10/2009: Report has been attached, please see below.

North Carolina Department of Health and Human Services
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Beverly Eaves Perdue, Governor

Lanier M. Cansler, Secretary

September 30, 2009

The Honorable Martin Nesbitt, Co-Chair
Joint Legislative Oversight Committee on Mental Health,
Developmental Disabilities and Substance Abuse Services
North Carolina General Assembly
Room 300B, Legislative Office Building
Raleigh, NC 27603

Dear Senator Nesbitt:

Under the provisions of Session Law 2009-0451 Section 10.68A.(a)(7)(j), the Department of Health and Human Services was mandated to complete a report on the plan to transition children out of Level III and Level IV group homes, for submission to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on or before October 1, 2009.

Planning for implementation, while initiated in June 2009 in anticipation of Legislative action, could not be finalized until the provisions were passed and the legislation enacted in August. Additionally, time has been required to carefully integrate this planning process with the other significant changes to Community Support Services and case management services. In light of these factors, the Department is requesting to extend the date of submission to be on or before October 31, 2009.

The required report has been preliminarily drafted. There has been significant collaboration among multiple divisions, Local Management Entities, providers and advocacy groups in planning for implementation of the changes to residential services for children and adolescents. Implementation will be handled in a careful fashion. Additional time is required to allow finalization of the details in the report prior to submission. Your consideration of these issues is greatly appreciated.

If you have questions or would like additional information, please contact me or Dr. Patti Forest, Acting Assistant Director, Clinical Policy and Programs of the Division of Medical Assistance at (919) 855-4260.

Sincerely,

Lanier M. Cansler

LMC:pf

cc: Allen Feezor
Dan Stewart
Craigan L. Gray, MD, MBA, JD
Sharnese Ransome
Jennifer Hoffman
Legislative Library (2)

Legislative Report to
The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services
Plan for Transitioning Children out of Level III and Level IV Group Homes
S.L. 2009-451 Section 10.68A.(a)(7)j

State of North Carolina

Department of Health and Human Services

Division of Medical Assistance

October 2009

Table of Contents

Executive Summary

This report is being submitted under the provisions of Session Law 2009-0451 Section 10.68A.(a)(7)j, that requires the Department to report on its plan to transition children out of Level III and Level IV group homes, for submission to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on or before October 1, 2009. An extension was requested by the Department until October 31, 2009.

The 2009 Conference Report on the Continuation, Capital and Expansion Budget, item #160, includes budget reductions in expenditures of state dollars of $15,860,000 in FY 2009 - 2010 and $22,554,622 in 2010 – 2011, or $45,485,976 and $64,682,025, respectively, in total expenditures for Level III and Level IV Group Homes. Based on total expenditures in State Fiscal Year 2009 of $163,397,281, these cuts represent 27.84 percent and 39.59 percent reductions, respectively over the next two fiscal years.

Provisions in SL 2009-045110.68A(a)(7)j to be implemented under this plan include new admission and continued stay criteria that must be met for children and adolescents to be admitted and to remain in residential treatment.

Department of Health and Human Services Divisions of Medicaid Assistance and Mental Health, Developmental Disabilities and Substance Abuse, began planning for implementation of these reductions in June 2009. The Residential Services Workgroup was convened with broad representation by stakeholders including child advocates, provider owners and staff, Local Management Entities, the Divisions of Social Services, Health Facility Regulations, Juvenile Justice and Delinquency Prevention, and ValueOptions, as Medicaid's authorizing agency. The workgroup met weekly from June through early August 2009 to develop the plan described in this Report. The development of the plan included the work of many additional subcommittees which met between meetings and developed work products for review and approval of the workgroup.

This plan is intended not only to reduce expenditures, but also to move the system towards best practices in the treatment of children and adolescents which support treatment in the child's own home and community or in other family-type settings. While the plan was developed at the state level, the implementation is occurring at the local level with the involvement of each child's Child and Family Team including family members, residential provider and other community resources.

The System of Care Coordinators are tracking implementation of the plan through weekly reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse. Medicaid is tracking expenditures through its claims data reports. Target utilization figures are still being finalized but it appears that the funding available for the last nine months from October 2009 to June 2010 will support approximately half of the historical typical utilization of these services. This utilization pattern will need to be continued to realize the overall savings required in State Fiscal Year 2011.

Significant progress has already been made in reducing the number of children in these levels of care and providing appropriate community based services. The plan includes careful clinical assessment, Child and Family Team planning, use of community based resources, and close monitoring of children in care to reduce the dependence on Residential Level III and IV care for children and adolescents. The need to cut expenditures has accelerated movement towards this goal.

INTRODUCTION

This report is being submitted under the provisions of Session Law 2009-0451 Section 10.68A.(a), that requires the Department to report on its plan to transition children out of Level III and Level IV group homes, for submission to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on or before October 1, 2009. An extension was requested by the Department until October 31, 2009.

The 2009 Conference Report on the Continuation, Capital and Expansion Budget includes budget reductions in expenditures of state dollars of $15,860,000 in FY 2009 - 2010 and $22,554,622 in 2010 – 2011, or $45,485,976 and $64,682,024.66, respectively, in total expenditures for Level III and Level IV Group Homes. Based on total expenditures in State Fiscal Year 2009 of $163,397,281, these cuts represent 27.84 percent and 39.59 percent reductions, respectively over the next two fiscal years.

Provisions in SL 2009-0451 Section 10.68A(a)(7)j to be implemented under this plan include:

- Submission of the Therapeutic Family Services State Plan Amendment to CMS by the Division of Medical Assistance.
- Reexamination of entrance criteria to promote least restrictive placement and adding requirements for parental involvement and inclusion in community activities for recipients.
- Requiring national accreditation within one year of SL 2009-0451 Section 10.68A(a)(7)j or within one year of enrolling in Medicaid.
- Tighten entrance criteria to require that placement be limited to children stepping down from a higher level of care or to those who have had an unsuccessful trial at Multisytemic Therapy or Intensive In-Home and who have been reviewed by the child and family team who has determined that placement is required for health and safety. Additionally, a complete discharge plan is required at the time of referral.
- Length of stay is limited to 120 days; any exceptions require submission of an independent psychiatric examination; Child and Family Team review of goals and treatment progress, family or discharge setting involvement in treatment.
- Submission of discharge plan is required in order for any request for authorization to be considered.
- Provider requirements for record maintenance, termination of services and notification requirements.
- Completion of a report on the plan to implement the transition of children and adolescents from Level III and Level IV Group Homes.

This report consists of the following sections: Background, Purpose and Goal; Plan Development Process; Implementation Process; Impact of Reductions and Targets for Utilization to Realize Savings.

BACKGROUND, PURPOSE AND GOALS OF THE PLAN TO TRANSITION CHILDREN OUT OF LEVEL III AND LEVEL IV GROUP HOMES:

By mutual agreement, the Department of Health and Human Services, the Department of Juvenile Justice and Delinquency Prevention, the Department of Public Instruction and the Administrative Office of the Courts have longed embraced a System of Care (SOC) approach to providing services to children, youth and families. The SOC principles guided the planning process and will guide the implementation of the plan. Those principles mandate planning activities and services that are:

- Family Driven and Youth Guided
- Individualized
- Strengths Based
- Child and Family Team Based
- Culturally and Linguistically Competent
- Persistent
- Outcome Based and Data Driven
- Community Based

And that include:

- Natural Supports
- Collaboration within each child's system of care

Purpose

Based on these principles, the development of the plan was driven, not only by the mandate to meet cost savings, but also by the Department's intent to reduce the reliance on out of home placements and to promote evidenced-based and best practices in the treatment of children and adolescents who have serious emotional disturbances and substance abuse problems. These practices include serving children and adolescents in the least restrictive, most inclusive settings with maximum involvement of parents and other significant care givers.

North Carolina Medicaid funds several community-based services that are now required to be tried prior to removing a child from his home and placing in a group setting. These include Multisystemic Therapy (MST) which is an evidenced-based practice for children, adolescent with significant behavior management issue and their families. For other children, Intensive In-Home Therapy must be accessed and tried prior to placement in a group setting. Other resources for community based services include core outpatient therapy services through which children and families can access individual, group and family therapy provided by licensed mental health professionals.

This plan also supports the use of Therapeutic Family Services as the preferred placement setting for foster care children and for children in parental custody who cannot be safely maintained in their own homes. A new definition has been developed and submitted in draft to CMS, with the official SPA to be submitted this quarter. The new service increases clinical oversight, supervision and staffing requirements. Research supports the use of these services when residential placement cannot be avoided.

Goal

The Goal of this plan is to reduce expenditures for, and reliance on, residential services while increasing the use of evidenced-based and best practices in community based, family-oriented services for children and adolescent who have serious emotional disturbance.

THE PLAN DEVELOPMENT PROCESS

In anticipation of action by the 2009 Legislature to require reductions in expenditures for Medicaid funded residential treatment for children and adolescents in Level III and Level IV group homes, in June 2009, the Divisions of Medical Assistance and Mental Health, Developmental Disabilities and Substance Abuse convened a broad based Residential Services Workgroup to develop a system wide plan for this initiative. The Workgroup membership included over 40 representatives from recipient and provider advocacy groups, parents, LMEs, providers; the Divisions of Medical Assistance, Mental Health Developmental Disabilities, and Substance Abuse; Social Services, Department of Juvenile Justice and residential services providers. Members ranged in position from Division Directors, Deputy Directors, Psychiatrists, LME directors and staff, program administrators, Chief Operating Officers, Licensed Clinicians, to owners of providers and front line staff. The tasks of this Workgroup included identification of plan components, delineation of roles, responsibilities, policies and procedures, communications to the field, timelines and the development of an implementation plan with an ongoing reporting mechanism.

The Workgroup held eight three hour meetings between June 8, 2009 and August 3, 2009. In addition, the members formed six subcommittees which met independently between meetings to accomplish tasks that were identified in and assigned by the whole workgroup. Subcommittees included:

- Transitional/Crisis Placement Subcommittee;
- Risk Assessment/Needs;
- Residential Discharge Planning;
- Role of LME;
- PRTF Rules and Standards Review Committee; and
- Several subcommittees formed to develop informational communications which were sent to families, LME's, the courts, County Social Services and to providers.

In addition, the development of alternative service definitions was prioritized by the Department's Service Definition Workgroup including a new Therapeutic Family Services Definition, as well as development of definitions for Children's Facility Based Crisis Services and Peer Support Services for Adults.

Deliverables from the Residential Workgroup and its Subcommittees:

- A revised Therapeutic Family Services definition and State Plan Amendment, submitted in draft to CMS in July and pending official submission.
- A new Children's Facility Based Crisis Definition
- Informational letters composed and sent to:
    - Providers of residential Level III or IV and
    - Local Management Entities, County Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention Chief Court Counselors, Administrative Office of the Courts)

- Data
    - A report on resources including the number of therapeutic foster homes, group homes number of children in these settings, by county and LMEs
    - Report on the number of current utilization review authorizations for children and adolescents in Level III and IV settings;
    - Risk factors for children in the settings, based on utilization review data;
    - Length of stay data
    - Alternative Services and Gap Surveys for each county and LME

- The plan with policies and procedures for implementation.

IMPLEMENTATION PROCESS

The planning activities described above were developed on a statewide basis; implementation of the plan is occurring on the local level, close to the child or adolescent's home and parents or legal guardian. The focus of responsibility for carrying out the plan is at the LME with the System of Care Coordinator overseeing the process.

The plan was implemented in August 2009 with the notification of LMEs of the list of names of all children and adolescents who are from their area and who were receiving residential services in July 2009. LMEs began coordinating Child and Family Teams as described below and all recipients have received the initial review.

The Child and Family Team (CFT) process, which will occur for every child in the system, is integral to successful transition of children/youth residing in Child Residential Level III and Level IV to other medically necessary services. This best practice approach is being used to the maximum extent to determine the appropriate services for youth affected by this legislation. The twenty-four Local Management Entities (LMEs) employ thirty-five (35) SOC Coordinators who operate under an established family-driven and youth-guided framework. These SOC Coordinators are and will continue to be actively engaged in the transition to ensure fidelity to the CFT process, to see that all processes occur in a timely fashion and that transitions are tracked and monitored.

Local Management Entity Role

The LME is the lead agency coordinating and overseeing the transition. The SOC coordinators have already received lists of children/youth in their catchment areas that are currently authorized to receive Level III or IV services. The SOC coordinators, in collaboration with Local Community Collaboratives comprised of families, community partners and child, youth and family-serving agencies, will provide System of Care training and technical assistance to the provider community as needed.

LME System of Care Coordinators and other LME care coordination staff have triaged the list of currently placed youth based on severity of need and authorization timelines. They will coordinate with the Community Support provider in order to ensure timeliness of transition plans. SOC coordinators, LME care coordinators, or Community Support providers will gather clinical information from the most recent authorization process, the current person-centered plan (PCP), and the Risk Questionnaire along with other helpful information to assist in the triage process and the organization of this information for the Child and Family Team meetings.

LME System of Care Coordinators and/or other LME care coordination staff are expected to attend all Child and Family Team meetings for youth in their catchment areas. In cases when this is not possible, a care coordinator will be in close contact with the Community Support Qualified Professional convening the team. LME System of Care Coordinators will ensure that the Child and Family Team process that occurs for each child/youth follows the best practice principles of the System of Care model.

Results from the LME Triage process plus the Child and Family Team (CFT) meetings will be coordinated to determine community needs and service gaps. The LME Provider Relations Unit will work closely with providers and the Local Community Collaborative(s) to strategically develop a plan reflecting realistic timelines that take into consideration the requirements surrounding each type of placement needed.

Specific tasks of LME:

1. SOC Coordinator will review the list of children/youth from LME catchment area in Level III and IV placement;
2. SOC Coordinator will identify who will convene and facilitate each Child and Family Team (CFT) meeting – either the SOC Coordinator, other LME care coordinator, or identified Qualified Professional (QP);
3. SOC Coordinator will convene and facilitate the CFT meetings for children/youth with the greatest challenges;
4. LME (Provider Relations) will contact all Child/Youth Community Support (CS) providers who serve children/youth currently in Level III and IV settings, and assure the CS provider has a current Person Centered Plan (PCP) for each child/youth in the residential setting, and that all identified instruments, including the Risk Questionnaire, are completed by the CS provider prior to the first CFT meeting;
5. CFT convener will assure that all appropriate individuals are invited to and urged to attend all CFT meetings;
6. CFT convener will facilitate CFT meetings, and assure CFT identifies appropriate options and timelines for discharging child/youth.

Community Provider Role

Community providers are instrumental in each step of the process. Community providers supporting individuals will have the most current information available which will be critical for triage, planning, and development of the transition plan. Along with the family and/or guardian, the current residential provider and the community support provider for each child will be among the most important sources for sharing knowledge of the child with the LME and the CFT. It is critical that representatives from these agencies attend CFT meetings and have input into the transition planning process.

Specific Tasks of Community Support Provider:

1. Community support QP will assure a full and current Person Centered Plan (PCP) is in place for the child/youth being discharged from the Level III or IV setting, including current, full crisis plan and identification of all considerations required for the child/youth to be successful in a new setting;
2. Participate fully in the CFT process;
3. Request of the vendor any additional units of CS which may be required in order to assure the successful case management of the child/youth through the transition to alternate services. Additional units, which must be justified in the request, may be used for arranging for

updated assessments as needed, completion of appropriate risk instruments and/or engaging appropriate CFT members to participate in the process;

4. Work with the parent and/or legally responsible party and current residential provider, to make certain that all are fully informed participants in the process. This includes keeping all participants aware of State protocols for the transition of youth out of Level III and IV settings and all information concerning their specific child/youth including CFT meetings, alternate service options and support for parents and family members.
5. Once new services are identified, the CS QP will identify appropriate supports for the child/youth through transition. If the appropriate service is either Psychiatric Residential Treatment Facility (PRTF) or Therapeutic Family Service (TFS), the CS QP will work with the individual and her/his parent and/or legally responsible person to select a provider agency which meets the needs of the individual. If the appropriate setting is home, the CS QP will work with the family and the individual to establish the appropriate supports for the individual in the home setting, including appropriate training for family members and appropriate services such as Intensive In-Home (IIH) or Multisystemic Therapy (MST) to assure success for the individual in the home setting.
6. The CS QP continues to monitor the progress of the individual in the home setting until another clinical home provider is in place as deemed medically necessary.

Specific Tasks of the Level III or Level IV Residential Provider:

1. The Residential Provider (RP) is expected to meet with the CFT, assure the PCP is current and represents the current level of progress for the child/youth, and that the crisis plan is current and includes any functional issues specific to school, home, and/or community involvement to ensure safety and stability for the individual should circumstances arise which necessitate interventions in any of the places he/she might be.
2. The RP will collaborate with the CS QP and participates in the CFT;
3. The RP will work with the individual to support the discharge plan and to minimize disruption to her/his life.

Local/State Agency Partner Roles

Local DSS staff are expected to participate in the Child and Family Team meetings to plan for the transition for all children/youth in their custody. It was estimated in August that approximately 400 of the total number of children in Level III and Level IV placements were in DSS custody.

DJJDP Court Counselors will participate in the Child Family Team meetings of all children/youth in their custody and in the meetings of all youth under their supervision based on severity of need. It is estimate that approximately 560 of the children/youth in residential placement are involved in the juvenile justice system. There is potential overlap among the 400 children and adolescents indentified with DSS involvement who are placed in residential group homes and those 560 youth in residential group homes with DJJDP involvement.

The Administrative Office of the Courts will inform the court system of the upcoming transition of children/youth away from Residential Level III and IV placements toward alternative placements and therefore court orders to this type of placement should take into account the decrease in availability of this option.

The Divisions of Medicaid and Mental Health, Developmental Disabilities and Substance abuse are responsible for overseeing the planning and implementation and for responding to issues and problems as they arise to develop timely response. These Divisions are ultimately responsible for tracking and expenditures to assure targets are being met.

Service Authorization Agency Role

In the process of the evaluation and transition of children and youth currently being served in residential placements, it is clear there will be the need for authorization of alternate services to provide medically necessary care, including adequate case management, during this period of time. The need to coordinate information, indentify community resources, and assist the family and youth during the transition period will intensify the need for supports. All authorizing agents (LMEs and the vendor) should be aware of the need to authorize brief additional supports for this population in a timely manner. The vendor will provide technical assistance to the field to facilitate complete and effective request for authorizations.

Additionally, the Authorization Agency will be reviewing all initial and concurrent requests to assure that the provisions in SL 2009-451 section 10.68A.(a) (7)(d)(e) and (f) required for approval of these services are met. These include: placement shall be step down from a higher level of care; Multisystemic Therapy or Intensive In-Home shall have been tried and been unsuccessful and the Child and Family Team has reviewed all other alternatives and recommendations and recommends Level III or Level IV placement to maintain health and safety.

For continued stay reviews over 120 days, the approved length of stay, the Authorization Agency will implement the provisions that require an independent psychiatric assessment, Child and Family Team review of goals and treatment progress, family or discharge placement setting active involvement in the treatment goals and objectives.

Submission of a discharge plan is required in order for the request to be considered complete. Failure to submit a completed discharge plan will result in the request being retuned as unable to process.

Tracking of Implementation

The System of Care Coordinators are responsible on a weekly basis for gathering and reporting the following data elements: These are aggregated and reviewed at DMH and DMA routinely to assess progress.

- *Name of Local Management Entity:*
- *Total number of recipients in the LME catchment in Level III residential services:*
- *Total number of recipients in the LME catchment in Level IV residential services:*
- *As of date of the report, what is the current number of recipients in Level III residential services?*
- *As of date of this report, what is the current number of recipients in Level IV residential services?*
- *What is the cumulative number of recipients who have been "paper triaged" as of the date of this report?*
- *What is the total cumulative number of recipients who have had an initial CFT meeting as of the date of the report?*
- *What is the total cumulative number of recipients who have had a follow up CFT meeting as of the date of the report?*
- *What is the total cumulative number of recipients who have been discharged from Level II residential services as of the date of the report?*
- *What is the total cumulative number of recipients who have been discharged from Level IV residential services as of the date of the report?*

- *Indicate the number of recipients that the LME anticipates being discharged to one or more of the following specific services?*
  - *Outpatient Individual Therapy:*
  - *Intensive In Home:*
  - *Day Treatment:*
  - *Residential Level II Program Type:*
  - *Therapeutic Foster Care:*
  - *Residential Level III:*
  - *Residential Level IV:*
  - *Psychiatric Residential Treatment Facility:*
  - *Jail:*
  - *Aged out:*
  - *Moved out of state:*
  - *Community Support:*
- *Identify the number of youth in need of the following services which are not currently available?*
- *What is the number of Level III beds in your catchment as of August 1, 2009?*
- *What is the number of Level III beds in your catchment as of date of the report?*
- *What is the number of Level IV beds in your catchment as of August 1, 2009?*
- *What is the number of Level III beds in your catchment as of date of this report?*
- *Top 3 CFT Successes:*
- *Challenges and Trends:*

Additionally, DMA will be running monthly reports on expenditures to track utilization and take additional steps to monitor implementation and process on meeting reductions in spending.

FISCAL IMPACT OF REDUCTIONS AND TARGETS FOR UTILIZATION TO REALIZE SAVINGS.

Methodology

To determine the fiscal impact of the required reductions, DMA calculated expenditures for the past 12 months, based on date of payment which was $163,397,281 for Levels III and IV. To allow for plan implementation, the required $45,485,976 in savings for year 2010 was calculated to occur over a 9 month period from October 2009 through June 2010, resulting in available funds for these services of $45,485,976. Over nine months, these funds will support close to 50 percent of last year's typical utilization each month. This utilization rate must be maintained during FY 2011 to reach required savings.

Point in time utilization is being tracked by DMH and Medicaid expenditures are being tracked by DMA. Since providers may bill for up to a year from the date of service, DMH's data and DMA's will not be the same. There will always be a lag in data gathered from claims. The plan for reaching these targets includes careful monitoring of the referrals at the LME SOC level to assure that each referral package meets the additional criteria included in SL 2009 451. Each new referral must indicate that the child or adolescent is stepping down from a higher level of care or has had a trial of community based Multisystemic Therapy or Intensive In Home, and that the child has been reviewed by the Child and Family Team which recommends residential placement. Additionally, each child must have a completed discharge plan that is signed by the recipient, family and SOC and that the plan defines discharge setting and services for the child.

For concurrent reviews for a child already in a residential setting, each re-authorization request must be accompanied by a concurrent psychiatric assessment completed by a practitioner who is independent of the residential services provider as well as by the discharge plan described in the paragraph above.

The Medicaid Authorizing Agency, ValueOptions, will be reviewing the requests to assure that the child or adolescent meets medically necessity to be admitted into or to continue in residential treatment. They will also be reviewing to assure that the new provisions required in order for the request to be processed are present with the request. However, as a Medicaid service, under Federal CMS provisions, ValueOptions does not have the authority to deny services if the authorization request meets medical necessity even if another service could be made available and would equally effective.

Current Status

These numbers are being provided to give a framework for understanding utilization and gauging progress. The Medicaid numbers are in the process of final approval. As noted above, Medicaid claims data will lag behind actual point in time numbers being collected by DMH. Additionally, DMH's numbers may include some duplication if children are placed out of their catchment area and then reported by both their home county and county of placement. Also, some children in the point in time count may be funded by sources other than Medicaid.

Based on actual Medicaid expenditure and claims data, 2,022 children and adolescents received Level III and IV services (combined) in June 2009. Based on Medicaid claims data, this number was reduced by 358 youth to a total served of 1664 for September 2009, already demonstrating reductions taking place due to activities conducted by the LME and SOCs and their partners in the field. To meet budget reductions, this number must be further reduced, incrementally over the next 9 months, to approximately 964 children and adolescents in Level III and Level IV (combined) by June 2010 and maintained the following year.

According to DMH's October 19, 2009, report from the LME SOCs for children in Residential Level III and IV, when compared to August numbers:

- 86 percent of children in Level III and Level IV have received the initial Triage
- 80 percent have had their initial Child and Family Team meeting
- 50 percent have had their second CFT meeting
- 45 percent of those children in Level III in August (all funding sources) have been discharged
- 51 percent of Level IV (all funding sources) have been discharged.

The subsequent service needs of these children, adolescents and their families have been indentified in the discharge planning process. For the majority of children and families, these services have been readily available. Services in some catchment areas may require expansion. These are listed below with the number of children identified in need of these services when not readily available, as included in the October 12, 2009 report. These services include Respite (57-state funded); Intensive In Home (5); Multisystemic Therapy (22); Substance Abuse Intensive Outpatient (7), Therapeutics Foster Care (30) and Psychiatric Residential Treatment services (35). The number indicates the There have been no reported problems by the SOC s related to any problems with accessing outpatient mental health treatment services with a licensed clinician for these children and families.

CONCLUSION

The plan for meeting the provisions of the 2009 Legislature relating to Residential Services Levels III and IV has been developed on a state wide basis through a joint initiative among the Divisions of the Department of Health and Human Services; the LMEs, providers, advocates, families. It is being implemented at the local level and under the guiding principles of the System of Care that bring families, case managers, LMEs, child and adolescents treatment teams to the table to plan for the most effective and least restrictive treatment interventions that will allow for the child to reach and remain placement in his community with his or her family or in a family like setting. Significant progress has already been made in reducing the number of children in these levels of care and providing appropriate community based services. The plan includes careful clinical assessment, Child and Family Team planning, use of community based resources, and close monitoring of children in care to reduce the dependence on Residential Level III and IV care for children and adolescents. The need to cut expenditures has accelerated movement towards this goal.

Appendix A

Listing of Acronyms

CFT	Child and Family Team
CMS	Centers for Medicare and Medicaid
CS	Community Support (Services)
DMA	Division of Medical Assistance
DMH	Division of Mental Health, Developmental Disabilities and Substance Abuse Services
IIH	Intensive In-Home (Services)
LME	Local Management Entity
MST	Multisystemic Therapy
PCP	Person Centered Plan
PRFT	Psychiatric
QP	Qualified Professional
RP	Residential Provider
SOC	System of Care Coordinator
SPA	State Plan Amendment
TFS	Therapeutic Family Services