

Unified Financing: Options to Support Comprehensive Systems Reform for Human Services

A Monograph Prepared for *One by One: A Safe Kids/Safe Streets Initiative*
Consultant: Jarle Crocker
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Introduction

The purpose of this monograph is to provide *One by One: A Safe Kids/Safe Streets Initiative* and the Madison County Coordinating Council for Families and Children (MC3) with an overview of how different approaches to unified financing can support comprehensive human services systems reform to improve outcomes for children and families. The monograph begins with a definition and explanation of the justification for efforts to reform the financial systems that provide funding for human service programs. The second section provides a "national snapshot" of different state and local initiatives that highlights four different strategies for pursuing financial systems reform. The third section includes two case studies of Milwaukee, Wisconsin's Wraparound Project and Indianapolis, Indiana's Dawn Project to offer a more in-depth illustration of how such efforts work on the ground. The fourth section concludes with recommendations for how the *One by One* partners and the MC3 could develop a process to evaluate whether unified financing is a promising fit to move forward current systems reform efforts.

Definition and Justification

A recent Government Accounting Office (GAO) report on child welfare found that 12,700 youth had been placed in the child welfare or criminal justice systems in 2001 by their parents or caregivers because it was the only way they could access needed mental health services. Perhaps most shocking, this number does not include data from 32 states, including the five largest, because they simply didn't know how many children had been sent by child welfare agencies into out-of-home care placements. The GAO found that a shortage of services and barriers created by a patchwork of eligibility standards were among two of the most significant causes of the growing problem. As the report's findings are summarized (Vedantam 2003: A2):

"Most of our mental health system is based on the crisis management model," Rep. Patrick J. Kennedy, (D-R.I.) said. "The real challenge in bringing costs down and to be more effective is to do more prevention and early intervention as well as more community-based support services." The GAO report found that communities that were able to lower the incidence of mental illness and keep troubled children and families intact were those that focused on prevention and flexibility.

What is unified financing? The term is shorthand for a much longer list of strategies now being used by communities to reform the financing of human services that includes decategorization, pooled funding, blended funding, wraparound, and refinancing, to name a few of the more common names given to such efforts. What is the problem that unified financing strategies are designed to solve? Part of the broader movement of collaborative systems reform initiatives for human services begun in the last two decades, unified financing strategies typically target the barriers to developing an integrated and flexible continuum of care created by categorical requirements at the federal, state and local level to spend program dollars in particular ways. Different funding "streams" that come into a community are usually separated by legal requirements that prescribe they be spent on

specific services (e.g. substance abuse counseling) and populations (e.g. children under five from families living below the poverty line).

It is important to stress that originally many categorical requirements were created for good reasons (Gardner 1994:4). For example, such restrictions in federal programs are in part a legacy of the 1950s and 1960s when concerns about the possibility of state governments diverting funds intended for minorities and vulnerable groups such as children led to legal requirements for how money was supposed to be spent. In other cases, categorical requirements are the result of prudent bureaucratic concerns to ensure accountability at different levels of government for how public funds are used. Finally, the creation of specific categories is one way advocates get around political barriers to compete for funding. Since in many cases getting one big "pool" of dollars that would cover all the unmet needs of a specific population is impossible, the incremental creation of categorical programs is a politically pragmatic way to go after smaller "streams" of funds that respond to larger social problems piece by piece.

Despite these good intentions, the unintended consequences of categorical funding requirements have produced a growing awareness of the need for reform. To strip down the argument for such changes to the basics, at-risk children and their families typically receive services from multiple providers to address a cluster of connected problems. The fragmentation of services typical in most communities means that these problems are often dealt with in a piecemeal rather than coordinated fashion. In response, systems reform initiatives such as *One by One* work to break down barriers in organizational structures through the creation of new collaborative bodies like MC3, the co-location of multiple service providers, the cross-training of front-line workers, the integration of multiple programs to create a seamless continuum of care, and similar innovations. However, the existence of categorical funding requirements can frustrate efforts at reform in a number of ways, including:

- **Duplication of bureaucracies and services:** By attempting to address the complex of challenges facing children and families one piece at a time, categorical requirements often force the creation of bureaucratically distinct programs that would otherwise be "natural fits" for integration to save resources and provide a more seamless continuum of care.
- **Limitation of program flexibility:** Categorical requirements on how program dollars are spent means that when the reality of the problems faced by children and families don't mesh with how resources are prescriptively targeted, there is only a limited amount of flexibility in how responses can be tailored to meet actual needs.
- **Emphasis on deficit-driven interventions rather than a continuum of care:** The vast majority of categorical requirements focus on targeting interventions towards "back end" services to address specific deficits, limiting the ability of communities to create comprehensive continuums of care that balance treatment with "front end" services aimed towards the prevention of potential problems.
- **Creation of incentives that promote turf conflicts:** Individual providers often respond to the fragmentation produced by categorical requirements by creating their own comprehensive programs that combine available resources. As this very

reasonable response expands the turf of individual providers, conflict almost inevitably results over competition for scarce resources because such requirements make it easier to "do it yourself" rather than collaborate with other providers.

- **Encouragement of output rather than outcome-based programs:** Categorical requirements are often motivated by a concern for accountability over how resources are used. The problem is that this approach emphasizes accountability for program outputs (e.g., that the money is spent on a particular population) without a complementary emphasis on outcomes (e.g., the reduction of the targeted problem in a particular population).

The incentives created by categorical funding requirements encourage responses by providers that make good sense at the level of the single agency or organization but unintentionally confound efforts at collaboration at the level of the system as a whole. As Gardner (1994: 7) summarizes the confounding effects of such requirements:

Currently, when agencies do manage to provide comprehensive and responsive services from within a single system, they do so by setting up parallel arrangements that mimic decategorization in microcosm, as if they had control over other agencies' resources or had been able to remove the categorical boundaries among agencies. What often happens is that agencies seeking to serve their clients' full needs attempt to add new program elements that are under their own control, rather than seeking to negotiate for these resources with outside agencies. For example, agencies serving low-income teen parents develop their own internal child care, transportation, and training programs, often in smaller amounts than might be available from outside agencies' resources, because they cannot achieve agreement with these other categorical agencies to provide some of their resources to the teen parents. In a time of limited resources, control of resources becomes more important than adding greater resources from outside sources.

If unified financing is such a good idea, why aren't more communities moving to integrate fragmented funding streams? There are three important answers to this question that also call out the challenges that any community undertaking such an initiative will inevitably face. The first is that these kinds of initiatives require a significant level of local-state collaboration and often need legislative action to change legal requirements stipulating how funding must be spent. As a result of the systems reform movement that has flourished in the last two decades, it is difficult to find a community that doesn't have some kind of collaborative initiative that brings together diverse stakeholders to tackle complex public policy issues. While not exactly easy going, efforts to integrate programs across agencies or develop new governance structures benefit from a level of scale that is usually limited to a single local government or at most one or two cities and the county where they are located working together. In contrast, truly comprehensive financial systems reform requires coordination between and the strengthening of

political will at the local and state levels since so many funding streams for human services flow through and are hence regulated by the states.

The second problem, closely related to the first, is that categorical requirements often create legal barriers to change. If a diverse group of stakeholders in a community decide to form a collaborative body to better coordinate their work, it's rare they would face significant legal obstacles to such a course of action. However, if a group of human service providers wanted the option of spending money categorically required for residential treatment programs on more community-based services, they couldn't simply decide to divert the funding stream by themselves.

The third problem is that the current categorical system creates strong financial incentives against change. For example, a move to decategorize money earmarked for out-of-home treatment programs to create options for community-based alternatives is obviously not in the financial interest of providers who rely on funding that supports residential services. Despite such difficulties, however, a growing number of state-local partnerships have both successfully taken on these challenges and produced tangible results that show the benefits of unified financing strategies. In the next two sections, four broad strategies for financial systems reform are illustrated with brief descriptions of initiatives undertaken in eight states, followed by more detailed case studies of how two communities have taken initially modest pilot initiatives to scale.

Four Strategies for Unified Financing

In a 1997 report, "Financing Strategies to Support Comprehensive, Community-Based Services for Children and Families," Mary O'Brien describes four different strategies pursued by eight states to promote financial reform in how human services for children and families are funded. What is especially compelling about these diverse initiatives is that despite the substantial financial and other changes in the human service arena of the last several years, the majority of them have survived and even expanded despite changes in state and local leadership and tightening budgets. The following "national snapshot" summarizes each of these strategies and briefly reviews the eight state-local collaborative initiatives. More information on each of the initiatives still in operation can be obtained through the hyperlinks at the end of each summary and in O'Brien's original paper, available online through the hyperlink in the resources section at the end of this monograph.

Strategy One: The state redirects funding to support local collaboratives

This type of strategy uses different options for refinancing or redirecting human services funding at the state level to support the work of local community collaboratives. Typically intended to serve a broad population, an interdepartmental body at the state level is set up to "steer" the initiative by setting overall goals and working to refinance existing funding streams, while the local

collaboratives do the "rowing" by assessing community needs, developing plans to address those needs, and then bringing together diverse stakeholders to provide comprehensive services for specific populations.

Missouri: Caring Communities

One example of this strategy is Missouri's Caring Communities initiative. Starting in 1988 from a pilot project at one elementary school, Caring Communities has expanded to include twenty-one Caring Community Partnership sites. At the state level, the governance body includes representatives from five departments -- Education, Health, Mental Health, Social Services, and Labor and Industrial Relations that set broad policy goals for workforce development, community public safety, child and family health, and education. A fifteen member Family and Community Trust that includes the heads of seven key state agencies and eight civic leaders appointed by the governor works to reallocate or redirect human services funding in response to local needs. At the local level, Caring Communities sites are typically located at a school or neighborhood and are composed of an organizing group that includes diverse local stakeholders. Multiple sites in a single community are organized into an "umbrella board" Community Partnership that has a fiscal agent to receive grant funds from the state and buy local services. At the state level, the unified financing strategy has two components. First, the interdepartmental governance body works with the localities to redirect funding where there is a gap between funds allocated in the state budget and local needs identified by the Caring Communities sites. Second, the Family and Community Trust, which was created by shifting smaller portions of the five agencies' funding into a joint Caring Communities budget, support from the private sector and foundations, and savings from various refinancing strategies, is used to support local initiatives. Starting at \$3.5 million in 1994, the Trust is now over \$25 million. For more information on Caring Communities, see www.mofit.org.

West Virginia: Family Resource Networks

A second example of this strategy is West Virginia's Family Resource Networks (FRN). In response to a Carnegie report critical of the state's education system, in 1990 the Governor and legislature passed legislation that created the Cabinet on Children and Families. At the state level, the Cabinet is composed of the top executives from the departments of Health and Human Resources, Education and the Arts, Employment Programs, the Superintendent of Schools, Vice Chancellor of the University System, the Secretary of the Department of Administration, the State's Attorney General, a member each from the House of Delegates and Senate, and a parent representative. The Families First Council, composed of members drawn in equal thirds from mid-level state officials, consumers, and community leaders, meets on a bi-monthly basis to oversee implementation of the FRN program. The initiative is funded by the Family Resource Planning Fund, developed in collaboration with the federal government, which decategorizes a small portion of the administrative funds from thirteen federal children and families programs that are matched by the state. Funding is then directed to local Networks governed by boards composed in the majority by non-providers (most

of who must be consumers), providers, and at least four public agencies (the health department, regional behavioral health center, health and human resources, and county school district). Networks typically develop a local needs assessment and service plan that emphasizes systems reform, then work with the state governance bodies to redirect funding streams to better meet local needs. For more information on the Family Resource Network program, see www.wvchildrenandfamilies.org.

Strategy Two: The state pools out-of-home care funds to support local collaboratives

The main difference between the first and second strategies is that in the former, the state redirects separate funding streams, while in the latter the state directly "pools" those streams together to support local collaboratives. This type of strategy is usually directed towards serving children who are in or at-risk of out-of-home care by changing restrictions on funds to support in-home community-based programs, with local collaboratives keeping any savings (between the amount allocated and the amount spent on services) to reinvest in services.

Virginia: Comprehensive Services Act

A first example of this strategy is the Virginia Comprehensive Services Act. Prompted by a 1990 Department of Planning and Budget study of residential care that found the 14,000 cases in the system actually involved less than 5,000 youth, three cabinet secretaries created a 145 member Council on Community Services to study the problem and recommend legislation. The result was a two-tiered governance structure at the state level composed of a State Executive Council (the heads of Health, Social Services, Mental Health/Mental Retardation/Substance Abuse, Education, and Youth and Family Services) that guides overall policy and a State Management Team (representatives of the five agencies, a parent representative, a district court judge, a provider representative, and representatives from the five state regions) that recommends policy. At the local level, a Community Policy and Management Team (the heads of those same five local agencies, a parent, and a provider representative) is responsible for implementing the Act by developing plans for comprehensive services and managing the funds, with a Family Assessment and Planning Team (representatives from the five agencies and a parent) responsible for working directly with the children and their families to develop individual service plans. The state level pool is created out of nine funding streams that support various residential services across four service areas (social services, mental health, education, juvenile justice). However, local Management Teams have also been used to manage other funds to develop local needs assessments and action plans.

Maryland: Systems Reform

A second example of this strategy is Maryland's Systems Reform initiative. Evolving from state requirements created in the early 1980s that localities develop interagency plans for at-risk youth, a 1987 grant from the Annie E. Casey Foundation for systems reform and the creation in 1990 of the Governor's Office, Subcabinet, and Secretary for Children, Youth, and Families substantially expanded upon these previous efforts. The Subcabinet (composed of the top executives from Health and Mental Hygiene, Human Resources, Juvenile Justice, the Superintendent of Schools, Budget and Fiscal Planning, Office of Individuals with

Disabilities, Housing and Community Development, and the State Planning Office) oversees broad policy to foster more comprehensive, outcome-based, family-oriented programs. At the local level, Local Management Boards (LMBs) comprised of public and nonprofit providers and other community representatives' work to improve services and negotiate outcomes with the state in return for the funding flexibility provided by the unified funds. The state-level pool is created from funds previously budgeted for out-of-home care and family preservation by the Departments of Health and Mental Hygiene, Human Resources, Education, and Juvenile Justice. Grants are then provided to the LMBs to serve children in out-of-home and family preservation programs through such innovations as wrap-around and other preventive and community-based services.

Strategy Three: Locally driven initiatives supported by the state

In the previous two strategies, the initiatives reviewed are primarily state-initiated and driven with broad and often mandatory participation by localities. The next two cases illustrate different ways that "bottom up" local reform initiatives can be harnessed to support a broader effort at systems reform, with the option to pool or blend funds at either the state or local level.

Iowa: Child Welfare Decategorization Project

The first example of this strategy is Iowa's Child Welfare Decategorization Project. Prompted by a 40% rise during the mid-1980s in foster care placements and an approach to child welfare that emphasized expensive out-of-home institutional care and out-of-state placements, communities and the state began to explore alternatives to the existing system of human services. In 1987, the General Assembly passed legislation to decategorize twelve state and federal funding streams that would be pooled and controlled at the local level to better meet the actual needs of communities. Governance at the local level must include the Department of Human Services, the juvenile court, and the county board of supervisors. Although almost all of Iowa's counties participate in the Project, implementation began with individual localities developing applications to receive the pooled funds, allowing communities to move forward at their own pace. The approach also creates maximum flexibility for localities to develop their own programs, and some, such as Linn County's Patch model (itself originally developed in Great Britain) became national examples of "best practices" in systems reform. Similar to the other examples, decategorization becomes the vehicle that makes possible the development of more integrated, community-based, and prevention-focused services because of the flexibility created by the local pool. As a result of the Project, state child welfare expenditures shifted from a 1991 distribution of 87% spent on out-of-home care and 13% for in-home services to a 1998 split of 57% and 47%, respectively. For more information on the Decategorization Project, see www.dhs.state.ia/us/ and www.aecf.org/publications/advocasey/decat

California: Youth Pilot Program

A second example of this strategy is California's Youth Pilot Program. Started in 1993 by the state in response to growing county interest in options for decategorization, localities are authorized to create a local pool of blended funds. At the state level, governance is provided by a team of all the departmental directors in Health and Welfare, along with top executives from the departments of Education, the Office of Child Development and Education, the

California Youth Authority, and the Office of Criminal Justice Planning. At the local level, a broad-based Coordinating Council is comprised of the superintendent of schools, a representative from the juvenile justice system, service providers, and community members. In each of the seven counties that participate in the Program, the local Council conducts a needs assessment and develops a strategic plan in response to the findings. As an illustration of the flexibilities of scale involved, one county began with a "mini-pilot" of only six children that was expanded as initially modest efforts proved the feasibility of the model. Additionally, some counties access federal Healthy Start planning and operations grants through the state Department of Education to support efforts at service integration. Many of the counties report that key to their efforts has been the ability to shift federal IVE foster care maintenance funds to create "front end" programs that emphasize more integrated, community-based, and prevention-focused services. For more information, see www.mch.dhs.ca.gov/programs/ypp/ypp.htm

Strategy Four: Locally pooled funds support reforms targeting specific populations of children served by multiple agencies

Similar to the third strategy in that the initiative is locally driven, this type of approach focuses more narrowly on specific populations of children that use services from multiple agencies to provide them with a more seamless continuum of care, typically accessing smaller amounts of funding drawn from sources that support out-of-home care programs.

Oregon: Partners Project

The first example of this strategy is the Oregon Partners Project in Multnomah County. Initially supported with a grant from the Robert Wood Johnson Foundation, the Project created a consortium of state and local partners to pool local funding streams to support services for about 150 children 5-18 years of age with severe emotional and behavioral disorders who receive services from at least two of the participating agencies. In this case, the local pool of \$2.5 million is primarily created out of Medicaid funds, with the remaining balance drawn from state and local child welfare, mental health, and education agency programs. At the state level, the governance structure is comprised of an Executive Committee of directors from the State Office of Medical Assistance Programs (Medicaid), the State Department of Human Resources, the Children's Services Division, and the chair of the Multnomah County Board of Commissioners. At the local level, an advisory committee of representatives is drawn from the Project's local partner agencies, service providers, and consumers. A Project Office with 10 managed care coordinators oversees the development of an integrated plan of care for each child. The financial structure of the Project provides each child with a prepaid health plan that covers \$1,618 of services a month, an approach that allows otherwise categorized dollars funds to be flexibly spent on wraparound services. 62% of this rate is supported by Medicaid funds, with the balance drawn from other state and local funding streams. [This initiative is no longer in operation.]

Ohio: Kids in Different Systems

The second example of this strategy is Franklin County, Ohio's Kids in Different Systems (KIDS) program. The goal of KIDS is to provide individualized treatment plans for children involved with two or more of the participating agencies who are at-risk of out-of-home placement or transitioning back into the community. A county-level pool of funds is created

from funding streams drawn from the state and local departments of child welfare, education, juvenile justice, the alcohol, drug addiction and mental health board, and the mental retardation/developmental disabilities board. In this case, the county contracts directly with local providers, but the pooled funds are not limited exclusively to those services. In 2000, the local pool totaled \$1.4 million, which is also used as a local match to claim other entitlement dollars to leverage additional financial resources. For contact information on the program, see <http://www.co.franklin.oh.us/jafs/services.htm>

Case Studies of Unified Financing: Milwaukee, Wisconsin and Indianapolis, Indiana

While the four strategies for financing human service systems reform just reviewed are intended to offer the reader a broad national snapshot of different ways such initiatives can be structured, the following two case studies are intended to provide a clearer picture of what this work looks like on the ground. In Milwaukee, the development of wraparound services for youth is funded by a public health maintenance organization that serves as the pool for human services dollars. In Indianapolis, a state-level Consortium of state and local agencies pools funds that are then channeled to Choices, a local nonprofit managed care corporation.

Wraparound Milwaukee

Wraparound Milwaukee is a comprehensive initiative aimed at reforming the financial and programmatic structure of human services serving the youth of the community. Housed in the Mental Health Division of the Milwaukee County Human Services Department, the Wraparound initiative uses a public managed care health maintenance organization (HMO) to provide enrolled youth with a comprehensive benefit plan that provides flexible access to a continuum of care that includes over 80 different types of services offered by a network of over 230 providers.

Local interest in systems reform grew in the early 1990s in response to rising costs in the county juvenile justice and child welfare systems associated with out-of-home placements and a parallel concern at the state level with Medicaid costs for youth in in-patient programs at psychiatric hospitals. As a result, Wraparound grew out of earlier efforts to "bridge" and "blend" funding streams to jointly address the needs of youth in psychiatric hospitals, residential care programs, and juvenile justice facilities. In 1994, Milwaukee County received a five-year grant from the U.S. Department of Health and Human Services Center for Mental Health Services as a result of a joint application that included the State Bureau of Mental Health and State Department of Health and Human Services working with the local Departments of Human Services, Child Welfare, Juvenile Justice, the chief judge, and the county executive.

In 1996, the project partners initiated an innovative pilot called the 25 Kid Project to test the feasibility of the Wraparound approach. At the time, Milwaukee County had a daily average of 364 youth in out-of-home placements at an annual cost of \$18 million. Of that number, twenty-five youth with no immediate discharge plans were identified to participate in the pilot. Using the wraparound philosophy that emphasizes community-based, integrated, and

prevention-focused services, in ninety days seventeen youth had been returned home or placed in community-based foster or kinship care, a number that rose to twenty-four of the participants at the end of eighteen months. The success of the 25 Kid Project was also a key factor in prompting the expansion of efforts at financial reform from strategies that used bridging or blended funding to the development of Wraparound's public HMO. The process began with a determination of a case rate for eligible youth that would be paid into a common pool provided by Medicaid (which includes a capitated payment,¹ Supplemental Security Income payments, and funding streams drawn from the local child welfare and juvenile justice systems). Currently, each youth enrolled in the insurance program is eligible for \$3,300 of services a month, compared to the previous fixed cost of over \$5,000 a month for out-of-home care. Of that amount, \$1,542 comes from Medicaid, with the remaining balance drawn from Supplemental Security Income payments and funding streams going into the child welfare and juvenile justice systems that previously paid for out-of-home programs. The current annual amount paid into the pool is \$29 million.

Crucial to the success of the Wraparound initiative has been collaboration with local service providers. While the strong local government leadership drove the shift from a system that had relied on straight contracts to the public HMO model, providers were included throughout the process. This is important because one challenge faced by the initiative was getting buy-in from providers whose budgets relied for funding upon out-of-home residential treatment programs. Key to getting buy-in for the initiative from this sector was working closely with these key stakeholders to develop new programs with community-based alternatives for care and otherwise provide capacity-building resources to manage the impact on providers of significant changes in programmatic and financial structures.

What does the Wraparound process actually look like on the ground today in Milwaukee? With over 600 families served by the program, each case is overseen by a Care Coordinator who assembles the Child and Family Team of family members and other professionals involved in the case plan, conducts the initial assessment, arranges for services through the provider network, and manages the implementation of the care plan. Plans are developed in collaboration with the families and stress treatment of needs as they are identified by the youth and involved care-givers by drawing on network services, family strengths, and other supports available in the community, such as YMCA programs. Additionally, a 24 hour Mobile Crisis Team is available when the Coordinator is not on call that can respond to emergencies and runs two eight bed group homes that provide short term placements as an alternative to longer term residential care. Wraparound sets the prices of the different program options on a fee for service basis, with individual vendors applying to offer services as part of the overall network of over 230 providers. In 1999, planning began on a new information technology system to help different parts of the new system work more seamlessly. Developed for a cost of \$750,000, by 2000 Wraparound had a secured Internet-based system that allows case managers (who work in eight different local agencies) to

¹ Capitation is a method of payment to health care providers. Unlike the fee-for-service method where the provider is paid by the procedure, capitation involves providing coverage through a pre-paid monthly amount, often called a per-member per-month (PMPM) fee. In this approach, the entity offering the insurance is typically financially at-risk if the cost of services exceeds the PMPM fee.

identify service providers, see what programs offered by the network have openings, authorize the services and forward the request to the vendor, develop a plan of care, and keep files on the progress of individual cases -- all online. Vendors can also access the system to invoice for services, and confidentially is managed by a system of tiered access that ensures only appropriately authorized individuals can see the case data.

The results from Milwaukee Wraparound are impressive. Out-of-home placements in residential care facilities fell from an average of 364 youth in placement on any given day to the current level of fewer than forty, with the associated cost of care dropping from \$5,000 to just \$3,300 a month for each enrolled youth, with the resulting savings used to expand the program from 360 to over 650 participants. As measured on the Child and Adolescent Functional Assessment Scale, the average score in a group of 300 delinquent youth enrolled in the program improved from a seventy-four (in the high range of impairment) to a fifty-six (in the moderate rate of impairment) after six months and forty-eight (also in the moderate range of impairment) after one year. In a study of 134 delinquent youth in the program by the county's Child and Adolescent Treatment Center, recidivism rates measured one year before and one year after program enrollment showed decreases of 11% to 1% for sex offenses, 14% to 7% for assaults, 15% to 4% for weapons offenses, and 34% to 17% for property offenses. For more information about Wraparound Milwaukee, see http://www.ncjrs.org/html/ojdp/jjinl_2000_4/wrap_1.html

The Dawn Project

Started in 1997, Marion County's Dawn Project uses a similar philosophy of care and wraparound approach to service provision married to a slightly different financial structure in comparison to Milwaukee. Prompted in part by earlier state-level work to develop a mental health plan using managed care principles, the initial move to create the project involved a collaborative effort by state and local agencies. The governance structure of Dawn includes a Consortium that acts as the policy and purchasing authority and is comprised of representatives from state agencies (Division of Mental Health and Division of Special Education) and county authorities (Office of Children and Families, the juvenile court, community mental health centers, and the county Mental Health Association). Funding is pooled at the state level from mental health treatment funding streams drawn from four agencies (Education, Child Welfare, Juvenile Justice, and Mental Health and Substance Abuse) and then channeled to Indiana Behavioral Health Choices, a nonprofit managed care corporation formed by the administrators of the four community mental health centers in Marion County. A case rate of \$4,130 a month for each participant was then contracted between Choices and the Office of Children and Families that covered services offered by over 150 participating providers.

Referred to the program by participating local agencies, Dawn is focused on serving youth with emotional problems who are in or at-risk of residential placement in the child welfare and juvenile justice systems. Dawn started out by adding ten youth a month to the program and grew to include 250 clients at the end of its first two years. A \$7 million federal grant received in 1999 from the Department of Health and Human Service's Center for Mental Health Services allowed the program to eventually serve over 600 youth a year. In each case, a Service Coordinator works with the family to assess their strengths and weaknesses. The

Coordinator then assembles a Child and Family Team that meets on a monthly basis to develop the care plan and evaluate progress that includes family members and other professionals involved with the youth. According to the most recent available project report, in 2000 Dawn involved 150 Marion County contract agencies to deliver community-based care. An average of 140 Child and Family Teams met monthly to develop and evaluate individualized treatment plans that encompassed school plans, court orders, probation requirements, and mental health plans. Twenty-four Service Coordinators facilitated the Teams, with over 2,000 community members participating as team members.

Dawn has also not been without its controversies. Some advocates have questioned the strong emphasis on family reunification in cases of physical and sexual abuse, an issue acknowledged by advocates of the program who respond that safeguards within the system exist to ensure children are not returned to dangerous situations. Others argue that the needs of some youth can only be met through in-patient care, a decision that is currently made on a case-by-case basis. In 2000, Consortium members revisited the mission of Dawn to address those and other issues, forming four work groups that included over forty participants from involved agencies and community organizations. Indeed, crucial to the success of the project has been the emphasis on collaborative approaches to problem solving that is broadly inclusive of state and local agencies, providers, and community members.

Results from the Dawn Project are extremely promising. A 2000 evaluation by the Indiana Consortium for Mental Health Services Research found that participants in the program improved their overall clinical functioning and were significantly less likely to return to the public system after enrollment in Dawn. The program was also evaluated as being successful at transitioning youth from restrictive placements into community settings and at \$4,130 a month per participant, was significantly less costly than the previous average of \$5,897 for residential placements. As a result of its achievements, the state is currently replicating the Dawn model in four sites, one of which includes a joint effort involving three rural counties. For more information on the Dawn Project, see www.kidwrap.org

Recommendations

The exploration of innovative funding mechanisms to sustain the systems reform efforts started by *One by One* and its partners is especially important given the end of federal funding for the initiative in September of 2004. As a potential program activity of MC3, the development of unified financing to support comprehensive systems reform is also in line with the mission of the collaborative to strengthen the financial system supporting human services for children, youth, and families without directly allocating funding to providers. Such an effort would also offer the opportunity to engage state agencies in support of local efforts and potentially pilot elements of the *One by One* initiative in other Alabama communities. A menu of potential options for moving forward to assess whether unified financing is a good fit with current work include:

- **Convening a peer-to-peer meeting to learn from other communities and professionals.** Currently available funding exists to support convening a peer-to-peer meeting that would include teams from other communities recognized for their work on

unified financing (Both Wraparound Milwaukee and the Dawn Project have presentations already prepared for such activities), individual professionals with expertise in financial reform, and other sites participating in the Safe Kids/Safe Streets initiative. Similar meetings have been used successfully by the Annie E. Casey Foundation and other philanthropies and public agencies to support the diffusion of innovations among communities engaged in human service systems reform initiatives. This approach would allow *One by One* partners to learn from different models and directly question their peers from other communities about the lessons learned. Additionally, representatives from state agencies and other communities in Alabama could be invited if feasible. A peer-to-peer meeting could also have the added benefit of building local consensus on the issue and supporting future grant applications to federal, state, and foundation programs by underscoring a strong local commitment to systems reform.

- **Convening an MC3 task force on unified financing:** Another option that could be pursued in parallel to the previous recommendation would be for MC3 to convene a task force to use this policy brief and other resources to explore the feasibility of pursuing unified financing strategies in Huntsville and Madison County. Representatives from public agencies and providers who might participate in such an effort should be included, which would provide another way to build consensus among key stakeholders and develop grant applications to support a unified financing initiative.
- **Developing a children's budget to complement the current report card:** Many communities lack a centralized source of information that breaks down the funding streams flowing into the locality that support programs for children, youth, and families. Such a budget would provide a method to track the financial outputs (i.e. the money spent on different services) to compare with the outcomes measured by the report card. The budget would also serve the use of identifying funding streams that could be blended or pooled at the local level to support work on the development of unified financing strategies.

A common theme throughout the case studies and literature on unified financing is the need to tailor such efforts to meet the needs of the community. Additionally, the growing use of such mechanisms at the state and local level provides a diverse pool of strategies to draw upon and a growing literature documenting and supporting their benefits. As made clear by the GAO study discussed at the start of this brief, there is a growing crisis in the financing of out-of-home care and other human services for children, youth, and families. Efforts to directly address this problem now are critical, since options and resources will inevitably narrow as the crisis grows. The development of unified financing mechanisms makes sense both as a support for current systems reform efforts and as a prudent response to a clear and present danger that threatens the achievement of successful outcomes for children, youth, and families in all communities.

Bibliography

Gardner, Sid *Reform Options for the Intergovernmental Funding System: Decategorization Policy Issues*. Washington, DC: The Finance Project. December 1994.

www.financeprojectinfo.org/Publications/options.html

O'Brien, Mary *Financing Strategies to Support Comprehensive, Community-Based Services for Children and Families*. Washington, DC: The Finance Project. March 1997
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Additional Resources

Executive summary of the Department of Health and Human Service's Substance Abuse and Mental Health Services Administration monograph *For the Long Haul: Maintaining Systems of Care Beyond the Federal Investment*. The study reviews how different sites that have developed interagency systems of care to serve youth with emotional problems have sustained program activities beyond an initial federal grant.

<http://www.mentalhealth.org/cmhs/ChildrensCampaign/2000execsum3.asp>

This brief four-page report summarizes national trends towards the use of blended funding mechanisms to support the development at Head Start sites of more comprehensive, integrated services for children and families.

<http://www.lyncburg.edu/business/i-piece/Changing%20Role.pdf>

This National Center for Mental Health and Juvenile Justice Program Brief *Funding Mental Health Services for Youth in the Juvenile Justice System*, by Bruce Kamradt, Director of Wraparound Milwaukee, details different innovations in funding the development of comprehensive mental health services for children and families.

http://www.ncmhjj.com/pdfs/publications/Funding_Mental_Health_Services.pdf

This SAMHSA website offers summaries of past and current reports and other resources available through the Administration's Managed Care Initiative, including technical assistance manuals, studies of financing strategies, and evaluations of managed care programs.

<http://www.samhsa.gov/mc/content/Who%20Are%20We/overview.html>

This is an annotated bibliography of resources available to support systems reform initiatives for human services. Topics covered include the development of community-based programs, the coordination of care, program financing, and evaluation.

<http://cshcnleaders.ichp.edu/CSHCNProgramManual/08b%20Bib%20Facilitate%20Systems.pdf>

This position paper of the National Council of Juvenile Court Judges assesses the role of the juvenile justice system in supporting comprehensive systems reform of mental health services for youth, including advocacy of the development of pooled funding mechanisms to create the flexibility necessary for such efforts.

<http://www.childrensprogram.org/media/pdf/RECSTWO.pdf>

Blending and Braiding Funds to Support Early Care and Education Initiatives by Margaret Flynn and Cheryl Hayes is a report by the Finance Project on different approaches to financing systems reform initiatives.

<http://www.childrensprogram.org/media/pdf/RECSTWO.pdf>

This report, *A System of Care for Children's Mental Health: Expanding the Research Base*, provides summaries of research projects that address different policy, outcome, and financing issues in systems reform initiatives to improve the delivery of human services for children, youth, and families.

<http://www.fmhi.usf.edu/institute/pubs/pdf/cfs/rtc/10thproceedings/10thchapt1.pdf>