Can you tell us about a few agencies that have **systems of care**?

The system of care approach was developed as a way to better serve children and youth with serious mental health conditions, and their families. The goal is to provide children and their families with the services they need in their homes and communities in order to avoid the need for inpatient and residential treatment.

A system of care is not a specific type of program; rather, it is an approach that combines a broad array of services and supports with a set of guiding principles and core values. Services and supports are provided within the context of the core values: services should be community-based, family-driven, youth-guided, and culturally and linguistically competent. Most important, services and supports are individualized to address the unique strengths and needs of each child and family. Each system of care develops its own guiding principles, but they should be aligned with these core values.

This information was prepared in response to a request for jurisdictional examples of systems of care in child welfare, particularly in states that have child welfare systems that are state-supervised and county-administered. Interviews were conducted with systems of care leadership in Colorado and Pennsylvania, both of which have county-administered child welfare systems, as well as Iowa, which has a state-administered child welfare system. Detailed descriptions of each state's system of care are provided below, along with common themes and lessons learned.

Highlights from the literature

Systems of care can vary widely in their structure and implementation, but when they adhere to the aforementioned core values, they have demonstrated improved outcomes at both the individual and systemic levels. Both the Substance Abuse and Mental Health Services Administration (SAMHSA)[1] and the Children's Bureau[2] have funded evaluations of systems of care, and a synthesis[3] of these along with other evaluations have found that systems of care are associated with a range of positive outcomes:

Systems of care are associated with…

- More stable living situations for children and youth, including fewer out-of-home placements and fewer placement changes.
- Improved school attendance and grades.
- Decreased suicide rates, substance abuse, juvenile justice involvement, and inpatient/residential stays.
- Improved family functioning and reduced caregiver stress.
- Increased family and youth involvement in services.
- Increased use of evidence-based practices and an expanded array of home- and community-based services and supports.
- Increased cross-system collaboration and improved use of Medicaid and other resources.

One study of child welfare systems of care also noted that caseworker job satisfaction showed a statistically significant increase,[4] indicating that the implementation of a system of care could potentially contribute to reduced turnover, a chronic challenge that has been found to negatively affect safety and permanency outcomes for children and youth.[5]

In addition, a recent analysis of the cost-effectiveness of systems of care found that the systems of care approach "provides an excellent return on investment".[6] According to this analysis, cost savings include both current and future costs, primarily from decreases in inpatient psychiatric stays, emergency room visits, residential treatment stays, juvenile justice involvement, and school failures.

At a glance

The table below highlights the key descriptive elements of the three models explored:

DESCRIPTOR	COLORADO	PENNSYLVANIA	IOWA
SOC TITLE	COACT Colorado	PA System of Care Partnership	Iowa Child Welfare System of Care
LAUNCH DATE	2004	2010	2017
PARTNERS	Colorado Department of Human Services (DHS), SAMHSA, and all state and local child and youth serving agencies, including the public health system, child welfare, juvenile justice, and education	PA DHS, Office of Mental Health and Substance Abuse Services, Bureau of Juvenile Justice, Office of Children, Youth & Families, Juvenile Court Judges' Commission, Department of Drug and Alcohol Programs, Department of Education, PA Healthy Transitions, Youth MOVE PA, PA Partners Learn Together, Youth and Family Training Institute, PA Families Inc., SAMHSA	Iowa DHS, contracted providers
FUNDING	• COACT Colorado: SAMHSA grant • Local funding streams include Medicaid, CMP, child welfare, CO Senate Bill 94	• PA System of Care Partnership: SAMHSA grant • Local funding streams include child welfare, Medicaid • 35 counties	Statewide
SCOPE	15 Communities of Excellence in 18 counties	35 counties	Statewide

Can you tell us about a few agencies that have systems of care?

DESCRIPTOR	COLORADO	PENNSYLVANIA	IOWA
CORE SERVICE(S)	• High-Fidelity Wrap-around • Family Advocacy	• High-Fidelity Wrap-around • Child & Adolescent Service Support Program • Family Group Decision-Making • Enhanced Interagency Service Planning Team with Youth & Family Supports • Open Table	• Child welfare emergency services • Foster care group care services • Supervised apartment living • Recruitment and retention of resource families • Training and support of foster parents
CORE PRINCIPLES	• Family Voice and Choice • Team-based • Natural supports • Collaboration • Community-based • Culturally competent • Individualized • Strengths-based • Persistence • Outcome-based	• Equal partnership on leadership teams • Youth driven • Family driven • Integration of child-serving systems • Valuing natural and community supports • Assuring cultural and linguistic competence • Youth & Family services and supports planning process • Evaluation and continuous quality improvement	• Families, children, youth, and caregivers will be treated with dignity and respect while having a voice in decisions that affect them. • The ideal place for children is with their families; therefore, we will ensure children remain in their homes whenever safely possible. • When services away from the family are necessary, children will receive them in the most family-like setting and together with siblings whenever possible. • Permanency connections with siblings and caring and supportive adults will be preserved and encouraged. • Children will be reunited with their families and siblings as soon as safely possible. • Community stakeholders and tribes will be actively engaged to protect children and support families. • Services will be tailored to families and children to meet their unique needs. • Child welfare professionals will be supported through ongoing development and mentoring to promote success and retention. • Leadership will be demonstrated within all levels of the child welfare system. • Decision-making will be outcome-based, resource-driven, and continuously evaluated for improvement.

Common themes

All of the states interviewed shared the following themes:

Core Principles

While the principles may vary from state to state, they all emphasize youth and family voice, as well as providing individualized services and supports. Establishing a common set of principles for all to work from was seen as critical to success.

Community Engagement

Each state's system of care is focused on keeping children in their communities and serving them through local providers. Communities play critical roles within the systems of care framework and must be viewed and valued as equal partners on the team.

Collaboration

Communication must include all relevant stakeholders, including those who might be wary of the idea of a system of care. Collaboration is necessary at all levels — individual, system, local, and state.

Data

Data was identified as a powerful tool at all stages of systems of care implementation: in engaging stakeholders and creating buy-in; in identifying needs and re-allocating resources; and in tracking outcomes.

COACT Colorado[7]

COACT Colorado is the state's system of care, developed to support children and youth with serious behavioral health challenges in reaching their full potential. COACT Colorado is a cooperative initiative between the Colorado Department of Human Services (DHS) and other state, local, and federal partners, including the child welfare, juvenile justice, education, and public health systems. The communities in which COACT Colorado operates are called Communities of Excellence; there are currently 15 Communities of Excellence in 16 counties, and these counties are where the majority of children in Colorado live.[8]

Core Components

The verb "coact" means to work or act together for a common purpose. COACT Colorado uses high-fidelity wraparound,[9] an evidence-based practice, to bring together a team that works to achieve the family's goals. The team includes the wraparound facilitator and a family advocate, who offers peer support to parents/caregivers. COACT Colorado is also developing youth peer supports in addition to parent peer supports. The wraparound process includes the following four phases: engagement, initial plan development, plan implementation, and transition.

The 10 principles guiding COACT Colorado are:

1. Family Voice and Choice
2. Team based
3. Natural supports
4. Collaboration
5. Community based
6. Culturally competent
7. Individualized
8. Strengths based
9. Persistence
10. Outcome based[7]

COACT Colorado also provides training and technical assistance to all of the Communities of Excellence on topics such as family involvement, LGBTQ issues, and cultural competence. Training and technical assistance are tailored to each community's unique needs, and are provided in the local community.

While high-fidelity wraparound is the care coordination component of COACT Colorado, the agency oversight component is built upon Colorado's Collaborative Management Program (CMP). The CMP is the result

of legislation passed in 2004 to establish county-level collaborative management programs that would improve outcomes for children, youth, and families involved with multiple agencies. There is also a state-level CMP led by the Colorado DHS Division of Child Welfare. Partner agencies at both the state and county levels include juvenile justice, behavioral health, public health, health care, education, and the judiciary. The CMP provided an already-existing structure for interagency groups to work together, including memoranda of understanding and resource sharing, which helped to facilitate the development of COACT Colorado. In addition, if a CMP achieves certain outcomes, it can receive incentive dollars from the state, which can be used to support COACT Colorado's efforts at the local level (see funding section below).

Funding

COACT Colorado is funded by a grant from the SAMHSA. COACT Colorado is on a second round of four-year grants, with three years remaining in the current cycle. However, because Colorado also wanted to build in sustainability in each Community of Excellence, COACT Colorado pays for half of the facilitator's salary and half of the family advocate's salary, and the community pays the other half of each salary. Many communities are using their CMP incentive dollars to cover these costs, and some are using child welfare flexible Core Service Dollars. There is also some funding available from Colorado's Senate Bill 94, which is focused on keeping youth out of detention.

Medicaid also provides funds for some of the services needed by the children in COACT Colorado. Colorado would like to leverage additional Medicaid funding to pay for wraparound and peer support. Residential services in Colorado are fee-for-service, but community-based behavioral health services are capitated, which allows for some flexible use of Medicaid funding. There are five behavioral health organizations in Colorado that receive all of the Medicaid dollars and then manage services for the entire Medicaid population in Colorado.

The biggest challenge that the Communities of Excellence have experienced with regard to funding are the restrictions on each funding stream (i.e., CMP, Senate Bill 94, Child Welfare Core Service dollars, Mental Health block grant dollars, Medicaid), as each funding stream has different criteria regarding what it can pay for. One solution they are proposing is to establish a case rate per child that each system would pay for each child or youth enrolled in high-fidelity wraparound services.

Assessing Need

In 2014, COACT Colorado released an analysis of service delivery prior to the existence of the system of care, looking specifically at the data regarding youth who crossed over into multiple systems. This evaluation[10] examined both the use and the cost of high-intensity services, as well as outcomes for those youth, and found that the child welfare system paid the largest proportion of inpatient and residential treatment services. In looking at the highest users of child welfare services (the top 20 percent) almost all of them were receiving mental health services, about half were involved in the juvenile justice system, and about a fifth were receiving substance abuse services.[11] These data have been key in communicating the message that these children are involved in multiple systems and therefore systems need to work together to better serve the children and their families.

The evaluation also found that about half of the children began receiving services through the child welfare system, while the other half began in the public mental health system. While most did not start in the juvenile justice system, many did end up there, reinforcing the need to find the most effective way to serve these children early, rather than managing the human and financial costs later.

With regard to assessing the needs of youth, COACT Colorado uses the Colorado Client Assessment Record,[12] the same tool used by the behavioral health system, allowing them to compare their youth outcomes to those of the general behavioral health population.

With regard to assessing availability of services in the community, COACT Colorado would like to conduct an analysis of what services are currently available and what gaps exist, but that has not been done to date.

Legislative/Policy Changes

No legislative or policy changes were needed to establish COACT Colorado, although if the CMP structure had not already existed, a legislative change might have been necessary to establish the information and resource-sharing structure that the CMP provides.

Communication and Collaboration

A key ingredient to the success of COACT Colorado has been building partnerships between the state and counties — while the state provides guidance, there has been room for community creativity at the local level. To create this partnership, guidelines and policies were developed collectively with the Communities of Excellence. To support this partnership, COACT Colorado has a principal investigator who focuses on the state system, and a project manager who focuses on working with the communities and serving as the communication link between the state and local levels. Monthly meetings are also held with the Communities of Excellence, in addition to periodic site visits to each community. This has been crucial in ensuring that the Communities feel heard and understood.

COACT Colorado has a steering committee that includes broad representation from state agencies, communities, families, youth, and community organizations, including residential treatment providers. Although these providers were initially wary of the idea of reducing the use of congregate care, they are now engaged in thinking about how they can approach their work differently and provide additional services beyond residential care. At each bi-monthly steering committee meeting, a Community of Excellence provides an update regarding their work, allowing them an opportunity to be heard and providing the committee with a chance to understand the work that is happening on the ground.

Each community's experience with buy-in and openness at the local level has been different, but it has been helpful to have leadership from each state agency at the COACT Colorado table. Their presence has demonstrated the state's dedication to the system of care, especially to agencies at the local level who may have had doubts or concerns at the outset.

Another strategy that helped to create buy-in was to co-locate the principal investigator of COACT Colorado at the Medicaid office two days per week. Since the five behavioral health organizations in Colorado have the discretion to identify priorities for services, the principal investigator's presence at the state Medicaid office has helped to build support for the use of high-fidelity wraparound among the behavioral health organizations.

Permanency

The goal of high-fidelity wraparound is to work on the family's goals. If a family goal is to achieve permanency, then permanency achievement will become part of the wraparound team's plan. Similarly, high-fidelity wraparound follows the youth: if a youth is removed from the home, then the team will continue to work with the youth and whomever they identify as an important part of their lives, including the foster family, the birth family, and/or relatives.

Services and supports are provided through community-based services as well as providers contracted through the various state agencies, such as child welfare and mental health. Economic support, including help with finding employment and housing, may also be provided if poverty is a barrier. As stated earlier, persistence is one of the key principles of

COACT Colorado, which is operationalized by never "giving up"— if the plan is not working, then it's not the right plan.

Outcomes

COACT Colorado does not have any provider contracts, but it does have contracts with each Community of Excellence, and it regularly gathers outcome data from the communities. During its first grant cycle, it picked four Wildly Important Goals (WIGs)[13] to track: school performance, perception of care, level of functioning, and number of crisis and correctional nights. These are measured with either a self-reporting instrument completed by the youth or caregiver or the professional-rated Colorado Client Assessment Record (CCAR).[14] COACT Colorado determined what it would consider "success" for each WIG, and then decided on an overarching goal: that at least 300 youth served by the system of care would reach the predetermined level of success on at least one of the four WIGs.

The 2016 interim evaluation of the initiative found that:[15]

- Nearly 70 percent of youth engaged in COACT Colorado demonstrated success on at least one of the WIGs.
- Measures of family functioning showed improvement on both the self-assessment and the CCAR measures.
- While social connectedness/social support was significantly improved on the self-report measure, with a trend in the right direction in the CCAR, it was not significant.
- Depressive symptoms also seemed to improve but not statistically significantly on either measure.
- Overall mental health symptoms and level of functioning did improve using the CCAR.
- Additionally, measures of substance abuse, school performance, and daily life all showed trends toward improvement on both the self-report and CCAR measures.

Pennsylvania's System of Care Partnership[16]

Pennsylvania's System of Care Partnership serves youth ages 8–18 with complex mental health challenges who are also involved in the child welfare and/or juvenile justice systems. The PA System of Care Partnership consists of state and local partners, including: Pennsylvania DHS; Office of Mental Health and Substance Abuse Services; Bureau of Juvenile Justice; Office of Children, Youth & Families; Juvenile Court Judges' Commission; Department of Drug and Alcohol Programs; Department of Education; PA Healthy Transitions; Youth MOVE PA; PA Partners Learn Together; Youth and Family Training Institute; and PA Families Inc. The Partnership is governed by the State Leadership and Management Team (SLMT), which includes youth leaders, family leaders, and state administrators from child-serving systems, including the child welfare system. Currently about 35 counties in Pennsylvania operate a system of care.

Core Components

The goal of the Pennsylvania System of Care Partnership is to create philosophical change in the way government works. This change is based on the Partnership's standards:

- Youth driven
- Family driven
- Integration of child-serving systems
- Natural and community supports
- Cultural and linguistic competence
- County Leadership Team
- Youth and Family services and supports planning process
- Evaluation and continuous quality improvement

This philosophical change is operationalized in part by using a full-team approach, and including youth and families in the decision-making process as equal partners. This happens at multiple levels: individual,

team, and state. At the individual level, there is a team that "wraps around" the youth and family and works together to meet their goals. At the county level, there is a leadership and management team that "wraps around" the county and works to ensure that youth and families partner with counties to develop policies and practices that are meaningful to them. And at the state level, the SLMT "wraps around" the state to change the way government operates by hearing regularly from counties, families, and youth regarding barriers and strengths in the system.

The PA System of Care Partnership does not rely on one specific program or practice, but rather encourages use of the following research-based practices and programs:

- High-Fidelity Wraparound
- Child and Adolescent Service Support Program[17]
- Family Group Decision-Making[18]
- Enhanced Interagency Service Planning Team with Youth and Family Supports
- Open Table[19]

Other planning meetings, such as Families and Schools Together or the Youth and Family Support Planning Process, are also being used in some areas. The decision to use any of the above programs or practices is at the discretion of each county. What is required, however, is that counties adopt and work on the Partnership's standards. The Partnership provides technical assistance to counties, depending upon their unique context, needs, and priorities.

The PA System of Care Partnership is staffed by a project director, a cultural and linguistic competency specialist, two family involvement specialists, two youth involvement specialists, a social marketing specialist, and an administrative assistant. There is also a principal investigator, who is the director of PA's Bureau of Children's Behavioral Health Services.

The role of the family involvement specialists is to identify and recruit new family members; train counties on how to better engage families; coach family members on how to be heard at meetings; and lead the Team Up for Families program, which empowers families to better understand the system and therefore how to speak up more effectively. The role of the youth involvement specialists is similar, albeit working with youth, as well as working with Youth M.O.V.E. PA, which is a chapter of Youth M.O.V.E. (Motivating Others through Voices and Experiences) National.

Funding

The Partnership is currently funded through a SAMHSA grant, its third since 2009. It is in the process of applying for a no-cost extension as well as another grant, as the current cycle came to an end on June 30, 2017. Some counties also have their own grants, and there is an agreement between the Partnership and those counties to share resources and information. The Partnership is working together with grant directors from those counties to learn about the barriers and strengths of resource-sharing, and how they can improve.

County children and youth agencies can also request funding for their systems of care through their needs-based budgets, as long as they are using evidence-based practices such as high-fidelity wraparound. Early and Periodic Screening, Diagnostic, & Treatment (EPSDT)[20] funds are available to cover most of the services needed, with only a few exceptions (such as respite care).

Assessing Need

Through a contract with the Youth and Family Training Institute,[21] the Partnership was able to develop data dashboards, which have helped counties see what the needs are in the service population. The youth involvement specialists have also been key in gathering information from youth across the state regarding needs and gaps.

In addition, the Partnership conducts an annual survey of participating counties, the PA County Assessment, to gather input on the standards and how they are working or not working at the local level. The results of this survey inform the work of the Partnership and the type of technical assistance offered.

The Partnership does not contract with service providers, but community-based services are generally available when needed. However, those providers are able to accept, reject, or eject youth from services at their discretion. If needed, a regional planning team can help connect youth with services.

Legislative/Policy Changes

The only significant change needed to support systems of care in Pennsylvania was the creation of the SLMT. However, policies and regulations are slowly changing to include systems of care language.

Communication and Collaboration

At the state level, the juvenile justice, child welfare, and mental health systems have been core participants in systems of care in Pennsylvania, and over time, the Department of Education and the Department of Drug and Alcohol Programs have also become regular participants in the SLMT. This change has been largely due to consistent relationship-building and persistence in inviting them to the table.

Beyond the SLMT, it has been important to have communication across all levels, from the local level up to the top levels of state leadership, although the Partnership acknowledged that it still has room for improvement in this area. The judiciary has been another important group to engage in this process, especially to ensure that judges understand how the system of care works. For example, families cannot be ordered to participate in the system of care in the way that a judge might order mental health or other services, because participation in the system of care has to be the family's choice. Buy-in from judges has varied from community to community, but the Partnership has found that gaining buy-in from judges can best be achieved when there is a local judge who understands the system of care and the identified program (i.e., high-fidelity wraparound in this case) and can act as a champion to educate fellow judges.

At the local level, one key strategy has been to understand the local community's needs, honor where they are coming from, and then provide effective solutions to meet their needs. The Partnership was able to do this by hiring a project director who came from the county level. He has been able to engage in those conversations and frame the system-of-care approach as one that can benefit child welfare agencies, because it can provide a way for families to develop their own plans so they no longer need child welfare services.

Permanency

Regardless of the practice or program that a county chooses to adopt in its system of care, the team surrounding the child and family should be working toward the child and family's goals, rather than any case plans identified by the systems involved with that family. Although case managers are typically a part of the team, the team itself is expected to remain neutral — clinical interventions and case management functions take place outside of the team environment. Therefore, permanency planning might be part of the team's plan, but that would depend on whether it is identified as a goal by the child and family.

Outcomes

The Partnership's first grant included an evaluation of high-fidelity wraparound services as part of the system of care, utilizing the following assessments: Child Behavior Checklist 6 to 18 (CBCL 6-18); Caregiver Strain Questionnaire (CGSQ); Delinquency Survey, Revised (DS-R); Columbia Impairment Scale (CIS); Revised Children's Manifest Anxiety Scale, 2nd ed. (RCMAS–2); Reynold's Adolescent Depression Scale (RADS–2); and Multi-Sector Service Contacts (MSSC–R).

Findings included improvements in both internalizing and externalizing youth behaviors, decreased caregiver

stress and strain, decreases in youth arrests and convictions, and decreases in crisis stabilization services, day treatment, psychiatric inpatient services, and residential treatment.

In addition, data collected between July 2011 and July 2016 indicated that the system of care in PA had led to improvements in four domains:[22]

Home

- 36 percent improvement in youth having one stable living arrangement
- 50 percent improvement in caregivers reporting stress or strain
- 17 percent decrease in youth living in residential treatment facilities

School

- 52 percent of youth improved their school performance
- 40 percent of youth improved their school attendance
- 33 percent decrease in youth being suspended or expelled from school

Community

- 9 percent decrease in youth arrests
- 16 percent decrease in youth being convicted of a crime
- 33 percent of youth report helping other young people learn about services and supports

Life

- 13 percent decrease in youth reporting clinically impairing depression and 8 percent decrease in clinically impairing anxiety
- 22 percent increase in youth reporting that they can make changes in life to live successfully with their challenges
- 24 percent decrease in youth inpatient hospitalizations

Finally, the 2016 PA County Assessment found that, on average, counties reported a score of eight out of 10 to reflect the current status of implementation of the system-of-care standards.

Iowa's Child Welfare System of Care[23]

Iowa's DHS recently developed a system of care that is led and overseen by the child welfare system, and is separate from its children's mental health system of care.[24]

Core Components

Iowa's child welfare system of care focuses on five key areas:

- Child welfare emergency services
- Foster care group care services
- Supervised apartment living
- Recruitment and retention of resource families
- Training and support of foster parents

Iowa utilizes performance-based contracting, with new provider contracts in these five key areas going into effect on July 1, 2017. These new contracts include practices that exemplify the system of care's guiding principles:

1. Families, children, youth, and caregivers will be treated with dignity and respect while having a voice in decisions that affect them.
2. The ideal place for children is with their families; therefore, we will ensure children remain in their homes whenever safely possible.
3. When services away from the family are necessary, children will receive them in the most family-like setting and together with siblings whenever possible.
4. Permanency connections with siblings and caring and supportive adults will be preserved and encouraged.

5. Children will be reunited with their families and siblings as soon as safely possible.
6. Community stakeholders and tribes will be actively engaged to protect children and support families.
7. Services will be tailored to families and children to meet their unique needs.
8. Child welfare professionals will be supported through ongoing development and mentoring to promote success and retention.
9. Leadership will be demonstrated within all levels of the child welfare system.
10. Decision-making will be outcome-based, resource-driven, and continuously evaluated for improvement.

One goal of Iowa's system of care is to keep youth close to their homes and communities, with a "no eject/no reject" policy that has been incorporated into the new contracts with shelter and residential care providers. Effective July 1, 2017, youth who need residential care must be accepted by a provider in their geographic service area (there are five service areas in Iowa).

Another significant goal is to become a relationship-focused system. A key component is Iowa's One Caseworker Model, which will be incorporated into resource family agency contracts. Resource family caseworkers will have a capped caseload and will be required to have substantive contact with each resource parent every month, including home visits every other month. By building relationships between caseworkers and resource parents, resource parents will hopefully feel more supported and more equipped to appropriately respond to the needs of the children in their care.

Funding

Iowa's system of care is funded like other traditional child welfare programs, using public dollars that have been allocated through the governor and the legislative process. Any Medicaid funding that is used for children in the system of care is applied in the same way that funding is used for any Medicaid-eligible child entering child welfare. Iowa also has "decategorization projects" in all five service areas, which are primarily funded by reinvesting the savings from child welfare's core service array. Decategorization dollars are flexible and provide a funding mechanism for filling gaps in the service array.

Assessing Need

One of the gaps that Iowa identified early in the implementation process was that the child welfare system did not have a standardized tool for assessing children's behavioral health. In the future, the Total Outcome Package (TOPs) assessment will be used as a common assessment when a child is placed in out-of-home care. The goal is to collect information regarding both child behavior and improvement, as well as provider performance. It may also be used to identify needs and gaps in services, and perhaps eventually to determine the level of care.

Similar to many states, Iowa struggles with the same challenges of availability of services in urban versus rural areas. However, Iowa's child welfare system offers statewide Community Care[25] services and Family Safety Risk and Permanency[26] in-home services through their contracted services.

In preparing for the "no eject/no reject" policy, Iowa analyzed data to determine where the youth who need residential care reside. Iowa found a need for more residential care beds in certain parts of the state and fewer beds in other parts of the state, and had to align contracts and policies accordingly.

Another need identified by data focused on relative placements. While Iowa places many children with relatives, a closer look at the data revealed that many of these placements were with unlicensed relatives. Therefore, the new resource family provider contracts require providers to meet with every unlicensed relative in person, to find creative solutions to any non-safety barriers to licensure.

Legislative/Policy Changes

No legislative changes were needed to implement the system of care in Iowa. Policy and contracting changes, however, have been significant. In particular, preparing for the "no eject/no reject" policy required changes to licensing rules so that providers have sufficient numbers of shelter and group care beds available. This new policy also required contract changes – instead of paying for an occupied bed, DHS will now be guaranteeing payment to residential providers regardless of whether the beds are filled. In addition, Iowa utilized past years' data to anticipate the level of future need, and then purchased 5 percent more volume than the anticipated need.

The goal is that once providers have a steady funding stream, they will be able to implement innovative strategies, such as wraparound, to support youth transitioning from congregate care settings to community-based services. In addition, 10 percent of the DHS contract is tied to performance in four areas: length of stay, recidivism over 12 months, the number of youth who re-enter care within 12 months of leaving residential care, and the number of youth who move to a family or family-like setting. Given these performance measures, residential providers will be incentivized to work with foster parent providers and community providers so that youth successfully move on from residential care. Building relationships among residential providers, foster parent providers, and community providers is aligned with the overall goal of having a relationship-focused system.

Because Iowa's state plan ties eligibility for Medicaid with out-of-home care, DHS is starting to think about whether the state plan will need to be altered or whether DHS will need to apply for a waiver that is aligned with its system of care.

Communication and Collaboration

Building partnerships for Iowa's system of care began in 2016 with a child welfare summit, where the focus was on the guiding principles. Conversations centered on the importance of keeping children close to home, as well as changing the conversation from "saving" kids to helping parents become the best parents they can be. Key partners in the process included judges, attorneys, and guardians ad litem. In Iowa, a child's level of care is set by judges in their court orders, so it is crucial that judicial partners understand both the philosophy and the goals of the child welfare system of care.

Engaging the provider community was critical, and DHS worked with leadership from the Coalition for Family and Children's Services in Iowa (a membership organization of provider agencies) to address concerns and ensure clear communication. DHS also made some changes favorable to the providers, such as the steady funding stream, and used data to demonstrate why beds would need to be reallocated so children could stay closer to home. Data were also used to demonstrate to residential providers youth outcomes on the four new performance measures, so the providers could better understand current performance and make plans for improvement as needed.

Permanency

Contracts include an emphasis on permanency, but nothing specific to the system of care.

Outcomes

Since the new contracts have not gone into effect, outcome data are not available.

Lessons Learned

There are several lessons learned and tips that were generated as a result of this exploration:

Using Data

In developing a system of care, it is critical to start with the data and continue to examine it regularly. Having a tool to gather data that can then be translated into achievement of outcomes is also an important consideration. In Colorado, for example, having data regarding crossover youth in multiple systems was key

to making the case that systems should work together to better serve these youth, rather than each system working in silos.

Iowa was also able to use data to identify where high-need youth lived and align its system of care accordingly. Iowa then used these data to create buy-in with its residential care providers and to justify some difficult changes to their contracts.

Using data dashboards, Pennsylvania is able to regularly look at data and use it to understand the needs of the children, youth, and families being served.

Setting Goals

All three systems noted the importance of setting and aligning the goals of the system of care, in terms of both outcomes and target population. Data were then used to determine whether goals were being achieved. For example, Pennsylvania wanted to reduce the use of residential care, but found that the children being referred to the system of care were not the ones with the most high-end needs; therefore, the system of care was not having an impact on residential care usage. The state decided to expand its referral criteria to achieve its goal of reducing the use of residential care. Colorado had a similar lesson learned, stating that "you have to get the right population [high-needs children] to get the outcomes that you want [reducing the use of residential care]."

Another critical lesson learned is that achieving the goals of the system of care requires creativity, because the system of care's principles are often contrary to the usual way of doing business. In Pennsylvania, for example, the system of care's goal is to have 50 percent family and youth and 50 percent professional representation in meetings. This is sometimes a challenge, since often there are numerous professionals who want to have a seat at the table. In counties that have multiple school districts, this can be even more challenging. One solution that has worked for some counties is to send their special education specialist to represent all the school districts.

When possible, it is also helpful to align the goals of the different child-serving systems that participate in the system of care, both with each other and with the system of care. This will help bring the different systems to the table, so that the system of care is not seen as a separate project but rather as a framework for achieving mutual goals.

Regular, Effective Communication

All three jurisdictions emphasized the importance of regular communication at both the state and local levels. Getting input from the community was identified as key to successful development, implementation, and sustainability of a system of care. Structures for effective communication have taken multiple forms, such the SLMTs at the county and state levels in Pennsylvania, or the staffing structure of COACT Colorado, which allows the Principal Investigator to focus on the state level while the Project Manager focuses on the community level.

Iowa shared the importance of launching the system of care conversation early, relative to when the new contracts would go into effect, and having it often – reaching consensus at the philosophical level may not be that hard, but identifying and attending to specific changes on the ground is much harder. In having those challenging conversations, Iowa noted the importance of identifying who might be wary of the change and addressing their concerns, especially with providers.

In Pennsylvania, one lesson learned has been "messaging up" to ensure that top-level leadership understands the goals of the system of care.

Building Value and Leveraging Medicaid

Iowa and Colorado both expressed the need to better leverage Medicaid: Iowa would like to find a way to access Medicaid without tying eligibility to a bed, while Colorado is capitalizing on the principal investigator's presence at the Medicaid office to build interest in COACT Colorado. Since Medicaid provides a capitated rate for community-based services in Colorado, making the system of care a priority at the state Medicaid level then makes it a priority with the regional behavioral health organizations. As the principal investigator explained, one way of gaining buy-in with the behavioral health organizations has been to understand their

funding streams, what their funder (Medicaid) wants of them, and how to influence their funder.

Understanding the Community's Culture
Just as systems of care teams need to understand youth and family culture, the governing structure of the system of care needs to understand the community's culture. Every community is different, so understanding their needs and their culture will make implementation of a system of care more successful, particularly in states that have county-administered child welfare systems. In Pennsylvania, the Partnership's director seeks ways to better understand individual county needs and culture so that he can anticipate a need before it is even requested. And in both Pennsylvania and Colorado, communities are asked to present at the state-level meetings so the state can better understand the priorities and challenges of each unique community.

Recognizing That Cultural Change is Challenging
All of the states acknowledged that implementing a system of care takes a level of time, work, and commitment that cannot be underestimated. But they also noted that a system of care is, at its core, about a culture shift, and cultural change is challenging. They emphasized the importance of focusing on the principles and how they translate into a better way of working together with children and families and, therefore, how they result in better outcomes.

Additional Resources

The table below provides additional resources for review and consideration:

SELECTED RESOURCES

AUTHOR/TITLE/DATE	RESOURCE LOCATION	DESCRIPTION
American Institutes for Research, *The Role of System of Care Communities in Developing and Sustaining School Mental Health Services* (2014)	http://www.air.org/sites/default/files/downloads/report/Systems%20of%20Care%20Communities%20in%20School%20Mental%20Health%20Systems.pdf	This brief provides strategies used by schools and communities in developing and financing school-based mental health programs and services.
Center for Health Care Strategies, *Making Medicaid Work for Children in Child Welfare: Examples from the Field* (2013)	http://www.chcs.org/media/Making_Medicaid_Work.pdf	This brief highlights examples of effective collaborative efforts states have undertaken across child welfare, Medicaid, and behavioral health systems to "make Medicaid work" more effectively for children involved with child welfare and their families and caregivers.
Center for the Study of Social Policy, *Results-Based Public Policy Strategies For Promoting Children's Social, Emotional and Behavioral Health* (2012)	http://www.cssp.org/policy/papers/Promote-Childrens-Social-Emotional-and-Behavioral-Health.pdf	This brief provides guidance on maximizing federal resources and highlights state examples of effective policies and financing approaches for behavioral health.

SELECTED RESOURCES

AUTHOR/TITLE/DATE	RESOURCE LOCATION	DESCRIPTION
Child Welfare Information Gateway, *Systems of Care Toolkits* (n.d.)	https://www.childwelfare.gov/topics/management/reform/soc/communicate/initiative/ntaec/soctoolkits/	This toolkit is a compilation of practical information designed to help communities plan, build, and sustain service systems to improve outcomes for children and families.
Georgetown University Center for Child and Human Development, National TA Center for Children's Mental Health, *Implementation and Financing of Home- and Community-Based Services for Children's Mental Health* (2015)	https://gucchd.georgetown.edu/products/FinanceBrief_HCBServices.pdf	This brief highlights the results of an environmental scan to explore home- and community-based services provided by states for children, youth, and young adults with mental health conditions, and their families. The scan assesses activities to implement the specific services and supports described in a joint informational bulletin released in 2013 by the federal Centers for Medicare and Medicaid Services (CMS) and SAMHSA.
Georgetown University Center for Child and Human Development, National TA Center for Children's Mental Health, *SOC Modules* (2015)	https://gucchdtacenter.georgetown.edu/the-soc-approach.html	This SOC Approach Curriculum assists communities, states, tribes, and territories in understanding the what, why, and how of System of Care Expansion.
Georgetown University Center for Child and Human Development, National TA Center for Children's Mental Health, *Toolkit for Expanding the System of Care Approach* (2015)	https://gucchd.georgetown.edu/products/Toolkit_SOC.pdf	This toolkit supports the development and implementation of strategies for expanding and sustaining a system of care approach throughout a jurisdiction.
Substance Abuse & Mental Health Treatment Services Administration, *Toolkit for Community Conversations About Mental Health* (2015)	https://www.samhsa.gov/community-conversations	This toolkit contains briefs, guides, and resources to help communities promote mental health and access to treatment and recovery services.

1 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2015). *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program*. Report to Congress 2015. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

2 U.S. Department of Health and Human Services, Administration for Children and Families. (2010). *Improving child welfare outcomes through systems of care: Overview of the national cross-site evaluation.* Retrieved from http://www.centerforchildwelfare.org/kb/socsrvc/Cross-SiteEvaluationOverviewReport.pdf

3 Stroul, B. A., Goldman, S. K., Pires, S. A., & Manteuffel, B. (2012). *Expanding systems of care: Improving the lives of children, youth, and families.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Retrieved from https://gucchdtacenter.georgetown.edu/publications/SOC%20Results%205-7-12.pdf

4 U.S. Department of Health and Human Services, Administration for Children and Families. (2010), p.16

5 National Child Welfare Workforce Institute. (2011). *Caseload/workload.* Retrieved from http://ncwwi.org/files/Caseload-Workload_1pager2.pdf

6 Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). *Return on investment in systems of care for children with behavioral health challenges.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Retrieved from https://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf, p. vi

7 Information in this section was gathered from COACT Colorado. (2017). *Strong minds, strong futures.* Retrieved from http://coactcolorado.org/.

8 COACT Colorado. (2017), para.1

9 California Evidence-Based Clearinghouse for Child Welfare. (2017a). *Wraparound.* Retrieved from http://www.cebc4cw.org/program/wraparound/detailed.

10 COACT Colorado. (2014). *Youth with high behavioral health needs in Colorado: Cross-system utilization patterns*. Retrieved from http://coactcolorado.org/site_media/media/servee_documents/2014._SOC_FINAL_REPORT_Nov_20_1.pdf

11 COACT Colorado. (2014), p.iv

12 This tool is Colorado-specific but is similar to the Child and Adolescent Needs and Strengths assessment.

13 McChesney, C., Covey, S., & Huling, J. (2012). *The 4 disciplines of execution: Achieving your wildly important goals.* New York, NY: Free Press.

14 Completed by a trained professional working closely with the child/youth and family

15 Fox, D., & Johnson Nagel, N. (2016). *COACT Colorado: Trauma informed system of care. Project wide results [PowerPoint].* Retrieved from https://www.health.solutions/wp-content/uploads/2016/05/Project-Wide-COE-Time-1-V3.0.pdf, slide 19

16 Information in this section was gathered from various Pennsylvania agency staff and from Pennsylvania System of Care Partnership. (2016). *Pennsylvania system of care partnership.* Retrieved from http://www.pasocpartnership.org/.

17 Lehigh County, Pennsylvania. (2017). *Child and Adolescent Service System Program (CASSP).* Retrieved from https://www.lehighcounty.org/Departments/Human-Services/Mental-Health/CASSP-Program

18 California Evidence-Based Clearinghouse for Child Welfare. (2017b). *Family group decision making (FGDM).* Retrieved from http://www.cebc4cw.org/program/family-group-decision-making/detailed

19 Open Table. (2017). *Relationship transforms communities.* Retrieved from http://www.theopentable.org/

20 Department of Health and Human Services, Centers for Medicare & Medicaid Services. (n.d.). *Early and periodic screening, diagnostic, and treatment.* Retrieved from https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

21 Youth and Family Training Institute. (n.d.). *Youth and Family Training Institute.* Retrieved from http://www.yftipa.org/

22 Pennsylvania System of Care Partnership. (n.d.). *Pennsylvania system of care partnership.* Retrieved from http://www.pasocpartnership.org/uploads/SOC_Data_Brochure_2016.pdf, pp. 1-2

23 Information in this section was gathered from communication with several agency staff and from Iowa Department of Human Services. (2017a). *Child welfares systems of care*. Retrieved from https://dhs.iowa.gov/child-welfare-systems.

24 Iowa's system of care is structurally different from the Colorado and Pennsylvania systems of care.

25 Iowa Department of Human Services. (2017b). *Community care overview.* Retrieved from http://dhs.iowa.gov/community-care

26 Iowa Department of Human Services. (2017c). *FSRP services overview.* Retrieved from http://dhs.iowa.gov/fsrp-services

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