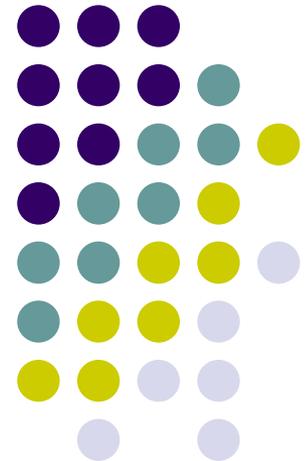


Care Coordination Pilot

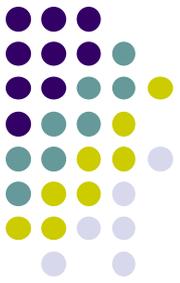
CWAC Full
3/20/14



Purpose of Today's Meeting



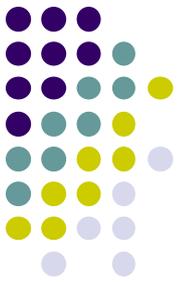
- Answer questions raised at Steering
- Allow for questions and answers
- Continue ongoing dialogue



Why this pilot?

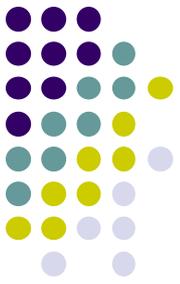
- Affordable Care Act (ACA)
- Save Medicaid Access and Resources Together Act (SMART)
- Director Hamos unveiled HFS' accelerated plan:
 - enroll over 50% of Medicaid enrollees in care coordination
 - include children with behavioral health concerns
 - begin implementation by January 2014

Why this pilot?



- Given pressures associated with managed care rollout, DCFS determined that we should discuss options with HFS for care coordination for wards.
- DCFS wanted care coordination services provided by a care coordination entity that had proven experience in addressing the complex behavioral health needs of wards instead of focusing on physical health of adults.
- DCFS discussed this with HFS and reached agreement that we would move forward with a pilot that would be mutually beneficial to both state departments.

What problems is the pilot intended to address?



- Length of time cases are open when wards are placed in Spec, Res, Group Home, TLP
 - Caseload tracking data shows that children placed in spec foster care begin to show longer lengths of time to case closing
 - Specialized Foster Care and Residential make up 44% of 5-9 years and 65% of 10+
- Number of CIPPS that result in increased level of care
 - Children referred to CIPP
 - Over 50% moved to more restrictive setting
 - Spec - 18% FY12 – 20% in FY13
 - Res - 39% FY12 – 35% in FY13

What problem is the pilot intended to address?



- Vermillion County

- One of the top five counties where Intake is increasing
- Court system
- Generally increasing intake trend in central region
(Data from most recent caseload tracking report)

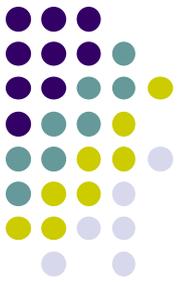
- Current Length of Stay in Residential

- Wards average 20 months per spell
- Overall length of stay in residential 3+ years
- Wards spend multiple spells in residential (step down from residential to group home to TLP)
- Sustained Favorable Discharge is measured at 90 days –
- However, children tend to bounce back to residential after six months in step-down placement
(Data from residential transition discharge protocol spell reports and performance-based contracting reports)

- 50% of children screened by SASS are hospitalized or have multiple screening events

(Data from SASSCARES.org)

What problem is the pilot intended to address?



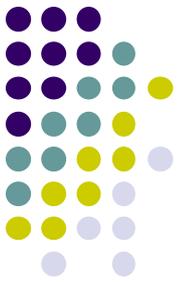
- Need for additional support for agencies transitioning children to step-down placements
 - Heavy reliance on residential staff to offer transition services outside of the agency (RTDP)
 - Need for robust and engaged Child and Family Teams to help with transition
 - Need more community based services to support wards
- Need to enhance regular Child and Family Team meetings with robust representation from child, family, natural supports
 - Child and Family Teams meetings usually held quarterly and not always well attended
- Need for relevant and timely data on services provided to children outside of residential
 - Very little visibility to services in foster care
 - Limited services data due to services and placement dollars being bundled in one rate
- Need for timely placement identification for children in shelters



What is the model?

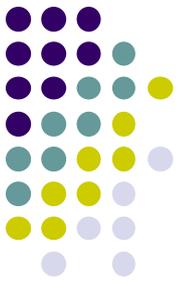
- **Systems of Care Principles (clinical)**
 - Family Centered Teams
 - High Fidelity Wraparound Process
 - Multiple state-agency funders
 - Provider Network Development
- **Care Management technologies (fiscal)**
 - Full Risk for Placement and Services
 - Case Rates
 - Individualized Services
- **Technology blending clinical & fiscal**
 - Real Time Data
 - Data driven decision making

How effective has the model been?



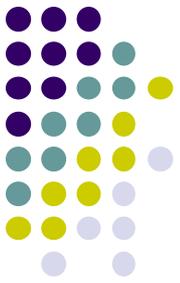
- Nationally recognized as a promising approach in child welfare services
- Model has been implemented with positive outcomes in:
 - New Jersey
 - Louisiana
 - Ohio
 - Milwaukee
 - Washington D.C.
 - Indiana
 - (Building Systems of Care, S. Pires 2008)

How effective has the model been?



- 469 youth were served in Indiana during fiscal year 2012.
 - 72.2% were referred from child welfare system and 27.3% were referred from probation system.
 - 25% were in residential
 - 52% were in therapeutic foster care and at risk for residential
 - 7% were in traditional foster care
 - 16% were in intact family services
- Outcomes:
 - For youth at risk for residential, 82% were successfully diverted and remained out of residential treatment.
 - At discharge 83% of youth were in a placement consistent with their permanency plan.
 - At discharge 95% of youth did not engage in subsequent delinquent behaviors.
 - The average length of stay in residential treatment was 125 days or 4 months during the Choices enrollment.
 - Of those in residential treatment **73% stepped down from that level of care.**

How effective has the model been?

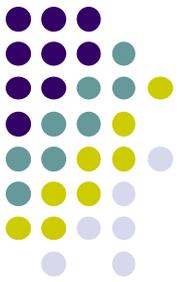


- The average length of Choices services in Indiana:
 - 116 days (4 months) for intact
 - 165 days (5.5 months) for traditional foster care
 - 207 days (7 months) for therapeutic foster care at risk of residential
 - 317 days (10.5 months) for residential
 - Over 80% of children served by Choices remained stable in their step-down settings

Where will we implement the model?



- Four Counties = Champaign, Vermilion, Ford and Iroquois
- Good balance of urban and rural, resource “rich” and resource scarce
- Manageable geography/population for piloting care coordination
- HFS and DCFS mutually agreed upon target area



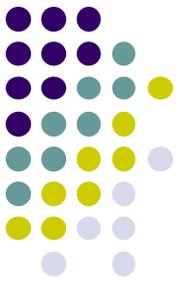
With What Populations?

- Foster Children who are having placement stability issues (referred for SOC or CIPP)
 - Average 12-13 per month (4 SOC/ 8 CIPP)
- Children currently in Specialized Foster Care
 - 100 currently identified



With What Populations??

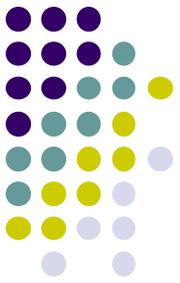
- Children who are experiencing psychiatric crises (screened by SASS)
 - Average 10 – 15 per month
- Children who are in residential and psychiatric hospitals stepping down into the target area
 - 56 currently in residential / 3 currently in psych hospital / 8 in group home (represents 4% of the residential population)



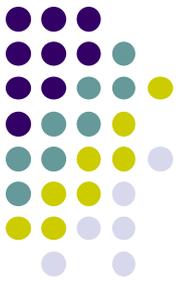
How many served?

- 200 – 240 children a day will be served once full enrollment is reached
- Number of children served will increase significantly when HFS contract with Choices is executed

Desired Outcomes from Pilot



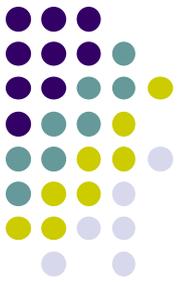
- Establishment of care coordination / managed care benefit that is specific to needs of child welfare population and children with complex behavioral health needs
- Increased availability and coordination of home and community based services to stabilize wards in the least restrictive placement possible
- Increased communication and collaboration between child-serving state agencies



Desired Outcomes from Pilot

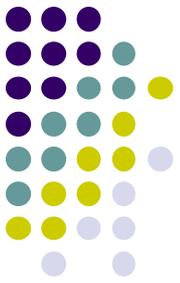
- Community Assessment
 - Determine service gaps
 - Determine availability of and need for evidence-based and trauma informed services
 - Develop and implement a service development plan
- Provider Network Development
 - Placement providers
 - community mental health centers
 - individual mental health practitioners
 - other non-traditional service providers

Desired Outcomes from Pilot



- Formal outcomes tracking process:
 - The utilization/expenditure ratio for congregate care versus other community based services;
 - The number of psychiatric emergency room visits and calls to the CARES hotline for crisis stabilization services;
 - School behavior and attendance, as measured by the CANS;
 - Improvement in caregiver's ability to meet the needs of the ward, as measured by the CANS;
 - Placement stability, including number of moves for foster children and number of days on run and in detention for residential children;

Desired Outcomes from Pilot



- Formal outcomes tracking process:
 - Consumer satisfaction, including child and family team members, provider network members and caseworkers;
 - Clinical improvement across life domains, as evidenced by the CANS;
 - Growth in providers offering evidenced-based practices; and,
 - Other outcome measures determined appropriate by Illinois Choices and DCFS.



Desired Outcomes from Pilot

- Placement stability
 - 80% for performance foster care
 - 70% for specialized foster care
- Increased sustained favorable discharge
 - Fewer than 20% of wards stepping down from residential will return to residential for more than 30 day stabilization
- Decrease need for crisis screening / psychiatric hospitalization
 - 75% of wards identified through SASS will not require another SASS screening

Desired Outcomes from Pilot



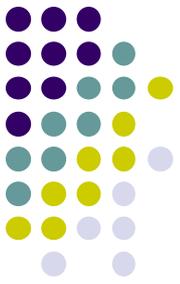
- 90% of enrolled wards will have received annual preventative physical health care and dental services within four (4) months of enrollment.
- 100% of enrolled wards will be up to date on immunizations (i.e., Tdap, Meningococcus, HPV) within 60 days of enrollment.
- Enrolled wards will achieve a 30% reduction in the number of emergency room visits during the first year of enrollment.

Why give up Medicaid dollars?



- Anticipated loss of Medicaid match = \$500,000 per year out of \$1.2 billion dollar budget
- Child and Family Teams will be able to authorize a broader, more flexible array of services for providers to offer and to bill
- Child and Family Teams authorizing services through a Plan of Care ensures that services are individualized to the child's specific needs

Why give up Medicaid dollars?

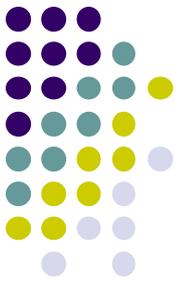


- Incentivizes providers to begin providing a broader array of services for which they can receive reimbursement (many providers report that they provide services for free that are not Medicaid-allowable).
- Loss of Medicaid match will be offset by savings related to keeping children stabilized in less restrictive settings for longer periods of time.

Where is the savings to the state?



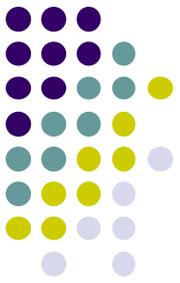
- It costs four times as much per year to keep a child in residential than it does to keep a child in traditional foster care
- It costs three times as much per year to keep a child in residential than it does to keep a child stabilized in Specialized Foster Care
- Stabilizing children at the foster care level results in a large cost avoidance for the state
- Cost avoidance for increased levels of care allows for the state to reinvest those budgeted dollars into more home and community based services for children



What is billing process?

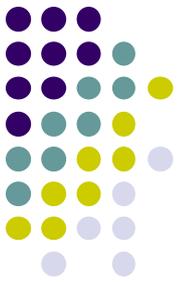
- Choices is currently working to interface with SDS and other electronic client record systems – will require some coding changes
- Timeframes for payment are similar to current schedule – what is submitted by end of the month is paid by the end of the next month

Why do we have to implement now?

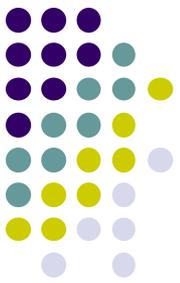


- Managed Care is rolling out across the state
- HFS contract is coming on line
- Need to have tested this model to determine if it is effective with our target populations and in our target area as soon as possible
- Children who required CIPPs and SOC are already being enrolled

Where are the wards in residential???

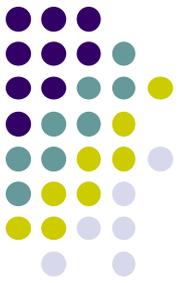


- See handout



What now??

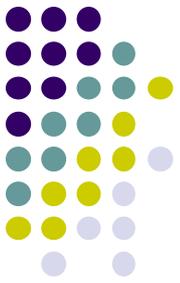
- Choices is setting up operations in the target area
- Hiring local staff and setting up infrastructure (office, IT, staffing)
- Have begun reaching out directly to providers to begin establishing provider network



What now??

- DCFS is educating caseworkers on pilot
- Setting up referral and outcome tracking process
- Outreach and engagement of providers

Questions/Answers/Next Steps



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Office

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