



Notes from Breakout Groups on Budget, Funding, and Finance

Funding for the Service Array

| Main Themes | Ideas |
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| <p>Treatment</p> | <ul style="list-style-type: none"> • Crisis intervention with trained, competent providers. • Transitional services: <ul style="list-style-type: none"> ○ Create more transitional services- aging out of foster care, turning 18, RTC to Home, moving to a new school, changing providers and psychiatrists, going into the workforce • Full continuum of care: <ul style="list-style-type: none"> ○ Current continuum of care has large gaps, where appropriate follow up and/or step-down services often are not available; (e.g. what is the follow up with referrals to pediatricians?). • Population specific services: <ul style="list-style-type: none"> ○ Autism; ○ Traumatic brain injury; ○ Developmentally appropriate services for “aged out youth” (they may be 21, but be functioning at a 16 year old level); and ○ Dual diagnosis providers-including those working with developmentally disabled, brain injury, and behavioral needs combined. • Residential treatment services. • In-home services: <ul style="list-style-type: none"> ○ Including incentives to providers to use this approach. • Treatment for parents (they may not have Medicaid or private insurance to enable access). • Alternative therapies: <ul style="list-style-type: none"> ○ True hope, vitamin supplements, Eastern medicine, sensory integration (e.g. massage chairs), and other therapies where there may not be evidence-based practices that fall into the traditional funding requirements; and ○ Nutrition and physical activity approaches. |
| <p>Non-Treatment Supports</p> | <ul style="list-style-type: none"> • Transportation options: <ul style="list-style-type: none"> ○ In rural areas prohibits being able to get to service providers. Parents have had to quit their jobs so that their kids can receive the services that they need; and ○ In urban areas, provide transportation to service providers (vans, wheelchairs, etc.) and training on how to get to service locations using local public transit. • Family support services: <ul style="list-style-type: none"> ○ Navigators/advocates and peer support, including funding to develop the peer support network among those who have |

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| | <p>been through the systems;</p> <ul style="list-style-type: none"> ○ Parent coaching; and ○ A continuum of support services that build on natural supports. <ul style="list-style-type: none"> ● Respite providers: <ul style="list-style-type: none"> ○ Planned respite of varying lengths, including out of home placements that could be multiple months in duration without resulting in a loss of parental custody (social service involvement); and ○ Emergency respite with skilled providers. ● Public education: <ul style="list-style-type: none"> ○ Increased media outreach to migrant families and kids and families not already in the system; and ○ Use of schools as a mechanism for public education, tying schools and community together to address mental health. ● Interpreter services: <ul style="list-style-type: none"> ○ Captioning; and ○ Interpreters. |
| <p>Service Delivery Infrastructure</p> | <ul style="list-style-type: none"> ● Funding to support service capacity in rural areas. ● Community-based centers with comprehensive services available: <ul style="list-style-type: none"> ○ Centralized community centers; ○ Learning centers; and ○ Expansion of community centers in rural areas. ● More follow up on referrals and finding out tangible outcomes ● System development: <ul style="list-style-type: none"> ○ Facilitators outside of system; or ○ Staff positions to build cross system collaborations (identify core competency standards, relationship building, build in money for TA, RFP's mandate collaborations, use existing groups and build) ● Family and youth involvement in policymaking: <ul style="list-style-type: none"> ○ Compensation for families and youth (gas, transportation, stipends, respite, vouchers so that families choose what they need); and ○ Training for staff at all levels on how to embrace and validate the family voice. ● Funding for workforce development, including: <ul style="list-style-type: none"> ○ More skilled providers and bilingual providers with diverse backgrounds; also a need for specialty providers (e.g. trained in both mental health and substance abuse, training in early childhood and behavioral issues, have worked with migrant workers, transgender youth); ○ Staff retention needs, as there is often an unstable, sometimes inconsistent relationship between case workers and clients due to high turnover for case workers; and ○ Mental health workers in non-mental health settings, such as |

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| | family physicians offices. Particularly important for migrant workers or individuals with co-occurring needs. |
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Policies Specific to Funding Streams

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| Insurance and Billing | <ul style="list-style-type: none"> • Mental health typically in a capitated versus substance abuse which is fee for service; providers that service both have difficulty knowing which funding stream is more appropriate to bill • Need to find gap coverage for those that exceed their number of sessions (private insurance) and those who have fluctuating Medicaid/SSI coverage; • Need to broaden Medicaid eligibility instead of month to month • Must wait for eligibility and paperwork to complete particular services and this does not always happen in a timely manner. • Difficulties receiving services when you have insurance and have Medicaid for child but need Medicare to pay for services (e.g. sensory integration, OT) or to support family treatment that includes family members without Medicaid • Medicaid reimbursements are too low—keeps providers from serving or providing appropriate services • Many do not qualify for Medicaid due to income, but can't afford insurance co-pays |
| Flexible Funding Infrastructure | <ul style="list-style-type: none"> • Funding streams do not prioritize preventive care. E.g., federal funds are often directed toward on out-of home services instead of home-based services, and billing rates for provisional diagnoses or without diagnosis are lower than rates for treating actual diagnoses. • Private grants may be successful, but not sustainable when the grant ends - continuous funding is needed to avoid re-creating the wheel. • Need blended and non-categorical funding. Look at models like HB1451 • Provide funding to counties that is equitable across the state and flexible enough for each county to meet unique needs – restrictive funding is easier to manage, but will not meet the needs. • Current state agency funding creates fragmentation; the line item funding and competitive approach needs to be rethought. • Centralize and distribute information about resources and grants from the state • Have outcomes with incentives—performance based contracting (NY and IL are good state examples; CO examples include Boulder, Chaffee, Teller) • In NJ they have employers donate \$1 for every employee per year into a catastrophic family fund which covers things that insurers would not cover (including mental health) • TANF reserves have too strict of guidelines—we need to explore how to get the money (Denver is coordinating with other metro counties |

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| | <p>to share funds); Need to strategize protocol for TANF; need a number in each county to access TANF dollars</p> <ul style="list-style-type: none">• Competition between different agencies for funding and loss of funding can roll over into loss of job and lack of funds• We need innovative funding strategies that engage communities, schools, and families to build a community around mental health issues.• Funding drives partnerships – when one partner receives funding and others do not, it can result in a breakdown in partnerships at the local level• Administration changes can modify priorities which can lead to reduction in money; even if administration changes, we need to set it up so that the philosophy doesn't change.• Need to explore national foundations and grants to fill in gaps in funding |
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Barriers to Service Delivery Arising from Funding Policies

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| Accessibility of services | <ul style="list-style-type: none">• Often you need a label to get your services (use of diagnosis leads to money, labeling is the connected to funding).• In order to receive some service, there are unrealistic expectations, including having stable housing, transportation, and other supports which may not be in place.• Must be on a medication a lot of times to get access to services.• Due to economy, families have to move and refill out school forms, find a place to live, children drop grade levels, and IEP takes a while to follow child. This needs to be more streamlined.• When transitioning out of systems the transition of meds and scripts don't always follow; results in paying for meds or going without them.• Need a more coordinated system; everything should flow from family and client needs. |
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Coordinated, Effective Infrastructure the Supports Funding Policy

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| Coordinated systems | <ul style="list-style-type: none">• Collaborating funding sources across systems; funding matrix being drawn at the state.• We need a strategic plan for the state—we are trying to do everything simultaneously and there is a great need for systematic thinking (undoing Tabor).Need joint and measurable outcomes, standardized and consistent data collection, and a sustainable framework and methodology that will remain even during political changeovers.• Evidence based practices should be used.• State should do a “mystery shopper” program and see how easy/hard it is for someone to navigate the system.• Ritter-Recidivism initiative based on data is a good model. |
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| | <ul style="list-style-type: none">• Have accountability at the local level and solicit local input.• Create a uniform language to reduce confusion.• Culture change is needed!<ul style="list-style-type: none">○ To support the system of care model; and• In communities and agencies is needed from the top down; state should model this for the local level. |
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