THE STEPHEN GROUP

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

Summary of The Stephen Group's findings and recommendations

April 20, 2016

Summary of TSG Review

- HHSC and DFPS directed TSG to perform a comprehensive assessment of how the Texas child welfare system serves children with high needs (outside foster care redesign areas) including:
  - Identification of gaps in policy, process, and knowledge that result in poor outcomes; and,
  - Generation of solutions.
- TSG approach:
  - Data analysis to define and understand the characteristics of the high needs foster care population.
  - Interviews of state office experts across disciplines.
  - Focused research in 4 regions (2, 3, 7, and 10) to identify Texas best practices and also system gaps.
  - In-depth analysis of several case studies of real high needs children to understand their experiences and system gaps.
  - Consultation of national experts and collected best practices.

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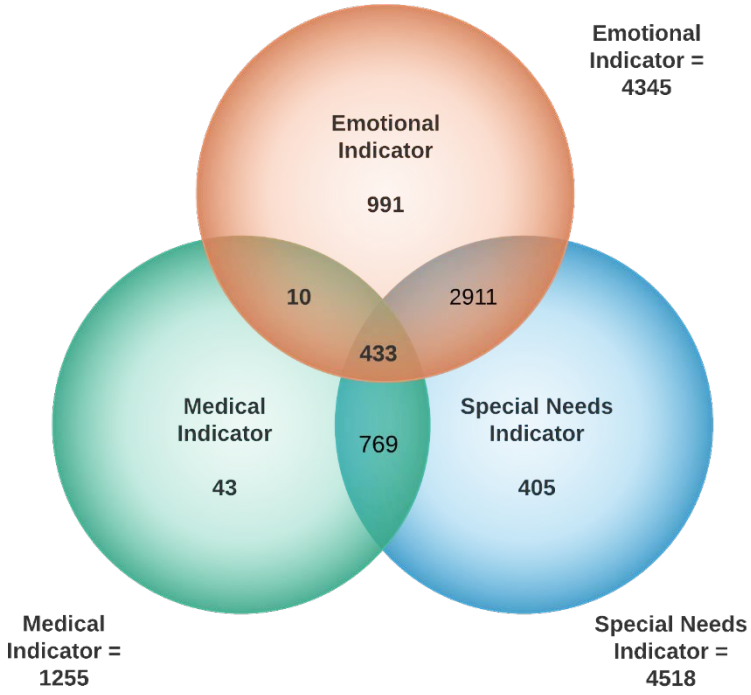
Who are High Needs Foster Children?

- There are many ways to define foster children with high needs.
- TSG used child characteristics data entered by caseworkers into IMPACT.
- There are dozens of different data points, but individual characteristics are mapped to higher-level “indicators.”
  - 3 relevant indicators include: Special Needs Indicator, Emotional Indicator, and Medical Indicator.
  - Approximately 5,900 of 29,000 children in care fit this definition of high needs (unduplicated count).
- These children are not all in crisis, but represent a pool of children who could be in crisis if they do not receive adequate services and supports.



Source:

Data analysis includes children in DFPS conservatorship in August 2015.

Outcomes for High Needs Children

- Not all 5,900 high needs children are in crisis. About half have moderate and basic level of care. They represent a larger pool of children who could be at risk if not provided the right services and supports.
- However, we do know, high needs children…
  - Have more placements than the average child.
    - 2.7 for average child in care in August 2015
    - 5.7 for kids with the emotional indicator; 5.0 for special needs indicator; 4.0 for medical indicator
  - Spend a longer time in care.
    - 1.93 years for the average child in care in August 2015
    - 3.1 years for kids with the emotional indicator; 3.7 years for special needs indicator; 4.0 years medical indicator
  - Reside in different placement settings.
    - Less likely to reside in foster homes and kinship homes.
    - Significantly more likely to be in RTC setting.
- It is more difficult for high needs children to achieve permanency.

Entities involved in Meeting Needs of High Needs Children in Foster Care

CPS

- Legal responsibility for children
- Coordinate and arrange for placement
- Meet child's needs
- Act as "parent"

CPA

- Contracts with DFPS
- Places children in a variety of settings
- Responsible for care delivery to the children placed with them

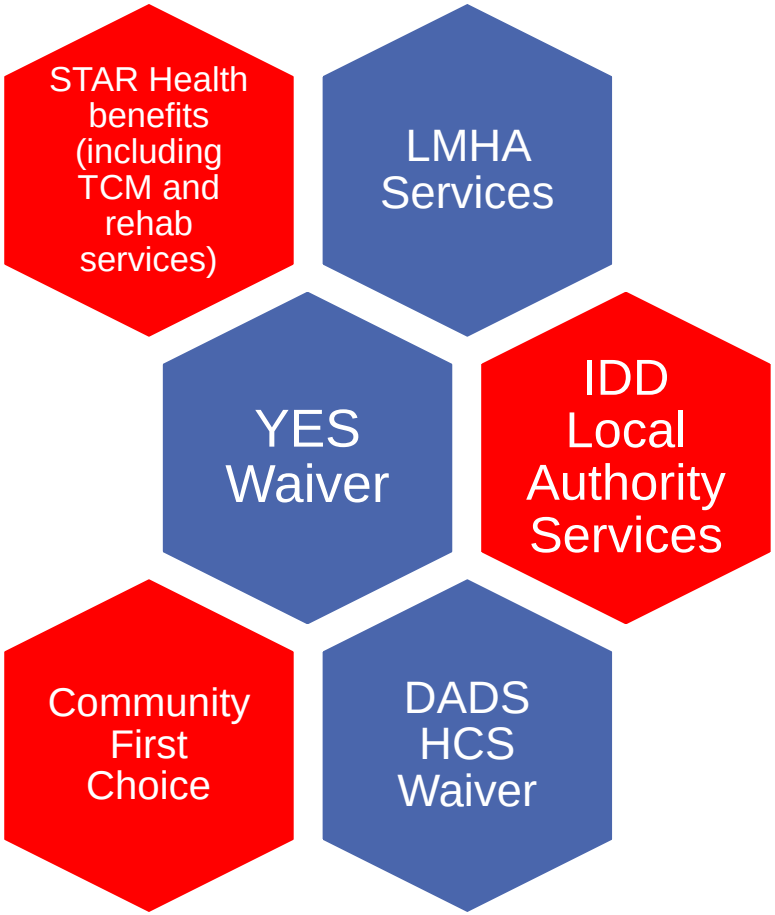
STAR Health

- Medicaid managed care program for children in foster care
- Vendor provides primary, behavioral, dental, and vision care by contracting with a network of providers across the state.

Local MH Authority

- LMHA is a service provider.
- Local government entity that contracts with DSHS to provide community-based mental health services.

What services are they eligible to receive?



How is the process supposed to work?

- TSG found that high needs foster children need a child welfare system with:
  - A skilled and well-trained CPS workforce
  - Coordination among the entities responsible for serving them (CPS, CPAs, STAR Health)
  - Services and placement options in the communities where they live
  - An ability to move seamlessly and rapidly between placement settings
- Ideally, when a high needs child comes into care:
  - The worker should identify their needs
  - The worker should identify necessary services
  - Services should be available
  - Providers should not reject serving the child or eject the child as needs change
- In practice, TSG found gaps in several places:
  - Workers may not be able to identify the child's needs
  - Workers may identify the needs but not know how to meet them
  - Services or placements may be unavailable
  - When available some essential benefits and services not utilized
  - Providers may be unwilling to serve or continue serving a high needs child

Strengths of the Texas System

- Mental Health has received significant resources from Texas Legislature, including creation of a leadership position at HHSC.
- The “Starfish” process elevates specialized needs of foster children and encourages collaboration within and outside the health and human services enterprise.
- Texas is a national leader with managed care generally and in design of the STAR Health program for foster youth. The contract has many new enhancements. The vendor is held accountable for statewide network adequacy.
- Foster Care Redesign is building service capacity in local communities and incentivizing improved permanency outcomes.
- The Texas System of Care includes use of national best practice training provided by the University of Texas, a statewide network of trained providers (LMHAs), and the legislative authority for CPAs to become providers of TCM and rehab services for foster youth.
- CPS regions demonstrate use of many best practices including psychiatric hospital diversion, reintegration, and supporting placements to prevent adverse outcomes.
- New efforts seek to improve collaboration with STAR Health to increase caseworker awareness about STAR Health benefits.
- There is concentrated knowledge in subject matter experts across the CPS system.
- CPS continues efforts to build provider capacity.
- Robust data exists to support creation of a more accountable system, including data captured in the IMPACT system and data collected by the STAR Health vendor.

GAPS

Case management functions are not coordinated by an accountable entity

- Caseworker, CPA, STAR Health have various case management responsibilities, which creates confusion.
- There is an absence of more comprehensive level of coordination across the CPS, STAR Health, CPA, and LMHA systems.
- The CPS worker lacks time, data/other information and leverage to truly manage these high needs cases.
- No one accountable entity is conducting data analysis at the system level.
- There is a lack of key performance measures to hold CPAs accountable for outcomes.
- Data and authority are not aligned.

Under-utilization of Medicaid services

Factors contributing to low utilization of Medicaid services:

- Significant gaps in CPS worker and caregiver knowledge about STAR Health benefits.
- Limited number of CPAs credentialed to provide TCM and rehabilitative services under Medicaid, despite statutory authority.
- LMHAs are credentialed to provide TCM and rehab services but barriers to using LMHAs exist including:
  - The degree of LMHA-CPS collaboration varies statewide.
  - LMHAs have historically lacked pediatric services.
  - LMHAs may have perceived foster youth to be outside their priority population.
  - CPS caseworkers may be reluctant to refer CPAs or DFPS foster parents to their LMHA.
  - There have been challenges in developing LMHA/CPA collaboration.

No Standard Definition of High Needs Children or Auto-Mechanism to Ensure Consistent Process is Followed

- No singular definition of high needs child or common understanding of the problem.
- No mechanism to identify these children when they come into care or as their needs change while in care.
- No automatic notification or referral to ensure that once identified, the best practice scenario occurs in 100% of cases.
- The result is that it is possible for a high needs child to have his/her needs met by the system the ***success depends on how the CPS caseworker and other elements of the child welfare system converge to meet that child's needs.***

Process and organizational challenges in how CPS works with these children

- Existing process concentrates knowledge among specialists, not the majority of caseworkers.
- Workers may not seek out the specialist for assistance (i.e., may not know who the specialist is, may not be co-located with specialist).
- Caseworkers have significant knowledge gaps about STAR Health benefits.
- There are communication gaps with CPAs and STAR Health.
- The existing escalation process (Starfish) may be too late in the life of a case.
- Practice gaps exist in preventing and addressing trauma, which may contribute to placement disruptions.
- The impact of systemic child welfare issues is pronounced (i.e., turnover, “crisis” focus instead of prevention, impact of external stakeholders).

Placement and Service Capacity Gaps

- Capacity to serve high needs children varies statewide.
- Barriers to building capacity exist.
- Even when capacity exists, providers may not want to serve high needs children.
- There is a critical lack of wraparound services to support placements.

RECOMMENDATIONS

Define “High Need” and Ensure Standard Protocol Followed

- Develop a uniform definition of children with “High Needs” as it relates to children coming into care and for children in care whose needs change while in care.
- Create an automatic mechanism to ensure the best practice process is followed for all high needs children:
  - Use the Comprehensive Texas Child and Adolescent Needs and Strengths (CANS) tool to identify high needs children coming into care.
  - Use IMPACT and STAR Health Data to gain a more robust understanding of high needs children based on their child welfare characteristics as well as health care utilization.
  - Use data to identify characteristics of children “at risk” of becoming “high needs” and develop related interventions.
  - Work with STAR Health vendor to identify the combination of child welfare data indicators and STAR Health clinical indicators that create the risk profile for children whose needs change while in care.

Build Accountable Case Management Process

- Conduct a pilot to test an integrated model of care including use of TCM and wraparound services for a clearly defined group of high needs children.
- A single accountable entity would take on the following responsibilities:
  - Placement
  - Greater service coordination role
  - Risk for the high needs children they agree to serve (with no eject policy)
  - Entity assumes responsibility that each high needs child accesses all of the services that are clinically appropriate, including TCM
  - The entity could get credentialed to provide TCM or sub-contract with an LMHA or credentialed CPA to provide TCM
- HHSC should work with partners to expand access to training required for TCM credentialing, including the Department of State Health Services and the University of Texas (the state's designated training entity).

Build Accountable Case Management Process (cont.)

- The Single Entity would need to be compensated for taking on additional case management duties.
  - Consider use of different compensation strategies including payment based on level of need and use of incentives to reward excellent providers for their performance in these key areas.
- Establish key measures to reinforce accountability and encourage excellence in child health, behavioral health, and key permanency outcomes.
  - Hold entity accountable for outcomes around children leaving psychiatric hospitals and close contractual and process gaps to reduce the number of placement challenges at this critical point.
  - Hold entity accountable for providing sufficient services to children leaving RTCs to increase the likelihood the next placement will be successful.
- Align each high risk child's case specific “outcomes" based on a single child plan of service to be used by all entities working with the child.

Recommendations for CPS

- Conduct utilization review of STAR Health data to ensure appropriate service delivery.
- Use data to hold CPAs accountable for child health and behavioral health outcomes.
- Continue capacity building work. Focus on high intensity in-home supports that provide the continuity for essential services to reduce the risk of recidivism.
- Identify internal protocols (escalation process, etc) to be used in conjunction with development of the mechanism to identify high needs children.
- Conduct training and communicate changes to staff; include regular refresher on STAR Health.
- Use of prevention strategies to stabilize high needs children who are not in crisis situations.

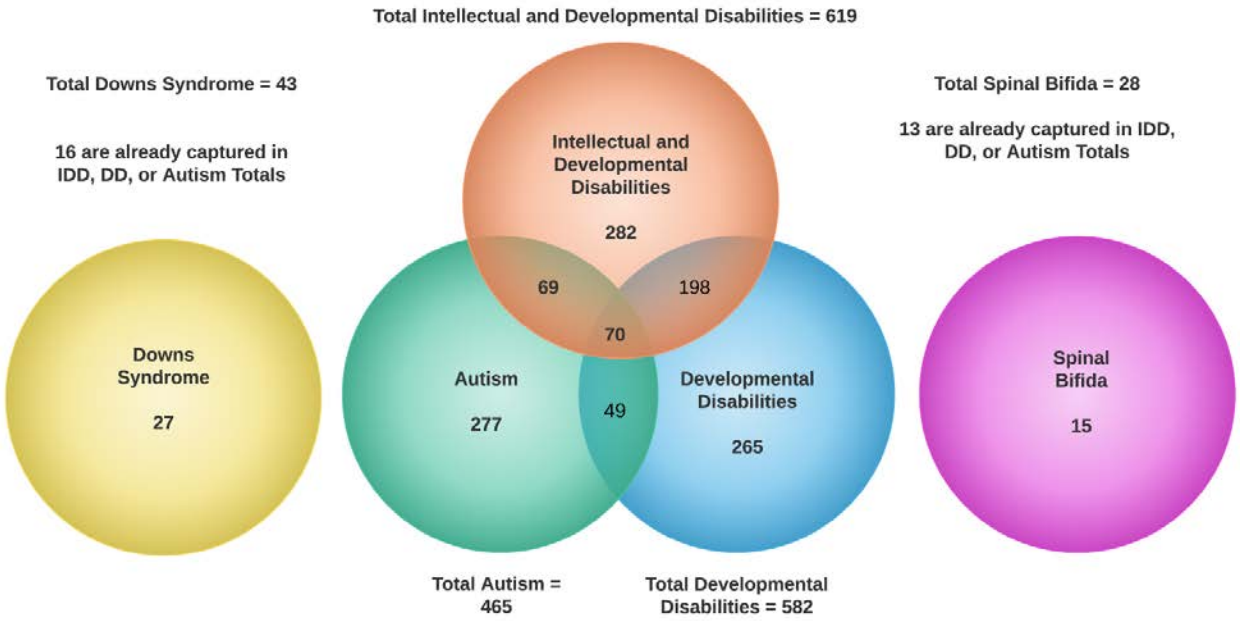
REFERENCE

High Needs Population with IDD

- 5 groups considered part of IDD foster child population; duplicated count = 1,737
- Most of these children are included in the Special Needs Indicator

	Developmental Disability	Intellectual and Developmental Disability	Autism	Spinal Bifida	Downs Syndrome	Total
Total	582	619	465	28	43	1737

- Unduplicated count = 1,252



National Best Practices

Virginia

- Intensive Care Coordination and the High Fidelity Wraparound model for youth with challenging behavioral health issues and who are at risk of out-of-home placement.

Louisiana Behavioral Health Partnership

- Offers an array of Medicaid State Plan and Home and Community-Based waiver services to all children and youth in need of mental health and substance abuse care and with significant behavioral health challenges or co-occurring disorders. The Coordinated System of Care is managed by Magellan Health Services.

California:

- Medi-Cal Intensive Care Coordination, Intensive Home Based Services, and therapeutic foster care are available for Katie A. Subclass Members. The sub-class refers to a California federal court settlement agreement designed to improve child welfare mental health services.

Wisconsin:

- Offers treatment foster care (therapeutic foster care), home-based care for Level 3-4 Foster Care Services. Foster parents can get 24-hour support from a Mobile Urgent Transport Team, in addition to monthly face-to-face meetings with caseworkers.

National Best Practices (cont.)

Illinois

- The Department of Children and Family Services System of Care implemented a pilot in 2014 in four counties targeting children in psychiatric hospitals, residential treatment, specialized foster care and entry-level foster care if they already showed signs of instability.
- DCFS contracted with Choices (outside vendor) for all care coordination. Services authorized by Choices Child and Family Teams include many services not available through Medicaid.

Florida

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