welfare system, managed care is a public operations model that allows county departments of social services to operate as managed care entities with certain limitations. Insofar as possible, the counties use the following tools to manage care for children and their families:

- Utilization review which can include prior authorization for treatment, and on-going review of treatment provided and outcomes achieved by the family and provider.
- Quality assurance where the county determines why outcomes weren't achieved. This area can relate to assuring that assessment accurately determined problem areas for treatment or that treatment was targeted to key areas to shorten length of stay .
- Greater accountability which is typically achieved through clearer definition about outcomes expected in provider contracts as well as sharing risk between the provider and the county.
- Line item flexibility where counties can determine the portions of their budget to be directed to fund staff, out-of-home placements, adoption subsidies or special circumstance child care
- Public-private partnerships where counties partner with providers to provide a continuum of treatment for children and families.
- Inter-agency integration where community partners such as mental health assessment and service agencies, alcohol and drug abuse managed service organizations, probation and education identify and approve services for families.
- Coordination of care which has occurred through co-location of staff from partner agencies and merging funding. As a result of this process, families may be able to access services from each partner without going through separate referral and application for services.
- Information systems where detailed data is available in some of the counties to study and improve the quality of services provided.
- Increased focus on the family where in most counties the family is participating in determining the course of treatment, and is being held accountable for treatment goals being met.
- Incentive/outcome based reimbursement where counties may keep general funds saved through the course of the year. These funds were directed to provide additional child welfare services.
- Rule waivers which can provide counties with additional flexibility in managing care through allowing counties to contract for case management with private providers, to be represented by contracted staff, and have greater flexibility with payment to providers.

These tools support a shift from traditional fee for service practice to a system that focuses on flexible

services that balance casework goals with fiscal management, and result in families getting the right amount of services needed.

GENERAL PILOT INFORMATION

Consistent with Senate Bills 97-218 and 98-165, six counties were selected to enter into performance agreements with the State. Those counties are Arapahoe, Boulder, El Paso, Jefferson, Mesa and Pueblo. Through performance agreements/Memorandums of Understanding (MOU):

- rule waivers were granted unless granting the waiver would cause non-compliance with federal or state law.
- outcomes were identified and achieved consistent with Federal requirements including domains of child safety, child permanency and child and family functioning. In addition to these outcomes, counties were also required to continue compliance with the Child Welfare Settlement Agreement (CWSA).
- counties kept unspent general fund savings, which were directed back into child welfare services.

The following information is a brief summary of county demographic information including county child population and child welfare average monthly Program Areas 4, 5, & 6 caseload for FY 2000 along with the date each pilot county entered into an MOU with the State. Because of the significant amount of work entailed in both implementing Managed Care Principles in counties and in finalizing MOUs, few of the counties began operations on July 1 of the year the pilot was approved. The last three columns include the amount of general fund savings each county was able to generate and direct to the delivery of child welfare services.

County	Child Population	Caseload	Pilot Begin	1997-98 Savings	1998-99 Savings	99-2000 Savings
Arapahoe	125,795	2,402	1998	NA	-0-	-0-
Boulder	66,671	1,311	1997	$30,287	$69,111	-0-
El Paso	138,134	3,492	1998	NA	$1,326,151	-0-
Jefferson	127,828	1,746	1997	-0-	$174,604	-0-
Mesa	29,191	748	1997	$278,915	$417,606	*

Pueblo	34,688	1,371	1998	NA	$268,578	-0-

*Final calculation of closeout savings not yet available

Following is how each county either planned to spend or spent their general fund savings:

- Boulder – to fund the sex offender project REACH and to fund match for grants for a substance abuse evaluator/consultant, programming for girls, and respite care for high-risk foster/kin placements.
- El Paso – to fund program initiatives including structured decision-making, multi-systemic therapy, drug and alcohol treatment, and a nursing home visitation program.
- Jefferson – to fund 5 new child welfare staff positions
- Mesa – to fund an in-county Residential Treatment Center in partnership with Colorado West/ Options MHASA.
- Pueblo – to fund contracted long-term follow-up services through a community agency for families who have a history of recidivism due to chronic problems.

DETAILED PILOT INFORMATION

Arapahoe

Arapahoe County's pilot centers on the concept of creating individualized pathways for families, matching levels of service to each family's needs. To accomplish this, two Pathways Teams were created: a resources team (initially called adolescent team) and an expedited permanency team for younger children. Key components of the team include:

- Community agency participation in the teams as appropriate
- Viewing the family as a partner. Caregivers are present when case plans are developed.
- A steering process involved all of the partners; and,
- Outcomes measurements.

The resource Pathways Team meets three times per week to approve Residential Treatment Center (RTC) placements. Features include:

- A focus on managing RTC placements for children ranging in age from 6 to 18. Cases of children who are at risk of RTC placement are also reviewed. Most children served are adolescents, given that

there are few under age 12 in RTC placements.
- Participation of probation, schools, mental health, SB-94 (SB94 provides funds for alternative services for potentially delinquent youth to prevent commitment or detention), an Alcohol and Drug Abuse representative, and family treatment team members from the county department.
- An initial review meeting where the treatment plan is approved, a service array identified and a 90-day review set.
- The first 90-day review focuses on whether the plan was successfully initiated.
- The second 90-day review focuses on the discharge planning process.

Once in an RTC placement, the county conducts concurrent utilization review focused on the treatment plan within the RTC. The review process is designed to ensure that the RTC maintains a focus on the county's placement goals, as opposed to longer-term clinical goals that the county traditionally saw many RTCs as pursuing. These utilization reviewers work to focus care on the goal of discharge back to a community or lower level of placement.

Another key component of the pilot is the Family Empowerment Team. This is an intake team that performs assessments and can work with families for a 60-day period. They may also provide short-term services. However, many cases are sent immediately to the Home Base Unit which is responsible for the majority of the ongoing Expedited Permanency Planning (EPP) cases. In addition there is a Family Group Conference Team that can assist in discharge planning, particularly with comprehensive searches for kinship care options and other family resources. One of the key approaches is to work with the family to facilitate decision making by all the significant people in the child's life in order to return the child to the home and keep the child safe. The specialized facilitation approach is geared to help families develop a sense of ownership in the plan to bring their children back home.

There has been increased collaboration with the local Mental Health Centers and the Mental Health Assessment and Service Agency (MHASA) in the management of Medicaid Mental Health services. The county has developed a contract that transfers funding for the treatment portion of the Child Placement Agency (CPA) placements to the MHASA for management. The transfer allows:

- Access to Medicaid match for these funds through the MHASA.
- More control over treatment costs. The CPAs are only paid room and board costs by the county. The MHASA can subcontract treatment services to the CPAs, but most services are provided by the contracted community mental health centers.
- Credentialing of CPAs by the MHASA as a Medicaid provider.

Additional activities to support the implementation of the managed care pilot include:

- Training
- Education of staff in determining best levels of care rather than historically used levels.
- Training regarding managed care principles.
- Communication efforts including meeting with line staff and administrators to keep line staff appraised of implementation.
- More flexibility at the worker level.

- An emphasis on more proactive discharge and treatment planning.

To increase accountability for managed care initiatives, the county created a Care Management Administrator position. All managed care functions report to this position allowing for increased coordination and a single point of responsibility. This position also impacts the day-to-day practices associated with the managed care pilot.

A point of change as a result of the managed care pilot is the increase in collaboration and ongoing dialogue between the county and the court. While the court continues to exercise ultimate authority over all involuntary cases, the court is also more aware of the alternatives to RTC placement.

Boulder

A hallmark of Boulder and its pilot is the high level, extensive collaboration between the county and community agencies. Rather than focus on redesign of the county department, Boulder developed a new organizational entity called Integrated Managed Partnership for Adolescent Community Treatment (IMPACT). Its goals are to:

- Reduce out-of-home placements and lengths of stay in out-of-home placements,
- Ensure levels of care provided are appropriate levels of care,
- Increase permanency,
- Increase educational involvement,
- Reduce contacts with the criminal justice system, and
- Increase community connectedness.

IMPACT employs a director and a utilization review staff of intensive case managers. IMPACT's key function is to manage out-of-home placements for social services, youth correction and mental health. Historical funding for each of these areas was collaboratively identified and turned over to IMPACT to manage.

Each participating organization contributes funds for IMPACT operations. Several measures are employed to maintain trust and avoid concerns of cost-shifting including:

- Budgets that are openly set by each agency at the beginning of the year, with savings against these budgets monitored and retained by IMPACT for reinvestment.
- A flexible process. It is often difficult to determine what percentage of savings is attributable to IMPACT and what to other independent agency efforts. Savings allocations are openly negotiated with each agency on an ongoing basis.
- Targeting of savings for reinvestment by an interagency planning group that oversees reinvestment of

the six systems that contribute to and benefit from IMPACT.
- Local tracking of expenditures that eliminates dependence on state reports.
- Reinvestment of savings during the year rather than retaining them until the end of the year, in order to maximize retention of both state and federal matching funds.

IMPACT employs two teams, with one team focusing on high-risk youth in the community and the other on children in placements. The goal is to review all such cases within this structure. The teams are:

- Community Evaluation Team – a resource commitment team, comprised of partner agency managers authorized to make decisions regarding resources, staffs each case of high-risk youth still living at home or returning to the community from a placement. A specific interagency treatment team for each child is established and an IMPACT intensive case manager is assigned to follow the case. The team employs wraparound services and other preventative interventions to maintain the child in the home.
- Placement Review Team – a similar interagency management team reviews cases of children going into placement at a CPA, RTC, hospital, or correctional setting. The team provides initial authorization and concurrent utilization review for these placements. IMPACT intensive case managers monitor treatment within the placement to ensure that the community's treatment goals are being pursued and that treatment is proceeding. Staff report that this review process has led to a change in the treatment culture of many providers.

Multiple efforts have been made to support staff through this transition, including:

- multiple training efforts, including presentations to caseworkers to help them view IMPACT as a care management approach rather than a cost containment effort, as well as cross-agency training on the IMPACT process;
- multiple retreats with staff and leadership;
- collecting feedback from staff; and,
- experiential feedback from supervisors to staff during the case review process.

Families are essential partners in this process. Families attend IMPACT case reviews or can choose to use a therapist or other person as a spokesperson. An increased focus on kinship care has also occurred. Kinship options are sought prior to an out-of-home placement. Kinship workers check and re-check with families to identify options. Kin is broadly defined to include friends and significant others in addition to extended family.

Intake is integrated into a single point of access rather than separate intake units for children and adolescents. Intake workers provide prevention and early intervention services following families with lower needs for up to 30 days without opening the case in order to connect them with other community services and avoid ongoing child welfare services.

Families with basic needs were referred to the county's Temporary Aid to Needy Families(TANF) program, but there was greater coordination between the TANF and child welfare programs. Expanded TANF child care initiatives, substance abuse services, and women's services provide increased support to families served

by child welfare staff, promoting enhanced stability for these families and better service coordination.

There was also more coordination up front with other child and family serving agencies. DSS intake workers received cross-systems training, and the Mental Health Center of Boulder County similarly integrated its access into a single coordinated process making referrals to mental health care easier up front. Cross-systems training involving DSS staff providing ongoing care and their counterparts in other county human services agencies has helped increase ongoing coordination regarding cases as well.

Also critical in Boulder's managed care model is the participation of Boulder's District Court, both through the participation of the Chief Judge on the IMPACT Board and daily coordination for high need cases by the IMPACT case managers. In addition, cases not served by IMPACT had greater access to their county caseworkers given the shift of high need cases to IMPACT, allowing for closer coordination with the court across the board.

El Paso

El Paso County's pilot is a comprehensive initiative spanning the entire county department, including child welfare and self-sufficiency TANF services. The genesis of this view was a decision by El Paso DHS leadership that theirs was the only agency with full risk and adequate resources within their county to provide a full range of services for children, families, and adults in need. To manage that risk, a detailed approach to managed care was developed, even prior to the initiation of the pilot program. Components of this approach include:

- Prevention – Food stamps, transportation, kinship services, teen services, domestic violence programming, poverty, and self-sufficiency programs serve as tools for strengthening families and preventing child abuse and neglect. TANF serves as the major prevention strategy for families at risk to divert entry into the child welfare system.
- Protection – The safety and well being of children and families is a paramount concern.
- Preservation – Managed care efforts center on a commitment to strengthen families.
- Placement – Much of the direct activity of the managed care initiative is focused here. By passing the CPA treatment dollars through the local MHASA, federal matching money doubles available resources. Simultaneously, 14 community-based CPAs have full responsibility for the children and families they serve including casework, family preservation services, and court testimony. A single worker from the county reviews the CPA's case plan progress, outcomes, compliance with statutory and regulatory requirements, and contractual obligations.
- Permanency – El Paso employs two strategies:
- Paying adoptive families a higher subsidy, equal to the rate paid to foster care families.
- Building additional supports for adoptive families through the local MHASA.
- Partnerships – Multiple partnerships in the community support DHS' activities. For example at the main DHS offices, there were approximately 350 DHS staff and 90 partner staff in the late summer of

1999. The county actively partners with other agencies such as the MHASA, local Community Mental Health Center, substance abuse providers and youth corrections. El Paso DHS also works with diverse community organizations such as Faith Partners, a coalition of over 100 local churches who provide mentoring, and Goodwill, their biggest co-located and self-sufficiency partner.

The community as a whole is reported to have embraced the county reform initiatives. Framing efforts as a means to increase accountability and as good business practices within the department was described as an essential component of this buy-in.

Joint Initiatives for Children and Families involve interagency collaboration among 23 health and human service partners with a common vision to improve the health and well being of families in their community.

The community has created a multi-agency review team to provide common assessments and planning for multi-problem, difficult to serve youth who may be placed in out-of-home care or committed to the youth corrections system.

A partnership among El Paso DHS, DYC, probation, and the Mental Health Center has created a team approach to provide multi-systemic therapy to high-risk youth and their families.

Staff describe some tension in the community between the desire of certain partners to continue to place youth in restrictive settings (e.g., courts, legal community, DYC, probation, foster care, and RTC providers) versus the community-based expectations of the DHS.

- Proficiency – State-of-the-art practice has been a key focus of the local reforms, particularly in the following areas:
- Outcomes – El Paso DHS measure outcomes and uses the results to adjust the way that they do business. There are division and unit outcome expectations and many supervisors produce a yearly report.
- Cultural competence – The agency has a diversity coalition within the agency and across the system as a whole.
- Training – Education programs have been developed through partnerships with universities and colleges.
- Family-centered practice – The organization has re-engineered processes toward a family-centered approach. Families participate in a range of activities, including involvement in the development of their case plans, representation on boards, contractor selection, and serving as co-trainers.

El Paso’s approach involves:

- Intake process reengineering – There has been a change in orientation away from investigation toward family-based assessment. They note that the difficulty with a strict investigation model was that families who were not eligible due to a lack of substantiated abuse often did not receive needed services and families who were found to have abuse present in the home sometimes received too

much intrusion into their lives. Implication of this shift include:

- Increased effort to identify high-risk families and intervene early
- Increased emphasis on giving families what they need through multiple levels of diversion and prevention so that they ideally do not have ever to enter the child welfare system as an open case.
- Development of single points of entry for some programs.
- Use of Child Protection Teams (CPTs) to review cases and oversee planning:
- El Paso employs criteria defining which cases get reviewed by CPTs.
- CPTs form in response to specific cases and involve the caseworker and supervisor, as well as partner agency staff. Each team makes decisions about its ongoing involvement.
- Community involvement through the CPT as a form of oversight and accountability, as well as a means to facilitate joint ownership of problems and access to additional resources.
- Management of ongoing cases through five teams:
- Three teams serve child protection cases in the home with a focus on comprehensive involvement to help move the family out of the system. Although some families still require sustained involvement, staff reports that most achieve their treatment goals within 12 months.
- Two Expedited Permanency Planning (EPP) units work with children under the age of 6 who are placed out-of-home (i.e. through foster or kinship care) to help move them into a permanent home within a year.
- Utilization management is overseen by the individual workers on the team, who are in turn managed by supervisors and the area manager as needed.
- Youth and Family Services – Five units, which include:
- Four family preservation programs with a 60/40 split between adolescent and child cases on each team. This includes one special team that responds specifically to court needs. Previously, when the court did not know what to do with a case, they tended to order placements. Now this team offers immediate responsiveness to the court (generally within an hour) and is believed to have avoided many unnecessary placements because of this rapid response.
- The fifth program was described as more "traditional," but moving toward a home-based model.
- El Paso has several years of outcome measurement data on these programs in their local database.
- Project Redirect – a specific program founded in 1992:
- Redirect focuses on serving the 100 most difficult children in the system, in terms of resource use and movement across multiple system.
- El Paso DHS and its partners collaboratively developed criteria for entry onto the team and for outcome measurement. Significant amounts of outcome data have been collected on this team.
- Redirect employs 10 staff with fixed caseloads of 10 families each.
- Pooled staff and funding – Staffing is 60% from DHS, 5% from mental health, 20% purchased using funds from School District 11, 5% from the local substance abuse provider, and the remainder from Goodwill Industries.
- CORE services development – this refers to funding for an array of treatment option s for children and families involved in the system, including:
- Contracted family preservation services.
- Contract with specific service providers for an array of services. This is evolving into one-stop shopping in which providers package multiple services together for families.
- Services provided with a goal of being flexible in order to help and reunify families.
- CPA Project – CPAs now do the casework for children they serve, and the MHASA provides mental health services through their provider network. Results of this include:

- Doubling of treatment resources through access to the MHASA's Medicaid match.
- Availability of onsite mental health staff person through the MHASA who is available to perform immediate assessment and authorization at foster homes the day following a placement.
- The county is planning to start providing health and dental assessments for placed children through the local community health center.
- Multi-agency need cases going to RTC or other settings received multi-agency treatment planning through various multi-agency community review teams, including the Placement Team, the Multi-agency Review Team, administrative reviews, Community Child Protection Team, MART, early release meetings, and permanency reviews. DHS, DYC, mental health, substance abuse services and probation representatives participate on the team. In addition, through specific initiatives related to permanency, there was an increase in the number of families from the community coming forward to adopt children through DHS. Support of kin placements, also increased through Kinship Foster Care programs and other supports.
- DHS leadership conducting ongoing dialogue with the courts to better facilitate communication. The El Paso approach focused on providing the most appropriate, least intrusive service available. Voluntary cases both in Child Welfare and TANF were not subject to court involvement. Involuntary cases have services coordinated between the worker and the court. The court's involvement is typically at or prior to intake and extends throughout each family's final disposition.

Jefferson

Goals of the county pilot center on moving children out of institutional settings and returning them to supportive families and communities. Key factors leading to the pilot included:

- Capping the county's child welfare allocation, which led to increased awareness of limited resources and increased flexibility with providers and pooling resources with providers;
- Development of a healthy level of competition among providers; and,
- Increased flexibility in how to use funding, particularly access to an improved array of services.

The central feature of Jefferson County's pilot is the Services Utilization Review Team (SURT). This is a collaborative effort between mental health and the county department with pooled staff resources to manage cases needing CPA or Residential Child Care Facility (RCCF) or RTC levels of care. Features of SURT include:

- Jefferson Center for Mental Health(JCMH) staff, Signal staff(ADAD MSO) and Jefferson DSS staff comprise the SURT team.
- The SURT interagency review team meets weekly to staff cases believed to need RCCF or RTC levels of care for single entry point for blended services and funding.

- Participants include the SURT staff, DSS managed care administration, the youth services coordinator, the delinquency services supervisor and JCMH clinicians, a substance abuse clinician and often probation and SB-94 staff.
- Where possible, DSS makes use of county administered placements.
- When a child is placed with an external provider (CPA or RTC) the SURT staff uses a standardized needs based level of care worksheet to negotiate an individual rate and length of stay with a placement provider.
- SURT staff provide monthly utilization review of children in RCCF/RTC placements and assist caseworkers and families to develop step-down placements and wraparound services following discharge. Utilization reviews occur in collaboration with CDHS administrative reviews at 6 month intervals.
- An MOU is negotiated and signed annually between the county department and JCMH to manage treatment services in CPA placements. This has resulted in:
- JCMH providing or subcontracting the treatment component of CPA placements
- Availability of Medicaid matching funds for county dollars, doubling available treatment funds for CPAs.
- Resources through JCMH's sub-contracted managed services organization, InNET, to oversee and manage CPA billing, with an emphasis on ensuring that payments match the level of care (and rate) authorized.
- Access to a therapist to provide treatment for children and a case manager to work with the CPAs to help them increase their compliance with Medicaid requirements and to provide utilization review of placements and services.
- Quarterly meetings with CPAs to improve collaboration, as well as increased training for CPAs.
- Monthly meetings of administrative and clinical staff from each organization.
- Development of a preferred provider list of CPAs willing to negotiate placement and treatment costs depending on the needs of the child.

Key supports put in place to help staff with the overall process of change as a result of the pilot implementation include:

- An educational focus centering on empower staff within the system to see themselves as purchasers with an ability to hold providers accountable; and
- Promotion of SURT interagency placement review team to make decisions, blend funding and purchase needed services.

Mesa

Mesa County's pilot is a comprehensive effort affecting the entire child welfare area of the county's functioning. Key business processes have been reengineered, in particular information system supports, and the continuum of care targeted for expansion, specifically the development of RTC and other placements with the county. Comprehensive outcome indicators have been developed. Mesa's goals for the program include impacting costs by reducing expensive care where possible and emphasizing prevention. There are

two goals for the pilot:

- To better serve children and families as well as the community as a whole;, and
- To manage county funds well enough to avoid the need for external, for-profit organizations to be brought in.

Mesa's approach to partnerships with other child-serving agencies centers on their relationship with Colorado West Mental Health Center. Key features include:

- Pooling of resources, particularly human resources pooled for joint endeavors; this includes Mesa DHS funding for two Colorado West positions placed at DHS, one to provide foster care coordination and another to perform mental health and drug and alcohol screens.
- Monthly meetings that include the executive management of each organization and other community partners' including DYC, Hilltop, and CPAs.
- Development of standardized policies and procedures between agencies whenever possible.
- Collaborative utilization reviews through DHS and support around obtaining authorizations through mental health. A full time mental health staff conducts utilization review meetings.
- Cross training, both didactic and through common work together on cases; and
- Cross-staffing of key committees in each organization (e.g., treatment teams, best practice committee).

Network development has been a key component of the pilot. Features of the service continuum development include:

- A WRAP project – This multi-agency collaboration initiated through House Bill 1171 in the early 1990s provides preventative services with a goal to prevent out-of-home placements.
- Early childhood intervention - Mesa has developed a home visiting model thr9ough a coalition of community providers and citizens who came together in early 1999 in response to three deaths related to child abuse (in western slope counties) that had occurred during the winter. The program targets higher quality day care standards, increased newborn birth weight, a professional nurse home visiting program for all children born in Mesa County (not just high risk births), dental access for Medicaid-eligible children, and community education to promote health families.
- Targeting of methamphetamine-abusing parents for multiple prevention efforts. MCDHS is part of the Partnership for a Drug Free Mesa County. Efforts include developing a "summit" on substance abuse issues and providing a media campaign that, in part, links users to resources available in the community.
- Early mental health intervention through using a mental health worker from Colorado West whose efforts include an assessment for all families with an open case that will receive "ongoing" involvement by the agency, facilitation of authorizations, and substance abuse screening.
- Parent advocates – County parents have expressed a wish for access to experienced parents for mentoring. Two parent advocates will be employed through WRAP and services offered to parents involved in the Dependency and Neglect Court procedures.

Another key feature of the county system was the development of a single point of entry. Components of the

system include:

- A basic needs assessment conducted in the intake safety plan, the findings of which are addressed in subsequent utilization review case meetings. Mental health screens are targeted for all families involved in ongoing cases, either through prior assessment or a new assessment performed at intake.
- Electronic data collection and case assignment. After the referral and intake are entered into a database system, a referral (with detailed background information) is electronically sent to a supervisor, who then electronically assigns it to a caseworker, who then electronically sign up for a 20 minute slot with the CORE Team to staff the case.
- Initial staff by the CORE Team:
- The CORE Team is a multi-agency team including child welfare, mental health, drug and alcohol, family preservation, school, and WRAP staff, as well as the child welfare administrator , who meet with each family at the outset of services.
- The team meets twice weekly to provide an initial multi-disciplinary review of each case going to ongoing services, develop a referral, authorize a level of care, initiate a treatment plan and create an ongoing multi-agency team made up of line staff from the various agencies.
- Caseworkers present each family's case using a standardized format (family needs and strengths are items on the single referral form staff use to obtain services from the various agencies present at CORE).
- Each participant has the authority to approve services from their agency.
- A next appointment for the family is scheduled at this meeting that will serve as both an initial treatment team meeting and an initial utilization review. This meeting will be within 60 days of case opening, if possible.

Ongoing services are managed by the specific multi-agency treatment team developed by the CORE Team through subsequent meetings that occur at least every 90 days, but often as frequently as weekly.

- A single, unified treatment plan is developed collaboratively between all parties, avoiding splintering of services or agencies working at cross-purposes and minimizing redundancy for the family.
- The county DHS sponsors training in treatment planning and in valuing the family as the most important member of the treatment team, as well as providing ongoing staff meetings to develop best practices for engaging families. This has involved a specific team of managers and has changed to twice monthly continuous quality improvement meetings that have representatives from mental health, drug and alcohol, and a community member who is a parent.

A specific utilization review meeting by DHS occurs no later than 60 days after the initial CORE Team staffing.

- The review includes a detailed process to assess the value and benefit of services.
- There is a specific protocol for the supervisor to go through with the case manager prior to the review meetings.
- The Utilization process may involve the caseworker, the caseworker's supervisor and Foster Care Reviewer, and the utilization review specialist from Colorado West.
- Mesa County DHS keeps a local database tracking variables such as which agency representatives

attend treatment team meetings and timeframes between when each service was authorized and the time it was delivered.
- New authorization decisions are made in this utilization review meeting.
- The goal of the process, in addition to cost containment, is to keep the focus on child welfare's permanency goal for the child.
- Parent satisfaction in monitored through the utilization review meeting.
- RTC utilization review is performed by a person funded by Value Options, Colorado West CMHC, and Mesa County DHS and occurs at the provider sites on the Front Range.

Another feature is a specific prior authorization and utilization review process for all out-of-home foster placement. Components include:

- A Child Welfare Support Team that provides centralized utilization oversight of the placement process. The support team has a number of responsibilities. One staff person is designated a the "Placement Coordinator". A computer program is used that tracks available openings in placements and matches children's needs with placements that can meet their needs. Another position is the "Medical Passport Coordinator," and this position is responsible for ensuring that children in out-of-home placement receive medical and dental check-ups.
- Development of one-page tools for determining level of care, one for young children and one for older children and adolescents.
- Another feature is management level involvement in out of county RTC placement decisions. Staff desiring RTC placement must present the case to DHS and Mental Health Directors for approval of the placement.

Quality improvement processes include:

- Development of continuous quality improvement with partner and community representatives;
- Discussion of changes and new developments stemming from the pilot implementation as a continual process, given the pace of change and significant staff turnover; and,
- Development of a client satisfaction measurement approach.

Mesa's information system is tied into multiple work processes:

- The system captures a large amount of data during the intake phone call.
- The information is electronically processed and forwarded to a supervisor and caseworker automatically.
- The system is based on an Informix database.
- There are over six years of very detailed data in this database.
- All forms are available on line.
- Staff can sign up electronically to staff cases with the CORE Team.
- MIS tracks multiple outcomes related to services.

The process of implementation for Mesa is supported through multiple cultural change strategies, including training, vision building efforts, committees, and performance tracking that integrates specific expectations into performance evaluations. Examples include:

- Leadership through a steering committee instead of an individual project leader.
- Development of the Loop Group to facilitate feedback between the line staff and management. The overall goal is to create multiple channels of formal communication to support development of comprehensive information and communication.
- Use of an out of county consultant, working with supervisory and administrative staff.

Pueblo

The goals of Pueblo County's pilot is to bring all county child welfare operations under a managed care approach. Key emphases on the pilot include:

- Focus on expedited permanency
- Increase emphasis on prevention; and
- Development of the service continuum through CORE Services funding, including development of intensive adolescent and child teams, day treatment, a sexual abuse program and specialized foster care placements.

The system includes a screening and prevention team that can provide up-front services, designed to prevent a family from having to be formally opened as an active child welfare case. They have small caseloads (approximately ten each) carried by senior caseworkers. Cases are tracked on the county's local data system (Amigo) even though they are not opened on the state data system, as well as supportive ongoing services to families whose cases have been closed in the state data system in an effort to prevent recidivism.

The county has established a Utilization Review Team.

- The team was developed to centrally manage out-of-home placement referrals and identify community-based alternatives through multi-agency planning and a treatment authorization process. This team staffs all out-of-home referrals and any placement must be authorized in order to be paid. Many referrals were diverted to either lower level out-of-home placements (e.g., kinship homes or county-administered foster homes) or to community-based alternatives such as community mental health center services.
- Once in an out-of-home placement the Utilization Review Team conducted concurrent utilization review focused upon the treatment plan within the placements. The review process was designed to ensure that the placements maintained a focus on the county's placement goals. These utilization reviewers worked to focus care on the goal of discharge back to the community or lower level out-of-home placement. Cases are also reviewed prior to returning children home or closure of the case.

Pueblo reports a high level of collaboration that they attribute to:

- A common perspective that views problems as community problems rather than agency problems;
- Less movement in and out of the community than other Colorado counties, which allows agency staff to get to know each other and develop trust over time. As new staff are hired, the existing positive relationships of senior staff foster continued collaboration;
- Strong relationships between line staff, as well as agency leadership, and
- A common commitment to helping children and effectively advocating for them, as well as commitment to good practice.

Several supports for staff are in place. These include:

- Monthly staff meetings to keep people informed about changes;
- Weekly unit meetings; and
- Continuous training.

INFORMATION RELATED TO THE RECOMMENDATIONS

As state and county staff worked together to determine the recommendations to be made in this report the following points were important to be stated as a prelude to the recommendations:

- Managed Care is not a one size fits all program. Depending on the community, certain principles of managed care work more efficiently than others. In the pilots there have been a broad range of activities with some counties seeming to overhaul their entire system and other counties only tweaking small parts which resulted in the biggest value for that particular community.
- All counties have to manage fiscal risk and can choose to implement all of the principles of managed care without entering into performance agreements with the State.
- The current managed care models are not true managed care models in that
- Counties do not have the opportunity to negotiate which populations they will and will not serve
- Counties do not negotiate the services to be provided and the cost at which the services will be provided
- If there is a significant caseload growth, beyond the counties' control, counties can not share financial

risk with the State wherein there is a guarantee of additional funding to serve the additional caseload.
- Allocations across all counties are not made on the basis of a specified caseload or case rate; rather, historical expenditures are a significant part of the allocation methodology.
- Counties do not retain control of either the gate or the packages of services provided to clients. The court can order both cases to be served and services to be provided by the county department, irrespective of the county's recommendation to the court. This hinders the county's ability to control the "gate" or to control the services to be offered.
- Less funds are available to direct to needs of clients as counties move children to permanence such as adoption with subsidy more quickly.

RECOMMENDATIONS

A list of recommendations were developed through three meetings of state and county staff. In determining which of the recommendations to put forward, the state proceeded as follows:

- Any recommendations to change the current county allocation process will be directed to the Child Welfare Allocation Committee since law already exists which governs the county allocation process (there are no recommendations to change the legislated allocation process);
- Any recommendations that can be addressed by a change in existing Volume 7 regulations will be handled through the State Board rule promulgation process; and
- Recommendations requiring statutory change to implement which the Department can support are listed here and are as follows:

1. **Adoption subsidies should become an entitlement program, outside of the Child Welfare Block with requirements specified as to how funding increases may be requested.** This recommendation supports permanency for children as quickly as possible, an outcome that is supported at all levels: federal, state, county and community. Additionally, as counties move more children to subsidized adoption, less funds are available to support the needs of existing or new children and families needing services to achieve safety, permanence or well-being.
2. **Continue legislation authorizing performance-based agreements between the counties and the state, allowing rule waivers and the retention of general fund savings.** This will allow additional time to more fully explore child welfare in a public system of managed care in Colorado without requiring statewide implementation.
3. **Authorize State Board to promulgate rules concerning principles to be used statewide in managing care for children and their families to assure child safety and permanency and child and family well being.**
4. **Through performance based agreements allow managed care counties to describe how they will manage to the populations they are mandated to serve, services to be offered, case outcomes to be achieved and how financial risk and savings will be handled.**

IN SUMMARY

SB97-218 contained several goals with respect to what child welfare reform was to accomplish (26-5-103 (2), C.R.S.):

a. More efficient and responsive service systems for children, youth, and families;
b. Increased flexibility and collaboration across multiple agencies and funding streams;
c. Encouragement and authorization for a truly integrated service system that incorporates blended funding and administration;
d. Focus on quality and out-come driven services with accountability for an entire array of services that families need rather than forcing families to be transferred from agency to agency;
e. Development of data systems to support these goals and to allow administration and policy makers to better manage and evaluate;
f. Authority and incentives for creative solutions at the local level that are not bound by the constraints of current agency barriers and categorical funding streams including authority for local policy makers to create new entities incorporating blended funding and administration;
g. Successful training efforts directed at county staff, judges, court staff, providers, parents, and families and other appropriate entities that are involved in managed care services systems.

As is demonstrated in the pilot counties, the foregoing goals have been met. In addition, the escalation in costs related to the out-of-home placement, which prompted the passage of SB97-218, have also been contained.