



Wisconsin  
Department of Health Services

P-00731 (07/2014)

**Division of Mental Health and Substance Abuse  
Children Come First Advisory Committee Recommendations Tracking Report 2013-2014**

Recommendation	Lead	Status
<b>Program Integration</b>		
1. Eliminate legacy Integrated Services Programs (ISPs) and operate a single program, Coordinated Services Teams (CST).		Completed. DMHSAS began implementing the change in 2013 by meeting with all existing ISPs to discuss the change. The ISPs are now fully integrated into the CST program, and are required to provide the same contract documents to DMHSAS as all other sites. Additionally, TA and training methods have been updated and are being applied consistently.
2. The state should minimize barriers to integrating CST and Comprehensive Community Services (CCS) for children and youth.	Sally Raschick with Cheryl Lofton	In 2013, DMHSAS began work to coordinate efforts between both programs. This included changes to the Strengths and Needs Assessment and Plan of Care, encouraging providers to use the CLTS screen to determine level of service, and identifying possible barriers in CCS for CST clients. Data collection requirements were changed to require the same input across both programs and using the same system to submit data. In 2014, a new CST staff (Sally Raschick) was hired who has expertise across both systems. Her role will include integration efforts statewide. Other CST staff are being trained in CCS to promote and encourage integration and dual resource development across the state. DMHSAS staff are developing new TA and Training for providers to encourage maximizing CCS for CST clients. This will be on the agenda for the 2014 Fall Project Directors' meeting.
<b>Funding Allocation</b>		
1. There should be a base amount of funding allocated to operate CST, regardless of site size or complexity. The state should analyze required CST components/ activities to determine this base funding level.	Joyce Allen	In the first year of the transition phase, the focus is on providing the counties and tribes with a base level of funding. The expansion is still in the transition phase of encouraging all counties and tribes to apply for funding, including the six counties who are not yet participating. DMHSAS will look at this issue again after all sites are up and running. See #3 regarding the transitional approach.
2. The committee does <u>not</u> support an allocation method that simply divides total funding by the number of sites. There is no utility in funding CST at a level that does not allow sites to meet programmatic requirements and produce good outcomes for children and families.	Joyce Allen	Due to the expansion, doubling of initiatives and getting the former ISPs on track, the focus in 2014 is on having all CSTs meet basic statutory requirements and aligning contract start dates to January 1st of each year for all counties and October 1st of each year for all Tribes.

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3. There should be a transitional approach to the new funding model, eventually resulting in a tiered funding model based on site characteristics and/or performance. In general, the committee supports a transition plan that does the following:	Joyce Allen	Current and future data collection methods are being analyzed that would allow DMHSAS to measure performance for sites. In addition, clarification about site characteristics are being looked at for a possible tiered approach. Better measurements in both of these areas will allow DMHSAS to consider opportunities for tiered funding.
a. In Year one, provide the same level of funding currently being received to existing CST grantees and legacy ISP sites, provide a TBD amount of funding to active CST sites no longer receiving CST grant funding, and provide TBD planning funds to sites without a current CST which express their commitment to implement CST.	Joyce Allen	Year one is a transition year for the CST sites. DMHSAS' priority is for each CST site to be in compliance with the statutes. A stepped approach is in place to bring consistency to the fund source, contract length, and start dates of contracts by January 2016.
b. In Year two, provide base funding to all CSTs statewide.	Joyce Allen	DMHSAS will be continuing with the transition, hoping to bring in the six counties not currently participating. Performance reports are required every six months for all sites. DMHSAS has protocols for contract administration and site development that will assess performance. A primary mechanism to evaluate performance and fidelity to the model will be initiating site visits. CCF committee members may be included in these visits if they are interested.
c. In Year three, implement a tier-based funding model consisting of base funding for all sites and additional funds based on TBD site characteristics and/or site performance.	Joyce Allen	A tiered funding model is complex and takes time to develop and implement. Mechanisms would need to be in place at DMHSAS to be able to set up performance based contracts. DMHSAS first needs to begin data collection methods through the above measures to assess performance and site characteristics. An analysis of this data will occur at the end of Year 3.
4. Dane and Milwaukee counties operate children's wraparound programs but are not CST grantees. There are eligibility limitations for these programs (e.g., require youth to be enrolled in Medicaid). During transition year one, the state should explore with Dane and Milwaukee the opportunity for CST funding and its potential impact on their programs.	Joyce Allen	DMHSAS will begin conversations with both counties, at a minimum about data collection (see #5 below). No decisions have yet been made regarding providing CST funding for these counties.
5. The state should have the flexibility to allocate a nominal amount of funding to non-CST wraparound initiatives (e.g., Wraparound Milwaukee, Dane County Children Come First) to enable their participation in statewide data collection and reporting.	Joyce Allen/Tim Connor	This is part of a larger conversation that requires compatible data collection systems and having Medicaid collect data for those children in the HMOs. DMHSAS will begin to explore collecting data on children/youth in these counties.
<b>Funding Duration</b>		
1. The duration of CST funding for sites should be ongoing rather than time-limited as it is today, contingent upon meeting all program requirements.		Completed. Due to legislative changes, funding will be ongoing for each site going forward. DMHSAS has authority to ensure each site meets statutory requirements in order to receive the same level of funding.

Recommendation	Lead	Status
<b>Application for Funds</b>		
<ol style="list-style-type: none"> <li>1. There should be an application process for CST rather than an automatic allocation of funds.</li> <li>2. All counties and tribes should have an opportunity to apply for CST funding, regardless of whether or not they have sustained CST operations post-grant, and regardless of whether or not they declined CST funding in the past.</li> <li>3. Existing CST grantees should reapply along with other counties/tribes, at a TBD date.</li> <li>4. Counties and tribes should be able to decline participation in CST.</li> </ol>		<p>Completed. Beginning in 2013, all new and renewed contract sites must complete a work plan that outlines measurable goals and SMART objectives for the contract period. A performance report will then be required every six months to demonstrates commitment and progress to those goals and objectives.</p> <p>Completed. All counties and tribes were offered the opportunity to apply for CST funding in 2013 through a Request For Application process. The application process will be done each year. The goal is to have CST be a statewide service.</p> <p>Completed. Beginning in 2013, all new and renewed contract sites must complete an annual work plan and budget to receive a contract. Performance reports will also be required every six months that demonstrates commitment and progress to the work plan and budget.</p> <p>Completed. Each county and tribe may decide if CST is a service in which they choose to participate. They may also provide CST services utilizing non-DHS funding.</p>
<b>Target Population / Eligibility</b>		
<ol style="list-style-type: none"> <li>1. CST sites should be required to regularly and periodically report on various demographic characteristics of population served.</li> </ol>	Tim Connor	Are there specific, additional demographics the committee recommends are collected? CST sites report basic demographic data currently as part of client data collection.
<ol style="list-style-type: none"> <li>2. The state should take measures to ensure that a minimum of 70% of the enrolled youth meet SED criteria (in aggregate at the state level).</li> </ol>	Joyce Allen	This requirement is not in the legislation. The 70% goal for youth with SED may be a reasonable standard to show that it's a priority for the state to service youth with SED.
<ol style="list-style-type: none"> <li>3. Recognizing the fact that children who meet SED criteria are identified by statute as a "priority target group," sites should use an eligibility form that identifies whether referred youth meet SED criteria. These forms should be submitted to the state for aggregate analytical purposes.</li> </ol>	Tim Connor	DMHSAS will continue to analyze this recommendation.
<b>Quality Assurance</b>		
<ol style="list-style-type: none"> <li>1. The committee recommends that the state research the effectiveness and cost-effectiveness of various methods of delivering training and technical assistance.</li> </ol>	Karen Bittner	One of the new CST staff (Karen Bittner) will focus on Training and TA. She will be evaluating the current assistance given to sites and make recommendations for changes and improvements as needed.
<ol style="list-style-type: none"> <li>2. The state should ensure mechanisms are in place to monitor the ongoing sufficiency of training and technical assistance available to CST sites.</li> </ol>	Karen Bittner	Same as above.
<ol style="list-style-type: none"> <li>3. The state should use existing DMHSAS staff to work on outcomes reporting for CST rather than allocate funds from CST for that purpose.</li> </ol>	Tim Connor	Completed. There are two DMHSAS evaluators who work on data collection and outcomes reporting for CST as well as many other DMHSAS programs.

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<b>CST System Components</b>		
1. Parent peer support should be considered an essential component of CST (i.e., sites would have to meet TBD standards/requirements). Other core components that should be required for sites to receive full funding are process fidelity, adherence to data collection/reporting requirements, a plan to address diversity, and a plan to address sustainability/expansion.	Joyce Allen	Some sites are utilizing parent peer support well and DMHSAS fully supports these efforts. DMHSAS will provide technical assistance to any sites interesting in adding this component to CTS. Other core components will be investigated in 2014 and 2015.
2. "System change" should remain as a core element of CST. In addition, it should be more clearly defined.	CST Team	It would be helpful to have more information from the CCF committee regarding this recommendation. DMHSAS' focus is on ensuring that Coordinating Committees are defining and working toward system change in their locales.
<b>Regionalization</b>		
1. The Department of Health Services should support and incentivize regionalization, but ultimately leave the decision to regionalize to counties and tribes.	Joyce Allen	Legislation allows for regional CSTs. Site assignments and orientation meetings for new sites are based on other current or future regionalization efforts. Counties and tribes may determine how they want to collaborate and pool resources, staff, and funding to maximize CST.
2. Multi-jurisdictional (i.e., multiple counties and/or tribes) CST sites should receive the same amount of total funding that they would have collectively received if applying individually.		As of 2015, this will be completed.
<b>Program Integration</b>		
The state should review and analyze the various programs serving children and make recommendations on how to better integrate programming to simplify access to services and to streamline program administration.	Joyce Allen/OCMH	DMHSAS is reviewing various coordination efforts to ensure children receive integrated services when appropriate. Sally Raschick is working in both the CCS and CST programs so that those services can come together in a more streamlined way. Through this coordination, DMHSAS will learn from the sites how those services can best work together. In addition, the Office of Children's Mental Health is working on this issue and DMHSAS is collaborating with them.
<b>Common cost-benefit measures</b>		
The state should research, recommend and implement an effective and efficient method of measuring CST cost-benefit in the aggregate.	Tim Connor	DMHSAS will identify cost benefit measurements to be collected through PPS, site visits, and performance reports by the end of 2014.
<b>Fidelity</b>		
The state should research and implement a valid and reliable method of measuring process fidelity at the system, team and service coordinator levels for all CST sites.	Joyce Allen	DMHSAS will be reviewing current fidelity measures in 2014.
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