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Partnering for Excellence:
Rowan County Post-Implementation Focus Group Themes

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Introduction

Since 2012, Partnering for Excellence (PFE) has aimed to create a coordinated partnership between the mental health and child welfare systems to better identify and treat trauma-related challenges in child socio-emotional functioning. More specifically, the goal of PFE has been to redesign how the child welfare and child mental systems interact so that they can provide trauma-informed services and improve child outcomes, reduce high-end services and prevent children from going into foster care. This project is funded by the Duke Endowment, led by staff at Benchmarks, Inc., and evaluated by researchers from Duke University's Center for Child and Family Policy. The project originated with a planning year in Cabarrus County in 2012, but was subsequently moved to Rowan County because of turnover issues within the Cabarrus County DSS. To evaluate system redesign, focus groups with key stakeholders have served as one source of information on challenges, successes, and iterative changes in the PFE activities. Because of PFE's quick transition to Rowan County, pre-redesign focus groups were not conducted in this county.

System redesign began in Rowan County in January 2014 with a 6-month usability testing phase. Staff were trained, new systems piloted, and process evaluation data used to make modifications as needed. The official implementation phase began in July 2014, with full system redesign and data collection in place. In April 2015, researchers conducted focus groups to learn about the first 16 months of PFE implementation. Researchers sought to understand the evolution of PFE in Rowan, the impressions of various stakeholders, and the strengths, barriers and lessons learned that could be used for further expansion of the redesign model to other counties. Four focus groups were conducted with various groups of professionals: (a) System of Care partners (SOC), (b) Rowan County Social Services personnel (DSS), (c) Cardinal Innovations Healthcare Solutions personnel (Cardinal Innovations: the MCO authorizing and paying for Medicaid mental health services), and (d) mental health providers. System of Care participants (n=5) represented mental health agencies and Cardinal Innovations staff who are actively involved in Rowan's System of Care. DSS representatives (n=9) included social workers and supervisors from the areas of assessment, in-home services, foster care, and program administration. Cardinal Innovations participants (n=4) included representatives from the departments of community operations, clinical operations, care coordination, and finance. Finally, four mental health providers/agencies and Prevent Child Abuse Rowan were included in the mental health providers group (n=10). A structured list of questions guided each focus group discussion, but content was also driven by participant input and concerns.

System Redesign: The Pipeline

From the beginning, Rowan County was very interested in building community awareness of and response to trauma and its effects. With PFE support, they have built and introduced a pipeline for identifying, assessing, and treating child mental health concerns related to trauma. This pipeline starts with a trauma screening tool for children involved with child welfare. If the trauma screen is positive (or if a supervisor and caseworker agree that trauma is present based on case history), the child is referred for a standardized Trauma-informed Comprehensive Clinical Assessment (TICCA). Highly trained

providers conduct the TICCAs, collecting information from the DSS worker, collaterals, the child and the caregiver. Currently these providers are supervised by a clinical consultant supported by PFE who provides technical assistance and quality control. As part of the TICCA, clinicians make service recommendations. Children who meet trauma-related criteria are referred for specialized trauma treatment services. Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is the evidence-based practice of choice in Rowan County. Rowan County clinicians have participated in the Child Treatment Program's TF-CBT collaboratives and upon successful completion become rostered in TF-CBT. Cardinal Innovations has approved an enhanced rate for TICCAs and for a prescribed number of TF-CBT sessions for children if provided by rostered and supervised clinicians.

Once the Rowan PFE partners decided on the system redesign components for traumatized children, Rowan County DSS had to make the difficult decision of when to complete the trauma screen. Should it be introduced as the families get a report and receive a family assessment, or should it be introduced after families have been found in need of services? The community predicted that a high number of child welfare-involved children would score positive on the trauma screen, but the number of highly trained clinicians had to be built up over time. A clear and deliberate decision was made by DSS to build the screening gradually over time to ensure that those children screening positive for trauma could then receive the services they needed. With approximately 150 new family assessments each month and limited capacity to do complete TICCAs and provide TF-CBT, leaders elected to roll out the trauma screening gradually, beginning with children aged 5 or older entering in-home services or foster care in February 2014. In this way, demand for TICCAs have remained relatively stable as new children enter the system, and TF-CBT caseloads have gradually increased over time.

To successfully implement the pipeline, Rowan County leaders recognized that education around trauma and development of a trauma-informed workforce were of utmost importance. This effort was led by Benchmarks, the Rowan County DSS, Cardinal Innovations and the Rowan County System of Care, whose leadership had to work through major obstacles to establish the trusting and collaborative environment that would allow for changes to take hold. .

The current report explores the current state of these efforts, based on information from separate focus groups with each major stakeholder: DSS, Cardinal Innovations, System of Care participants, and involved clinicians. The report is organized according to themes that emerged from these four focus groups. Themes include: capacity, training, assessments, timeliness, collaboration and communication, authorization and billing, transitions, and service quality. We conclude this report with the participants' thoughts on PFE expansion and with the list of issues that participants felt still need to be addressed.

Capacity Building

Respondents across all four focus groups reported that building capacity has been a difficult process and remains one of the key challenges to PFE implementation. The PFE pipeline requires trained clinicians to provide both the TICCA and the TF-CBT, with caseloads increasing over time as more children enter in-home services or foster care. Community partners have expressed eagerness to participate from the beginning, but as the process unfolded roadblocks have emerged. Involvement in PFE requires significant up-front investment from the providers, both in terms of additional clinical

training/supervision and in supporting a culture shift with regard to how business is done. Some providers have had to withdraw from PFE involvement, reducing the number of available clinicians.

Treating children with complex trauma according the guidelines agreed upon by PFE partners involves ongoing training of the existing workforce in terms of an enhanced, standardized assessment and rostering in TF-CBT. Training has been conducted by the Child Treatment Program (CTP) utilizing Learning Collaborative methodology to train providers in TF-CBT. The TF-CBT Learning Collaborative lasts a full year and requires provider teams and a senior administrator to participate in 8 days of face-to-face training with additional biweekly supervision calls. To become rostered, clinicians must complete treatment with two clients with fidelity. Providers also receive extensive training and follow-up technical support to conduct the TICCAs by a licensed clinician. Because of the time-intensive training process, there are limited training slots and slow expansion of the trained providers.

This careful, deliberate and well-monitored training process is a successful way to create a capable workforce, but it may sometimes be at odds with the existing mental health service delivery system and with the urgency of capacity building experienced by Rowan County. Focus group responses reflected this tension:

- Respondents across PFE partners noted that there is increasing difficulty in meeting timelines for assessment and services given the shortage of trained, rostered clinicians. Some worry that this delay will damage the reputation of PFE.
- Providers expressed frustration that the Child Treatment Program does not allow providers already nationally certified in TF-CBT to be automatically rostered, but requires them to go through the full TF-CBT collaborative. This is both time-consuming and expensive.
- Providers also noted that the learning collaborative process, with its emphasis on provider teams with a senior leader, makes it very difficult for individual private providers or smaller agencies to get trained.
- Finally, some frustration was voiced around the issue that some providers may have to go through the collaborative multiple times (having to also pay multiple times) if the clients who are needed to complete the training drop out half way through the required TF-CBT sessions. Despite the frustration, providers acknowledged CTP's efforts to provide high quality training and to make the training process easier by inviting them to continue their training with a different group.

In addition to training-related issues, respondents noted that the existing culture of the mental health system can be a barrier to capacity, as providers are generally expected to bill for a certain number of children per day. Even with enhanced rates for services, providers experience push back as their caseloads decline. Several respondents noted that clinicians available to provide TICCAs and TF-CBT may become overbooked with other clients to maintain high caseloads, thus making them less available for PFE referrals as they come in. One idea voiced by a focus groups participant was the consideration of a separate trauma-informed clinician workforce that is trained to complete TICCAs but does not require CTP rostering for TF-CBT.

Though the majority of comments related to capacity challenges pertained to mental health clinician availability, DSS staff also noted that the PFE process has been hard and overwhelming at times due to increased demands. This is especially true in recent months while they have been short-staffed. Though the trauma screening tool is the most obvious addition to DSS workload, they reported that they are also spending more time with families in general. As they have started to talk more about trauma and focusing of family engagement, they have built better rapport and trust. Families call them more and want more involvement. Though this takes more time, case workers noted that they hope increased engagement will result in fewer families returning to the system.

To date, capacity remains a barrier to timeliness and all community stakeholders agree that the PFE pipeline cannot be currently expanded to serve any additional child-welfare involved children. On the positive side, respondents noted that Rowan began PFE at ground zero, with no chance for preparation or foundation building given their late involvement in the project. Several voiced their pride in the Rowan community for the ongoing progress and hard-work, despite the fact that systems change is a slow process.

Education and Training

Trauma 101 training

To begin the process of building a trauma-informed community, one of the first things to be put in place was trauma training for DSS staff, mental health providers and the wider Rowan community. Respondents reported that training has been widely implemented and quite effective in building collaboration and mutual understanding of trauma-related issues.

<u>DSS</u>

- The DSS Program Administrator was trained to deliver the Trauma 101 training, which she has already delivered six times with the help of the System of Care Coordinator. Moreover, this training occurs with DSS and mental health providers sitting next to each other and provides opportunities for getting to know one another as well as getting to know one another's systems and mandates.
- 85% percent of all DSS staff have been trained to date in Trauma 101, including receptionists and other support staff.
- DSS staff are seeing a positive culture shift in their language, areas of focus, and compassionate solution-seeking. Staff are actively seeking trauma-informed services and evidence-based practices.
- Assessors who attended Trauma 101 training spontaneously began giving out the trauma brochure to parents when they first make contact to educate them on the impact of trauma.
- Reception staff are more patient and understanding in responding to parents and managing challenging interactions.

<u>Parents/Foster Parents</u>

- Foster care parents have been trained in the North Carolina Traumatic Stress Network's Resource Parenting curriculum and expressed their gratitude for being taught to understand the

types of things that might "trigger" their child. Moreover, some foster parents are branching out looking at other places like the Johnson C. Smith University for additional information and resources. They appear more empowered and confident in understanding and managing behaviors.

- DSS case workers hope that the impact of this training will produce more stable placements and help with foster parent recruitment.
- Biological parents also are building better rapport with DSS, more engaged in interactions and more likely to call with requests for assistance.

Community

- Department of Juvenile Justice workers have already been trained in Trauma 101 and school social workers and guidance counselors are next.
- Respondents noted that professionals in the community were more likely to recognize that traumatized kids are being "triggered" rather than labeling them as "nutcases."

TF-CBT and TICCA training

Mental health providers who participated in the TF-CBT training noted that TF-CBT can be a game changer for some children, and overall they felt that TF-CBT can make an enormous difference in children's lives. Moreover, the technical assistance and supervision provided by the clinical supervisor has been invaluable to them and has standardized and improved the quality of the TICCAs. They did bring up some challenges with training and implementation worth noting:

- Providers felt that the training offered on measures used for the TICCAs was not sufficient and that some of the clinical supervision was taken up by learning to score and interpret the instruments.
- A few providers voiced the concern that the PTSD diagnosis may be too widely used and the trauma screening instrument may need some improvement.
- Mental health providers felt that the cases that come to their attention have a generational dysfunction component that is very difficult to address even through the trauma training they received.
- Mental health providers mentioned that when a child is stepped down from a higher level of care to a lower placement they are asked to do a TICCA, but they cannot bill it at the enhanced rate.
- Delivering TF-CBT with fidelity requires caregiver involvement and that is not always an option, even in cases where one might think it was feasible. For example, children in higher level care like a group home may not always be brought to treatment by the same staff person.

Cardinal Innovations staff also commented on the training and supervision offered, reporting that the creation of a standardized TICCA and a clear process from screening to treatment was extremely beneficial. The oversight that PFE has contributed as well as CTP's training and supervision have allowed Cardinal to trust the process and be more open to accommodating cases on an individual basis.

Assessments

For in-home cases, at the first Child and Family Team (CFT), the social worker discusses the whole PFE process with the families, starting with the screening, a possible TICCA referral depending on the screening results, and further referral for services. Moreover, the CFT facilitator explains the Strengths and Difficulties instrument and how they can fill it out at every CFT to track the child's progress. Respondents noted the following advantages and challenges with the assessment process and resulting information:

- Trauma screening has shifted DSS attention to child mental health needs. Staff reported that this is a change from previous focus just on parents, and they now recognize mental health concerns in a far larger percentage of children.
- DSS and mental health providers both noted that the TICCA provides them with considerably more information that is useful in working with children and families.
- Parents have responded positively to the utilization of the Strengths and Difficulties questionnaire because it allows them to see how their child's behavior changes over time.
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- Mental health providers block 5 hours for completion of a TICCA, but if the family does not show up, this means 5 less billable hours for the clinician. This problem has been considerably alleviated by the DSS workers, who volunteered to bring the children/families to the clinicians to ensure appointments were kept.
- Non-profit mental health agencies cannot afford the baseline cost of the TICCA instruments.

Timeliness

As children go through the PFE pipeline, certain time criteria were put in place for each step to ensure timely completion. During the initial usability testing phase, several barriers to timeliness and completion were encountered. With regular cross-agency meetings to problem-solve, many of these challenges have been resolved (though as mentioned, capacity remains a threat to timeliness). Here are some examples of the issues that had to be worked through:

- DSS records are still kept on paper and as a result case information collected during family assessments that is necessary to fill out the screening instrument did not reach the in-home/foster care workers on time. To overcome this barrier a protocol was put in place that allowed in-home workers and/or foster care workers to receive the 5010 structured documentation forms electronically.
- In-home case workers are supposed to keep their cases open for up 180 days. Early in PFE implementation, there were times when a TICCA took 90 days to complete, hindering the DSS worker's progress.
    - Comprehensive TICCAs include information from the child, collaterals, and caregivers and collection of that information is time consuming.
    - Children referred for a TICCA who had a recent assessment or had been receiving services by a non-rostered clinician had to follow a different process. The rostered provider had to receive the previous TICCA or talk with the service provider, but phone

calls and requests were not always answered. With input from all involved parties this issue was recently resolved with the following procedure: if the previous clinician does not respond to two contact attempts, then the new provider informs them in writing that another TICCA will be done.

Timeliness of the TICCAs has improved greatly as communication, capacity, and transportation issues have been addressed.

- Some mental health providers who originally agreed to participate realized they could not possibly meet the imposed timeframes. Additional providers have been/are being recruited to expand capacity.
- Timely initiation of clinical services has also been challenging. Originally, providers would complete the TICCA and then attempt to contact the family to schedule the first service appointment. This type of contact interruption, however, led to more delayed service initiation because providers would have trouble getting in touch with the families and they had to contact the DSS worker again to facilitate the process. To avoid this unnecessary delay, providers started scheduling services at the first TICCA contact with the family, which DSS staff reported has greatly increased the timely initiation of services.

Collaboration and Communication

Collaboration and communication improvements were consistently emphasized across all focus groups as central benefits of PFE. Below are some specific points reported by respondents that attest to the true level of collaboration in this effort.

- Participants recognized the role of Partnering for Excellence and its leadership in building bridges and creating partnerships among community agencies:
    - "Partnering for Excellence has really done an amazing job of bringing a lot of organizations together to work in collaboration."
    - "It has really shown us that when you truly invest in collaboration and partnership … it just works better, not just for the child, not even just for the family, but for the entire community."
- Some great examples of the atmosphere of honesty and trust among providers were offered:
    - during care reviews, providers step up and offer to see a client immediately when a crisis occurs
    - mental health providers meeting with a family may offer to contact another mental health agency because the other agency's approach may fit the family's needs better

  These examples suggest that the Rowan community has been reaching a level of collaboration where stakeholders are able to go beyond their individual agency's mandates and internalize their common goal, which is to help children and families.
- The leadership of both DSS and Cardinal acknowledged that child welfare and mental health are integrally related to one another, but traditionally operated as separate entities with often contradictory mandates. One glaring example of these contradictory mandates is that DSS is trying to keep children in the same placement and may get penalized by losing funding if they do not, whereas mental health treatment mandates short term mental health care that attempts to

move children from higher to lower levels of care. These types of systems difficulties, and the realization that child wellbeing is the goal of all child serving agencies, provided the impetus for Rowan County providers to sit around the table and come up with creative, out-of-the-box ways to best serve children on a case-by-case basis.

- The attitude and investment of both the DSS and Cardinal leadership was brought up on multiple occasions as a crucial factor in creating the trusting and open atmosphere in which everybody feels free to be honest and voice their opinions.
- The co-location of a care coordinator supervisor from Cardinal Innovations within DSS has also facilitated communication. Even though she is at her DSS office only four hours a week, she helps social workers with anything that comes up from navigation of the mental health system, to appeals for a denied authorization, to clinical opinions about a client and advice when children transition from one placement to another. All the above activities are certainly worthwhile, but the major thing the co-location has accomplished is to help social workers build a relationship with Cardinal and have a point person when they have a question. It has also helped with changing the DSS culture from one of reacting to crises situations to one of planful and proactive thinking of cases. DSS staff reported that the co-location has made them feel very supported and empowered to make informed decisions.
- PFE has fostered understanding of mandates and procedures across systems/agencies, which helps them to have more ideas for working together and streamlining services. Across systems, staff feel more of a mutual investment, which helps with problem solving and understanding rather than frustration and blaming.
- Similarly, Cardinal Innovations staff noted that it is easier to determine what quality should look like and know what to expect from services.

Other signs of collaboration and communication were brought up throughout the focus groups:

- When families move from one mental health provider to another, the providers feel free to talk to each other. Within agencies, providers are also more likely to talk with each other or ask for an opinion when they feel stuck with a case.
- Both DSS workers and mental health providers feel free to call or e-mail each other freely.
- When no shows for TICCAs became an issue, DSS workers stepped up to the plate and started bringing the children to the TICCAs themselves. Clinicians can see that DSS staff members care and are noticing the needs of families – they feel more like a team now.
- DSS took the initiative to purchase ShareFile, a secure environment in which they upload the PFE intake form, the screening, the case decision summary and the CPS case history for the TICCA providers to enhance collaboration.
- Mental health providers noticed that DSS workers follow up with them more often and keep them accountable.
- Mental health providers also acknowledged that having a point person within Cardinal has made communication and problem solving easier.

- Respondents across focus groups emphasized the importance of having an independent PFE project director, who can help bring people together to problem-solve issues and build connections.
- Providers reported that participating in CFTs in person is very difficult for them because they cannot bill for that time, but they sometimes provide feedback for CFTs via phone calls or emails.

Authorization and Billing

The introduction of the trauma screen and the standardization of the TICCAs made it easier for Cardinal Innovations to authorize services because they could see clearly that a child was traumatized and understand why the assessor recommended TF-CBT.

At times however, authorizations and billing for TICCAs and TF-CBT have been delayed as the process evolved for numerous reasons and at different levels of the process.

- The lack of a code for trauma-informed services is a major issue that Cardinal had to face not only within its own system but also with the state Medicaid system. The current Medicaid system has a set of national codes and modifiers that Cardinal uses to be reimbursed from the state Division of Medical Assistance. Trying to fit the trauma-informed services within the current system has caused delays in the process. This combined with the enhanced rate for these services exacerbated the delays.
- Some difficulties arose from the fact that Cardinal's electronic system did not allow for a new process to be initiated seamlessly. Cardinal staff had to institute a manual process of receiving requests, authorizing and billing that slowed down the process.
- Authorization of additional sessions has at times become an issue for children who change placements while they are receiving TF-CBT; the re-traumatization caused by the placement change can delay the therapy progress, and thus the therapy may last longer than the average TF-CBT case. Cardinal representatives agreed that such decisions cannot be made just by looking at paper claims and recognized that clinicians know the cases better and should use their clinical judgement.
- Cardinal Innovations commented that higher level placements like Level III group homes and PRTFs that include clinical services within their rate may not have clinicians who are trauma-trained. The issue then became a financial one of supporting trauma-focused therapy when dollars were already paid towards their mental health services.
- Cardinal's hope is that as capacity increases and more clinicians have trauma-informed training and are rostered, they will only have to thoroughly check a small percentage of authorization requests.

Transitions

Transitions from one level of care to another or from one provider to another are inherently problematic. Providers should not be keeping a child at a higher level of care if that is not necessary, but at the same time changing placements introduces the potential for further traumatizing the child if a

careful transition plan is not in place. Below is what providers said about their efforts to make transitions better:

- Cardinal has assigned care coordinators to each PRTF, and usually a second care coordinator has facilitated the step-up care of a child to PRTF. The two care coordinators who are already familiar with the child and the family are then involved in the step down, ideally starting with the last Child and Family Team in the higher level facility. The new care coordinator then 'picks up the baton' and follows up for a period of time.
- Cardinal and DSS have worked together to try to prevent unnecessary moves. A great example of their efforts is when a child has been stable at a Level II placement, but their family of origin is not yet ready to receive them back. Working together, the two parties have agreed to step down the child to Level I care, but within their Level II home.
- Another difficult situation that Cardinal had to face as PFE unfolded was when a child involved with DSS was already receiving mental health services from a provider who had not been trained in trauma-informed care. Should Cardinal switch the child's provider? Wouldn't that be detrimental to the child if the original provider had a good relationship with the child? To solve these types of dilemmas, a process has been put in place whereby the two providers discuss the case and, if they agree that trauma services are necessary, they may conduct a couple of transition sessions together.

Some additional issues were raised around transitions that have to do with Medicaid eligibility:

- When a child is removed from home and is in DSS custody, the child receives Medicaid coverage but the parents may not have any insurance to take care of their own mental health needs. As a result, children who do well with TF-CBT services may be put back into homes where adults have not received the needed services, increasing the likelihood of re-traumatization.
- In addition, if a child in DSS custody receives TF-CBT and is then moved back to a family of origin without Medicaid, mental health treatment may have to be interrupted. A similar issue occurs when children receiving TF-CBT move from Rowan County to another county that does not have trauma-informed providers. These children's treatment may be interrupted with significant negative consequences.

Service Quality

DSS workers and Cardinal Innovations staff reported on the "amazing" quality of the TICCAs and TF-CBT services received by the children, which they said was beyond anything they have seen before in terms of quality. Some TF-CBT providers shared that TF-CBT can be a "game changer." Children with significant behavioral and emotion regulation problems are able to identify coping skills and build those into service and safety plans. This is teaching children to recognize quickly when there is a problem and how to get help in resolving it. Likewise, DSS staff noted that parents really like TF-CBT and feel that it is working where other services have not. The DSS program manager and the Cardinal care coordination supervisor also shared that within a few months of the pipeline, they noticed that children who have

gone through the process are not moving to an elevated level of care, which was a common occurrence before.

Conclusions and Recommendations

Overall, the Rowan County community has made great strides towards redesigning how the local mental health and the child welfare systems intersect to offer trauma-informed services to children in in-home and foster care services. Focus group participants admitted that it took a lot of hard work and is sometimes overwhelming, but they feel strongly that it is the "right way to do things." One DSS staff member noted that "from a systematic view, you can't do child welfare without mental health partnering." They see it making a large difference for the children they serve, and they actually reported feeling a bit guilty that they have it all to themselves. They hope to see it expand in the coming years.

Leaders of PFE, DSS and Cardinal Innovations played a key role in modeling positive partnerships by coming together and having the difficult discussions that needed to happen when barriers arose. The trauma trainings and continuing support have changed the culture of Rowan County DSS as staff are starting to use trauma-informed language, identify intergenerational cycles of trauma, notice when children are 'triggered', and feel compelled to educate other professionals when their first reaction is to call a traumatized youth a 'nutcase'. On an administrative level, DSS has become more empowered to ask questions of providers and expect them to submit paperwork within the prescribed timeline. Cardinal Innovations in turn has contributed to this endeavor by agreeing to pay an enhanced rate for specialized trauma-informed care, working hard to navigate rigid federal and state billing systems and lack of appropriate service codes. Mental health agencies, becoming more knowledgeable about the effects of trauma, are investing their time to participate in specialized trainings that improve the quality of services they can offer. Finally, the Rowan County System of Care has supported the PFE effort by adopting the trauma lens into its own vision and mission.

The good work occurring in Rowan County is slowly becoming better known within the county, but also across other counties. The PFE pilot is thus creating competition among mental health providers, which will hopefully increase the capacity and the quality of mental health services. Mental health providers in the Cardinal southern area who provide evidence-based interventions other than TF-CBT in neighboring counties are interested in partnering with Rowan DSS to serve the child-welfare population better. All the anecdotal information collected from the focus groups suggests that the PFE pilot in Rowan County is going well. Collecting and analyzing child-level outcome data from those children and youth participating in the PFE pipeline will provide more scientific evidence to support the available anecdotal information.

Despite the reported progress, challenges continue to exist in Rowan County, some of which could be addressed within the current project structure.

1. The current limited capacity is affected in part by two factors:
    a. CTP can only train a limited number of providers in each Learning Collaborative.
    b. The rostering process does not allow nationally certified TF-CBT providers to access the enhanced rate for that service without completing the Learning Collaborative.

These conditions are in place to ensure the highest quality services and are required by payers (not just by CTP). A discussion between the Rowan County community of providers and CTP could lead to at least a better understanding of the CTP processes and decisions and may even result to further opportunities to build capacity in Rowan County. Evaluation of long-term TF-CBT fidelity comparing certified versus rostered clinicians would also help to support the rationale for this requirement.

2. Mental health providers mentioned a couple of issues that may be resolved by further communication and discussion with Cardinal:
    a. Providers reported that when youth step down from a higher level service to a lower one, they are asked by the MCO to provide an additional TICCA, but without getting reimbursed at the enhanced rate.
    b. Mental health providers seemed unclear about what services can co-occur with reimbursement. For example, providers mentioned that a child in day treatment also needed TF-CBT services, but the providers were not sure Cardinal would authorize it. Cardinal on the other hand reported that authorizing both services would not be a problem because EPSDT allows them flexibility. Some additional training around what services are allowed to co-occur might be helpful.

Other issues would require systems level changes that will take more time to resolve:

1. There is a central conflict of goals between the mental health and the child welfare systems. DSS emphasizes stability of placement for children, whereas the mental health system aims at moving children as quickly as possible from a higher level of service to a lower one. Because reimbursement amounts are reduced as children move to lower levels of care, children are generally not able to remain in the same placement as they move between levels.
2. There are no codes and appropriate service definitions in the current Medicaid system for trauma-informed services. As a result there are no clear specifications and guidelines for Cardinal to follow in fitting their PFE-related codes within the state Medicaid system.
3. Cardinal's own client management system is not able to flexibly adapt to authorizing enhanced rates for PFE services (i.e., TICCA and TF-CBT with rostered clinicians). As a result, a manual process was instituted for the children in the PFE pipeline, but this is time-consuming and not easily expanded. This systems problem is difficult both for Cardinal staff who spend time in manual authorization and for providers who may experience a longer delay in receiving authorization and payment.
4. PFE and the Child Treatment Program have provided major oversight to ensure that Rowan County clinicians provide high quality TICCAs and TF-CBT services with fidelity to the children entering the PFE pipeline. Currently, Cardinal Innovations does not have the capacity to provide fidelity monitoring and supervision of TF-CBT trained providers. It will be important for stakeholders to discuss options for sustainability strategies regarding monitoring and supervision for both services in the near future.
5. Issues with Medicaid coverage were frequently brought up during the focus groups as a major difficulty for the PFE-involved children:

a. Children who enter DSS custody automatically receive Medicaid, but when they go back to their families Medicaid may be discontinued. As a result, if a child is in the middle of treatment and returns to his/her family, he/she may not able to continue treatment in a seamless way.
b. Though children in DSS custody qualify for Medicaid and can receive treatment services, their parents may *lose* this coverage when children are removed. Consequently, a child who receives treatment and makes progress may go back to an environment that is unstable, has not progressed in terms of parenting skills or mental health, and/or has heightened likelihood for re-traumatization.
c. Children with private insurance who enter in-home services with DSS do not have access to the enhanced rate, and are thus not eligible to participate in the trauma-informed pipeline services.

An expansion of Medicaid coverage to those families involved in in-home or foster care services would help to address these issues. Cardinal Innovations respondents suggested that the system needs both mandatory family therapy while a child is in residential care and funding for family services while the child is in out-of-home placement. Mental health providers suggested 12 months of additional Medicaid coverage for parents once their children are removed. In the long run, these services may improve outcomes and prevent families from returning to the system.

6. Clinicians have a challenging time attending Child and Family Team (CFT) meetings, because CFTs are not a billable service (and provider agencies require a high percentage of time spent only on billable services). Adding a CFT code that would allow them to bill for attending these meetings would greatly facilitate their presence in CFTs. If this is not possible, development of a clinical feedback template would help clinicians to provide standardized information on services and needs.

PFE has already brought significant changes in Rowan County to help child-welfare children receive high quality trauma-informed services. However, when focus group participants were asked what else they would like to see happen in Rowan County, some important suggestions were offered.

1. Trauma-informed assessments and services for adults: If these services were to be offered in Rowan County, child welfare-involved children who make progress through their own trauma-informed services may be able to go back to a home that will provide them with the support and warmth they deserve to grow up happy and healthy.
2. Trauma-informed education and training for mental health providers who provide services to youth in higher level care facilities (e.g., group homes): Mental health providers involved in providing services to children and youth in higher level care are often not familiar with trauma and its effects and thus cannot provide the children with what they need. Specialized trauma training for all mental health providers, ideally during their college training, would be highly recommended.
3. Expansion of PFE to include all child-welfare involved children and all children with trauma or PTSD diagnoses: Both DSS and mental health providers felt that limiting trauma services to the small PFE population of children and youth was unfair to all the remaining children who have

experienced trauma, and would like to see these services expanded. Of course, provider capacity would have to be greatly expanded before any such steps could be taken.

4. Better parent engagement for children receiving trauma-informed mental health services: All focus group participants voiced frustration about the fact that the parents of some of the children in the PFE pipeline are not engaged in their children's services. This in turn impacts the effectiveness of the services the children receive. Parent engagement is a huge issue that will not be easily resolved. Continuous and high quality community education about trauma and mental health services may help bypass these barriers.
5. An electronic scoring system for measures used in the TICCAs and in TF-CBT: Providers felt that they spend a lot of time scoring instruments by hand and that their time could be better spent working with the clients. Creating such a system, even though desirable, would likely take time because some instruments are copyrighted and others may not even have an electronic scoring system. In the short-term, funding for smaller agencies to afford electronic scoring systems for instruments that have them (e.g., CBCL) would be helpful.
6. An electronic system for DSS record keeping: In Rowan County DSS does not have an electronic system of record keeping, which makes processing and utilizing information for all child welfare-involved-children slower. The DSS director has included money in next year's budget to purchase such software, but budget cuts may not allow for that to happen.

Lessons Learned for Replication

The final question posed to the focus group participants was what PFE should consider if it were to expand the redesign of child welfare and mental health services to another county. Numerous ideas were offered:

- **Include Rowan partners in planning and communicating with a replication county.** Focus group respondents recognize the large strides they have made, the hurdles they have overcome, and the motivational stories of improved outcomes that they have to share. They suggested that prospective counties may benefit from their lessons learned and be inspired by their successes to date.
- **Use implementation science to guide implementation efforts.** Rowan county DSS suggested that an effort to expand PFE should be preceded by training key stakeholders in implementation science. They reported that this training was invaluable in helping them understand the phases of implementation, the necessity of doing things "right", and the expectation that the process would take considerable time to be successful. Further, respondents recommended that all expansion begin with an exploration process that, guided by implementation science, will examine the current capacity of the prospective county and how the redesign process might fit within the existing structures, supports and values.
- **Do a readiness assessment of mental health capacity.** A readiness assessment of what it would take to build capacity among mental health providers was of primary concern. Rowan County did not have the chance to do that and capacity continues to be an issue to date. Moreover, a realistic estimate of capacity would allow the implementation team to choose a target

population that could be fully served by the available mental health practitioners, as well as prepare a plan to build capacity as service needs grow.

- **Lay the groundwork for collaboration.** All entities, including DSS, Cardinal and providers clearly voiced that they had to work very hard to create the collaborative atmosphere in which blame is not laid on any stakeholder, and everyone is ready to be part of the change and the solution. Cardinal Innovations noted that in other counties they are constantly asked: "Okay Cardinal, what are you going to do about this?" instead of "What can we all do together to help the children in our community?"
- **Leadership commitment is necessary.** On multiple occasions leaders of DSS and Cardinal mentioned that without the other agency's leadership commitment, PFE would not have occurred. Agency leaders can act as role models for their staff, being willing to sit down and discuss how to solve difficult issues, while at the same time staying unwavering in their commitment to carry out changes that will benefit children and families.
- **The presence of a skilled independent entity facilitates the collaboration process.** Skilled PFE leadership has played a critical role in Rowan County. Because this role is independent from any agency, it was easier for the PFE Project Director to view things broadly and objectively, identify problems, and call people from all agencies to the table to talk and problem solve. All focus groups reported that this role is indispensable to the success of PFE.
- **Trauma education is crucial.** Stakeholders and the community need to become educated about what trauma is, how it manifests itself, and the likely long-term outcomes without effective services. Without that training, parents' and children's behavior is likely to be misinterpreted and exacerbated, and the generational cycle of trauma will be continued. Multiple and ongoing inter-agency trainings will increase knowledge of trauma and appropriate responses to trauma-related behavior, while at the same time facilitating relationship-building and cross-agency understanding of roles and mandates. Moreover, all social service agencies can provide basic trauma information to the families with whom they work.
- **Provide quality trauma-informed training for assessments and services, along with extensive technical assistance.** Without the quality training and the continuous supervision/technical assistance that Rowan County mental providers received, the PFE effort would not have been as successful.
- **Consider ways to address imbalance for children who cannot benefit from PFE.** Children who are in the system prior to the start of PFE, children with private insurance, and children who don't reach in-home services or foster care are not able to receive the services provided through PFE. This cannot be entirely avoided (e.g., to be successful, the pipeline must start slowly with only new children entering the system), but there may be ways to offer some form of additional support or services to those children who cannot fully participate in PFE.

The PFE system redesign in Rowan County has brought about some very positive changes for the child welfare-involved children who receive in-home services or foster care. These positive changes were fostered by a level of collaboration and dedication among all involved stakeholders that is quite unprecedented among the existing siloed social services in North Carolina. It is apparent that DSS and Cardinal leaderships have reached a level of trust and open communication that can bypass challenges

like lack of electronic records or rigid existing data systems to help the children who have experienced serious trauma in Rowan County.