Integrated Family Services
Testimony - House Appropriations
February 3, 2014

Overview

Integrated Family Services (IFS) is currently operationalized as a pilot in one region, Addison Co., with Franklin/Grand Isle Counties joining as a pilot in April 2014. Additional regions are expressing interest and we will be engaging with them over the next several months to determine their readiness.

It's important to note that concurrent to rolling out IFS in the pilot regions we are also making statewide system improvements to help the other regions capitalize on some of the benefits of IFS and get on the path to readiness.

Outcomes

We are in the process of gathering the data and information to answer the common questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

How much did we do?

In the Addison pilot 678 children or pregnant women were served in the initial pilot year (FY13). The age range includes prenatal- up to 22 years old.

The Designated Agency's per member per month target:	228
The Designated Agency's per member per month rate:	$1290
The Parent Child Center's per member per month target:	75
The Parent Child Center's per member per month rate:	$771

We have access to the amount of services provided but would need some time to pull the data.

How well did we do it?

We developed population based outcomes for IFS and have recently developed the measures for the DA and PCC. We are in process of developing the tools to track and report on the measures and to create a quality improvement process. (see attached outcomes and measures)

Is anyone better off?

The data staff from across the agency is working on pulling data related to the population in Addison Co. and the population served. We should have data available within a few weeks. We are aware of several cases where children and families received services they may not of previously.

Organizational Structures

There have been changes at both a local level and a state level. The changes support the overarching concepts of IFS and have been implemented from the state and local experience and the several reports completed and years of families expressing what would most benefit them.

Examples of the changes include:

At a state level -

- Creation of an IFS Senior Management Team and IFS Implementation Team
- We are in the process of developing an inter-professional workforce development plan
- Working with the family advocacy organizations to develop certified family/peer support using a national curriculum
- Combining over 30 grants and contracts to one common grant for the DA and PCC

- Reduction of the number of reporting requirements (with more work to do)
- Writing an IFS manual which combines all child and family service expectations, rules, frameworks etc…into one place
- Combing expectations of intake, evaluation, integrated care plan and documentation
- Adopting a common screening/evaluation tool for outcome measurements
- Identifying frameworks in which to work (Strengthening Families, Bright Futures)

At the Local level –

- Within the DA, an integrated approach across developmental disabilities and mental health services
- Creation of a Resource Team (multi-disciplinary team for all disabilities)
- Residential Review Team
- Interagency Recruitment Committee
- PCC and Mary Johnson Children's Center are successfully using DA's electronic medical record.
- Child and family practice includes combining staff with the expectation that everyone is focused on the family; hired more skills workers to support youth in the community ; attending evidence based trainings that support the family based model
- Use of screening and assessment tools in a more systematic way
- Intake - "no wrong door" approach vs the single point of entry
- Increased consultations between programs –use of school-based ABA staff to consult with IFS and DS staff
- Key data elements identified and collected
- Create more opportunities for providers to work with primary care, even being able to place staff within primary care settings.

Limitations and restrictions from a siloed system

Currently AHS children's services fall in six Departments and multiple divisions of the agency. Division and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines about our work with children and families. With the inception of the Global Commitment waiver, these siloed Medicaid funding structures no longer exist. The IFS approach seeks to bring all agency children, youth and family services together in an integrated and consistent continuum for families. Families have experienced conflicting messages, expectations to meet several different criteria in order to access an integrated plan and lack of access to needed services because of not meeting one aspect of criteria. Providers have experienced conflicting messages and expectations, not being able to provide what they identify a family needs and programmatic conflicts that prevent a comprehensive multi-disciplinary approach. The goal of IFS is to change all that.

With the IFS model the payment reform, the programmatic changes and the streamlined expectations allow providers to serve families in a more preventive way. Families do not need to wait until they meet a criteria that says it's "bad enough" to receive the needed services. The flexibility of the payment reform model allows the providers the option of serving families who may need a few support services all the way to more intensive services and to provide population based supports such as a parenting course or developing wellness activities. The move from a system that only responds when issues are identified to one that allows prevention supports will help us change the trajectory in a more positive direction. The streamlining of expectations helps free up the providers time from unnecessary actions (documentation, process of meeting criteria etc..) and collection of uninformative data to one that gives us the information we need to gauge outcomes and quality and provides additional direct service time.

We have not had a lot of issues with children floating in and out of eligibility. With the PMPM approach as long as a provider bills the average minimum number needed the provider is in a position to support those who may be currently uninsured. This does not mean they can take on all needs without additional resources but it does provide a flexibility that did not exist before. Additionally in order to address the federal mandate of Early Periodic Screening, Diagnosis and Treatment (EPSDT) this flexibility provides a wider net in identifying needs early and providing the necessary services before a child and family need something more intense.

With the IFS approach we are using the funding more effectively and reaching more children and families. The providers have begun to ask the question "what do we need to do to prevent the children and families from needing us in the first place?" rather than "what do we do once they come to us?" The main funding stream for IFS is Medicaid Global Commitment and because of the GC waiver, as mentioned earlier, we no longer have to operate within "the artifacts of history that are multiple and created fragmented funding streams, policies, and guidelines." The additional funding to support IFS includes GC investment and any federal funding we may receive. We are also purposing aligning our work with the efforts of the Agency of Education (AOE) as it relates to the Race to the Top grant (RTTT), the School-Wide Integrated Framework for Transformation grant (SWIFT), Positive Behavior Intervention and Supports (PBIS) and the Multi-Tiered System of Support (MTSS). We are in the process of cross-walking the AOE and AHS frameworks and intend to work with the pilot regions to bring these efforts together.

In closing, there are many facets of integrating and changing systems, it's important and challenging work. Systems and people do not just change because we say to, we must be willing to change ourselves and show them the benefit of doing the hard work. IFS has been a concept for some time, has been attempted in some way in the past but this is the first real effort to make these large changes to the system. The science now confirms what we have known: nature and nurture go hand in hand – both genetics and environment matter; building wellness and strengths helps off-set deficits and challenges; healthy parents help create healthy children so it's important to make sure the parents needs are addressed as well; and health promotion and prevention work!

I've attached 2 short videos – one speaks to the importance of this work in relation to the economics and the other speaks to that in a similar way but includes the importance of addressing parent needs. Recently it was stated at the Adverse Childhood Experience Conference – the number one public health issue facing us today is developing parenting skills.

http://developingchild.harvard.edu/resources/multimedia/videos/theory_of_change/

http://heckmanequation.org/content/resource/why-early-investment-matters