Integrating Family Services: Lessons Learned

The AHS integration efforts across services for children and families propels individuals, organizations and systems at the state and community level to work together more collaboratively, use resources more flexibly, and make supports and services more family-friendly so children, youth and families are better off as a result of their interaction with AHS and its community partners.

Overview

The goal of integrating children's and family services in two pilot regions was to move from a "waiting until things were bad enough" to a more upstream and proactive approach. Due to the reality of the funding streams supporting treatment and intervention, AHS created a payment model that provided some flexibility to be responsive to the continuum of needs existing within each region. Addison County was the first AHS region to receive integrated grants on July 1, 2012 with two IFS grantees (Counseling Service of Addison County-Designated Agency and the Addison Parent Child Center). A second pilot was established in Franklin/Grand Isle on April 1, 2014 with a single grantee (Northwestern Counseling and Support Services-Designated Agency).

What's different because of IFS?

Before IFS	After IFS	How has this changed practice at the community level?
• When billing fee for service a clinician is not reimbursed for time at trainings, traveling or writing documentation • Makes it challenging for providers to work with the whole family • Limits provider availability to participate in team meetings to coordinate services for children and families • Children become eligible for services when circumstances became *bad enough* to qualify for services • Multiple individual providers with separate systems and standards, eligibility, intakes, budgets based on separate expectations from each AHS division/department	• Case rate payment model allows providers to not spend time counting hours to ensure they are billing enough time to cover what is not reimbursable • There is a decrease in administrative burden allowing for more time to serve children, youth and families • The child and family level of need drives the intensity and type of service • Needs are addressed earlier, helping reduce the need for more intensive and costly services • Unified local network/continuum for direct services	• The grantee coordinates an interagency community team that works collectively to improve population health outcomes • "John" –a young man with an extensive history of hospital and residential placement was supported with a skills worker. As a result, he was able to remain at home with his mother, successfully attend the local Teen Center and is moving towards greater independence. Prior to the pilot in Addison, skills workers were only available to a few youth annually who received Medicaid Waiver services. • NCSS has provided outreach to schools when incidents (e.g., bus crash, youth death) happen to support youth without the youth needing to be open to the agency and billed for. • Prior to IFS, services were limited to case management supports for children not on developmental services (DS) waivers. IFS has enabled families to receive full wrap-around supports if needed. • In non-IFS regions, they have quality case reviews that include case file reviews and day-long commitments from agency staff from ADAP, CIS, DMH and Developmental Services. Each team from the AHS Department has a tool they use to review files. Through IFS we created an integrated case review that entails one tool and a multi-disciplinary team from all of the above-mentioned departments which also means one day of review for local and state agency staff to coordinate and one report that encompasses services provided by local community partners funded through AHS. This is much more efficient, stream-lined and saves time in the community that can then be focused on serving children, youth and families.

What led to the thinking behind IFS?

The following are some examples of the barriers that existed (and still do in non-IFS regions) creating challenges for community partners to deliver the best services to children, youth, and families:

- Different expectations from AHS departments regarding similar services or the same state plan authority. For example, the frequency of documentation and treatment plan development for Intensive Family Based Services and DMH's fee-for-service were different enough that DAs often keep two charts for the same child/family which is no longer the case across all regions.
- Children needing high level services (such as a MH or DS waivers) often did not meet eligibility requirements because teams worked hard to prevent hospitalization and therefore these children did not meet criteria for a waiver. If they did not then meet criteria this limited the availability of funding for additional supports and services.
- Data requirements are different within each department (yet similar enough they can reasonably be streamlined). These disparate mandates and compliance structures resulted in multiple audits for client charts, each with an emphasis on one specific treatment component. Disjointed mandates make it difficult for treatment providers to consider the child's/family's treatment needs holistically.
- Different eligibility requirements make holistic integrated care a challenge. For example, children with an Intellectual Disability or Developmental Disability may not meet a funding priority for DAIL Home and Community Based Services which has limited the services and supports that can be made available to children with a ID or DD.

What health and human service integration efforts are being focused on now?

1. Increasing teamwork and case/care coordination across care and service providers and state Departments/Divisions.
2. Supporting mechanisms to increase bundled and/or outcome- and value-based payments that increase service flexibility and focuses accountability on results.
3. Using data and mutual accountability to drive decision making, establish priorities, and fill service gaps.
4. Promoting prevention and population health strategies.
5. Supporting diverse, inter-disciplinary community teams to address population health for children, youth, and families.

IFS Lessons Learned

This grid presents an overview of what has been learned since IFS began and next steps to continue moving payment and service delivery reform forward.

	Financing and Payment Reform	Collaborative Leadership and Decision-Making	Accountability and Oversight	State and Local Service Delivery
Opportunities	• Greater flexibility to determine how much funding to direct to services/supports • Eliminated funding silos and provides the opportunity to provide more health promotion activities	• Stronger community leadership teams exist in each region to assess community needs, gaps, collective resources and population health • AHS Managers & Directors of programs coming together with an eye towards interagency collaboration. (Implementation Team)	• IFS performance measures and population indicators were embedded in the FY17 grants. We will be able to start comparing data across regions in the fall 2017 • Implemented the CANS (Child and Adolescent Needs and Strengths) a progress monitoring tool to gather data about how children and their families are doing as a result of the intervention. • Integrated Chart Review convened to create one review with CDD, DMH, DCF, DAIL, and ADAP at IFS grantees.	• No longer need DS eligibility to provide services • Both IFS regions have created a cross-departmental "Utilization Review" team to discuss the need for increased support or stepdown from residential care for children and youth • Convened a statewide Autism Workgroup that has participants from families, providers, stakeholder, DMH, DAIL, CDD, and AOE to focus on the system of care for children/youth on the spectrum. • Moved away from counting hours to focusing on the need of the family and adjusting to those needs.

	Financing and Payment Reform	Collaborative Leadership and Decision-Making	Accountability and Oversight	State and Local Service Delivery
Challenges	• The IFS regions have different funding in their bundles and other regions have more providers that receive funds from AHS which means the current configuration would be very difficult to replicate • DS waiver funds were placed in the IFS bundles which means they function differently than other regions where the funding follows the child • Global budgets have created challenges as regions adjust to this new funding mechanism • DCF waiver funds that went into the case rates were determined by point in time counts, and have not been adjusted since the portfolios began; this reality fails to take into account the increased number of children in custody and increased complexity of those children's needs • Case rates are complicated and we have not had a clear process for looking at the allocations to adjust as needed	• There was some confusion in the regions and concern about the Core Team members having oversight of IFS grantees budgets. That has been clarified. Agencies are solely responsible for their own budgets • Regional core teams create work plans that define their priorities and the resources each partner will contribute to address those priority goals	• There are still unique requirements for each Dept./funder, so community partners continue to feel like we continue to "staple things together" rather than integrate • There continues to be lack of clarity of the role and authority of the IFS Director to oversee IFS grants	• Integrated services can create expectations that providers suddenly have greater resources – IFS grants in the two pilot regions created more flexibility in how those funds could be used • Due to funding constraints and capped budgets it has been challenging for regions to fully realize prevention and promotion work

Financing and Payment Reform Overview

Funding Stream	Prior to IFS		Current	
	Addison	Franklin	Addison	Franklin
DCF-Family Services Division				
Waiver-DS and DMH waivers are purchased	Individual budgets	Individual budgets	In IFS Case Rate	In IFS Case Rate
Individualized Services Budget	Contract with DCF-FSD	Contract with DCF-FSD	In IFS Case Rate	In IFS Case Rate
Intensive Family-Based Services	Contract with DCF-FSD	Contract with DCF-FSD	In IFS Case Rate	In IFS Case Rate
VT Coalition of Runaway/Homeless Youth	Contract with DCF-FSD	Contract with DCF-FSD	In IFS Case Rate	Contract with DCF-FSD
DCF-Child Development Division				
Therapeutic Child Care	Contract with DCF-CDD	Contract with DCF-CDD	In IFS Case Rate	Not Applicable
Children's Integrated Services	Contract with DCF-CDD	Contract with DCF-CDD	In IFS Case Rate	In IFS Case Rate
Strengthening Families	Contract with DCF-CDD	Contract with DCF-CDD	Paid by invoice	Paid by invoice
Base Grants	Contract with DCF-CDD	Contract with DCF-CDD	In IFS Case Rate	In IFS Case Rate
Learning Together	Contract with DCF-CDD	Contract with DCF-CDD	In IFS Case Rate	In IFS Case Rate
VDH-Alcohol and Drug Abuse Programs				
Substance Abuse Outpatient/Intensive Outpatient/Case management Tx - Uninsured–Adolescent	Paid by separate contract with VDH	Paid by separate contract with VDH	In IFS Case Rate	Initially in IFS case rate. As of 7/1/17, this will be paid by separate contract with VDH at the request of the provider
Substance Abuse OP/IOP/CM Tx - Medicaid – Adolescent	Paid by separate contract with VDH	Paid by separate contract with VDH	In IFS Case Rate	Initially in IFS case rate. As of 7/1/17, this will be paid by separate contract with VDH at the request of the provider
Project Rocking Horse	Paid by separate contract with VDH	Paid by separate contract with VDH	In IFS Case Rate	In IFS Case Rate
DVHA				
ABA (Applied Behavioral Analysis)	Fee for service	Fee for service	Fee for service at request of provider	In IFS Case Rate at request
DMH-Children's Funding				
Investment: Exhibit B	Fee for service	Fee for service	In IFS Case Rate	In IFS Case Rate

Funding Stream	Prior to IFS		Current	
	Addison	Franklin	Addison	Franklin
Fee for Service: Exhibit B	Fee for service	Fee for service	In IFS Case Rate	In IFS Case Rate
Respite, Special Services, Access: Exhibit C	Grant with DMH	Grant with DMH	Paid outside of Case Rate	Paid outside of Case Rate
Access Fee for Service: Exhibit B	Fee for service	Fee for service	In IFS Case Rate	In IFS Case Rate
Waiver Room and Board (GC)	Applied for by agency	Applied for by agency	In IFS Case Rate	In IFS Case Rate
Jump on Board for Success	Contract with DMH	Contract with DMH	In IFS Case Rate	In IFS Case Rate
MH Individualized Services budget	Contract with DMH	Contract with DMH	In IFS Case Rate	In IFS Case Rate
DCF Waiver (GC)			In IFS Case Rate	In IFS Case Rate
Youth in Transition	Contract with DMH with federal funds	Contract with DMH with federal funds	In IFS Case Rate	In IFS Case Rate
DAIL				
DS Waiver (Global Commitment)	Paid out through DAIL	Paid out through DAIL	In IFS Case Rate	In IFS Case Rate
Bridge Program/Bridges TCM Program	Paid out through DAIL	Paid out through DAIL	In IFS Case Rate	In IFS Case Rate
Flexible Family Funding	Paid out through DAIL	Paid out through DAIL	Paid out through DAIL	Paid out through DAIL
Family Managed Respite	Did not exist	Paid out through DAIL	In IFS Case Rate	Paid out through DAIL

Next Steps:

1. Engage in focused dialogue with payment reform experts to assess more fully how payment reform should evolve given what we have learned in IFS pilots.
2. Continue focusing on lessons learned and continuous quality improvement in the two regions with IFS funding.
3. Clarify and develop community structures to address population health improvement.
4. Determine how the Agency of Human Services (AHS) can think as an Agency of One rather than separate parts related to communication and funding of family voice.