DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CHILDREN AND FAMILY SERVICES BUREAU

SYSTEM OF CARE PLAN

I. MISSION

The mission for the system of care is to support the normal development of children by enabling them to achieve and maintain optimum mental health so that they may remain at home, succeed in school, and function well in the community. The system of care for children and their families must provide a culturally competent, accessible, comprehensive spectrum of community-based mental health services, including those aimed at prevention, early identification and intervention. These services should be integrated into coordinated, interagency networks. Services should be provided in the least restrictive, most appropriate setting with a child's needs guiding service intensity. The service planning and delivery should include parents/family members or other adult caregivers.

The system of care for children must reflect the fact that children are different from adults. Children, unlike adults, face a multitude of developmental tasks resulting from their growth in physical, cognitive, social, and emotional dimensions. As a result, the system of care for children must address their growth-promoting, habilitative needs. In addition, children are almost always dependent because they are a part of a family.

II. GOAL

The goal for the Los Angeles County Children and Family System of Care (SOC) is to develop a comprehensive, interagency system of services that assures continuity of care for each at-risk child and his or her family. The system of care will be established through the development of an interagency collaborative planning process for program design, service delivery and blended funding/revenue maximization strategies. The system of care will begin to link and incorporate the mental health services in the current Fee-For-Service Medi-Cal system with services in the Short-Doyle/Medi-Cal system, and will be structured in anticipation of a shift to fully capitated and consolidated mental health Medi-Cal services.

Although this SOC planning document is specific to the DMH-Children and Family Services Bureau, the participants involved in the drafting of the plan believe that the conceptual framework of a broader, fully integrated SOC that encompasses all county public and private child/family-serving agencies is the overarching goal of this planning process. To this end, it is crucial that the other county agencies and participants incorporate these concepts into their own planning processes as we work toward a more coordinated and seamless system.

III. PLANNING PROCESS

Because children have historically been underrepresented in planning efforts for mental health systems, participation in planning and implementation efforts on behalf of children is essential. In planning for children we must continue to identify the needs of children as different from those of adults in any system of care. Because of the child's dependence on a family or surrogate family, and because of the developmental fluidity of a child, children and adolescents are more vulnerable to illness and trauma, but also are resilient and often show a rapid response to intervention. The system of care also recognizes that collaboration with other key public sector agencies is essential not only because of their legal authority and responsibility, and specialized knowledge, skills and resources, but because of the potential to provide better integrated and expanded services to children and families. The Children and Family SOC collaboration and planning efforts include the following:

- Participate in local planning/implementation of Managed Care for children and family mental health services in order to identify and make recommendations regarding special clinical and policy issues for children.

- Participate in State SOC and Managed Care planning activities to understand and be at the forefront of new State and Federal initiatives, ensure that they are enacted within the context of children's unique needs, and ascertain how they relate to Los Angeles County.

- Advocate for equitable funding for child-serving agencies to reflect the proportion of children in the community that need mental health services.

- Establish Children and Family SOC planning Task Forces in all eight service areas.

- Assess available resources; assess service needs based upon community characteristics, such as population, physical size, proximity to other communities, unique resources and special features of the population.

- Foster the development of programs utilizing the "wraparound services" model for children who are public responsibility because it permits children to live in less restrictive, less costly, and more natural community settings.

- Utilize blended funding concepts to maximize revenues and resources so that the greatest number of children and families may be served appropriately with available resources.

- Ensure access for special groups of children who may need mental health screening and assessment, such as children with physical disabilities, children in special education, foster children, and children in the juvenile justice system, by developing screening protocols and clear linkages to other child-serving agencies.

- Establish ongoing communication between child-serving agencies, institutions and clients/families.

- Develop a forum for families to meet regularly with agency planners and service providers to identify and correct gaps in the service system, advocate on their own behalf and improve service delivery.

- Facilitate cross-training among agencies and departments participating in the SOC to: 1) Facilitate common goals, language, procedures, and expertise in essential concepts, such as cultural competence and interagency collaboration, and; 2) learn about the characteristics and needs of special populations, including dual diagnosis clients, (SED/substance abuse and SED/DD); victims of physical and sexual abuse; wards and dependents of the court; and juvenile justice/incarcerated youth.

- Work collaboratively with Adult SOC planning body around issues of transition from adolescence to adulthood for youth in need of mental health services, vocational rehabilitation, housing, etc.

IV. SERVICE PRINCIPLES

The following set of core values and principles will guide the development and implementation of a coordinated system of care:

- Provide need-based, individualized services within the context of family, culture, and community.
- Be community-based and emphasize co-location of multiple services.
- Serve children and families in the most appropriate, least restrictive environment.
- Assure that responsibility for the child is fixed at a single point of responsibility, is child-focused and family-centered.
- Emphasize prevention and early intervention whenever possible.
- Enable easy access, with multiple access points, to a full continuum of care.
- Require interagency collaboration leading to integrated services.
- Assure public/private partnership at all levels.
- Assure parent/professional partnership at all levels.
- Maximize "system literacy" by making information about services available to parents/caregivers as early as possible.
- Incorporate local flexibility and accountability (performance standards).
- Be guided by statewide policy and standards.
- Be cost-effective.
- Under a capitated system, assure that the community mental health program has control over the amount and type of services provided to individuals for which it has assumed full risk.

V. SERVICE POPULATIONS

A. 904 Plan Target Population Under Short-Doyle/Medi-Cal:

The California Mental Health Master Plan (904) set a precedent for children served by multiple agencies who are at greatest risk of out-of-home care. Historically, given the limited resources available within the Short-Doyle/Medi-Cal system, those children in the following Group I priority category have been targeted first for funding and services in the system of care. Families with an ability to pay for services rendered by the public mental health system have been charged on a sliding fee scale based on their income. These guidelines will continue to be considered as we expand services by consolidating the Short-Doyle/Medi-Cal and Medi-Cal Fee-For-Service systems.

As funding options and additional monies become available from cost avoidance realized in other departments participating in the system of care, Groups II and III respectively will receive funding for primary and early intervention services. The ultimate goal is to provide adequate services to all priority categories, to move toward serving less disturbed children, and to provide focused preventive and early intervention mental health services.

Priority categories for funding and services are as follows:

Group I: Children with serious mental or emotional disturbances at risk of or in out-of-home placement. (Group I must have 1, 2, and 5; 1, 3, and 5; 1 and 4; or 6 below.)

Group II: Children at risk of entering the Group I target population due to an emotional disturbance for whom intervention would prevent the disturbance from escalating. (Group II must have 1 and 2 below.)

Group III: Children in populations identified as potentially high risk for developing serious emotional disturbances. Such populations have a significantly higher incidence of behavioral, emotional, social, and academic problems than most children. Homeless children and children from abusive families are two examples.

Criteria for determining priority target population are as follows:

1. Diagnosis:

   A child has an Axis I or II diagnosis as specified in the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Children with a diagnosis of substance abuse, developmental disorder, or DSM "V" Code (conditions not attributable to a mental disorder that are a focus of attention or treatment) are included only if they have a psychiatric disturbance as the primary diagnosis. Organic mental disorders are included only if and while a child manifests behaviors that are a danger to self or others.

2. Functional Impairment:

Due to a mental disturbance, and not to intellectual, sensory, or health factors, a child is substantially impaired in at least two of the following areas, taking into consideration expected developmental levels:

a. Self-care and ability to function autonomously as is age appropriate.

b. Ability to function in the community. (As a direct result of a mental disturbance, a child has become isolated, has no friends or peer groups, or has lost or failed to acquire the capacity to pursue recreational or social interests.)

c. Ability to function in a family or family equivalent. (As a direct result of a mental disturbance, the child's ability to carry out usual roles and functions in the family is grossly impaired and the family is severely disrupted.)

d. Ability to progress in school or at work. (As a direct result of a mental disturbance, a child is unable to work or attend school, has experienced a serious diminution in academic or vocational performance, or is facing imminent expulsion from job or school.)

3. Duration of Emotional Disturbance:

The emotional disturbance must have been present for more than six months or, based on the specific diagnosis, is likely to continue for more than one year without treatment.

4. Symptoms/Risks:

One of the following must be present:

a. Psychotic symptoms;

b. Suicidal risk; or

c. Risk of violence (due to mental disturbance, has recently caused or is likely to cause injury to persons or significant damage to property).

5. Family Separation:

A child is at risk of being removed from the home or has already been removed.

6. Legislative Mandate:

A child meets special education eligibility requirements under Chapter 26.5 of the Government Code (AB 3632).

B. Expanded Population Under Medi-Cal Consolidation:

The Children and Family Services Bureau will be responsible for ensuring the provision of medically-necessary mental health services in accordance with federal and state Medicaid requirements. In addition to the 904 Plan target population,

services will be available to all Medi-Cal-eligible children and families based upon medical necessity. Medi-Cal beneficiaries will receive medically necessary services through our system of care and its network of public and private providers.

VI. OUTCOMES

Meaningful outcome assessment must be an integral part of a managed system of care for children and families. The guiding principles should be based upon the California System of Care model and philosophy, and support and inform the Los Angeles County SOC Plan for Children and Families. To this end, the Children and Family SOC planners will develop a comprehensive **Outcome Assessment Plan** that is:

- **Multi-dimensional**, encompassing several key domains that reflect how children and their families are progressing in areas of school attendance and achievement, recidivism in the juvenile justice system, child and family functioning, social functioning, living arrangements, daily activities, health, parent and child satisfaction, and family empowerment.

- **Multi-perspective**, by taking account of multiple sources of information available in the child's life from home, school, parent, caretaker, clinician, and participating agencies and systems.

- **Ongoing**, by repeating measures at intervals over time to establish baselines and track changes in impact that correspond to program changes.

- **Collaborative and educational**, with a clear understanding that the primary objective of the outcome assessment effort is to guide the evaluation of programs toward greater effectiveness.

- **Efficient and effective**, with a streamlined comprehensive approach that avoids duplication.

- **Reliable and valid**, by using standardized measures when possible to increase comparability on local, state, and national levels.

- **Culturally effective**, by acknowledging the diversity in Los Angeles County and supporting systems and services that respond to ethnic needs.

VII. SERVICE AREA ORGANIZATIONAL STRUCTURE

A. Children and Family SOC Service Area Network - Key Points:

- Each of the eight Children and Family SOC Service Area Networks will provide a full continuum of **service area- and community-based** mental health services for children, adolescents and their families, including prevention, early identification and referral, non-intensive, intermediate, intensive, emergency and specialized services.

- **Service area-based** components will include: DMH-CFSB oversight and management; Interagency Service Area Management Teams; Interagency Child and Family Teams; and linkage with key child-serving agencies. **Community-based** components within service areas will include: Geographic Children and Family Lead Agencies and Community Satellites. Mental health services at the community level will be provided by directly-operated, County-contracted, Fee-For-Service and Health Maintenance Organization (HMO) providers.

- **The primary child-serving agencies will collaborate in each SOC Service Area Network at the policy, management, and service levels** to better meet the complex needs of those children and families involved with **multiple service providers.** Interagency teams will be responsible for screening, assessing, planning, linking and coordinating the full spectrum of mental health and other related services for target population children who require interagency collaboration.

- The **interagency** components of each Network will be administered and monitored by an Interagency Service Area Management Team. Each interagency child/family served by the SOC Service Area Network will have their services coordinated by an Interagency Child and Family Team.

- Resources will be distributed equitably throughout each service area, based upon several key factors, including number of Medi-Cal-eligible children; number of children in out-of-home placement; poverty rate; etc.

B. Interface with Adult System of Care - Key Points:

- Within each of the eight service areas, Adult SOC "clusters" may be aggregated for the purpose of interfacing with the Adult SOC in relation to planning, administration, funding and service delivery. Thus, corresponding with every cluster or group of clusters, will be either a DMH-Children and Family Services Bureau directly-operated or

contracted Geographic Children and Family Lead Agency.

- The Children and Family Lead Agency may directly provide the mental health services for the "cluster aggregate" or may subcontract with Community Satellite programs. There may be more than one Children and Family Lead Agency per service area, depending upon the number of cluster aggregates formed.

- The Children and Family Lead Agency will be responsible for interfacing with the Adult SOC at the cluster "concierge" level, particularly in relation to meeting the mental health needs of: a) parents/surrogate parents of seriously emotionally disturbed children; b) adolescents/young adults transitioning to the adult system; and c) chronically mentally ill adults with children.

C. Geographic Children and Family Lead Agency - Key Points:

- Each Children and Family Lead Agency will be responsible for: participating in service area-wide planning; coordinating and providing an array of mental health services for children, adolescents and adults, within the context of a family-centered model, in one cluster aggregate; and coordinating with other lead agencies in the service area.

- The Children and Family Lead Agency will have the screening, assessment, diagnosis and service access functions for the cluster aggregate, which may or may not include assessments for AB 3632 eligibility. At minimum, the Children and Family Lead Agency is responsible for providing directly, or providing access to, all services under Levels 1-3 and Family Services.

- Children and Family Lead Agency staff, in collaboration with children, their families and significant others (individuals, schools, agencies, etc.), will determine the amount and type of services needed.

- The DMH-CFSB management will oversee the Children and Family Lead Agencies.

D. Children and Family Community Satellites - Key Points:

- The Lead Agency may subcontract with Children and Family Community Satellite programs. The Community Satellites may be County-contracted, Fee-For-Service, or directly-operated programs. There may be one or more Community Satellite programs per cluster aggregate.

- Children and Family Community Satellite programs will vary among cluster aggregates based upon demographic, geographic, language and cultural needs.

- Children and Family Community Satellite programs will provide one or more services under Levels 1-3 and Family Services. The services provided will be authorized by the Children and Family Lead Agency.

E. SOC Service Area Network Community Resources:

- County Department of Children and Family Services
- DCFS Family Preservation lead agencies/networks
- County Probation Department
- County Juvenile Court
- County Department of Public Social Services
- County Department of Health Services (hospitals, clinics, drug and alcohol treatment programs)
- State Department of Rehabilitation
- Law Enforcement
- Community-based human services organizations/specialty programs (Family Services, Visiting Nurses, HIV/AIDS, gay/lesbian, Big Brothers/Sisters, YMCA, etc.)
- Fee-For-Service Hospitals
- Regional Centers
- Community Colleges/Universities
- School districts/SELPAs/LACOE
- Private Industry Councils/JTPA
- City/County Department of Parks and Recreation

F. SOC Interagency Coordination Mechanisms:

1. **County-level Mechanisms:**

   a. **Interagency Countywide Policy Team** - Comprised of upper-level managers who represent each of the SOC agencies in the county. Also includes both a parent representative and a children's advocate. **The functions and responsibilities of the Policy Team include:** Engage in interagency strategic planning for SOC services; develop and monitor MOU among all SOC agencies; establish policies and procedures to facilitate effective service delivery; establish standards for service areas to meet in developing and delivering services; monitor and evaluate performance (outcomes data) of the SOC at both service area and

county levels; engage in resource development; determine allocation of resources per service area; develop innovative funding strategies.

b. **Memoranda of Understanding (MOU)** - MOU among all SOC agencies outline the type, scope, volume of services and/or funding to be provided by each participating agency. The MOU will address the need for communication and coordination in service planning for children and families receiving services from more than one service provider.

2. **Service Area-level Mechanisms:**

a. **Interagency Service Area Management Team** - Comprised of managers who represent each of the SOC agencies in the service area. These managers are empowered by their agencies to make service area-level decisions vis-a-vis policies, procedures, and allocation of agency resources. Also includes both a parent representative and a children's advocate. **The functions and responsibilities of the Management Team include:** Develop interagency SOC service area plans, including goals, objectives, outcomes measures, needs/gaps in service area resources, and resource development strategies; implement and monitor terms of the MOU among all SOC agencies; monitor and evaluate performance (outcomes data) of the SOC at the service area level; interface with the Children and Family SOC Service Area Task Forces and the Adult SOC as part of the planning process; provide consultation and technical assistance to SOC service providers and other related child-serving agencies, groups and individuals.

3. **Client-level Mechanisms:**

a. **Interagency Child and Family Team*** - Comprised of those persons most involved and influential in the child's life. The Child and Family Team has the responsibility to coordinate those resources needed to successfully implement the child's service plan(s). At a minimum, the team should include:

- The parent and/or surrogate parent (i.e., foster parent, therapeutic foster parent, or guardian);
- If the child is in custody, the appropriate representative of the county (social worker or probation officer);
- The child's primary mental health therapist;

- A lead teacher and/or vocational counselor;
- Service delivery staff from all SOC or other agencies who are, or will be, involved with the child/family;
- An advocate of the child and/or parent;
- Any other person influential in the child's or parent's life who may be instrumental in developing effective services, such as a neighbor, a physician, a relative, or a friend, and;
- The child, depending upon age and maturity level, unless to do so would be detrimental to his or her development.

The functions and responsibilities of the Child and Family Team include: Identification/assessment of the child's/family's strengths and needs in all of the child's life domains (residential, family, social, educational/vocational, medical, psychological/emotional, legal, safety, cultural/ethnic needs, etc.); interagency service plan coordination and implementation for the child/family; frequent communication among team members to identify the need for changes in services and to perform ongoing review of the child's progress and program outcomes; advocacy on behalf of the child/family.

b. **Interagency Service Plan Coordination*** - The DMH shall coordinate with other child-serving agencies to ensure that agency planning documents are consistent with one another and based upon the identification of strengths and needs in all of the child's life domains (residential, family, social, educational/vocational, medical, psychological/emotional, legal, safety, cultural/ethnic needs, etc.). A simple form shall be developed by DMH-CFSB upon which the details of each agency's plan and services will be described. The goal will be to incorporate the objectives, goals, services to be provided, and desired outcomes relative to each of the agencies involved with the child/family into a coordinated plan that shall be shared among the participating agencies.

***Interagency Team and Interagency Service Plan Coordination for multiagency children and families only.**

G. <u>SOC Program Design</u>: The Children and Family SOC for mental health services is designed with the following levels and intensity of services, which progress from the least intensive to the very high-end services needed by the target population and requiring interagency collaboration. Coordinated within each service area, the system of care includes four levels: Mental Health Promotion,

Non-Intensive Services, Intermediate Services and Intensive Services. Also coordinated at this level are Family Services. Coordinated under Countywide Services are Emergency and Specialized Services. Services can and will overlap depending upon the child/family's individual needs; thus. these categories should not be seen as mutually exclusive.

1. **Level 1 - Mental Health Promotion:** Level 1 describes a level of care currently available in the medical and human services community that provides pre-mental health screening, counseling, and medical treatment for conditions appropriately treated and supervised by non-mental health practitioners, such as pediatricians, school counselors, and other human service providers. Mental health providers may or may not be involved at this level. EPSDT (CHDP in California) mental health screening and referral into the mental health system of care may take place at this level.

   This level also includes activities and services geared to early identification and intervention. These activities are designed to mitigate the need for referral into the mental health system by providing a trained paraprofessional level of counseling and support, with professional supervision.

   Array of Services:

   - Parent Education and Training
   - Mental Health Consultation
   - Community Support/Outreach
   - Advocacy
   - Mental Health Screening
   - Interagency Referral for Mental Health Services

2. **Level 2 - Non-Intensive Services:** Level 2 is the entry level of the mental health system. These are non-intensive mental health services with easy access and a defined number or period of services. **Responsibility for case coordination will be provided by the mental health clinician.** Currently Fee-For-Service psychiatrists and psychologists and the HMO's Medi-Cal providers provide this level of care. **Services that need to go beyond the defined number or period of benefits, with determination of medical necessity, may be authorized for additional services at this level.** Children and families who require services of greater intensity, frequency, and duration will be evaluated to enter Level 3 services.

Array of Services:

a. **Short-term** (less than two months):

- Assessment
- Outpatient Treatment
- Transition Services

b. **Long-term** (more than two months):

- Assessment
- Case Coordination
- Outpatient Treatment
- Transition Services

3. **Level 3 - Intermediate Services:** Level 3 encompasses those services which provide alternatives to the most restrictive out-of-home placement by providing intensive outpatient, day treatment or less-restrictive 24-hour care modalities. **Authorization by a DMH Coordinator will be required at this level,** with a determination of medical necessity to ascertain the intensity and frequency of services. **Multiagency services should be coordinated by the Interagency Child and Family Team.** This interagency approach coordinates the services of all participating agencies, includes the parents in the case planning, and considers an array of services that goes beyond traditional mental health services.

Array of Services:

- Assessment
- Case Management
- Interagency Team/Interagency Service Plan Coordination*
- Intensive Outpatient Treatment
- Day Treatment
- School-based Services
- Mental Health Services in Therapeutic Foster Care**
- Mental Health Services in Therapeutic Group Home Care**
- Other 24-Hour Treatment
- Transition Services
- Evaluation for Intensive Services

*Interagency Team and Interagency Service Plan Coordination for multiagency children and families only.

**DMH or DMH-contracted mental health services provided within programs that are not funded by DMH.

4. Level 4 - Intensive Services: Level 4 encompasses those services which are needed when medical necessity requires a 24-hour inpatient level of care because the treatment needs of the child cannot be sufficiently met in a less-restrictive setting. **Authorization by DMH will be required at this level.**

   Hospital Services:

   - Psychiatric Hospital
   - State Hospital
   - IMD/SNF/PHF

5. **Countywide Services:** This category encompasses services that are best planned and managed at the county level, either because they need to be centralized, are extremely specialized, or because they address problems too low in prevalence to support service area-level efforts. Countywide services include: **Emergency services; services for individuals with low incidence disabilities,** (e.g., hearing impaired individuals); and **services for special populations,** (e.g., unique ethnic/cultural groups).

6. **Family Services:** This category encompasses non-intensive services provided to **adult family members** of children and families who are receiving AFDC.

   Array of Services:

   - Family Therapy
   - Individual and Conjoint Therapy for Parents
   - Parenting Groups
   - Medication Support for Parents

H. Outcome Assessment Plan: This plan, as described, would require a fully-funded Children and Family SOC, with an evaluation and research capacity which is beyond the current funding capability. However, this model Outcome Assessment Plan will serve as our guide as we move toward a managed system of care, and will be implemented in phases as SOC pilots are funded in Los Angeles County.

Client and system performance outcomes should have maximum value for all stake holders--consumers, clinicians, administrators/managers and policy makers--and should regularly report data in a clear and understandable format. The key

domains and objectives for the Children and Family SOC Outcome Assessment Plan include:

1. **Child/Youth Mental Health:**

   - Reduce problem behaviors and symptoms.
   - Reduce substance use.
   - Reduce out-of-home residential, in-patient mental health placements.
   - Achieve and maintain optimum mental health.

2. **Child/Youth School Adjustment:**

   - Increase school attendance.
   - Improve academic performance.
   - Improve school behavior.

3. **Child/Youth Social and Other Adjustment:**

   - Increase compliance with laws, norms.
   - Avoid involvement/decrease recidivism in Juvenile Justice.
   - Improve relationship with others in and out of home.
   - Improve daily living skills.

4. **Family Preservation and Caretaker Support:**

   - Keep children in their families whenever appropriate.
   - Increase training for family members and caretakers.

5. **Health:**

   - Increase regular medical and dental screening and care.

6. **Parent/Child Satisfaction with Services and Perceived Benefit:**

   - Improve parent satisfaction/perceived benefit.
   - Improve child/youth satisfaction/perceived benefit.
   - Increase family empowerment.

7. **Cost Savings to County:**

   - Reduce redundancy in services.
   - Reduce absolute cost of out-of-home placement.
   - Reduce cost per unit of service.

- Access additional funds (non-county) for mental health services.

8. **Collaboration Within the System:**

   - Increase collaboration among agencies and providers in case planning.
   - Increase involvement of client families in case planning.

9. **Preparation for Adulthood:**

   - Increase vocational services and linkages to adult system.

Tracking of client outcome variables is required by federal and state initiatives in California children's mental health programs and is currently being implemented in counties where applicable. These initiatives include: 1) The AB 377/AB 3015 legislated requirements for evaluation; 2) the Center for Mental Health Services proposed evaluation design; 3) the community functioning evaluation requirements for Rehabilitation Option and Coordinated Services, and; 4) the Mental Health Outcome Survey for Children and Adolescents from the State Department of Mental Health.

The instruments and measures agreed upon for these programs may be used on a sample of clients or, if funding allows, can be part of the clinical assessment and treatment protocols for all children, adolescents and families served in the system of care. In addition to demographic data on utilization and cost information available in the mental health system, the outcome measures under consideration are the following:

1. Achenbach Child Behavior Checklist
2. Achenbach Youth Self-Report
3. Restrictiveness of Placement/Living Arrangement Scale
4. Child Satisfaction Scale
5. Parent Satisfaction Questionnaire
6. Child and Adolescent Functional Assessment Scale
7. Parent Empowerment Scale

I. <u>Blended Funding Strategies/Interagency Resource Pool</u>:

The Children and Family SOC Planning Committee will look at ways, through the use of interagency blended funding, to reduce the cost of children and adolescents in out-of-home placement by maintaining them either in their own homes or less restrictive types of placements. For example, the DMH-CFSB and the DCFS could authorize the creation of alternative, community-based pilot

programs in which providers are funded, at a higher rate, to design services that effectively maintain these children and adolescents within a family setting. During the pilot phase, the County and providers would proceed under a shared risk model, with the goal of shifting full risk to the providers if the pilots prove to be successful. It is assumed that the higher rate given to the providers would be funded through the diversion of funds for foster care, group home and residential placements.

J. Budget/Funding Structure - Key Points:

- Under a **managed care** model, the Department of Mental Health will provide a separate policy/benefits package for children and adolescents to support a comprehensive **child and family services system**. Built into the rate structure and included in this package will be **child/family-related services for adults.**

- Under a **managed care** model, the **Children and Family Lead Agency** will assume **full risk** for individuals receiving services.

- Under a **capitated system** it is assumed that **AFDC recipients**, both children and adults, **will be capitated under the Children and Family SOC programs**, and that **adult SSI recipients will be capitated under the Adult SOC programs.**