UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK
THE INSTITUTE FOR INNOVATION AND IMPLEMENTATION

TITLE PAGE – TECHNICAL PROPOSAL – ORIGINAL

RFP Subject: DOJ Subject Matter Expert Services (CRFP 0506 HHR2000000001)

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Date: 9/6/2019

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Introduction

The Institute for Innovation & Implementation (The Institute) at the School of Social Work (SSW), University of Maryland, Baltimore (UMB) proudly submits this proposal in response to *CRFP 0506 HHR2000000001, West Virginia Department of Human Resources DOJ Subject Matter Expert Services,* to provide Subject Matter Expert (SME) services in the design and delivery of children's mental health services and to provide technical assistance to the Department of Health and Human Resources (hereinafter referred to as "Agency") to reach compliance with the Memorandum of Understanding between the United States Department of Justice (DOJ) and the State of West Virginia, dated May 14, 2019 (hereinafter referred to as the "Agreement"). **As demonstrated throughout this proposal, the UMB team has superior knowledge and proficiency with children's community-based mental health services, Medicaid and child welfare systems.**

As discussed more fully in Section II, UMB operates the National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC), funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide training and TA to states, tribes, territories, and communities focused on improving children's behavioral health, regardless of whether or not a site has a SAMHSA grant. The UMB Team will coordinate and leverage support from NTTAC, as applicable and allowable by contract, to support West Virginia in enhancing its children's behavioral health system, to include connecting with other states implementing similar reform efforts. Additionally, as part of NTTAC, the UMB Team works to coordinate with other technical assistance centers including the SAMHSA-funded Region 3 Addiction Technology Transfer Center, Mental Health Technology Transfer Center, and Prevention Technology Transfer Center, to leverage and maximize available resources and technical assistance opportunities.

Section I – Project Goals and Proposed Approach

4.2.1. Goals and Objectives

4.2.1.1. Provide technical assistance to help the Agency reach compliance with the Agreement. Specifically, the Agreement requires the Agency to (i) **increase the availability and quality of in-home and community based mental health services**; (ii) **decrease the unnecessary use of Residential Mental Health Treatment Facilities**; and (iii) **develop a Quality Assurance and Performance Improvement system**.

Since the U.S. Supreme Court's 1999 landmark decision in *Olmstead v. L.C.* (Olmstead), many states have grappled with how to reduce reliance on residential care for children with behavioral health needs. Like many other states, West Virginia faces a variety of barriers in promoting home- and community-based services (HCBS) including workforce development, fiscal pressures, and concerns about quality and safety for children, and their family and community. Our Team has assisted numerous states and counties, and advised federal agencies, in approaches to addressing similar barriers through the provision of its robust, data-driven technical assistance, consultation, data analysis, and evaluation including designing, financing and implementing evidenced informed, high quality delivery systems using Medicaid, Title I-VE and other relevant funding sources. Our approach supports states to implement individualized, evidence-based, trauma-informed services and supports that meet the needs of

youth and their families, and support sustainable system level changes for counties and states. Further, we recognize that our technical assistance must establish measurable goals to track indicators of progress toward achieving the integration mandate of the American with Disabilities Act; and must align with requirements for screening, service provision, and reporting related to Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

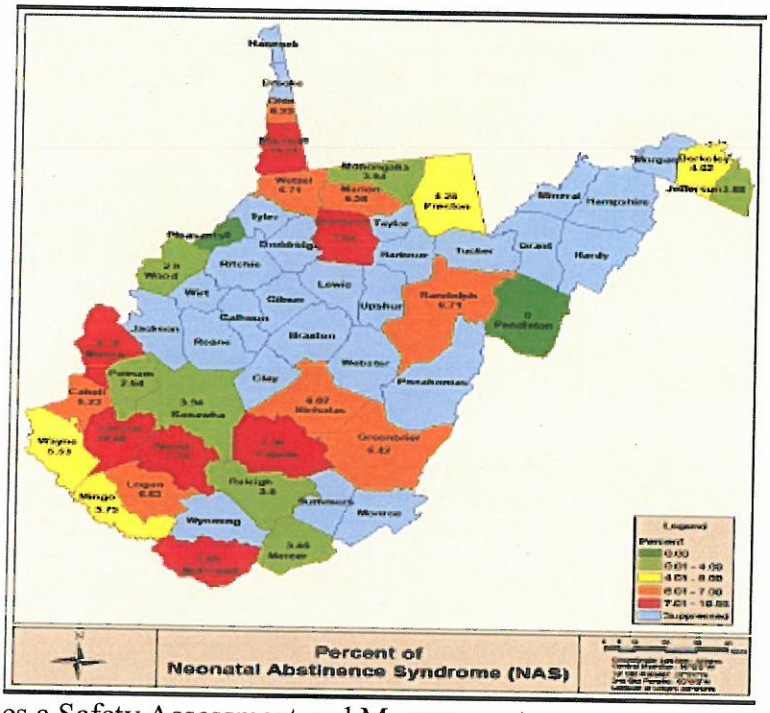
UMB is fully prepared to support the Agency with consultation, technical assistance, identification of needed data and reporting elements, identification of financing and other regulatory elements, data analysis, planning and implementation to support trauma-informed, community-based mental health services to children under the age of 21 who (a) have a serious emotional or behavioral disorder or disturbance that results in a functional impairment, and (i) who are placed in a residential mental health treatment facility or (ii) who reasonably may be expected to be placed in a residential mental health treatment facility in the near future; and (b) meet the eligibility requirements for mental health services provided or paid for by the Agency. Support will be provided in each of three focus areas set forth in the Agreement:

Focus Area I – Increase the availability and quality of in-home and community-based mental health services – Critical to meeting the behavioral health needs of children and their families is having a robust array of HCBS in place with a demonstrated ability to address the needs of children with behavioral health challenges. Our Team's extensive experience will assist West Virginia in shifting its programming toward an evidence-based system in which all children live in a safe, permanent home that preserves, to the fullest extent practicable, the child's familial, peer/social, educational, and cultural ties, and where home- and community-based supports are available to meet the needs of children and their families. Critical to this work will be building upon West Virginia's success with its Safe at Home, Title IV-E Demonstration waiver by continuing to reduce out-of-home placement while simultaneously limiting congregate care to a short-term intervention, offered only when necessary to meet the clinical and behavioral health needs of children, youth, and young adults.

To accomplish the vision in which all children have access to high quality HCBS UMB will provide superior technical assistance to West Virginia's child-serving agencies to improve the availability and accessibility of evidence-based behavioral health interventions. Our comprehensive approach includes detailed service and system planning, financing, workforce readiness, implementation support, data and quality management, and evaluation strategies that draws on our collective lessons learned to avoid merely offering services but rather to ensure that children and caregivers are truly able to access high-quality, family-driven, culturally and linguistically competent care. In order to improve behavioral health services, addressing other components of service delivery are essential. These include: retention and workforce development; payment rates that reflect provider skill and ongoing professional development; reimbursement approaches that incent value over volume and drive continuous quality improvement; and coordination with child welfare-specific system needs such as foster parent recruitment and retention and frequent changes in placement, particularly for undeserved communities and transition-aged youth.

West Virginia has grappled with one of the most difficult public health and child welfare challenges in the nation: familial substance use disorders. Driven by a rising number of open child abuse and neglect cases linked to substance use, highest in the nation rates of opioid and drug overdose deaths (49.6 and 57.8 per 100,000, respectively);[1] and a neonatal abstinence birth rate of 38.1 births per 1,000 (compared to a national rate of 6.4 per 1,000),[2] West Virginia developed and received approval for an innovative, first-in-the-nation State Plan Amendment (SPA) that leverages its success in enrolling children in public health programs[3] to provide targeted case management, evaluation and assessment, and supportive counseling for infants with Neonatal Abstinence Syndrome. The adoption of the SPA demonstrates the State's commitment to innovatively addressing this child welfare challenge.

Figure 1: Percent of Neonatal Abstinence Syndrome by County. Retrieved from: http://wvahc.org/wp-content/uploads/Prez-on-Child-Welfare-1.pdf



In an effort to keep children safe, West Virginia uses a Safety Assessment and Management System (SAMS) that includes an assessment of family functioning. Driven by a record number of child protection referrals, familial substance use disorders, and federal funding strictures, the State currently removes a significant number of children from their homes – approximately 17.8 per 1,000 children 17 and younger, compared to the national average of 5.8 per 1,000 in FY2017.[4] The number of removals is rising, from just over 4,000 in 2013 to nearly 7,000 by July 2019, with the majority of those entering care age 10 or younger.[5] Once awarded, UMB will explore the SAMS data collected, including but not limited to formal and informal safety services provided as part of family assessment and treatment plan in order to align data metrics and reporting on for HCBS and the reduction of residential treatment under this Agreement.

Focus Area II – Decrease the unnecessary use of Residential Mental Health Treatment Facilities – Children in foster care have high rates of mental health, substance use, and physical

[1] Kaiser Family Foundation. (2017). Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). Retrieved from: https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Opioid%20Overdose%20Death%20Rate%20(Age-Adjusted)%22,%22sort%22:%22desc%22%7D

[2] Health Resources and Services Administration, Maternal Health Bureau. (undated). National Outcome Measures. Retrieved from: https://grants6.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures

[3] Kaiser Family Foundation. (2017). Health Insurance Coverage for Children 0-18. Retrieved from: https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22asc%22%7D

[4] Williams, S.C. & Sepulveda, K. (2019, Jan. 3). In 2017, the rate of children in foster care rose in 39 states. Child Trends. Retrieved from: https://www.childtrends.org/2017-the-number-of-children-in-foster-care-rose-in-39-states

[5] West Virginia Department of Health and Human Services. (various dates). Legislative Foster Care Reports. Retrieved from: https://dhhr.wv.gov/bcf/Reports/Pages/Legislative-Foster-Care-Reports.aspx. *See also,* http://wvahc.org/wp-content/uploads/Prez-on-Child-Welfare-1.pdf

health care issues. Due in part to these special health care needs, Medicaid agencies spend more money on youth in foster care than on all other non-disabled children.[6] Some studies have noted prevalence of mental health and other behavioral and developmental disorders among this population to be as high as 80%.[7,8,9] Indeed, youth exiting foster care are some of West Virginia's most vulnerable citizens and are at greater risk of unemployment, poor health, incarceration, homelessness, and early parenthood than the general population.[10] Given their unique social and familial circumstances as well as their complex health care needs, children in foster care (and the larger population of youth involved with the child welfare system) as well as those involved in juvenile justice require modification and adjustments to the usual Medicaid eligibility/enrollment policies and procedures, benefits array, and provider network. Policies that support cross-agency coordination and collaboration, including data sharing, are critical to transforming the delivery system.

Decisions to place a child in residential treatment are complex and typically involve an array of child-serving systems including courts, caseworkers, parents and other family members, attorneys, and local social service agencies. To prevent removal and to comply with the Family First Prevention Services Act (FFPSA), UMB will advise West Virginia on shifting its Title VI-E[11] and Medicaid service dollars away from costly residential services with associated poor outcomes (such as lower educational test scores and increased delinquency)[12] toward prevention-focused and evidence-based HCBS. UMB's experts have deep experience advising states and localities on how to leverage home, school, neighborhood and community resources to serve children and their families in the least restrictive environment to maintain continuity of relationships while supporting placement and permanency outcomes.

Reducing the unnecessary use of residential treatment facilities will require the cooperation of placement agencies that often find themselves using residential care due to a shortage of home- and community-based options for youth, particularly for older youth with externalizing behaviors.[13] Child-serving agencies may have developed separate, overlapping systems, and may be offering parallel or duplicative services that increase the difficulty in accessing and ensuring continuity of HCBS. Many states struggle to prepare for and meet the needs of youth transitioning out of child services into adult treatment services and adult focused social supports. Efforts to bridge these gaps and align parallel systems will be important to reducing residential

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[6]Geen, R., Sommers, A., & Cohen, M. (2005). Medicaid Spending on Foster Children. Washington, D.C.: The Urban Institute.

[7] Clausen, J.M. et.al. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7(3).

[8] Chernoff, R., et. al. (1994). Assessing the health status of children entering foster care. *Pediatrics*, 93(4).

[9] *Supra* at 8.

[10] Child Welfare League of America. Programs and Resources for Children Aging Out of Foster Care. Retrieved from: *http://www.cwla.org/programs/fostercare/agingoutresources.htm*

[11] Casey Family Programs. (2019, May). State-by-State Data. Retrieved from: https://www.casey.org/state-data/

[12] Casey Family Programs. (2018, Feb. 5). What are the outcomes for youth placed in congregate care settings? Retrieved from: https://www.casey.org/what-are-the-outcomes-for-youth-placed-in-congregate-care-settings/

[13] Gabrielli, J., Jackson, Y., & Brown, S. (2015). Measurement of Behavioral and Emotional Outcomes of Youth in Foster Care: Investigation of the Roles of Age and Placement Type. Journal of psychopathology and behavioral assessment, 37(3), 422–431. doi:10.1007/s10862-014-9464-8

treatment. We anticipate the need to work with the child-serving agencies to align their individual mandates, system needs, and challenges to ensure West Virginia's success:

- Bureau for Children and Families, responsible for the day-to-day delivery, program and policy development, research and evaluation, and fiscal oversight of child protective services, foster care, and adoption;
- Bureau for Behavioral Health, the state authority for planning, directing, and funding mental health and substance use disorder, intellectual and developmental disabilities prevention, treatment, and recovery services;
- Bureau for Medical Services, the single state agency responsible for the administration of the State's Medicaid program, as well using various authorities to expand the array of services available to children and families, including developing the 1915(c) Children with Serious Emotional Disturbance Waiver and overseeing the existing 1115 Substance Use Disorder Demonstration Waiver;
- Bureau for Public Health, which collects data on overdose fatalities, neonatal abstinence syndrome in addition to overseeing the Birth to Three early intervention program, and collecting state and county vital statistics and other data;
- West Virginia Department of Education, including the Office of Diversion and Transition Program, which provides educational services to children in residential and State-operated facilities. Although the Agency indicated it did not intend to braid education and health funding in its June 14, 2019 responses to public comment on the pending 1915(c) waiver, UMB has substantial expertise understanding the interaction between these sectors, including school-based behavioral health service delivery, collaboration and coordination of home visiting programs, and the Individuals with Disabilities Education Act Part C programs; and
- West Virginia Department Military Affairs and Public Safety, which oversees the Division of Juvenile Services (DJS). DJS operates several detention centers that provide behavioral health services and sits on the Juvenile Justice Reform Oversight Committee created by SB 393 in 2015 alongside the Agency and other stakeholders.

In addition, UMB understands that the West Virginia is finalizing submission of a 1915(c) HCBS waiver, Children with Serious Emotional Disorder, to serve children, youth, and young adults aged three (3) to 21 with a diagnosable mental, behavioral, or emotional disorder that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities. Based on stakeholder engagement beginning in late 2018, the waiver includes six HCBS services: (1) family support and training; (2) crisis services; (3) counseling and therapeutic services; (4) respite care; (5) case management; and (6) therapeutic foster care.

Following an amendment to West Virginia's Section 1115 Waiver, "Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders" (Project #11-W-00307/3), the State plans to automatically enroll beneficiaries in a specialized managed care plan for children and youth to reduce cost and enhance care coordination. Enrollment will be facilitated by Medical Eligibility Contracted Agent (Psychological Consultation & Assessment, Inc.) and an Administrative Services Organization (KEPRO). The waiver proposes a fast ramp up, projecting 500 children will be served in Year I, rapidly increasing to 2000 children by Year III, with 250

slots reserved for children who are in Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers out-of-state, and those who are in such facilities in-state.

West Virginia proposes to use the Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) to determine functional eligibility for waiver services. UMB is very familiar with the CAFAS and PECFAS, as well as the Child and Adolescent Needs Assessment (CANS) tool. Our familiarity and expertise with the CAFAS and CANS will make resulting data analysis easier if the state wishes to incorporate longitudinal data from the state's Safe at Home Title IV-E Demonstration Project, as well as CANS data from the proposed case management service. The Institute has been the CANS training center for Maryland for the past ten years. Detail on our work with integrating CANS in the Wraparound process is described in Section II in the description of our National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC) past performance.

Focus Area III – Develop a Quality Assurance and Performance Improvement System
UMB understands that a Quality Assurance (QA) and Performance Improvement System must be realistic to implement, ensure alignment with other reporting and required metrics, use validated evaluation principles to ensure that data is accurately collected and appropriately analyzed, provide transparency to agency partners, stakeholders and youth and their families receiving care; , and be timely. QA must validate data at every level to evaluate the impact of practice on process and outcome measures, and provide recommendations for action. To support the Agency in developing its Quality Assurance and Performance Improvement System by November 2020, UMB will draw upon our experience to:

- Define and support the implementation of the quality management process consistent with the Agreement;
- Provide technical assistance on integrating quality management processes throughout all agencies, departments, and programs to include continuous monitoring;
- Identify, assess, and communicate preferred practices;
- Create a culture of collaboration, continuous learning, and recognition to include internal and external stakeholders;
- Review existing measures and reports to ensure that existing quality metrics and reporting is leveraged whenever possible, and
- Align with other federal or state reporting requirements to minimize duplication of metrics, reports and processes when possible.

UMB recognizes that developing a Quality Assurance and Performance Improvement System requires moving technical assistance beyond theoretical and conceptual frameworks to specific operational and implementation strategies including governance structure, capacity building, workforce development, policy and regulatory change, financing, family and youth engagement, oversight, and data-driven systems redesign. Our recommendations will be informed by data analysis – both qualitative and quantitative – to ensure the Agency, and its State and community partners, maximize their respective strengths and assets while identifying and addressing gaps and needs.

While we will draw upon our knowledge of best practices and extensive work with other states and counties, our proposed strategies will be customized to meet the unique needs of West Virginia. Such strategies may include improving the availability and accessibility of care in West Virginia's 34 rural counties; creating interagency agreements and governance structures that account for recent legislative developments; developing reimbursement approaches such as bundled payments or case rate methods; constructing financing strategies to support value and quality; refining or scaling-up integrated health models children and youth; and reducing health disparities amongst subpopulations (i.e., youth with diverse sexual orientation and gender identity, youth of color, homeless youth). Our baseline analysis will account for historical successes, ongoing needs and gaps, opportunities, and priorities articulated by the Agency.

4.2.1.2. Provide a semi-annual assessment of the Agency's compliance with the Agreement, including the implementation plan and all supplements and schedules

UMB's semi-annual assessment will build upon our baseline assessment. The baseline assessment will draw upon a review of internal documents, including the Agency's implementation plan submitted to the DOJ on September 16, 2019; Departmental and Bureau policies; reports of quantitative data indicators; quality assurance reports; interviews with key Agency staff and case managers in the central intake units; and other indicators of organizational capacity such as budgets, the current Medicaid state plan and forthcoming amendments or waivers, existing service contracts, and data describing the composition of the child welfare workforce and current caseloads. See below under 4.2.2.1 for additional detail on the approach to the Mandatory Requirement for a baseline report with preliminary observations and recommendations by November 14, 2019.

Each semi-annual assessment will include:

- a brief overview of the Agreement with the DOJ;
- the status, activities, and accomplishments of the reporting period, including data collection and analysis, communication, training, and interagency collaboration;
- significant findings to date, including lessons learned; and
- recommendations and activities planned for the next reporting period

UMB will be in communication with the Agency and DOJ throughout the assessment process to share and discuss issues as they arise. This clear and continuous communication process will ensure that all parties are aware of findings prior to receipt of draft reports from UMB.

The timeline, below, sets forth the milestones required per the Agreement and RFP. UMB **anticipates on-site technical assistance meetings will be held on a quarterly basis or upon request, with weekly telephone and/or video conferencing communication with the Agency.** Per the staffing discussion in Section II, the Project Director, Suzanne Fields, will lead the management of UMB's technical assistance and will be the point of contact for the Agency. UMB will begin with a kickoff meeting via teleconference within one week of the contract effective date (CED). The purpose of the kickoff meeting will be to discuss project objectives, goals, and task timelines, with a focus on how we will work collaboratively to maximize effectiveness of the work and output in compliance with tight timeframe required per the Agreement and RFP.

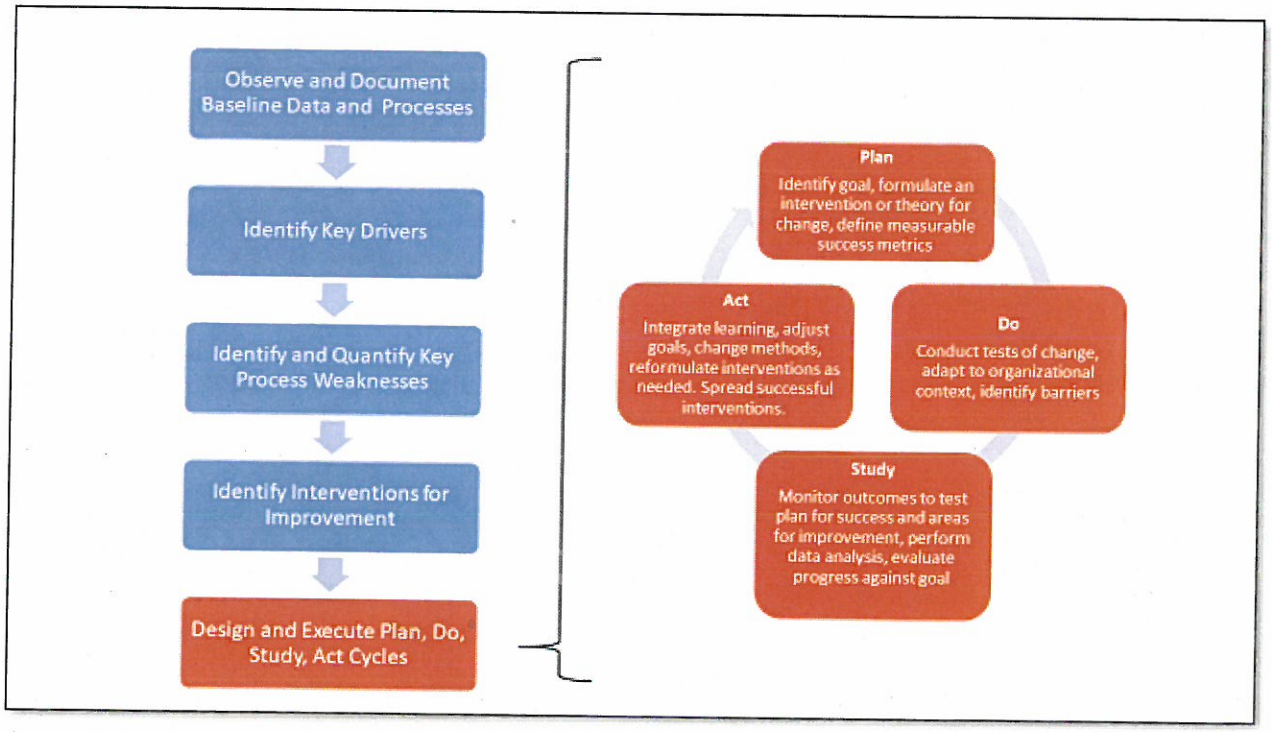
Table 1 – Milestone Timetable

CED – November 2020	
Agency submits Implementation Plan to DOJ	9/16/19
Award date /final contracting	9/30/19
UMB will hold a kickoff meeting via teleconference	Within one week of CED
DOJ provides comments on Implementation Plan	By 10/16/19
UMB submits initial draft semi-annual report, a baseline with preliminary observations of and recommendations for the Implementation Plan prepared by the Agency	11/14/19
DOJ and Agency provide comments to draft report	Within 2 weeks
UMB submits initial final semi-annual report	After receiving feedback from Agency and DOJ and 1 week prior to 1st semi-annual meeting
Initial Semi-Annual Meeting	12/19/19
UMB provides technical assistance using PDSA to ensure compliance with Agreement and support continuous quality improvement for Implementation Plan	Ongoing from CED
UMB submits draft assessment and comprehensive semi-annual report 30 days prior to Semi-Annual Meeting	4/14/2020
DOJ and Agency provide comments	Within 2 weeks
UMB submits final semi-annual report	After receiving feedback from Agency and DOJ and 1 week prior to semi-annual meeting
Semi-Annual Meeting	TBD – May 2020
Agency updates Implementation Plan	By 9/16/2020 (at least annually per Agreement)
Agency has programs available statewide	10/1/2020
Agency develops **Quality Assurance and Performance Improvement System**	11/14/2020
UMB submits draft assessment and comprehensive semi-annual report 30 days prior to Semi-Annual Meeting	11/14/2020
DOJ and Agency provide comments to draft report	Within 2 weeks
UMB submits initial final semi-annual report	After receiving feedback from Agency and DOJ and 1 week prior to semi-annual meeting
Semi-Annual Meeting	TBD – November 2020
December 2020 - Ongoing	
UMB submits draft semi-annual assessment and comprehensive reports to include data analysis from Quality Assurance and Performance System and PDSA TA	Dates TBD
DOJ and Agency provide comments to draft report	Within 2 weeks
UMB submits final semi-annual reports	After receiving feedback from Agency and DOJ and 1 week prior to semi-annual meeting
Semi-Annual Meetings	May and November each year
Agency updates Implementation Plan	At least annually each September

4.2.1.3. Provide any recommendations to facilitate the Agency's compliance

Supporting the State's compliance will require clarity of goals, clear action steps and timelines, and clarity on roles and accountability. The implementation plan will need to serve as the roadmap for compliance. In addition to the Agency's implementation plan, attention to policies and procedures, training, open communication between UMB and the Agency, proactive auditing and/or corrective action planning, and the Agency's enforcement of policies and procedures and prompt response to compliance issues. Underlying all of the above is the need to measure; UMB will work the Agency to identify process and outcome measures that matter; that is, a process to select performance metrics by defining key goals and then obtaining needed data to measure these goals, including considerations related to balancing the administrative burden of data collection against its predictive value.
UMB intends to use a Plan, Do, Study, Act (PDSA) approach to providing technical assistance to support the Agency to achieve compliance. By applying the recurring sequence of PDSA, the Agency can achieve continuous improvement quickly, attain goals, and sustain an organization-wide culture of quality and excellence.

Figure 2: Plan, Do, Study, Act Cycle



UMB recognizes that specific attention to monitoring access and quality of care will be critical to facilitating compliance. For example, monitoring penetration rates is a specific strategy that can be used to inform how well subpopulations of children are being served by the system and can help identify disparities in service use which can be an important strategy for targeting patient and provider interventions and overall quality improvement efforts. Ensuring that Medicaid data such as claims and utilization for the populations they serve is available to providers can play an important role in helping providers to better target interventions, and engage and outreach

underserved populations. The use of health information technology to promote data sharing with and between providers such as inpatient admissions, pharmacy claims, and emergency department usage (subject to Federal and State restriction) is important to promote continuity of care and appropriate care coordination.

Analysis of existing utilization patterns and penetration rates also helps us understand populations not well served by the current system. Analysis of utilization patterns can also reveal information about provider capacity. For example, high emergency department or inpatient utilization may reflect inadequate outpatient provider capacity and/or a need for more responsive provider practices such as offering same-day or urgent appointments. Making the connection between service use by current participants and the availability of particular types of practitioners or providers will assist West Virginia as it moves forward and plans for the future.

Of course, these strategies are dependent on having data collection mechanisms that can track provider performance as well as identifying the special populations in question. This requires an understanding of existing data, exploring adding particular data fields to current data collection systems, and/or adding modifiers on claim codes to properly monitor system/provider performance. Our approach is to focus on collecting data based on its specificity, sensitivity, ability to identify meaningful change, ease of collection, and importance. UMB consistently builds data systems and reports that move beyond mere collection and warehousing to data-driven decision-making. Given that many of these special populations are served by multiple agencies (e.g., housing, child welfare, juvenile justice, corrections), data sharing and collaboration agreements among the various agencies are also necessary to develop a complete picture of how well the system is performing. Additionally, standardized efforts to collect individual level identifiers (e.g., race, ethnicity, gender, age, etc.) for these special populations can provide useful information for reporting on outcomes, including any disparities.

4.2.1.4. Prepare a comprehensive report on the Agency's compliance including recommendations to facilitate or sustain compliance.

UMB will prepare and submit semi-annual comprehensive reports to include the semi-annual assessment of the Agency's compliance with the Agreement, per 4.2.1.2. As stated above, UMB will be in communication with the Agency and DOJ throughout the assessment process to share and discuss issues as they arise. This clear and continuous communication process will ensure that all parties are aware of findings prior to receipt of draft reports from UMB.

While UMB's expertise will be invaluable in the early stages of facilitating compliance with agreement, we recognize that Agency will need to develop its own internal capacity to monitor its performance and develop actionable performance improvement strategies. Our recommendations to facilitate and then sustain compliance will focus building this internal capacity to improve the quality and accessibility of HCBS, increase supports for familial supports and kinship care, improve placement stability using respite care and crisis response services, and decrease the use of congregate care. Central to these recommendations will be providing technical assistance on contract development and monitoring, provider performance monitoring (including relative to other similar providers), and quality improvement processes.

Sustaining compliance will require the Agency to develop improvement strategies and understand how to accurately track progress toward achieving the goals set out in the Agreement, notably a 25% reduction in children living in residential health treatment facilities by the end of 2022 (as compared to the number living in residential treatment on June 1, 2015). Facilitating and sustaining compliance will also require an approach to technical assistance that is flexible enough to permit the Agency to set priorities consistent with its leadership and stakeholder vision, with increasing latitude to manage ongoing child welfare system reform as successes are achieved.

4.2.2. Mandatory Project Requirements

4.2.2.1. Provide a baseline report with preliminary observations and recommendations by November 14, 2019

As the baseline report is due approximately 4-6 weeks after the expected contract award, UMB expects our early work to focus on establishing relationships with the Agency, including interviews with key staff; reviewing the State's implementation plan and addressing opportunities and weaknesses therein; gathering and reviewing relevant documents such as Agency and partner reports; requesting and reviewing quantitative data from the Agency and its partners; and gaining an initial understanding of opportunities and needs from stakeholders.

In general, our approach to ongoing assessments will include some or all the following, with each report building upon the previous report:

- Stakeholder Interviews: Brief, structured interviews with Agency staff, youth, and caregivers/parents served by Agency, foster service agencies, and the Department of Juvenile Services. Interviewees will be drawn from geographically diverse areas to ensure we are capturing the array of protective and risk factors for child placement, including poverty, substance use disorder, ready access to behavioral health services, etc.
- Data Analysis: UMB will examine quantitative outcome and internal data provided by the Agency or its partners to assess the Agency's responses to reports of maltreatment, abuse, and neglect; permanency and safety; and well-being. We will also determine compliance with current policies and procedures, and current data collection and validation processes. The analysis will also consider whether existing measures appropriately collect information on population health, the availability of reliable data (e.g., timeliness, reliability by place, race/ethnicity, age, socioeconomic status), and how progress is being communicated within the Agency and to external partners.
- Organizational Readiness and Capacity for Reform: UMB will analyze information related to responsibilities of front line and supervisory workforce; business processes; technology (including information sharing); initial and continuing education, training, coaching, and professional development; and current quality assurance protocol and quality improvement mechanisms, including oversight.
- Resource Allocation: UMB will examine the Agency's budget, Medicaid and other reimbursement rates, and recent patterns of Federal and State expenditures.
- Service Array, Availability, and Quality: We will compare what services are available to actual patterns of service use, including referral processes and ongoing care coordination, including between levels of care, care transition, and discharge planning, as well as processes for credentialing, licensing, and monitoring provider agencies and organizations.

- Policies and Procedures: To understand West Virginia's current child welfare practice model, we will compare State and local policies against best practice standards. UMB anticipates reviewing the current processes for disseminating quality assurance findings to current staff to improve outcomes.
- Strategic Direction: We recognize that the work of the State and its agencies is not static but that West Virginia is constantly striving to improve lives of West Virginians. As such, we would assess how other initiatives relate to and advance the goals of improving HCBS and reducing the reliance on residential treatment facilities.

4.2.2.2. Provide a semi-annual (every six months) comprehensive report on the Agency's compliance with the Agreement, including recommendations to facilitate compliance

UMB will provide a draft semi-annual report 30 days prior to each semi-annual meeting and will incorporate any comments from the Agency and the DOJ before producing a final report, seven days before each meeting. Per 4.2.1.2, the comprehensive reports will include the semi-annual assessment of the Agency's compliance with the Agreement.

Figure 3: Comprehensive Report Development Process

The semi-annual reports will be foundational documents as the Agency develops a Quality Assurance and Performance Improvement System, including a data dashboard, to analyze performance on outcome measures related children receiving services under the Agreement such as arrest, school suspension or expulsion, and the prescription of anti-psychotic medication. Our technical assistance will be informed by progress toward the overarching goal of a 25% reduction of the number of children living in residential mental health treatment facilities by December 31, 2022, compared to the number living there on June 1, 2015. In order to accomplish this goal, the semi-annual report will contain an action plan , with each task or item listed to enable easy tracking. In addition, UMB will focus technical assistance on the foundational elements establishing and using data, including that investments in workforce development and training keep pace with system needs, and that policies and practices support and routinize the use of data in decision-making.

UMB's reporting will have a sustained focus on outcomes to improve the children's delivery system and reduce residential treatment. To accomplish this, the semi-annual reports and the data dashboard must have meaningful indicators that signal progress. Our technical assistance approach recognizes that local context and expertise should inform the development of these indicators and that regular communication is necessary to make progress. Our team also recognizes that despite procedural and managerial safeguards, the path to system improvement does not always proceed as planned. Our experts are prepared to adapt and overcome barriers in the complex environment that is child welfare.

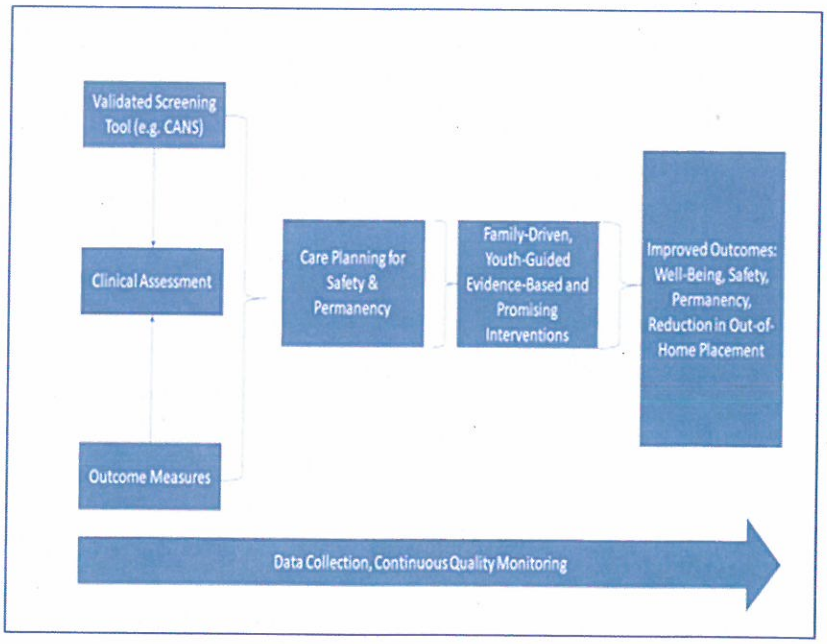
4.2.2.3. Provide technical assistance to the Agency on the development and delivery of statewide children's mental health services

There are several national guideposts that provide leadership and policy direction for UMB's technical assistance. These include seminal reports such as the President's New Freedom Commission on Mental Health; the Surgeon General reports *Mental Health: A Report of the Surgeon General* and *Mental Health: Culture, Race and Ethnicity,* the Substance Abuse and Mental Health Services Administration (SAMHSA) *Description of a Good and Modern Addiction and Mental Health Service System,* as well SAMSHA's *Evaluation of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances* reports to Congress, and joint Centers for Medicaid and CHIP Services/SAMHSA informational bulletins on coverage of behavioral health and substance use services.

In addition to general practice guidelines for children with behavioral health concerns, we will focus our technical assistance on developing practices found effective for the child welfare population such as Assertive Community Treatment, Multi-Systemic Therapy, Parent Child Interaction Therapy, Circle of Security, Parents as Partners, Functional Family Therapy, Supported Employment, Integrated Treatment for Co-Occurring Disorders, Trauma-Focused Cognitive Behavioral Therapy, and peer and family support services. Many of these services have been covered by Medicaid in other states. For example, Massachusetts, Pennsylvania, Oklahoma, Texas, Georgia, Wyoming, Connecticut, and Minnesota all cover peer or family support services, which can help promote engagement in mental health and substance use services for many of these special populations. Oklahoma, North Carolina, and Connecticut cover Multi-Systemic Therapy, which has proved to be an effective treatment of youth with mental health needs involved with juvenile justice. Numerous states cover Assertive Community Treatment, including North Carolina, New Jersey, Indiana, Oklahoma, Rhode Island, Illinois, Massachusetts and Maryland, which can be effective in serving persons with serious mental illness who may be experiencing housing insecurity or homelessness.

The technical assistance needed to reach compliance with the Agreement must be grounded in transforming West Virginia's continuum of care into a system that can deliver intensive, community-based services to children and adolescents that often have co-occurring behavioral health, intellectual and developmental, education, and/or physical health needs requiring multi-system involvement. UMB will partner with the Agency to design a service delivery model that reduces reliance on residential treatment and embraces the cultural, linguistic, trauma-informed, socioeconomic, and other needs of youth and families requiring services. The service delivery model must provide a

Figure 4: Model Continuum of Care



broad array of prevention and treatment that can be flexible and individually customized to reduce the current reliance on out-of-home placement.

UMB will focus on data collection so we may identify and adopt technical assistance strategies in the following core areas:

- Implementing policy, administrative, and regulatory changes
- Developing and/or expanding services and supports
- Creating or improving financing strategies
- Education and outreach to stakeholders
- Workforce training and coaching
- Generating support and sustaining continuous quality improvement
- Understanding other Medicaid, public health, child welfare and behavioral health changes and opportunities that can be leveraged to support this effort

These core areas inform distinct strategies to develop a family-driven, youth-guided continuum of care. This robust continuum begins with prevention services, uses a standardized assessment tool (e.g., the CANS, CAFAS, or PECFAS), and provides trauma-informed and evidence-based services that ensure children are safe, remain with their families whenever practicable, and achieve permanency through adoption, if needed. A standardized tool such as the CANS or CAFAS supports care planning and level of care decision-making, facilitates quality improvement initiatives, and allows for outcome monitoring. Transparency through a data dashboard will provide information to the Agency and stakeholders on State measures used to monitor the status of children served by West Virginia's child welfare system.

Table 2 – Focal Technical Assistance Strategies

Focus Area	Result
Implementing policy, administrative, and regulatory changes	• Consensus-built, interagency structures (e.g., memoranda of understanding and interagency agreements) to set policy, guidance, and regulations underlie a high-quality children's behavioral health delivery system
Developing and/or expanding services and support	• A benefit package, within available funding, that supports recovery and resilience, including prevention and early intervention services, an emphasis on cost-effective, individualized, evidence-based and best practice service approaches, with special consideration for service delivery to rural and frontier areas and to reducing racial, ethnic, and geographic disparities across child-serving systems • A system that integrates high quality medication management and psychosocial interventions so that both are available children and families.
Creating or improving financing strategies	• Maximizing Medicaid to finance services by adding new services, changing existing service definitions, obtaining waivers, etc. to finance services and supports • Maximizing the use of federal grants to finance infrastructure and/or services • Redeploying funds from higher cost to lower cost services.
Education and outreach to stakeholders	• Expanding family/caregiver and youth involvement in the planning and delivery of their own culturally and linguistically competent services to improve outcomes

Workforce training and coaching	• Creation of an adequate number and distribution of appropriately credentialed and competent behavioral health care providers • Using data to assess staffing, continuing education, and professional development needs; evaluation becomes a permanent part of service delivery
Generating support and sustaining continuous quality improvement	• Cultivating partnerships with provider agency and organization leaders, managed care organizations, and other key leaders • Promoting program standards, including common service definitions, utilization management measurements/criteria, quality requirements, system performance expectations, and consumer/family/youth outcomes

UMB's technical assistance approach closely aligns with implementation science theory through our developmentally staged dissemination. Our model builds on the resources and strengths to effectively address the Agency's needs at multiple levels of implementation; it is designed to be data-and field-driven and dynamic. System of care values of family-driven and youth-guided, community-based, culturally and linguistically competent and coordinated care for children, youth, and their families are the foundation that inform the strategies we use to rebuild service delivery in partnership with states and communities.

UMB strongly believes in building and strengthening collaborative state agencies, providers, and advocacy groups. Improving the quality and availability of HCBS must be driven by the needs of the field, data-informed, and encompass the diverse expertise of other child-serving agencies in West Virginia, including the Agency's Bureau for Children and Families, Bureau for Behavioral Health, Bureau for Medical Services and Bureau for Public Health, as well as the cooperation of West Virginia Department of Education and West Virginia Department Military Affairs and Public Safety to:

- Coordinate with block grant based funding for maternal health and substance use disorder services;
- Collaborate to streamline credentialing and licensing processes for home- and community-based providers and services;
- Partner with West Virginia's Expanded School Mental Health Initiative, faith communities, civic organizations, and the business community;
- Develop and deliver programming to link children and families to needed social supports at the local level;
- Promote further integration and adoption of evidence-based and promising practices to achieve optimal outcomes with individualized plans of care;
- Maximize the use of Medicaid for intensive behavioral health services;
- Educate providers, caregivers, and families on culturally and linguistically competent services;
- Leverage technology and workforce development strategies to improve staff recruitment and retention, with particular attention to ameliorating the 23% vacancy rate in Child Protective Services; and
- Enhance diversionary programs that reduce placements for status and low-level delinquency offenses, including youth who crossover between the child welfare and

juvenile justice systems.

Our approach will leverage our national and state expertise in child welfare, Medicaid, strategic planning, system design, financing, workforce development, implementation science, and program evaluation to develop a truly actionable implementation plan with a strong central structure for management and cross-agency coordination to ensure that evidence-based services are available to all West Virginian children and families in a well-integrated continuum of care.

Section II – Qualification and Experience

UMB is a public, non-profit, educational institution and a constituent institution of the University System of Maryland, an agency of the State of Maryland, with the necessary capacity, working capital, and other resources to perform and complete the proposed application. UMB received $667.4 million in grants and contracts in fiscal year 2018.[14] The Institute for Innovation & Implementation (The Institute), founded in 2005, is a department within the UMB School of Social Work (SSW). The Institute works to build research-based, innovative, sustainable, and transformative child-and family-serving systems, services, and workforce capacity in partnership with government agencies; provider, community, and family- and youth-run organizations; and other leaders and stakeholders to integrate systems and improve outcomes for and with children, youth, and families. It serves as a national training, technical assistance (TA), evaluation and policy center focused on children's systems and manages more than 50 contracts, worth approximately $20 million annually, with the federal government, multiple state governments, foundations, and private organizations that span multiple parties and years.

Since 2013,[15] The Institute has served as the coordinating entity for the **National Technical Assistance Network for Children's Behavioral Health (TA Network),** which operates the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA) National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC) and provides training and TA to states, tribes, territories, and communities focused on improving children's behavioral health. The TA Network provides support to communities funded by SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program ("system of care grantees"), including youth and family leadership and organizations. The TA Network includes a diverse group of partner organizations and consultants to ensure a broad array of specific expertise who are each deeply committed to supporting high quality, cost effective, and community-based services and supports. The TA Network's contract includes an interagency agreement with the Administration for Children and Families Children's Bureau (CB) to support implementation of the Family First Prevention Services Act (FFPSA) focusing on the necessary service array for states to meet the needs of children and families involved with the child welfare system to safely prevent foster care and shorten lengths of stay. The Institute is also the **CB's National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for LGBTQ2S Children and Youth in Foster Care**

[14] UMB's federal tax exempt letter is available online at www.umaryland.edu.

[15] In 2013, UMB received its first SAMHSA TA Center contract to provide training and TA to approximately 90 grantees. UMB organized the TA Network as part of the proposal. In 2015, SAMHSA released the NTTAC RFP, which expanded the TA Center, to provide training and TA to states, tribes, territories and communities without SAMHSA grants and logistical support. UMB, on behalf of the TA Network, was awarded the expanded contract in 2015.

(LGBTQ QIC), collaborating with the CB and four local sites to develop, integrate, and sustain best practices and programs that improve outcomes for youth in foster care with diverse sexual orientation and gender identity and expression (SOGIE). Additionally, the Institute is part of the **CB-funded National Adoption Mental Health Training Initiative** led by the Center for Adoption Support and Education; The Institute is responsible for developing, maintaining, and evaluating the online training modules for adoption and mental health professionals. The Institute is also the recipient of Maryland's **CB-funded Youth At-Risk of Homelessness Demonstration Grant,** known as Thrive@25, and serves as the **CB's National Center on Evidence-Based Practices in Child Welfare.**

In addition, The Institute is home to the **National Wraparound Implementation Center (NWIC) and two state centers of excellence in Maryland and Texas,** which have played substantial roles in providing technical assistance and capacity building support to ensure children receive mental health services in their homes and communities in those states. For example as part of its Maryland Center, The Institute has provided grant administration, policy analysis, TA, and/or evaluation for many federal grants, including at least nine SAMHSA and two CMS demonstration grants. The Institute currently supports the Maryland Department of Human Services (DHS; child welfare agency) with its implementation and evaluation of its Title IV-E Waiver Demonstration Project, providing technical assistance to all 24 local departments of social services in MD on identification, selection, and implementation of evidence-based and promising practices; data collection, analysis, and reporting for all continuous quality improvement activities related to interventions implemented under the Title IV-E Waiver; conducting the federally required evaluation of the Title IV-E Waiver; and, providing technical assistance (TA) on policy, financing, and systems design, including Medicaid financing and the Family First Prevention Services Act. The Maryland Center at The Institute has also run the Maryland Evidence Based Practice Center for nearly ten years, serving as the intermediary for MST and FFT for Maryland, and has completed annual service array analysis, by jurisdiction, for juvenile services for several years and will start doing the same for child welfare this year.

In addition, The Institute leads the Maryland DHS-funded **Children's Quality Services Reform Initiative**, including developing service specifications; developing and implementing performance measures to align with service specifications; drafting Medicaid State Plan Amendments; and providing training and TA to community based providers and State agencies. UMB was also a participant in a CMS-funded multi-state quality collaborative with the Center for Health Care Strategies from 2010-2015 and currently facilitates quality collaboratives for the LGBTQ QIC and TA Network. The Institute's faculty and staff have nationally recognized expertise and leadership in the fields of children's behavioral health; systems of care; clinical practice; care management; Medicaid, managed care, and financing; child welfare, juvenile justice, and public child- and family-serving systems; parent, infant, and early childhood development and mental health; housing and homelessness; LGBTQ youth and young adults; evidence-based and promising practices; policy analysis and development; and, developing and disseminating adult online learning content.

The SSW's Ruth H. Young Center for Children and Families (RYC), home to Maryland's Child Welfare Academy, Child Welfare Accountability Project, and initiatives related to ending and preventing trafficking, will be integrating with The Institute in fall 2019. This merger will provide streamlined support and capacity to numerous child welfare initiatives. The Maryland DHS has

partnered with RYC for more than 25 years.

The Institute's administration and business operations and grants team provides accounting services and supports procurement, human resources, professional development, travel, and general business functions. The Institute's Executive Management Team, including the Assistant Dean at UMBSSW and Director of The Institute, collectively manages the contracts, personnel, and quality of work. The Institute maintains an instructional design and multi- media team, meeting support and events team, communications and marketing team, and an international continuous quality improvement and implementation team to provide the necessary infrastructure to ensure quality, conduct webinars, disseminate information through social media, and facilitate meetings and training events.

4.3.1. Qualification and Experience

In addition to our UMB organizational experience, our Team for this effort comes to UMB with a depth of experiences at the federal, state and community levels in their prior roles as federal and state officials and national consultants. Their **individual experiences, in addition to UMB specific work, are also reflected in the table below**. Our team is staffed with experts in children's behavioral health and child welfare, Medicaid service delivery and financing who lead, design, finance and implement, and evaluate efforts for federal programs and state agencies. We have conducted case studies; collected policy and program-level data from state agencies; assisted in the development of technical guidance tools and products for states; created webinars and online learning communities of practice; implemented large national in-person and virtual meetings, expert panels, and state policy academies; and conducted trainings for the provision and financing of evidence-based practices and promising interventions. We are skilled at writing and editing plans, reports, articles, toolkits, curricula, and other products—generating clear, concise reports and products. Most importantly, we have served in state leadership roles, have been responsible for behavioral health reforms and understand the complexities and challenges in executing successful system-wide changes with limited resources and abbreviated timeframes. For example, as noted in Suzanne's Fields CV, she was responsible for the system design, financing, and implementation related to the Massachusetts Rosie D. EPSDT class action lawsuit.

As set forth in the table below and more fully described in the past performance responses that follow in response to each of the mandatory requirements, **our Team's qualifications and expertise in providing services and solving problems similar to those requested in this RFP significantly exceed the mandatory requirements and demonstrate superior knowledge and proficiency with children's community-based mental health services, Medicaid and child welfare systems.**

Table 3 – Past Performance Project Table

Location	Project Type	Contract Project Manager Name and Contact Information	Community-based children mental health services	Reducing the reliance on residential treatment facilities	CQI and quantitative and qualitative data analysis	Wraparound Facilitation^	Behavioral Support Services^	Children's Mobile Crisis Response^	Therapeutic Foster Family Care^	Assertive Community Treatment^	Prevention services in the child welfare system	DOJ Consent Decrees or Similar Agreements
FEDERAL/NATIONAL												
SAMHSA - NTTAC	National TA Center individualized TA to states, communities, tribes and territories	Eric Lulow SAMHSA eric.lulow@samhsa.hhs.gov (240) 276-1782	X	X	X	X	X	X	X	-	X	-
CMS Medicaid Innovation Accelerator Program (Suzanne Fields, Private Consulting)	Technical assistance related to states' SUD waiver demonstrations	Lavonia LeBeau IBM Watson Health llebeau@us.ibm.com (781) 507-4140	X	-	X	-	X	-	X	X	X	-
CB- National Adoption Mental Health Training Initiative	Design, develop and host on-line training modules	Debbie Riley Center for Adoption Support and Education Riley@adoptionsupport.org (301) 476-8525	X	-	-	-	X	-	-	-	X	-
CB - National Center on Evidence-Based Practices in Child Welfare	Operate National Center for Evidence-Based Practice in Child Welfare to build the capacity of child welfare and mental health practitioners	Jan Shafer Division of Program Innovation, Children's Bureau jan.shafer@acf.hhs.gov (202) 205-8172	X	X	X	-	-	-	X	-	X	-
CB - National LGBTQ2S QIC	National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for LGBTQ2S Children/ Youth in Foster Care	Taffy Compain, Children's Bureau, Administration for Children and Families Taffy.Compain@acf.hhs.gov (202) 205-7793	X	-	-	-	-	-	X	-	X	-
CMS – Multi-state CHIPRA Quality Collaborative	Multi-state Quality Collaborative with Georgia, Maryland, Wyoming to improve health care quality for children with serious mental health needs	Brian Hepburn (retired) now Executive Director National Association of State Mental Health Program Directors) Brian.Hepburn@nasmhpd.org (703) 739-9333	X	X	X	X	X	X	X	-	-	-
National Wraparound Implementation Center	Minnesota, Hawaii, Indiana, Nevada, Tennessee, Georgia, South Carolina, Mississippi, Louisiana, California	Contacts for each state are available upon request	X	X	X	X	-	-	-	-	X	-

Location	Project Type	Contract Project Manager Name and Contact Information	Community-based children mental health services	Reducing the reliance on residential treatment facilities	CQI and quantitative and qualitative data analysis	Wraparound Facilitation^	Behavioral Support Services^	Children's Mobile Crisis Response^	Therapeutic Foster Family Care^	Assertive Community Treatment^	Prevention services in the child welfare system	DOJ Consent Decrees or Similar Agreements
STATE/COUNTY												
Washington	Medicaid and Behavioral health authority system design, financing and implementation support for services specific to EPSDT settlement agreement	Tina Burrell Washington State Health Care Authority Tina.Burrell@HCA.WA.gov (360) 725-9409	X	X	X	X	X	-	-	-	-	X
Alabama	System design, financing and implementation to support state EPSDT settlement agreement	Kim Hammack Department of Mental Health Kim.hammack@mh.alabama.gov (334) 242-3209	X	X	X	X	X	-	-	-	-	X
Illinois	Technical assistance to the State's Implementation Plan in response to ILs Consent Decree	John O'Brien Technical Assistance Collaborative JOBrien@tacinc.org (617) 266-5657	X	X	X	X	X	X	-	X	-	X
Ohio	Technical assistance on cross-agency blended funding and child behavioral health service delivery design	John O'Brien Technical Assistance Collaborative JOBrien@tacinc.org (617) 266-5657	X	X	X	X	X	X	X	X	X	-
Delaware (Suzanne Fields, Private Consulting)	Behavioral health and substance use needs assessment	John O'Brien Technical Assistance Collaborative JOBrien@tacinc.org (617) 266-5657	X	X	X	X	X	X	-	-	-	-
Texas	Center of excellence to support high quality, effective behavioral health services, including 1915c waiver	Courtney Seals Health and Human Services Commission Courtney.Seals1@hhsc.state.tx.us (512) 838-4353	X	X	X	X	-	-	-	-	X	-
Nevada	FFPSA Plan development and implementation	Kathryn Roose NV HHS kroose@dcfs.nv.gov (775) 301-7141	X	X	X	X	X	X	X	-	X	-
Los Angeles County, CA	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Medicaid maximization assessment	Kalene Gilbert Los Angeles County Department of Mental Health kgilbert@dmh.lacounty.gov (213) 739-0238	X	X	X	-	X	X	X	-	-	X

Location	Project Type	Contract Project Manager Name and Contact Information	Community-based children mental health services	Reducing the reliance on residential treatment facilities	CQI and quantitative and qualitative data analysis	Wraparound Facilitation^1	Behavioral Support Services^1	Children's Mobile Crisis Response^1	Therapeutic Foster Family Care^1	Assertive Community Treatment^1	Prevention services in the child welfare system	DOJ Consent Decrees or Similar Agreements
Prince George's County, MD (Melissa Schober, prior employment)	Behavioral health needs assessment, gap analysis, and action plan	Jack Meyer (retired) Health Management Associates DC Office (202) 785-3669	X	X	X	-	X	X	-	X	-	-
Arkansas	Contract analysis for quality measures relevant to the foster care population	Pamela Tew Center for Health Care Strategies ptew@chcs.org (609) 528-8400	-	X	X	-	-	-	-	-	X	-
Illinois (Suzanne Fields, Private Consulting)	Olmstead related Williams Consent Decree providing technical assistance in the development of HCBS	Susan Parker Parker Dennison & Associates susanp@parkerdennison.com 480-419-4147	X	X	X	-	X	-	-	X	-	X
Mississippi	Behavioral health needs assessment per DOJ Agreement	Sandra Parks Division of Children & Youth Services MS Department of Mental Health Sandra.parks@DMH.state.ms.us (601) 359-1288	X	X	X	X	X	X	X	-	-	X
Maryland	Title IV-E Waiver Demonstration Project	Rebecca Jones Gaston Social Services Maryland Department of Human Services rebecca.jonesgaston@maryland.gov (410) 767-8939	X	X	X	-	X	-	-	-	X	-
Maryland (Melissa Schober, prior employment)	1915(i) Intensive Behavioral Health Services for Children, Youth and Families	Brian Hepburn (retired) now Executive Director National Association of State Mental Health Program Directors) Brian.Hepburn@nasmhpd.org (703) 739-9333	X	X	X	-	X	X	-	-	-	-
Maryland (Melissa Schober, prior employment)	1945 Health Home State Plan Amendment	Brian Hepburn (retired) now Executive Director National Association of State Mental Health Program Directors) Brian.Hepburn@nasmhpd.org (703) 739-9333	X	X	X	-	X	-	-	-	-	-

Location	Project Type	Contract Project Manager Name and Contact Information	Reducing the reliance on residential treatment facilities	CQI and quantitative and qualitative data analysis	Community-based children mental health services	Wraparound Facilitation^	Behavioral Support Services^	Children's Mobile Crisis Response^	Therapeutic Foster Family Care^	Assertive Community Treatment^	Prevention services in the child welfare system	DOJ Consent Decrees or Similar Agreements
Maryland (SSW, Ruth Young Center)	Quality Assurance/ Continuous Quality Improvement Process	Rebecca Jones Gaston Social Services Maryland Department of Human Services rebecca.jonesgaston@maryland.gov (410) 767-8939	-	-	X	-	-	-	-	-	X	-
Maryland (SSW, Ruth Young Center)	Child Welfare Accountability Project	Rebecca Jones Gaston Social Services Maryland Department of Human Services rebecca.jonesgaston@maryland.gov (410) 767-8939	-	X	X	-	-	-	-	-	X	-
Maryland (SSW, Ruth Young Center)	Annual Child Welfare Performance Indicators Reports	Rebecca Jones Gaston Social Services Maryland Department of Human Services rebecca.jonesgaston@maryland.gov (410) 767-8939	-	-	X	-	-	-	-	-	X	-
Maryland (SSW, Ruth Young Center)	Examination of Reentry into State Sponsored Out of Home Care after Reunification	Rebecca Jones Gaston Social Services Maryland Department of Human Services rebecca.jonesgaston@maryland.gov (410) 767-8939	-	-	X	-	-	-	-	-	X	-

Proposed Staffing Plan

UMB has assembled a Team with strong children's behavioral health backgrounds, policy expertise, Medicaid expertise, and a practical understanding of children's mental health (MH) and substance use disorder (SUD)service delivery, financing, and oversight. Moreover, our Team has extensive direct experience working with state Medicaid agencies and behavioral health authorities, providing technical assistance and evaluation.

Through many projects conducted for federal agencies including SAMHSA, ACF and CMS, and state and counties, our Team has extensive knowledge of how to design, finance, and implement and provide oversight to behavioral health services. This knowledge will allow us to quickly identify priorities and issues, identify proposed approaches and solutions, and implement in a timely fashion.

Our Team includes staff with federal and state Medicaid, child welfare and behavioral health

experience. These staff members have first-hand experience with court ordered agreements, providing policy guidance and implementing technical assistance to states in mental health and substance use disorder program design approaches, Medicaid state plans and waivers, behavioral health innovations (e.g., health homes), IVE, and alternative payment models. We place great emphasis on assigning personnel with the most appropriate technical and project management experience to ensure the successful completion of project tasks. We have assembled a team with children's MH and SUD, child welfare, policy and financing expertise and Medicaid. Our team has collaborative relationships and connections with federal and state mental health, substance use, Medicaid, child welfare, juvenile justice, and public health authorities and administrations.

In addition to the SME/Project Lead, Suzanne Fields and the SME, Melissa Schober, our Team will include Christopher Bellonci, MD and Terry Shaw, PhD to provide limited, but directed, consultation on residential reform, psychotropic medication, health integration, child welfare data systems, and evaluation strategies and metrics. We also plan to draw upon our UMB and national consultant pools to address specific priorities and needs of West Virginia that are identified, which we anticipate may include rural engagement, cultural and linguistic competency, and workforce recruitment and retention strategies. For further detail and examples of SME expertise, see the SME Pool, bios and CVs set forth below in 4.3.2.

As demonstrated in the above Past Performance Project Table, much of our work spans across the required areas of experience set forth in RFP paragraphs 4.3.1.1 through 4.3.1.6. We have selected examples of relevant project goals/objectives and our approach as they pertain to each of the required expertise in the sections that follow. We welcome the opportunity to share additional detail on how each of the Past Performance Projects demonstrate inter-related expertise in each of the required areas of expertise

4.3.1.1. Experience in the delivery, design, and/or implementation of community-based children mental health services

Our team has extensive experience and expertise in providing SME services to state and federal agencies related to the delivery, design and implementation of community-based children mental health services. **Project descriptions include relevant project goals and objectives and how they were met.**

SAMSHA's National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC)

The purpose of the NTTAC contract is to serve as SAMHSA's training and technical assistance (TTA) center with the goals of moving systems of care and cross-system reform efforts towards wide-scale adoption, and to increasing the effectiveness of mental health services for children and youth with serious behavioral health needs and their families across the nation. NTTAC is responsible for providing TTA to states, tribes, territories and communities funded by the Comprehensive Community Mental Health Services for Children and Their Families Program (approximately 73 to 90+ each year), as well as to all states, tribes, territories, and local governments without grants and the field at large. Objectives, which vary each contract year, are addressed through a work plan, developed with and approved by SAMHSA, with over 100 strategies. For

example, the NTTAC contract includes an optional task funded by the CB through an interagency agreement with SAMHSA with current focus on: 1) FFPSA design and implementation; and, 2) a four-year partnership with the deans and faculty of 15 Schools of Social Work to develop, test and incorporate behavioral health curriculum into MSW degree programs to improve the knowledge, expertise, and overall preparedness of graduates to provide effective mental health services to children, youth, and young adults with mental health needs and their families.
Our approach is to provide field-driven TTA that:

- is grounded in real world examples and concrete strategies
- ties to cross-cutting systems issues and reforms underway in states, tribes, territories, counties, and cities
- connects to initiatives funded through other grant mechanisms, including through other federal agencies
- focuses on specific design and operational issues
- encourages and supports family and youth partnerships and leadership and cultural and linguistic competence
- maintains an overarching strategy to embed system of care practice into mainstream delivery systems as a fundamental strategic approach to sustainability and expansion
- includes a flexible array of generalized, individualized, and intensive technical assistance (TA) options:
    - Generalized TA: Includes weekly TA Telegram (electronic newsletter/resources), the Monthly Minute (animated video short explaining a particular TA topic), and the TA Tidbit (highlight of a particular TA response) to a listserv of over 13,000, regular webinars and distance learning opportunities, content specific publications, products, and technical assistance resources.
    - Individualized TA: Includes assignment of a lead consultant, available as needed, to support individualized and dynamic TA plans; this level of TA also includes our Rapid Response TA system for specific questions or requests for resource material.
    - Intensive TA: Focuses on sites that are in stages of development where an intensive and customized approach will accelerate their ability to advance system of care expansion and sustainability; this level of TA may include peer-exchanges and on-site TA from the TA Network partner organizations or Consultant Pool.

Specific strategies include:

- Maintaining a website with an inventory of resources organized by topics: **Cultural and Linguistic Competence; Family Engagement and Leadership; Youth Engagement and Leadership, Tribal Support; Policy, System Design and Financing; Clinical Best Practices, Wraparound and Workforce Development; Systems Integration; and Social Marketing and Communication.**
- Working with SAMHSA, the CB, regional offices, and TA Network partners to identify and address gaps in TTA as well as tipping point issues to impact large-scale reform.
- Developing resources for the field including tip sheets, issue briefs, and toolkits (over 25 resources last contract year) as well as videos, animated shorts, and online training modules.
- Designing and implementing quality learning collaboratives (QLC) and expert convenings such as the QLC on **Improving the Use of Psychotropic Medications in Residential Treatment Facilities.**
- Managing a state-of-the art interactive online learning center/LMS, which hosts webinars (in

excess of 40 per year) and 11 learning communities (**Clinical High Risk & Early Psychosis, Cultural & Linguistic Competency, Early Childhood, Family Leadership, Rural Mental Health, Social Marketing, System Leadership, Tribal Systems of Care, Young Adult Services & Supports, Youth Leadership, Youth with Co-Occurring Substance Use & Mental Health Disorders**).

- Highlighting exemplar work across the nation and facilitating peer connections between and across states, tribes, territories and communities.
- Designing and conducting evaluation of quality and impact of TTA and incorporating into **continuous quality improvement mechanisms**.

Examples of specific products include:

- **Program and Practice Standards for Intensive In-Home Behavioral Health Treatment** - Intensive In-Home Behavioral Health Treatment (IIBHT) programs for children and youth with emotional and behavioral disorders and their families operate in nearly every U.S. state and occupy a critical position in the continuum of care. Most IIBHT programs operating in state service systems today are "home grown" programs that are less strict with respect to EBP practice parameters, organizational requirements, training and coaching expectations, and fidelity and outcomes monitoring. While such flexibility may make these IIBHT programs more likely to be used in "real world" service systems, it may result in lower quality practice and poorer youth/family outcomes. There has not to date been a systematic effort to develop a cohesive set of program and practice standards for IIBHT. To fill this gap for the public children's behavioral health field, the TA Network convened an expert advisory group to develop such program and practice standards through a multi-step iterative process. These steps included:
  - A review of the relevant literature;
  - Interviews with experts in the field of IIBHT;
  - Development of an initial set of practice and program standards by a small task force of experts; and,
  - A multi-round Decision Delphi process, whereby initially proposed standards were refined and improved based on quantitative and qualitative input of IIBHT experts, providers, purchasers, ad family and youth leaders. Respondents were asked to rate each standard's acceptability with respect to inclusion (i.e., content) and language (i.e., wording).

  The ultimate goal of this ongoing project is to support purchasers (i.e. states, jurisdictions, and managed care entities) in their IIBHT contracting, quality assurance, and accountability efforts. The standards also hold promise for guiding provider efforts in conducting high-quality workforce development (training, coaching, and supervision) and continuous quality improvement. Next steps for the project, to take place over the coming year, are to:
  1. Use these standards as the basis for development of reliable and valid measures of IIBHT quality and fidelity;
  2. Engage states in a learning community focused on application of the standards across the above purposes; and,
  3. Conduct research on the capacity of training, measurement and feedback, and other quality improvement activities using the standards to improve IIBHT quality, satisfaction, and outcomes.
- **National Association of State Mental Health Program Directors, Children's Crisis**

Continuum of Care Assessment - Assessment of a children's crisis continuum of care, including screening and assessment, mobile response and stabilizations services, system coordination and collaboration with child welfare and other agencies, workforce development, and financing and sustainability strategies. Assessment focused on the value of children's crisis services, including reducing reliance on residential and acute care. https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

- **Effectively Integrating the CANS into the Wraparound Process** – An issue brief developed in partnership with the National Wraparound Initiative, NWIC, Chapin Hall and Praed Foundation, recognizing the increasing number of states and systems requiring CANS for use within Wraparound programs and providing guidance (see https://nwi.pdx.edu/pdf/Integrating-CANS-Into-Wraparound.pdf). See also webinar held in April 2019. Companion guidance, **Putting CANS to Use at the Wraparound Program and System Levels**, is in development.
- TA Network Issue Briefs (see https://theinstitute.umaryland.edu/our-work/national/network/policy/resources/), including:
    - **Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization** (2016)
    - **Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Intensive In-Home Services** (2016)
    - **Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Respite Care** (2016)
    - **Considerations in System of Care Expansion: Expanding Early Childhood Systems of Care** (2016)
    - **Coverage of Behavioral Health Services for Youth with Substance Use Disorders** (2016)
    - **Flexible Funds for Customized Goods and Services** (2016)
    - **Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs: Expert Convening** (2018)
    - **Turnover Among Wraparound Care Coordinators, Perspectives on causes, impacts, and remedies** (2018)
    - **Telehealth and Mobile Technology in Child, Youth, and Young Adult Behavioral Health** (2019)

Examples of Learning Collaboratives/Meetings include:

- **Mobile Response & Stabilization Services (MRSS) Peer Meetings** – These cooperative peer convenings were held for (up to eight) participant teams to learn about innovative 'best practice' models of MRSS that include home- and community-based stabilization and case management services, on-site face-to-face therapeutic response; assessment; crisis intervention and stabilization; psychiatric consultation; psychopharmacology; and referrals and linkages to other services and supports. Participant teams met in New Jersey for two days of collaborative work with peers, and experts from Connecticut, Milwaukee County Wisconsin, Nevada, New Jersey, and Oklahoma, to work on self-identified goals and strategies for developing, implementing and sustaining MRSS for children, youth, and young adults in their states and communities. The meetings also provided the opportunity for 1-2 individuals from each participating team to shadow a mobile response team for 'hands-on'

observation of New Jersey's approach, the day before the meeting.

- **Innovations in Medicaid Managed Care for Children, Youth and Young Adults with Behavioral Health Challenges** - These academies were practical, how-to working meetings designed to explore a range of managed care strategies relevant to children, youth and young adults with behavioral health challenges and their families and receive technical assistance from faculty and peers on a specific managed care project or related issue identified by the participating teams. Teams left the meeting with their own tailored managed care strategies to address their identified goals. Working sessions addressed such topics as: what to include within Medicaid managed care Requests for Proposals (RFPs) and contracts to ensure appropriate customization for children and youth; population-based strategies, including management of sub-populations of children with intensive needs, such as those involved with child welfare or juvenile justice; youth substance use disorder issues; rate setting and risk adjustment; benefit design including evidence-informed benefits; provider network requirements; customized care coordination, levels of care coordination, and health integration approaches including intensive care coordination using Wraparound and health homes; data dashboards and data sharing; quality and measurement; value-based purchasing strategies; health disparities and youth and family engagement in managed care practice and policy.

4.3.1.2. Experience in providing SME services to state or federal agencies related to reducing the reliance on residential treatment facilities for children with serious emotional or behavioral disorders or disturbances

As demonstrated in the project table above and more fully described below, UMB's Team has extensive experience and expertise in providing SME services to state or federal agencies related to reducing the reliance on residential treatment facilities for children with serious emotional or behavioral disorders or disturbances. **Project descriptions include relevant project goals and objectives and how they were met.**

CHIPRA

This CHIPRA Quality Demonstrative Collaborative with CMS, the Center for Health Care Strategies and Georgia, Maryland and Wyoming sought to improve the health and social outcomes for children in Medicaid/CHIP with serious emotional disturbance (SED) by implementing and/or expanding a Care Management Entity (CME) approach to improve the quality and better control the cost of care for children who are enrolled in Medicaid or CHIP. Through the implementation or expansion of a CME provider model, the Collaborative sought to reduce use of residential treatment facilities through improving community-based capacity and demonstrate:

- Improved clinical and functional outcomes
- Improved access to home- and community-based services
- Improved cost outcomes per capita
- Increased resiliency for youth and families

Core Functions of a CME include:

- Provision of intensive care coordination (at low ratios) using the wraparound practice model
- Facilitation of child and family team meetings
- Management of a plan of care

- Access to home- and community-based services and supports, including:
  - Family and youth peer support
  - Mobile crisis response and stabilization
  - Other professional and natural supports (e.g., intensive in-home services, individual therapy, expressive therapies, mentoring)

Maryland – 1915(i) Intensive Behavioral Health Services for Children, Youth and Families
Draft and led the development of a Medicaid State Plan amendment (SPA) with to convert a time-limited demonstration project used a special authority granted by the federal government under Section 1915(c) of the Social Security Act to provide home and community-based services for children and youth with emotional disturbances to reduce reliance on psychiatric residential treatment and acute care facilities. Using qualitative and quantitative data, the 1915(i) was designed to sustain and refine the initial approach by developing service descriptions, rates, regulations and policy to provide Intensive In-Home Services, mobile Crisis Response Services, Community-Based Respite Care, Out-of-Home Respite Care, Family Peer Support, Expressive and Experiential Behavioral Services, and Customized Goods & Services for qualifying children. See https://mmcp.health.maryland.gov/pages/1915(i)-Intensive-Behavioral-Health-Services-for-Children,-Youth-and-Families.aspx.

Maryland – 1945 Health Home State Plan Amendment
Draft and led the development of Health Home SPA to target children, youth, and young adults with serious emotional disturbance, serious mental illness, and/or opioid substance use disorder to improve health outcomes and reduce reliance on residential and acute care.
Services were developed to enhance person-centered care while reducing avoidable hospital encounters included comprehensive care management, comprehensive transition care, care coordination, individual and family support, health promotion, and referral to community and social support services. In addition to designing training and guidance, the approach included substantial partnership with the Chesapeake Regional Information System for our Patients (CRISP), as well as an eMedicaid online portal, to provide data on real-time hospital encounter alerts and pharmacy use data. See https://mmcp.health.maryland.gov/Pages/Health-Homes.aspx.

4.3.1.3. Experience in providing SME services to state or federal agencies related to continuous quality improvement and quantitative and qualitative data analysis

As demonstrated in the project table above and more fully described below, the UMB Team has extensive experience and expertise in providing SME services to state or federal agencies related to continuous quality improvement and quantitative and qualitative data analysis. **Project descriptions include relevant project goals and objectives and how they were met.**

Maryland – Quality Assurance (QA)/Continuous Quality Improvement (CQI) Process Revised in 2011 based on findings from RYC research, the QA/CQI Process is designed to assess and evaluate the practices and policies of the Local Department of Social Services (LDSS) based on the child welfare indicators of children's safety, well-being, and permanence. The QA/CQI Process assesses five program assignments within the child welfare system:

- Investigations

- In-Home Services
- Out of Home Services
- Adoptions
- Resources Homes

The QA/CQI Process determines gaps among services, sets expected performance and outcomes, and identifies actual performance and outcomes. In collaboration with Maryland DHS, each jurisdiction completes the QA/CQI process every three years. The CQI Process is composed of three main parts:

- LDSS Self-Assessment
- DHR/SSA Quality Assessment (QA) Review
- Continuous Quality Improvement Plan (CIP)

The QA Process also uses the Results Accountability RA framework to report and track data on selected Child Welfare indicators. The framework is structured around these four questions:

- How well did we do?
- How well did we do it?
- Is anyone better off?
- The "Story behind the data"

Prior to an on-site review, each jurisdiction completes a self-assessment on their agency. This report is data driven and requires six different sections:

- Description of the Jurisdiction
- Description of the LDSS
- Stakeholder Focus/Work Groups
- Result Of the Citizen's Review Board for Children (CRBC) Review
- Analysis of CQI Indicator Data and designation of Areas of Strength and Areas Needing Improvement.
- Additional Areas of Discussion

The self-assessment needs to be approved by DHS before the on- site visit can occur.
DHR/SSA Quality Assessment (QA) Review: Prior to the onsite visit, a case review is conduct on a random sample of 30 cases, 10 cases from each program assignments (In-Home, Out of Home, CPS). During the four day on-site review, case related and stakeholder interviews are conducted. Both qualitative and quantitative data from the interviews are used in the On-Site Report.
Continuous Quality Improvement Plan (CIP): Based on data from the Results Accountability indicators, the Self-Assessment and the On-Site Report, the jurisdiction' strengths and areas needing improvement (ANI) are identified. Once identified, a Continuous Quality Improvement Plan (CIP) is compiled to show how the jurisdiction will maintain their strengths or improve on their ANIs. Once the CIP is approved by DHR, continuous 6 month monitoring occurs for each jurisdiction.

CMS Medicaid Innovation Accelerator Program

The goal of the Medicaid Innovation Accelerator Program (IAP) is to improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms through targeted technical support. The Medicaid IAP represents CMS's unique commitment to support state Medicaid agency efforts toward system-wide payment reform and delivery system innovation. Objectives include the provision of direct technical assistance (TA) to states across several CMS priority areas, including SUD, related to:

- Development and implementation of states' SUD waiver demonstrations, behavioral health

payment models, and analytic tools to monitor care quality
- Design, implementation, and evaluation of system-wide payment and delivery system innovations

Direct work with state Medicaid authorities to build or enhance their data analytic capacity related to SUD including use of data metrics, analysis and development of SUD specific data dashboards.

Prince George's County, MD

Developed a Behavioral Health System Needs Assessment, Gap Analysis, and Action Plan to improve community-based behavioral health care delivery while reducing reliance on hospital and residential treatment and recapturing cost-savings to bolster prevention and evidence-based services. Conducted extensive qualitative and quantitative review of county-level health data, including utilization trends, provider inventory and workforce capacity, infrastructure, policies, quality monitoring and oversight, key informant interviews, and data measures to produce short-, medium-, and long-term recommendations.

4.3.1.4. Experience in providing SME services to state or federal agencies related to the following community-based services: Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment

As demonstrated in the project table above and more fully described below, the UMB Team has extensive experience and expertise in providing SME services to state or federal agencies related to the following community-based services: Wraparound Facilitation, Behavioral Support Services, Children's Mobile Crisis Response, Therapeutic Foster Family Care, and Assertive Community Treatment. **Project descriptions include relevant project goals and objectives and how they were met.**

National Wraparound Implementation Center (NWIC)

Support states, communities, and organizations to implement Wraparound as part of broader health reform strategies by focusing on research-based drivers of implementation. Focus is on three main areas of implementation: 1) Organizational and System Development; 2) Workforce Development; and 3) Accountability. NWIC uses innovative approaches grounded in implementation science and spanning the policy, financing, evaluation, and workforce development areas to comprehensively support implementation and build sustainable local capacity to provide high-quality Wraparound. NWIC provides intensive and individualized support focused on building sustainable local capacity to provide model-adherent, high-quality Wraparound. NWIC works with states and sites at any stage of implementation, from initial planning to established initiatives, using an integrated, tailored, and intensive approach to implementation support. NWIC uses a strategic combination of in-person and technology- enabled strategies. NWIC's expanding array of technology-enabled communication options include telephone and video conferencing, a virtual training center, the Virtual Coaching Platform (VCP), and web-based implementation fidelity tracking systems.

Ohio

Provide technical assistance to the States multi-agency child system reforms including developing a blended funding and service delivery approach across agencies to meet the needs of youth with SED

involved in child welfare and juvenile justice. Using qualitative and quantitative data, develop and implement changes to OHs Medicaid program, and align with OHs child welfare Family First Prevention and Services Act plan including developing service descriptions, rates, regulations and policy to provide services, financing strategies, and changes to relevant state plan and Medicaid authorities.

Texas

Operate the Texas Center as a center of excellence to support state and local child- and family-serving systems and organizations with the design, implementation, and sustainability of high quality, effective behavioral health services and supports for children, youth, young adults, and their families. In partnership with the Youth Empowerment Services (YES) 1915c waiver, the primary effort is to provide continuous quality improvement, policy, financing, research and evaluation, and workforce development expertise to support installation of Wraparound across Texas.
The Texas Center leverages national, state, and local expertise to support innovations in children's behavioral health service delivery systems, inclusive of collaborations within child welfare, juvenile justice, education, Medicaid, and managed care organizations. As a center of excellence, The Texas Center provides:

- Implementation support for evidence-based and promising practice
- Research, evaluation, and data linking expertise
- Concrete strategies to engage partners and enhance collaboration
- Strategic planning and policy and financing expertise
- Workforce development strategies to support successful and sustainable implementation and maintenance of effective home- and community-based services and supports

4.3.1.5. Experience in providing SME services to state or federal agencies related to the delivery, design, and/or implementation of the prevention services in the child welfare system

As demonstrated in the project table above and more fully described below, the UMB Team has extensive experience and expertise in SME services to state or federal agencies related to the delivery, design, and/or implementation of the prevention services in the child welfare system. **Project descriptions include relevant project goals and objectives were and how they were met.**

National Center on Evidence-Based Practices in Child Welfare

In partnership with the Children's Bureau, operate the National Center for Evidence-Based Practice in Child Welfare to build the capacity of child welfare and mental health practitioners to collaboratively assess mental health needs, target treatment to needs, engage youth and families in treatment, monitor progress, and to build capacity of leaders to promote and support effective utilization of evidence-based treatments that help youth and their families achieve safety, permanency, and well-being. The Partnering for Success (PfS) model was developed for training and capacity building and then four sites were selected to test and further develop the model. The sites' child welfare and mental health agency partners received technical assistance and training to enhance their interagency collaboration by jointly participating in a leadership learning series, an implementation team, integrated training, and ongoing transfer of learning. This resulted in a shared knowledge base, as well as common protocols, practices and tools to assess needs, support treatment

and monitor progress. PfS builds capacity in two main areas: a) effective partnership and b) Cognitive Behavioral Therapy+. CBT+, an integrated strategy of cognitive behavioral therapy (CBT) treatments for anxiety, depression, and trauma, as well as parent management training (PMT) for behavior problems. Together, the model addresses the four most common childhood mental health conditions. The effective partnering aspect of the model intends to overcome the long-standing lack of effective policy, program, and practice coordination between the child welfare and mental health systems. The model draws on research-based insights about installing and sustaining evidence-based programs from implementation science.

The National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for Lesbian, Gay, Bisexual, Transgender, Questioning, and Two-Spirit Children and Youth in Foster Care (QIC-LGBTQ2S)

Operate the QIC-LGBTQ2S on behalf of the Children's Bureau (CB) to build knowledge to improve outcomes for LGBTQ2S youth in foster care and improve placement stability, well-being, and permanency of youth with diverse Sexual Orientations, Gender Identities and Expression (SOGIE) in foster care. Identify common misconceptions among the child welfare workforce about children and youth with diverse SOGIE that may contribute to a lack of culturally responsive supports and services. The QIC conducted an extensive QIC-LGBTQ2S Literature Review. In partnership with the CB, selected four Local Implementation Sites. Extensive technical assistance and support is provided to the Local Implementation Sites to identify, select, adapt, implement, and evaluate evidence-based, evidence-informed, and/or promising programs and interventions that address the unique needs of children and youth with diverse SOGIE in foster care. Services, supports, and interventions provided are comprehensive, culturally responsive, trauma-informed, and aimed at enhancing individualized services for children and youth with diverse SOGIE in foster care, the skills and abilities of caregivers of children and youth with diverse SOGIE (foster, kinship, and families of origin), the child welfare workforce, contracted providers, and/or system partners.

Nevada

Support Nevada in the design and implementation of their Family First Prevention Services Act (FFPSA) plan to include:

- Service description and oversight
- Evaluation strategies
- Waiver requests
- Monitoring child safety
- Consultation and coordination
- Child welfare workforce support
- Child welfare workforce training
- Prevention caseloads

Support and technical assistance is provided for project management; work plan development, defining "child who is candidate for foster care" and "imminent risk"; designing and administering service array assessment and selecting services for inclusion in plan; designing rigorous evaluation strategies; determining and addressing workforce development and training needs; assessing congregate care use and determining compliance needs; and developing the prevention services plan. Approach also includes conducting an analysis of cross-agency funding for FFPSA services efficient way of financing them and incorporating federal funding maximization, including Medicaid, and

well as conducting policy and regulatory analyses to determine needed changes to align with service, funding and congregate care approaches.

Maryland – IV-E Waiver

Supported the Maryland Department of Human Services, Social Service Administration (SSA) in the ongoing design and implementation of Maryland's Title IV-E Waiver Demonstration Project by providing technical assistance and expertise to both SSA and local departments of social services (LDSS) to prevent foster care entry; increase permanency; reduce/prevent placement reentry; and, address behavioral health needs of children.
Technical assistance and support included:

- Policy, Implementation, Financing Service Array, and Evaluation Technical Assistance
- Implementation Support and Continuous Quality Improvement for Evidence-Based and Promising Practices being implemented by LDSS (including Functional Family Therapy, Incredible Years, Multisystemic Therapy, Nurturing Parenting Program, and Parent-Child Interaction Therapy);
- Facilitation of statewide breakthrough series & learning collaborative on trauma-responsive interventions & secondary traumatic stress;
- Child & Adolescent Needs and Strengths (CANS) and CANS-F training and coaching statewide to improve meaningful use of assessments;
- Design and implementation of a statewide Integrated Practice Model for all child, youth, family and adult services;
- Statewide service array assessment and gap analysis; and
- Installation and implementation of the START (Sobriety Treatment and Recovery Teams) model in Maryland in 13 LDSS.

Maryland – Child Welfare Accountability Project

Project works on development and implementation of a process to measure the efficiency and effectiveness of Maryland's child welfare services. The services assessed address the safety, permanency, and well-being of children in the care and custody of the state.
The continuous examination of child welfare services in Maryland includes:

- Technical reviews of Maryland DHS processes;
- Consultation on existing quality assurance measures;
- Evaluation of the family centered practice model;
- Foster parents survey for recruitment and retention;
- Analysis of local supervisory review instruments; and,
- Child welfare data available through Maryland's Children's Electronic Social Services Information Exchange system (MDCHESSIE).

4.3.1.6. Experience in working with the Department of Justice and other states with consent decrees or similar arrangements or agreements.

As demonstrated in the project table above and more fully described below, UMB has extensive experience and expertise in working with the Department of Justice and other states with consent decrees or similar arrangements or agreements. **Project descriptions include relevant project goals and objectives and how they were met.**

Washington

Support the goals and of objectives outlined in the T.R. Settlement Agreement, including the statewide implementation of Wraparound with Intensive Services (WISe), including Medicaid and managed care review, RFP development, including sample model contract, quarterly reporting, model coaching plan; addressing rural access and specialized populations.
Provide consultation and technical assistance in the following six (6) areas:

- System Infrastructure -address issues related to Medicaid, behavioral health and state general revenue financing; transitions to HCA and Medicaid agency and health plan processes to support WISe implementation, expansion and quality.
- Evaluation, Quality, Data Metrics and Data Use Plan & Implementation across the System- ongoing effort to utilize current robust data, new training and coaching workforce data to promote quality and system improvement.
- Specialized Populations- identification and implementation of strategies to support needs of high priority underserved populations including but not limited to co-occurring mental health and developmental disabilities, youth experiencing homelessness, LGBTQIA, emerging adults, and co-occurring SUD including research, identification of best practice examples, review/development of policies, quality metrics, training to support underserved populations.
- System Partnerships & System Level Coaching Infrastructure- system level partnerships with sister agencies including coordination, policy and protocol issues; and system level coaching needs to advance policy infrastructure.
- System level coaching-support DBHR/HCA staff in system level coaching plan development and implementation to address policy, youth and families.
- Work onsite with state staff on performance tasks related to objectives outlined in the T.R. Settlement Agreement, including the statewide implementation of Wraparound with Intensive Services (WISe).

Alabama

Provide system design, financing and implementation to support state EPSDT settlement agreement including deign, rate setting and workforce development to implement five new services; provide training and coaching, and support quality. Provide expert feedback on consent decree compliance, implementation of new services, develop and implement a statewide training and coaching plan for five new services, develop a state specific training and coaching capacity to sustain efforts, develop a quality management approach to ensure the availability of meaningful metrics to guide decision-making.

Illinois - Olmstead

Developed a 1915(c) home- and community-based waiver in response to the Williams v. Quinn Consent Decree. Provided technical assistance to the Department of Human Services, Division of Mental Health to develop new and strengthen existing Medicaid-reimbursable services (including, but not limited to mental health crisis treatment, assertive community treatment, illness management/self-management, supported employment, and peer support) needed to successfully transition residents out of Institutions for Mental Disease (IMDs) and into integrated community-based setting appropriate to their individual needs.

Illinois - EPSDT

Assist the Subject Matter Expert (SME) to provide technical assistance to the States Implementation Plan in response to Ilinois' Consent Decree including system design, financing, quality indicators, and workforce needs. Provide input and specific written recommendations regarding the Consent Decree Implementation Plan. Provide technical assistance and recommendations regarding changes in MCO contracts and state monitoring efforts. Provide technical assistance and recommendations regarding an initial network development plan for key services in the Consent Decree. Provide technical assistance and recommendations regarding initial indicators for tracking state's progress regarding the roll out of the network.

Los Angeles, California

Conducted Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Assessment per State and County *Katie A.* Settlement Agreement. Provided technical assistance to the Department of Mental Health in evaluating current EPSDT claiming guidelines and practices in relation to the California Department of Health Care Services (DHCS) State Plan and All County Information Notices (ACINs) in order to identify necessary changes to the guidance provided by DMH with the goal of increasing Medicaid claiming of EPSDT for specialty mental health services provided by the Department or its contract agencies to eligible children, with particular attention paid to services associated with State and County *Katie A.* Settlement Agreements including intensive care coordination and intensive home-based services.

Mississippi

In support of a DOJ settlement agreement to resolve DOJ's claims relating to services for children with mental health conditions, completed an assessment of the state's children's behavioral health system, to include a review of Medicaid fee for service claims data comparing institutional services vs. home and community based services for children's and youth's behavioral health. Information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Medicaid and DMH participant characteristics, claims, and encounters; and 2) An in-depth qualitative analysis of all relevant documents, selected records of youth's care and interviews with stakeholders, youth and adult consumers, family members, associations, advocacy groups, and state personnel. Specific methods included:

- Analysis of populations served, service utilization, Medicaid claims and expenditures, quality data, and other system indicators from DMH;
- Review of one hundred two (102) state documents;
- Review of eighteen (18) client records; and,
- Discussions with two hundred eighteen (218) key informants.

4.3.2. Mandatory Qualification/Experience Requirements

As set forth in SME Skill Matrix, below, and described more fully in the bios that follow, the **UMB Team exceeds the mandatory qualifications and demonstrates superior knowledge and proficiency with children's community-based mental health services, Medicaid and child welfare systems. Mandatory 4.3.2.1, 4.3.2.2 and 4.3.2.3 qualifications are included in Table 4.**

Table 4 – SME Skill Matrix

Mandatory Qualifications	SME: Suzanne Fields, MSW	SME: Melissa Schober, MPM	SME Pool: Chris Bellonci, MD	Total SME Pool
4.3.2.1. Master's degree in an area related to the subject matter of the Agreement (e.g., social work, psychology, psychiatry, public health, or public administration)	X	X	MD	X
4.3.2.2. Experience in working with vulnerable populations, including children or families living in economically challenged and rural geographical areas (minimum five years)	X	X	X	X
4.3.2.3. Experience in public policy or the administration of behavioral health or child welfare service systems, or both (minimum five years)	X	X	X	X
4.3.1.1. Delivery, design, and/or implementation of community-based children mental health services	X	X	X	X
4.3.1.2. Reducing the reliance on residential treatment facilities for children with serious emotional or behavioral disorders or disturbances	X	X	X	X
4.3.1.3. Continuous quality improvement and quantitative and qualitative data analysis	X	X	X	X
4.3.1.4. Wraparound Facilitation Service	X	X		X
4.3.1.4. Behavioral Support Services	X	X	X	X
4.3.1.4. Children's Mobile Crisis Response	X	X	X	X
4.3.1.4. Therapeutic Foster Family Care	X			X
4.3.1.4. Assertive Community Treatment	X			X
4.3.1.5. Delivery, design, and/or implementation of the prevention services in the child welfare system	X	X	X	X
4.3.1.6. Experience working with the Department of Justice and other states with consent decrees or similar arrangements or agreement	X	X	X	X
Agencies Requiring Partnership/ Cooperation per RFP Section 4.1				
Bureau for Children and Families/ child protective services, foster care, and adoption	X		X	X
Bureau for Behavioral Health/ mental health and substance use disorder, intellectual and developmental disabilities prevention, treatment, and recovery services	X	X	X	X
Bureau for Medical Services/Medicaid	X	X	X	X
Bureau for Public Health/ state public health authority, data collection and analysis	X	X	X	X
Department of Education/state education authority	X	X	X	X
Department Military Affairs and Public Safety/juvenile services		X	X	X
Other Essential Experience and Expertise Identified by UMB per Background and Terms of Agreement				
Olmstead	X			X
Medicaid including EPSDT	X	X	X	X
Title IV-E	X	X	X	X
Cross-System Financing	X	X	X	X
Blended/Braided Financing	X	X		X

Trauma-Informed Services	X	X	X	X
Family-Driven Care	X	X	X	X
Youth-Guided Care	X	X	X	X
Cultural and Linguistic Competence			X	X
Strength-Based Approach and Services	X	X	X	X
Evidence-Based Services	X	X	X	X
Screening and Assessment	X	X	X	X
CANS	X		X	X
Data Dashboards	X	X	X	X
Workforce Development	X		X	X
Implementation Science	X	X	X	X
Outreach and Education of Stakeholders	X	X	X	X
Quality	X	X	X	X
Community/Provider engagement	X	X	X	X
Strategic planning	X	X	X	X
Rural Strategies	X	X		X
Substance Use Disorders	X	X	X	X
Housing/Homelessness	X		X	X
Psychiatry			X	X

SME Bios

Suzanne Fields, MSW

Suzanne Fields, MSW, is a clinical social worker with 25 years of experience. Her work has spanned multiple settings including Medicaid, managed care, mental health and substance use, child and adult services, and child welfare. Currently, Ms Fields is Faculty and the Senior Advisor for Health Care Policy and Financing at the University of Maryland, School of Social Works Institute for Innovation and Implementation. She also provides consultation and coaching to states involved in the Centers for Medicare and Medicaid's Innovation Accelerator Program. Previously, she served as the Senior Advisor to the Administrator for Health Care Financing with the Substance Abuse and Mental Health Services Administration. In that role, she was responsible for leading the agency's work on the Affordable Care Act and Mental Health Parity and Addictions Equity Act, including policy, financing, regulations, federal and state implementation, and collaboration with federal partners. Prior to joining SAMHSA, Ms. Fields worked for the Technical Assistance Collaborative (TAC), a national nonprofit consulting firm. In that role, she assisted states in numerous Medicaid, managed care, mental health and substance use disorder efforts, Olmstead and EPSDT related agreements, dissemination of best practices, cross system financing, system design and delivery, and quality initiatives. Prior to joining TAC, Ms. Fields was director of the Office of Behavioral Health for Massachusetts Medicaid, where she was responsible for the purchasing, delivery, and quality of mental health and substance use disorder services for adult and child Medicaid beneficiaries through fee for service, integrated managed care plans and specialty behavioral health organizations. Additionally, Ms. Fields was responsible for the service design and implementation of best practice services for children and youth under the Rosie D. EPSDT lawsuit.

Melissa Schober, MPM

Melissa Schober, MPM, is a Senior Policy Analyst for the Institute for Innovation and Implementation at the University of Maryland School of Social Work. Ms. Schober has more than 10 years experience in health policy including policy and regulatory design and implementation; public health advocacy; and the provision of technical assistance to managed care organizations, state Medicaid agencies, provider associations, and family-led organizations. Ms. Schober has worked with states to develop Section 1945 Health Homes, 1915(i) state plan amendments, and 1915(b) and (c) waivers to expand the delivery of evidence-based behavioral health services to children, youth, and their families. Prior to joining the University of Maryland, Ms. Schober was a senior consultant at Health Management Associates in Washington, DC. Her other past positions include serving as the Director, Office of School Health, at the Maryland Department of Health where she was responsible for improving the health of all school-aged children by strategically integrating public health activities carried out in school settings with ongoing statewide delivery system reforms. From 2010-2014, she served as Director of Medicaid Policy for the Maryland Mental Hygiene Administration (now Behavioral Health Administration) where she focused on expanding access to publicly funded mental health, integrating mental health and substance use services, and on increasing care coordination for individuals with chronic conditions.

SME Pool

As part of NTTAC, UMB operates a large partner network and consultant pool to address the needs of over 90 grantees as well as to be able to respond to needs of communities, states, tribes and territories without SAMHSA awards. UMB will have the ability to draw upon the expertise of the TA Network expert pool, as needed, to support the Agency in addressing needs identified in the Implementation Plan and semi-annual assessment and comprehensive reports, to include our Intensive In-Home Behavioral Treatment (IIBHT) experts involved in the above-described research. UMB's TA Network partners and consultants span the nation with expertise that includes, but is not limited to, primary prevention; child welfare (including child protection, foster care, permanency, adoption, guardianship, foster parent recruitment and training, IV-E, IV-B, TANF, CFSR); Medicaid; mental health; substance use; juvenile justice, education; housing; early childhood; youth-in-transition; residential treatment; trauma; workforce training and adult learning; screening and assessment tools; use of data and predictive analytics; policy and financing; home and community based services; evidence-based practices; family and youth engagement and leadership; cultural and linguistic competence; rural and tribal considerations; LGBTQ youth; pregnant and parenting youth; substance-exposed newborns; caregivers with substance misuse disorders; commercial exploitation and sex trafficking; implementation science; continuous quality improvement; change management; and capacity building.

In addition to the broad array of expertise available through UMB's TA Network, UMB is a public health, law, and human services university dedicated to excellence in education, research, clinical care, and public service. It is comprised of six professional schools – dentistry, law, medicine, nursing, pharmacy, and social work – as well as an interdisciplinary graduate school, and is a thriving academic health center combining cutting-edge research and exceptional client care. Across the University, there is a diverse array of national experts that can be drawn upon that is inclusive of child development; pediatric physical and mental health; pediatric psychiatric care and treatment; pediatric pharmacoepidemiology and psychotropic medication usage and outcomes in children and

youth; child and family legal support; early childhood mental health; substance exposed newborns; all child and family serving systems, inclusive of child welfare, juvenile justice, and education; child and family program evaluation and research; and all areas of social service provision, including an emphasis on cross-system work and care coordination. Additionally, our School of Medicine operates the National Center for School Mental Health (NCSMH), a technical assistance and training center with a focus on advancing research, training, policy, and practice in school mental health. It is anticipated that the NCSMH will be valuable resource and part of our SME team.

The bios for a non-exhaustive list of SMEs we anticipate engaging for this work, including Dr. Bellonci and Dr. Shaw, are listed below.

Christopher Bellonci, MD

Dr. Bellonci brings 25+ years of experience as a Board Certified Child, Adolescent and Adult Psychiatrist working directly with children and families in outpatient, inpatient and residential settings. He has consulted with state and federal child welfare and mental health agencies helping those agencies develop best practices and service systems to identify, prevent, treat and support children with behavioral health needs and their families. His expertise has led to Congressional testimony and recently advising the Senate Finance Committee regarding the Family First Prevention Services Act. Dr. Bellonci is a leader in the field of children's mental health best practices. He serves on the American Academy of Child and Adolescent Psychiatry's (AACAP) Quality Issues Committee responsible for developing the field's clinical practice guidelines defining best practices in treating behavioral health conditions. He also serves on AACAP's Community-based Systems of Care Committee. Dr. Bellonci has led or participated in numerous quality collaboratives and training and technical assistance initiatives. He currently serves as the Medical Director of the National Training and Technical Assistance Network for Children's Behavioral Health funded by SAMHSA. He is a clinical consultant to a Children's Bureau Quality Improvement Collaborative developing best practices to support LGBTQ youth in the child welfare system. He is leading a nine site national quality collaborative developing best practices for the use of psychotropic medications in residential treatment settings. Dr. Bellonci is an Adjunct Associate Professor at Tufts University School of Medicine and Vice President of Policy and Practice/Chief Medical Officer at Judge Baker Children's Center. He has several research initiatives underway including a practice parameter on deprescribing in child psychiatry and a systematic review of polypharmacy trials for children. Dr. Bellonci has worked with states such as Tennessee in their response to a settlement in a class-action lawsuit in the state's Child Welfare agency which successfully led to the state exiting the lawsuit. He has presented on his work to ensure appropriate prescribing of psychotropic medications at an Annie E. Casey Foundation conference held in West Virginia. As past President of the Association of Children's Residential Centers (ACRC), he knows many of the residential providers serving youth in West Virginia and supports their developing a full range of community-based alternatives to residential interventions consistent with the Building Bridges Initiative of which he was a founding participant.

Terry V. Shaw, MSW, Ph.D, MPH

Dr. Shaw is the Director of the Ruth H, Young Center for Families and Children and an Associate Professor at the SSW. Dr. Shaw's background and expertise is in leveraging existing administrative data systems to improve state policy and practice related to child and family health. His focus is on examining the pathways into and through child serving systems focusing on opportunities for state

systems to collaborate, understand service overlaps, improve overall service delivery and address the multiple needs of the children and families involved with these systems (including child, youth and family physical and mental health; surveillance of psychotropic medication use; pathways to permanency; educational access; interactions between the court and child welfare services, and child maltreatment prevention). Dr. Shaw has over two decades of experience and expertise in developing the infrastructure, relationships and programming structure to successfully implement multi-agency data linking systems (having instituted data linking projects in South Carolina, California, and Maryland). I have expertise in advanced statistical methods and extensive experience utilizing longitudinal data systems to answer questions related to service outcomes to inform policy and practice.

Haksoon Ahn, PhD

Dr. Ahn's research has focused on the impact of child welfare policy and services with the goal of improving the well-being of vulnerable children and families. To this end, her research examines children and families at multiple levels and uses a variety of methods with the aim of improving child welfare policy, practice, and outcomes. She has conducted evaluations of child and family welfare policies and services on state, national, and international levels, and has integrated them into all aspects of my research and scholarship, teaching, and service. The funded projects include an evaluation of effectiveness and efficiency of child protection services to respond to child abuse and neglect, Continuous Quality Improvement in Child Welfare Policy and Practice, Federal Children and Families Services Review, Family Centered Practice, and Recruitments and Retention of Foster Parents. Prior to joining the University of Maryland, Dr. Ahn worked at the Economic Policy Institute in Washington, D.C. as a Research Economist.

Margo Candelaria, PhD

Dr. Candelaria has significant evaluation as well as clinical and training expertise in Infant and Early Childhood Mental Health (IECMH) screening, diagnosis, assessment, EBP implementation and CQI, and systems development across multiple community systems. She has worked with young children and families in medical systems, community mental health agencies, early intervention agencies, and Head Start/Early Head Start (as a consultant). She also has a history of working in the NICU and Growth and Nutrition Clinic with medically fragile and substance exposed infants, and am the current psychologist in the NICU Follow-Program. She participated in the development of the SMART Clinic in Carroll County Maryland focusing on building a developmental clinic to serve children with behavioral and developmental needs and their families, including creating a network of providers to server families and tracking referral and assessment processes and outcomes. Additionally, she currently oversees all evaluation efforts for two SAMHSA funded IECMH SOC grants (BRIDGE and E-SMART), two programs focused on implementation and evaluation of programing for pregnant and parenting at-risk youth (HHS pregnancy Assistance Fund and SAMHSA funded TREE grant), and a locally funded intervention with the Maryland Academy of Pediatrics in pediatric primary care, training providers on promoting parent-infant interactions. In addition, she also served as the evaluation PI for the prior Maryland LAUNCH program for the last three years of the project. Across all these projects, she has focused on program evaluation and implementation science aimed to improve programs for families with young children by using data and engaging in CQI processes.

Susan dosReis, PhD

Dr. dosReis' clinical training and research expertise span the fields of pharmacy practice, pharmacoepidemiology methods for drug utilization, safety, and outcomes research, patient-centered outcomes research, and quantitative and qualitative (mixed) research methods. Federally-funded research grants through the National Institute of Mental Health and the Patient Centered Outcomes Research Institute have allowed her to build a foundation of research on psychotropic medication use among children and adolescents. Over the past 20 years, she has developed a program of pediatric pharmacoepidemiology and outcomes research, with publications addressing health system and patient- and family-centered factors that affect psychotropic use for youth treated in community outpatient settings. Her research on psychotropic medication use for children and adolescents has addressed the growing national interest on youth in foster care and has been cited in the New York Times. Collaboration with child-serving agencies has provided an opportunity to integrate large administrative data from individual agencies to assess outcomes for youth treated with psychotropic medication. She accomplished this in naturalistic, quasi-experimental studies using innovative designs and advanced statistical methods to control for confounding. She has expertise in stated preference methods using best worst scaling and discrete choice experiments to evaluate trade-offs in decision making with regard to stimulant and antipsychotic medication for youth. She is applying novel methods to better understand disparities in treatment decisions from a variety of patient groups, and in particular the underserved communities.

Deborah Harburger, MSW

Ms. Harburger is a Clinical Instructor and Co-Director of the Maryland Center at The Institute for Innovation & Implementation at the University of Maryland School of Social Work. A trained Title IV-E public child welfare social worker with more than a decade of experience in public child- and family-serving systems, Ms. Harburger has knowledge of financing for behavioral health (including Medicaid and child welfare financing), systems of care, and the intersection of child welfare and homelessness. Her focus is on sustainable financing and the use of high quality, effective, and less costly home- and community-based services and supports. Ms. Harburger has experience serving as Project Director of two Centers for Medicare & Medicaid Services-funded demonstration projects as well as two Children's Bureau-funded grants. She has experience in providing individualized technical assistance, implementation design and support, strategic planning and policy and financing analysis with state and local child welfare and behavioral health organizations and family support organizations. She has particular expertise in the areas of older youth in foster care, youth aging out of foster care and the intersection with homelessness, sustainable financing for home- and community-based services, and interagency initiatives. She also oversees The Institute's policy and financing work in Maryland.

Brooke Kearley, PhD

Dr. Kearley is a Research Assistant Professor at the University of Maryland School of Social Work and research faculty at The Institute for Innovation and Implementation. She was a dissertation fellow of the National Institute of Justice and received her Ph.D. in Criminology and Criminal Justice from the University of Maryland in 2017. Dr. Kearley's research interests include criminal and juvenile justice policy and program evaluation with a focus on substance use and delinquency prevention and intervention programs. She has expertise in quantitative and experimental methods, with over 15 years' experience managing randomized field trials and multi-site evaluations. Dr. Kearley is currently Principal Investigator of a long term follow up of a randomized controlled trial

of Functional Family Therapy for gang at risk and gang involved youth as well as an evaluation of a local Family Recovery Court. Her recent research has appeared in Prevention Science and Criminology and Public Policy.

Jill Farrell, PhD

Dr. Farrell is a Research Assistant Professor at the University of Maryland School of Social Work and research faculty for The Institute for Innovation and Implementation where she conducts research and provides technical assistance in the development and implementation of a statewide evidence-based case management model for the Maryland Department of Juvenile Services and serves as the lead evaluator for several evidence-based programs implemented with children, youth, and families in Maryland. Dr. Farrell is also a Co-Investigator for a statewide multi-agency data collaborative that focuses on linking and leveraging administrative data systems to improve policy and practice. Prior to joining the School of Social Work, Dr. Farrell conducted applied policy research at the University of Maryland's Innovations Institute, the Institute for Governmental Service and Research, the Urban Institute, and the Maryland State Commission on Criminal Sentencing Policy.

Elizabeth Manley, MSW

Ms. Manley is a Clinical Instructor for Health and Behavioral Health Policy at the Institute for Innovation and Implementation. In this capacity, Ms. Manley provides technical assistance to states and communities specific to children's behavioral health innovations with a specific focus on policy, financing and development of service array within a of systems of care. Ms. Manley is the former Assistant Commissioner for NJ's Children's System of Care. In this capacity, Ms. Manley led transformation and implementation of system innovations including integrating individuals with developmental/intellectual disabilities, substance use and integration of physical health into the Children's System of Care. She had direct oversight of the statewide child behavioral health, substance use and development/intellectual disabilities systems. This includes a wide range of home and community-based services, outpatient and residential interventions. Ms. Manley was the DCF representative on the NJ Board of Social Work Examiners and the Governor's Council on Alcohol and Drug Abuse; the Principal Investigator on NJ's Promising Path to Success, a SAMHSA System of Care Expansion Grant with the focus on improving care for youth in need of an residential intervention; Vice Chair of the National Association of State Mental Health Program Directors (NASMHPD); and has presented at several national conferences. Prior to joining DCF Ms. Manley was the CEO of Caring Partners of Morris/Sussex, Inc., a Care Management Organization (CMO) specializing in working with youth with complex behavioral health challenges. Ms. Manley worked for Capitol County Children's Collaboration, the Mercer County CMO, as the Director of Operations, at the time of its inception in 2002. She came to that position after spending 15 years at SERV Behavioral Health, in various positions with her final position at SERV as the Director of Children's Services for SERV Behavioral Health with oversight of residential interventions and partial care services for youth with complex behavioral health needs.

Shannon Robshaw, MSW

Ms. Robshaw has over twenty-five years of experience in state government and non-profit executive leadership positions focusing on policy and system reform to improve mental health and health service delivery systems. Since joining the TA Network for Children's Behavioral

Health, University of Maryland in October 2013, Ms. Robshaw has provided a range of technical assistance to more than 14 state level system of care grantees and 20 local community grantees, and now serves as a trainer/coach for the National Wraparound Implementation Center. Ms. Robshaw has also served as faculty for TA Network hosted meetings on Integrated Care, Innovations in Medicaid Managed Care and Financing Systems of Care, and at the National Wraparound Implementation Academy. She has contributed to the production of array of educational publications and briefing documents from the TA Network. She most recently served as Executive Director of the Continuum of Care in the South Carolina Governor's Office, whose mission is to provide care coordination services for the state's children and youth with the most serious and complex behavioral health disorders. She also served on multi-agency Leadership Team developing South Carolina's statewide Palmetto Coordinated System of Care (CSoC) She served as the Director of the Louisiana Coordinated System of Care and led planning and start-up efforts for the Governor's cross-departmental initiative to build a new service delivery system for children and youth at risk of out of home placements. Ms. Robshaw also managed a broad-based planning process which resulted in the development of the system design, service array and operational structure for the Louisiana CSoC, as well as financing strategies including Medicaid waivers and state plan amendments necessary to leverage funds in support of CSoC implementation. Past service as the Executive Director of the Louisiana Health Care Quality Forum, an Executive Management Officer in the Office of the Secretary of the Louisiana Department of Health and Hospitals and as the Executive Director of the Mental Health Association in Louisiana.

Dayana Simons, MEd

Ms. Simons has over 28 years of experience in policy and service design, development, and implementation; contract and project management; Medicaid and public sector managed care; and the provision of technical assistance. She currently serves as an SME for the EPSDT consent decree in Illinois. Additionally, as part of the core leadership team for the TA, she co-leads and manages a national Quality Collaborative on Improving the Use of Psychotropic Medication for Youth in Residential Treatment Facilities; is responsible for administration of the TA Network's Mobile Response and Stabilization Services Peer Curriculum; and serves as a primary technical assistance resource and coach to 11 System of Care grantee sites across the country. She serves as liaison and adjunct faculty for the Finance and Policy hub; and other responsibilities include development and implementation of quality assurance and improvement processes for material produced by and disseminated by the TA Network. Prior to her current position, Ms. Simons coordinated and managed a multi-year CMS funded multi-state quality collaborative focused on improving cost, quality and coordination of services and supports for children, youth and young adults with serious behavioral health challenges and their families. Past work experience includes management of efforts to improve the mental health delivery system for children involved in the child welfare and juvenile justice systems; and participation in state level re-design of the children's behavioral health service delivery system in response to EPSDT litigation; and providing oversight and monitoring service design and implementation for EPSDT remedy services.

Denise Sulzbach, JD

Ms. Sulzbach currently serves as the Deputy Director of SAMHSA's National Training and Technical Assistance Center for Child, Youth and Family Mental Health. Ms. Sulzbach is

responsible for leadership and oversight to the TA Network. Ms. Sulzbach also serves as the lead for an Interagency Agreement between SAMHSA and the Children's Bureau (CB) with focus on the FFPSA. As part of this work, she leads a group of experts in providing financing, policy and children's behavioral health expertise; serving as a repository for and providing guidance on FFPSA questions; and providing technical assistance on cross-system FFPSA planning and implementation to SAMHSA, the CB and the field. She has over 20 years of experience in program, policy, legal and fiscal analyses of child, youth, and family behavioral health organizations and systems, with specialty in supporting local/state/federal linkages and cross system partnerships. In addition to FFPSA planning and implementation, work has included writing, analyzing and implementing Medicaid waivers and State Plan Amendments; drafting regulations and policy to support reform efforts; conducting financial mapping approaches to help states/localities make data-informed decisions; supporting discussions to blend and braid dollars across systems; identifying funds for use as non-federal Medicaid and other federal program match; and supporting states to conduct data analytics on the needs of children and use that data to inform system design. As a former prosecutor assigned to a child advocacy center, she specialized in child abuse, sexual assault and juvenile law and gained unique expertise in and understanding of the unmet cross system needs of youth with complex behavioral health needs and their families. Other positions include Deputy Secretary at the Maryland Department of Juvenile Services and other high-level Governor appointed positions, including Director of Systems of Care and Interagency Policy at the Governor's Office for Children.

Kate Wasserman, MSW, LCSW-C

At the Institute, Ms. Wasserman oversees program and policy work for all parent, infant and early childhood activities. In this role she leads program development, project oversight, workforce training and policy work related to infant and early childhood mental health (IECMH) efforts including: Pyramid Model training, coaching, and statewide implementation; she serves as the Program Director for an IECMH SAMHSA-funded System of Care grant and consultant for a second SOC grant in our state. She is also the Co-lead for the TA Network's Early Childhood Systems Learning Community; and a statewide consultant and trainer for Maryland State Department of Education funded IECMHC program. Ms. Wasserman is a licensed clinician with extensive IECMH experience and former mental health consultant in Early Head Start and pediatric primary care settings. She has implemented intimate partner violence protocol within pediatrics. She is faculty and curriculum contributor to the UMB School of Medicine IECMH certificate, and has designed and is currently teaching a PIEC SSW course for our school's MSW program. She has a background in public policy, and brings expertise in public health policy, program development, and direct service perspective to projects. She has extensive experience providing and supporting the implementation of evidence-based practices in a range of disciplines that work with families, including home visitors, educators, early intervention providers and primary care as well as specialty care medical providers. She is a National Trainer of the Fussy Baby Network and has trained primary care providers, mental health consultants, and home visitors on trauma-informed, family-focused infant mental health competencies.

NAME Suzanne Fields, MSW	POSITION TITLE Faculty & Senior Advisor for Health Care Financing, University of Maryland School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Northern Illinois University	BA	1991	Psychology
University of Illinois, Urbana-Champaign	MSW	1994	Social Work

Summary of Qualifications

Suzanne Fields, MSW, is a clinical social worker with **25 years of experience**. Her work has spanned multiple settings including Medicaid, managed care, mental health and substance use, child and adult services, and child welfare. Currently, Ms Fields is Faculty and the Senior Advisor for **Health Care Policy and Financing** at the University of Maryland, School of Social Works Institute for Innovation and Implementation. She also provides **consultation and coaching to states involved in the Centers for Medicare and Medicaid's Innovation Accelerator Program**. Previously, she served as the Senior Advisor to the Administrator for Health Care Financing with the Substance Abuse and Mental Health Services Administration (SAMHSA). In that role, she was responsible for leading the agency's work on the **Affordable Care Act and Mental Health Parity and Addictions Equity Act, including policy, financing, regulations, federal and state implementation, and collaboration with federal partners**. Prior to joining SAMHSA, Ms. Fields worked for the Technical Assistance Collaborative (TAC), a national nonprofit consulting firm. In that role, she assisted states in **numerous Medicaid, managed care, mental health and substance use disorder efforts, Olmstead and EPSDT related agreements, dissemination of best practices, cross system financing, system design and delivery, and quality initiatives**. Prior to joining TAC, Ms. Fields was director of the Office of Behavioral Health for Massachusetts Medicaid, where she was responsible for the **purchasing, delivery, and quality** of mental health and substance use disorder services for adult and child Medicaid beneficiaries through fee for service, **integrated managed care plans and specialty behavioral health organizations**. Ms. Fields was also responsible for the service design and implementation of best practice services for children and youth under the Rosie D. **EPSDT** lawsuit.

Professional Positions

Faculty & Senior Advisor for Health Care Financing, School of Social Work, University of Maryland,
Baltimore, MD, 2014-present
Key accomplishments:

- Assist the School of Social Work in the development of curricula to address health financing; support policy research related to the financing and service delivery of public sector systems including behavioral health, health integration, Medicaid, managed care and child welfare.
- Convene expert panels addressing research and policy priorities addressing health integration, care coordination, quality, and financing and implementation strategies in Medicaid and managed care.

- Convene Medicaid Policy Academy's for state Medicaid and behavioral health authorities to address improvements in behavioral health systems through managed care approaches.
- Consultation to numerous states including Washington, Alabama, Ohio, California, Idaho, Utah, Mississippi, Alabama, Delaware, Georgia, Hawaii, Illinois, Connecticut, South Carolina, New Mexico, New York, Maine, Nevada, and Louisiana on Medicaid, system design, financing, quality measurement, managed care, implementation, children's services.
- Consultation to SAMHSA on MHPAEA, Coordinated Community Behavioral Health Clinics Demonstration, value-based purchasing, Medicaid authorities, and health homes.

Private Consultant, Baltimore, MD, 2014-present
Key accomplishments:

- Provide technical assistance to states pursuing Medicaid 1115 waivers to address SUD
- Provide consultation and coaching to state Medicaid authorities participating in the CMS IAP for SUD including coaching to states on state specific action plans, development and dissemination of curriculum and learning materials, and development and moderating of national webinars. Focused on state plan and waiver opportunities, data analytics, and development of data dashboards.
- Provide consultation support to the CMS Team on the development of the PMH learning content and technical assistance approach to states.
- Provide consultation and support to CMS and its contractor regarding development of an IAP track to address the needs of persons with sever and persistent mental illness
- Provided technical assistance to SAMHSA and participating state Medicaid authorities on MHPAEA, and worked directly with states to conduct parity analyses, and implement any required program changes to comply with MHPAEA.

Senior Advisor to the Administrator for Health Care Financing
Key accomplishments:

- Effectively advised the Administrator on current mental health and substance use related issues and policies; and represented the Administrator to other federal agencies and external organizations to ensure her positions, concerns, and issues are appropriately represented.
- Led inter-agency and intra-agency workgroups to promote budget, policy and program initiatives on behavioral health, financing, managed care, dually-eligible and health integration issues.
- Led technical assistance review teams for the states and other purchasers including health home consultation in concert with CMS, Innovations Grants from the Center for Medicare and Medicaid Innovation, and health reform related regulatory activities with other federal agencies.
- Led SAMHSA's national eligibility and enrollment campaign to support access to insurance affordability options for persons with behavioral health conditions.
- Led development of numerous briefs and toolkits including the Medicaid Handbook, Assessing the Evidence, Behavioral Health Needs Assessment, and Best Practices in Managed Care for Behavioral Health. Partnered with CMS to develop several informational bulletins.

Senior Consultant, Technical Assistance Collaborative, Boston, MA 2010-2012
Key accomplishments:

- State of California 1115 waiver needs assessment on behavioral health
- State of Delaware needs assessment on children's behavioral health
- State of New York on design of a managed care delivery system for children's services
- State of New Mexico on health home implementation, Medicaid financing, and managed care procurement
- State of Montana children's mental health reform effort including PRTF waiver, 1915(i), and service system implementation
- State of Connecticut Medicaid Home and Community based 1915(c) waivers for persons with developmental disabilities
- State of Illinois Olmstead related Williams settlement agreement to develop HCBS services
- Contributed to ASPE policy paper on funding to advance supported employment with Medicaid
- Consultant to the State of Washington on an EPSDT settlement agreement
- Consultant to Legal Action Center on Medicaid and health reform
- Consultant to the Annie E Casey Foundation on Medicaid and health reform

Executive Office of Health and Human Services, State of MA, Boston, MA, 2007-2010
Director of the Office of Behavioral Health for Medicaid (MassHealth)
Key accomplishments:

- Successfully developed and implemented services to remedy EPSDT (Rosie D) class action lawsuit ensuring that the state met court ordered timelines, including development of the state plan, negotiating the state plan with CMS, and designing the benefit package, service requirements, rate-setting parameters and provider qualifications
- Procured Medicaid managed care organizations to serve enrollees
- Readied strategic models to integrate behavioral health in state planning for dual eligibles and for procurement of care management organization

Select National Webinars, Peer-Reviewed Publications, Reports, & White Papers:

- Identifying the Need for Youth and Young-Adult-Specific Strategies and Current Initiatives Centers for Medicare and Medicaid Services Innovation Accelerator Program National Dissemination Webinar. March 4, 2019.
- Using Data to Better Understand the Medicaid Population with Serious Mental Illness Centers for Medicare and Medicaid Services Innovation Accelerator Program National Dissemination Webinar. November 15, 2018.
- Pires, S.A., Fields, S., and Schober, M. (2018). Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs: Expert Convening. The National Technical Assistance Network for Children's Behavioral Health.
- Medicaid Value Based Purchasing Strategies for SUD Centers for Medicare and Medicaid Services Innovation Accelerator Program National Dissemination Webinar. October 26, 2017.

- SUD Benefit Design & Care Continuum. Centers for Medicare and Medicaid Services Innovation Accelerator Program National Dissemination Webinar. July 20, 2016.
- Linking & Merging Data Sources. Centers for Medicare and Medicaid Services Innovation Accelerator Program National Dissemination Webinar. September 28, 2016.
- Behavioral Health and Primary Care Integration: Challenges and Opportunities. Federal Congressional Briefing, 2016 Bipartisan Health Policy Retreat, Friday, January 29, 2016.
- Lowther, J., Harburger, D.S., Fields, S., Zabel, M., Pires, S.A., & Allen, K. (2016). Partnering with Medicaid to Advance and Sustain the Goals of the Child Welfare System. Baltimore, MD: The Institute for Innovation & Implementation, UM SSW.
- Integration of Behavioral and Physical Health. 2015 Medicaid Leadership Institute, October 14-15, 2015.
- Meaningful Quality Measures for Children with Behavioral Health Conditions. Discussion with the New York State Conference of Local Mental Health Hygiene Directors, October 13, 2015.
- Incorporating Substance Use Disorder Services Into Managed Care. Centers for Medicare and Medicaid Services Innovation Accelerator Program Targeted Learning Opportunity, October 8, 2015.
- Medicaid Managed Care. Presentation to the Substance Abuse and Mental Health Services Administration, September 30, 2015.
- Developing Effective Payment Approaches for Substance Use Disorder Services. Centers for Medicare and Medicaid Services Innovation Accelerator Program High Intensity Learning Collaborative, September 16, 2015.
- Institution for Mental Disease, Briefing for the Substance Abuse and Mental Health Services Administration, July 8, 2015.
- Julie Seibert , Ph.D., Suzanne Fields , M.S.W., L.I.C.S.W., Catherine Anne Fullerton , M.D., M.P.H., Tami L. Mark , Ph.D., Sabrina Malkani , M.P.H., Christine Walsh , B.A., Emily Ehrlich , M.P.H., Melina Imshaug , B.S., Maryam Tabrizi , Ph.D.Use of Quality Measures for Medicaid Behavioral Health Services by State Agencies: Implications for Health Care Reform, Psychiatric Services, March 2015.
- Pires, S.A., Stroul, B., Harburger, D.S., Boyce, S.P., Fields, S.C., & Zabel, M. (2015). From Analysis to Implementation: A Financing Toolkit for States, Tribes, and Communities to Support and Sustain Systems of Care. Rockville, MD: SAMHSA. Toolkit.
- Federal Updates: What's Happening in Children's Behavioral Health. 27th Annual Children's Mental Health Research and Policy Conference, University of South Florida, March 5, 2014.

NAME Melissa Schober, MPM	POSITION TITLE Sr. Policy Analyst, The TA Network Institute for Innovation & Implementation, University of Maryland, Baltimore, School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
St. Joseph College, West Harford, CT	BA	2001	Political Science
University of Maryland School of Public Policy, College Park, MD	MPM	2013	Public Management, Health Policy

Melissa Schober currently serves as the Senior Policy Analyst for SAMHSA's National Training and Technical Assistance Center for Child, Youth and Family Metal Health. She has more than 15 years of experience in health policy, including policy and regulatory design; public health advocacy; and the provision of technical assistance to managed care organizations, state Medicaid agencies, provider associations, and family and consumer-led organizations

In her current role, Ms. Schober serves as a lead consultant to System of Care grantee sites across the county and providing subject matter expertise in Medicaid financing, including rate setting, state plan amendments, and waivers; behavioral health system design; and policy, statutory and regulatory analysis. She has researched and written a variety of white papers, technical reports, and briefs on children's mobile crisis response and stabilization services, telehealth, school-based health services, substance use services for youth, federal regulatory changes, and physical and behavioral health integration. She also has experience in stakeholder engagement, strategic planning, and program design and evaluation as part of statewide delivery system reform.

Ms. Schober has worked closely with several states and localities, including Maryland (with its unique all-payer system); Kansas; Nebraska; Los Angeles County, California; Stark and Hancock, as well as the State of Ohio; and Washington State. Her work has included strategic planning, maximizing federal match for public mental health systems, drafting and implementing Medicaid State Plan amendments and waivers, rate setting, and coalition-building.

Ms. Schober was deeply involved in the processes to integrate Maryland's mental health and substance use agencies into a single behavioral health authority amid major system redesign following the enactment of the Patient Protection and Affordable Care Act. Apart from agency integration, she was the behavioral health staff lead for creating a Section 1945 Health Home to serve individuals with co-occurring disorder, converting a time-limited, federal 1915(c) waiver to a 1915(i) state plan amendment to serve children with serious emotional disturbance, transitioning from ICD 9 to ICD 10, and initial efforts to procure new MMIS system. Prior to joining the state, Ms. Schober worked in Washington, DC as an advocate for expanding public health and safety net programs.

Selected Professional Positions

2016- Present	Senior Policy Analyst, The TA Network for Children's Behavioral Health
2015-2016	Senior Consultant, Health Management Associates

2014-2015	Director, Office of School Health, Maryland Department of Health and Mental Hygiene
2010-2014	Director, Medicaid Policy, Behavioral Health Administration, Maryland Department of Health and Mental Hygiene
2009-2010	Project Director, Society for Public Health Education
2006-2009	Senior Legislative Analyst, Women's Policy, Inc.
2004-2006	Legislative Associate, The MayaTech Corporation
2001-2003	Legal Assistant, NARAL Pro-Choice America

Professional Service

- Departmental Designee, Maryland School Based Health Center (SBHC) Policy Advisory Council, 2014-2015.
- Staff Lead, Health Homes Workgroup, Behavioral Health Integration, Maryland Department of Health and Mental Hygiene, 2011-2012.
- Subject Matter Expert, Provider Enrollment and Provider Management, Medicaid Enterprise Restructuring Project, Maryland Department of Health and Mental Hygiene, 2011-2012.

Selected Publications & Presentations:

- **Schober, M.** & Baxter, K. (forthcoming 2019). A Survey of Medicaid Funding for Family and Youth Peer Support Programs. The National Technical Assistance Network for Children's Behavioral Health.
- Robshaw, R., and Pires, S.A. (2018). Telehealth and Mobile Technology in Child, Youth, and Young Adult Behavioral Health. The National Technical Assistance Network for Children's Behavioral Health.
- Manley, E., **Schober, M.**, Simons, D. & Zabel, M. (2018) Making the Case for a Comprehensive Children's Crisis Continuum of Care. National Association of State Mental Health Program Directors. This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.
- Pires, S.A., Fields, S., Schober, M. (2018). Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs: Expert Convening. The National Technical Assistance Network for Children's Behavioral Health.
- Harburger, D.S. & **Schober, M.** (2017) Rate Setting for Wraparound and Peer Support. National Wraparound Implementation Academy. Baltimore, MD.
- English, K., Lieman, R.B., Fields, S., & **Schober, M.** (2017). Services in Support of Community Living for Youths with Serious Behavioral Health Challenges: Respite Care.
- **Schober, M.** (2016). *Change in the Medicaid Free Care Policy*. The National Technical Assistance Network for Children's Behavioral Health.
- **Schober, M.**, Field, S. & Pires, S. (2016) *Coverage of Behavioral Health Services for Youth with Substance Use Disorders*. The National Technical Assistance Network for Children's Behavioral Health.

- **Schober, M.**, Pires, S.A., Field, S., Robshaw, R. (2016). TA Network Summary: Managed Care Regulation. The National Technical Assistance Network for Children's Behavioral Health.
- **Schober, M.** (2014). School-Based Health Centers and Public Mental Health Services. Presentation at the School Health Interdisciplinary Program Conference. Timonium, MD.
- **Schober, M.** (2014). HB 883 (Chapter 620 of the Acts of 2014) 2014 Report on Safe and Healthy Schools Hours. Maryland Department of Health and Mental Hygiene.
- **Schober, M.** (2012). Overview of Current Behavioral Health System Financing. Presentation at the Behavioral Health Integration Stakeholder Meeting. Annapolis, MD.
- **Schober, M.** (2011). Presentation on Maryland's 1915(i) State Plan Amendment to the Maryland Advisory Council on Mental Hygiene/P.L.102-321 Planning Council.

NAME Christopher Bellonci, M.D.	POSITION TITLE Chief Medical Officer, Vice President of Policy and Practice, Judge Baker Children's Center, Boston, MA
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR
Boston University, Boston, MA	BA	1984
University of Texas, San Antonio, TX	MD	1988

- Medical Director, National Training and Technical Assistance Center for Children's Behavioral Health.
- Clinical Consultant, National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for LGBTQ Children and Youth in Foster Care. Children's Bureau.
- 2012-15 Clinical Consultant, Six State Psychotropic Medication Quality Improvement Collaborative funded by Annie E. Casey and administered by the Center for Healthcare Strategies

Certification

1993 Certified in Psychiatry. American Board of Psychiatry and Neurology
1994 Certified in Child Psychiatry. American Board of Psychiatry and Neurology

Current Faculty Academic Appointments

2019- Faculty, Harvard University School of Medicine
2010- Adjunct Associate Professor, Tufts University School of Medicine

Other Recent Applicable Professional Positions

2018 SAMHSA Experts Meeting on Implementation of Best Practices in Antipsychotic Prescribing for Children and Adolescents
2009- SAMHA Working Group to Address the Needs of Children and Youth who are Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two-Spirit (LGBTQI2-S) and their Families

Professional Societies

1991 American Academy of Child and Adolescent Psychiatry
1998-2002 Member, Residential Treatment Committee
2001-2003 Member, Foster Care Task Force
2008- Member, Committee on Quality Issues

1995-2010 Child Welfare League of America
1995-2007 Member, Residential Advisory Board
1997-2010 Member, Mental Health Advisory Board

2005- Association of Children's Residential Centers
2005-16 Board of Directors
2012-14 President

Major Research Interests

- The Role of Residential Treatment in the Service Array for Youth with Behavioral Health Disorders
- Appropriate Use of Psychotropic Medications for Foster Youth
- Best Practices in Meeting the Needs of LGBTQ Youth in the Foster Care System

Selected Recent National Invited Teaching and Presentations

2019 Primium non Nocere: Deprescribing of Psychotropic Medications in Residential Care / Presenter
63rd Annual Association of Children's Residential Centers Conference, New Orleans, LA

2019 Promoting Positive Outcomes for Justice-Involved Youth: Implications for Policy, Systems and Practice / Presenter. 32nd Annual Research and Policy Conference on Child, Adolescent, and Young Adult Behavioral Health, Tampa, FL

2019 Use of Data and Collaborative Problem Solving to Improve Service Delivery and Response at a Statewide Child Welfare Hotline / Presenter. 32nd Annual Research and Policy Conference on Child, Adolescent, and Young Adult Behavioral Health, Tampa, FL

2019 Preventive Health Services: Supporting Adolescents in Leading Health Lives Webinar/Presenter. Office of the Assistant Secretary for Health – Regions 3, 5, and 8

2018 Role of Psychosocial Services in Appropriate Prescribing of Antipsychotics for Children and Adolescents / Presenter. SAMHSA, Rockville, MD

2018 Antipsychotics Collaborative Expert Panel /Panelist. National Collaborative for Innovation in Quality Measurement

2018 One Size Does Not Fit All: Programs Supporting Best Practices in Psychotropic Prescribing / Discussant 65th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. Seattle, WA

2018 Completing the Puzzle: Strategies on How to Link the Pieces of Evaluation, Treatment Planning, and Collaborative Care for Children in the Foster Care System / Discussant. 65th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. Seattle, WA

2018 State Oversight of Prescribing Psychotropic Medications: Practice Enhancements and Unintended Consequences / Discussant. 65th Annual Meeting of the American Academy of Child and Adolescent Psychiatry. Seattle, WA

Clinical Innovations

Practice Pathways Tool: Helping Young People Transition from Foster Care to Adulthood (2013)	The Practice Pathways Tool helps states identify effective practice components, evaluate existing practices and boost collaboration to advance comprehensive practice reform (https://www.aecf.org/resources/practice-pathways-tool/)

Selected Publications

Lee T, Fouras G, Brown R, Walter HJ, Bukstein OG, **Bellonci C**, Benson RS, Chrisman A, Hamilton J, Hayek M, Keable H, Rockhill C, Schoettle U, Siegel M, Stock S. Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System. J Am Child Adolesc Psychiatry. 2015; 54(6): 502-517.

Barnett ER, Concepcion-Zayas MT, Zisman-Ilani Y, **Bellonci C.** Patient-centered psychiatric

care for youth in foster care: a systematic and critical review. J Public Child Welfare. 2018; 1028. Epub 2018 Sep 11

Small RW, **Bellonci C**, Ramsey S. Creating and Maintaining Family Partnerships in Residential Treatment Programs: Shared Decisions, Full Participation, Mutual Responsibility. In: Whittaker JK, del Valle JF, Holmes L., editors. Therapeutic Residential Care for Children and Youth: Developing Evidence-Based International Practice. London, U.K.: Jessica Kingsley. 2014; pp 156-167.

NAME Terry Shaw, MSW, Ph.D., MPH	POSITION TITLE Director Ruth H. Young Center for Families and Children and Associate Professor
eRA COMMONS USER NAME tvshaw	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Truman State University	B.S.	06/1991	Computer Science
University of Missouri, Columbia	MSW	06/1997	Social Work
University of California, Berkeley	Ph.D.	06/2006	Social Welfare
University of California, Berkeley	MPH	06/2007	Interdisciplinary

Subject Matter Expertise/Personal Statement

My background and interests focuses on leveraging existing administrative data systems to improve state policy and practice related to child and family health. I am particularly interested in examining the pathways into and through child serving systems focusing on opportunities for state systems to collaborate, understand service overlaps, improve overall service delivery and address the multiple needs of the children and families involved with these systems (including child, youth and family physical and mental health; surveillance of psychotropic medication use; pathways to permanency; educational access; interactions between the court and child welfare services, and child maltreatment prevention). I have over two decades of experience and expertise in developing the infrastructure, relationships and programming structure to successfully implement multi-agency data linking systems (having instituted data linking projects in South Carolina, California, and Maryland). I have expertise in advanced statistical methods and extensive experience utilizing longitudinal data systems to answer questions related to service outcomes to inform policy and practice.

Professional Positions

1997-2001 Health and Demographic Researcher – Program Coordinator II
South Carolina Budget and Control Board, Office of Research and Statistics, Health and Demographics, Columbia, SC.

2001–2007 Graduate Student Researcher VII – California Performance Indicators, Center for Social Services Research, University of California at Berkeley

2007-2016 Assistant Professor, University of Maryland, School of Social Work

2014- Co-Director Dual Degree (MSW/MPH) Program, University of Maryland, School of Social Work

2014– Associate Professor, University of Maryland, School of Social Work

2014- Director, Ruth H. Young Center for Children and Families, University of Maryland, School of Social Work

Selected Presentations, Training, Teaching

Shaw, T.V., Farrell, J, Betsinger, S. (2018, May). *Predicting Reentry and Juvenile Services Involvement for Children Exiting the Child Welfare System.* 26th Annual Meeting: Society for Prevention Research; Optimizing the Relevance of Prevention Science to Systems. Washington, DC.

Shaw, T.V. (2017, July). *The impact of child welfare involvement on Kindergarten readiness.* Workshop presented at the National Association for Welfare Research and Statistics (NAWRS) conference. Pittsburgh, PA.

Shaw, T.V. (2017, July). *Using administrative data to calculate a pregnancy rate for youth in out of home care.* Workshop presented at the National Association for Welfare Research and Statistics (NAWRS) conference. Pittsburgh, PA.

Shaw, T.V., Goering, E., Shipe, S., Betsinger, S. & Farrell, J. (2017, July). *Child Welfare Reentry and Multi-System Involvement: Examining cumulative risk and protective factors.* Workshop presented at the National Association for Welfare Research and Statistics (NAWRS) conference. Pittsburgh, PA.

Shaw, T.V., & Jedwab, M. (2017, January). *Foster Care Reentry: an examination of initial vs repeat child welfare experience.* Workshop presented at the Society for Social Work and Research (SSWR). New Orleans, LA.

Shaw, T.V. (2016, March). *Reentry into State Sponsored Out of Home Care after Reunification: Impact of Multiple System Involvement.* Paper Discussion Symposium at the Society for Research on Adolescence (SRA). Baltimore, MD.

Shaw, T.V., Farrell, J., Kolovoski, K., Nadiv. S and Betsinger, S. (2016, January). *The Promise and Pitfalls of Big Data in the Human Services.* Round table presented at the Society for Social Work and Research (SSWR). Washington, DC.

Shaw, T.V., Ayer, D. and Carter, L. (2015, October). *An Examination of Reentry into State Sponsored Out of Home Care after Reunification in Maryland: Results from a State Report on Foster Care Reentries.* Workshop presented at the Maryland Association of Resources for Families and Youth Annual Conference, Ocean City, MD.

Selected Peer-Reviewed Publications, White Papers, Selected Reports

A Complete List of Published Work can be found in My Bibliography: http://www.ncbi.nlm.nih.gov/sites/myncbi/10ESxZdg6ahAo/bibliography/48904602/public/?sort=date&direction=ascending

Jedwab, M., Chatterjee, A., & **Shaw, T.** (2018). Caseworkers' Insights and Experience with Successful Reunification. *Children and Youth Services Review. DOI: https://doi.org/10.1016/j.childyouth.2018.01.017*

Goering, E.S. & **Shaw, T.V.** (2017). Foster Care Reentry: A survival analysis assessing differences across permanency type. *Child Abuse & Neglect.* DOI: 10.1016/j.chiabu.2017.03.005

Shipe, S.L., **Shaw, T.V.**, Betsinger, S., & Farrell, J. (2017). Expanding the conceptualization of re-entry: The inter-play between child welfare and juvenile services. *Children and Youth Services Review.* DOI: 10.1016/j.childyouth.2017.06.001

Shaw, TV. & Kolupanowich, N. (2017). 2017 Child Welfare Performance Indicators Report (3rd annual legislatively mandated report to the Maryland Department of Human Resources Social Services Administration). [State Report]

Ahn, H., Hartzell, S., & **Shaw, T.V.** (2016). Participants' Satisfaction with Family Involvement Meetings: Implications for Child Welfare Practice. *Research on Social Work Practice.*

Shaw, TV., Farrell, J., Kolivoski, K. (2016). Big Data in the Human Services. (Brief for the TA Network and SAMHSA). http://files.ctctcdn.com/57c33206301/8d64082d-12e4-467d-b4dc-6f8c81f1ce71.pdf [White Paper]

Shaw, T.V., Bright, C., & Sharpe, T. (2015). Child Welfare Outcomes for Youth in Care because of Parental Death or Parental Incarceration. *Child Abuse and Neglect.*

Shaw, T.V. (2015). *An Examination of Reentry into State Sponsored Out of Home Care after Reunification in Maryland.* [State Report].

Shaw, T.V., Barth, R., Mattingly, J., Ayer, D. & Berry, S. (2013). Child Welfare Birth Match: The Timely Use of Child Welfare Administrative Data to Protect Newborns. *Journal of Public Child Welfare.* 7(2): 217-234.

NAME Haksoon Ahn, Ph.D.	POSITION TITLE Associate Professor
eRA COMMONS USER NAME Not applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Yonsei University, Seoul, Korea	BA	1993	Social Welfare
Yonsei University, Seoul, Korea	Master	1995	Social Welfare
Brandeis University, MA, USA	Master	2004	Social Policy
Brandeis University, MA, USA	PhD	2009	Social Policy

Subject Matter Expertise/Personal Statement

My research has focused on the impact of child welfare policy and services with the goal of improving the well-being of vulnerable children and families. To this end, my research examines children and families at multiple levels and uses a variety of methods with the aim of improving child welfare policy, practice, and outcomes. I have conducted evaluations of child and family welfare policies and services on state, national, and international levels, and have integrated them into all aspects of my research and scholarship, teaching, and service. The funded projects include an evaluation of effectiveness and efficiency of child protection services to respond to child abuse and neglect, Continuous Quality Improvement in Child Welfare Policy and Practice, Federal Children and Families Services Review, Family Centered Practice, and Recruitments and Retention of Foster Parents. Prior to joining the University of Maryland, I worked at the Economic Policy Institute in Washington, D.C. as a Research Economist.

Professional Positions

2015 – present Associate Professor, University of Maryland School of Social Work
2014 – 2015 Research Associate Professor, University of Maryland School of Social Work
2009 – 2014 Research Assistant Professor, University of Maryland School of Social Work
2003 – 2004 Research Economist, Economic Policy Institute (EPI), Washington D.C.
Supervisor: Dr. Jared Bernstein, Research: Evaluation of the Welfare Reform in the U.S

Selected Presentations, Training, Teaching

Ahn, H. (organizer), Barth, P. R., DePanfilis, D., Shaw, T., Unick, J., Finigan-Carr, N. (2019 January). Research on Child Welfare Policies and Services to Inform the Policy and Practice. Symposium at 2019 Annual Conference of the Society for Social Work and Research. San Francisco, CA.

Conway, D. **Ahn, H.**, Rollins, K. (2019, April). Using CFSR Case Review Results within a CQI Framework to Inform Strategies for Outcomes Improvement. Workshop at 21st National Conference on Child Abuse and Neglect (NCCAN). Washington DC.

Ahn, H. (organizer), Berrick, J. D., Slack, K. S., Testa, M. F., & Wulczyn, F. (2018, January). Research on States' Child and Family Welfare Policies and Services: Universities'Partnership

with State Agencies. Roundtable panel discussion at 2018 Annual Conference of the Society for Social Work and Research. Washington DC.

Ahn, H., Greeno, E., Bright, C. L., Hartzel, S., & Reiman, S. (2018, January), A Survival Analysis of Length of Services and Implications for Retention of Foster Parents, Poster presentation at 2018 Annual Conference of the Society for Social Work and Research. Washington DC.

Ahn, H., Carter, L., Reiman, S., & Hartzel, S. (2017, January). Implementation of Quality Assurance Model to Evaluate Child Welfare Policy and Practice. Poster presentation at 2017 Annual Conference of the Society for Social Work and Research. New Orleans, LA.

Ahn, H. & Harzel, H. (2016, January). Effects of Family Involvement Meetings on Outcomes of Child Welfare Services, Family Strength, Engagement, and Children's Safety. Poster presentation at 2016 Annual Conference of the Society for Social Work and Research. Washington DC.

Ahn, H., (2015, June). Economic Well-Being, Employment, and Child Care among Low-Income Families, Paper presentation at 2015 International Social Work Conference. Seoul, Korea

Ahn, H. (2015, September). United States Census Bureau Panel Dataset: Survey of Income and Program Participation (SIPP). Internationally invited presentation at Korean Panel Conference organized by Korean Department of Health and Social Welfare and Seoul National University. Seoul National University, Seoul, Korea.

Ahn, H., Osteen, P., Shaw, T., O'Connor, J., Carter, L. (2014, October). Development of measurement for Research and Evaluation of Child Welfare Policy and Practice. Paper presentation at the Council on Social Work Education, 60th Annual Program Meeting. Tampa, FL

Selected Peer-Reviewed Publications, White Papers, Selected Reports

Ahn, H., DePanfilis, D., Frick, K., & Barth, P. R. (2018) Estimating minimum adequate foster care costs for children in the United States. *Children and Youth Services Review,* 84, 55-67.

Xu, Y., Bright, C., & **Ahn, H.** (2018) Responding child maltreatment: Comparison between the United States and China. *International Journal of Social Welfare,* 27:2, 107-120. DOI:10.1111/ijsw.12287

Ahn, H., Greeno, E., Bright, C., Hartzel, C., & Reiman, S. (2017a) A survival analysis of the length of foster parenting duration and implications for recruitment and retention of foster parents. *Children and Youth Services Review*. 79, 478-484.

Ahn, H., Carter, L., Reiman, S., & Hartzel, S. (2017b) Development of quality assurance and continuous quality improvement (CQI) model in child welfare system. *Journal of Public Child Welfare*. 11:2, 166-189.

Ahn, H. Keyser, D., & Heyward, A. (2016a) A multi-level model analysis of individual and agency effects on implementation of family-centered practice in child welfare. *Children and Youth Services Review, 69, 11-18.*

Ahn, H., Hartzel, S., & Shaw, T. (2016b) Participants' satisfaction with family involvement meeting: Implications for child welfare practice. *Research on Social Work Practice.*

Ahn, H. (2015) Economic well-being of low-income single mother families following welfare reform in the USA. *International Journal of Social Welfare,* 24(1), 14-26.

Ahn, H., Osteen, P., O'Connor, J., Shaw, T., & Carter, L. (2014) Developing a measurement of child welfare policy and practice: Local Supervisory Review Instrument. *Human Service Organizations Management, Leadership & Governance, 38*(1), 29-43.

Ahn, H. (2012). Child care subsidy, child care costs, and employment of low-income single mothers. *Children and Youth Services Review,* 34(2), 379-387.

Michalopoulos, L., **Ahn, H.**, Shaw, T., & O'Connor, J. (2012). Child welfare workers' perception of implementation of family-centered practice. *Research on Social Work Practice,* 22(6), 656-664.

NAME Margo Candelaria, Ph.D.	POSITION TITLE Research Assistant Professor, UMB SSW
eRA COMMONS USER NAME MCANDELARIA	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
The Pennsylvania State University	BA	04/1995	Psychology
UMBC	MA	01/2002	Applied Developmental Psychology
UMBC	Ph.D.	12/2005	Applied Developmental Psychology
The Pennsylvania State University	BA	04/1995	Psychology

Summary of Qualifications

I have the necessary evaluation as well as clinical and training expertise in Infant and Early Childhood Mental Health (IECMH) screening, diagnosis, assessment, EBP implementation and CQI, and systems development across multiple community systems to fulfill the consultant role of this project. I have worked with young children and families in medical systems, community mental health agencies, early intervention agencies, and Head Start/Early Head Start (as a consultant). I also have a history of working in the NICU and Growth and Nutrition Clinic with medically fragile and substance exposed infants, and am the current psychologist in the NICU Follow-Program. I participated in the development of the SMART Clinic in Carroll County Maryland focusing on building a developmental clinic to serve children with behavioral and developmental needs and their families, including creating a network of providers to server families and tracking referral and assessment processes and outcomes. Additionally, I currently oversee all evaluation efforts for two SAMHSA funded IECMH SOC grants (BRIDGE and E-SMART), two programs focused on implementation and evaluation of programing for pregnant and parenting at-risk youth (HHS pregnancy Assistance Fund and SAMHSA funded TREE grant), and a locally funded intervention with the Maryland Academy of Pediatrics in pediatric primary care, training providers on promoting parent-infant interactions. In addition, I also served as the evaluation PI for the prior Maryland LAUNCH program for the last three years of the project. Across all these projects, I have focused on program evaluation and implementation science aimed to improve programs for families with young children by using data and engaging in CQI processes. Therefore, I am uniquely qualified to offer consultation across a variety of early childhood evaluation and clinical topics and settings.

Professional Positions

2006-2009 *Post-Doctoral Research Fellow.* Department of Pediatrics, Growth and Nutrition Division. UMB, School of Medicine (SOM). Mentor: Maureen Black, Ph.D.
2009-2011 Instructor. Department of Pediatrics, UMB SOM.
2010-2011 Instructor. Department of Psychiatry, UMB SOM.
2011-2013 Assistant Professor. Departments of Pediatrics & Psychiatry, UMB SOM.
2014- Assistant Professor. Department of Pediatrics, UMB SOM.
2016- Research Assistant Professor. UMB School of Social Work. The Institute.

Honors and Awards

2001-2002 Public Policy Graduate Intern. The American Psychological Association. Washington, DC.
2001-2002 Applied Developmental Psychology Distinguished Student Fellowship. UMBC.
2003 Graduate Student Research Day Award Recipient. UMBC.
2005-2005 Dissertation Fellowship (Summer). UMBC.
2006-2009 Diversity Supplement Post-Doctoral Fellowship. NIDA.
2007-2009 NIH Loan Repayment Program recipient.
2010-2012 Robert Wood Johnson Foundation New Connections Scholar.

Certifications/Licensure

2001 Brazelton Neonatal Behavioral Assessment Scale
2005 NCAST – teaching and feeding scales
2009 Autism Diagnostic Observation Schedule (ADOS)
2013 Fussy Baby Network/FAN Model Level I
2017 Chicago Parent Program
2017 Early Childhood Service Intensity Index
Maryland Licensed Psychologist, [redacted], issued November 23, 2009

Selected Peer-Reviewed Publications, White Papers, Selected Reports

1. **Candelaria, M.**, Martoccio, T., Lipsky, L. & Fry, J. (2018). Maryland LAUNCH Final Evaluation Report.. MarylandLAUNCH
2. **Candelaria, M.**, Wasserman, K., Martoccio, T., & Lipsky, L. (2018). Maryland State Department of Education Social & Emotional Foundations for Early Learning (SEFEL) Infant and Toddler Training and Coaching Activities Report. SEFEL-ITP2018Report
3. Wasserman, K., Lowther, J., **Candelaria, M.**, & Harburger, D. (2017). Southern Maryland BRIDGE Finance Plan Executive Report. BRIDGEfinanceplan2017
4. Nadiv, S., **Candelaria, M.A.**, Martoccio, T., Harburger, D. (2017). Kindergarten Readiness in Baltimore City: The Role of Early Care and Education, Barriers to Success, and Levers for Change. Baltimore's Promise & Institute for Innovation and Implementation.
5. Hurley, K. M., Pepper, M. R., **Candelaria, M.**, Wang, Y., Caulfield, L. E., Latta, L., Hager, E. R., Black, M. M. Systematic Development and Validation of a Theory-Based Questionnaire to Assess Toddler Feeding. (2013). *Journal of Nutrition, 143*(12), 2044-2049.
6. Hager, E. R., **Candelaria, M.**, Latta, L., Hurley, K. M., Wang, Y., Caulfield, L., Black, M. M. (2012). Maternal perceptions of toddler body size: Accuracy and satisfaction differ by toddler weight status. *Archives of Pediatrics & adolescent medicine, 166*(5), 417-422.
7. **Candelaria, M.**, Teti, D. & Black, M. (2011). Multi-risk Infants: Predicting attachment security from sociodemographic, psychosocial, and health risk among African-American preterm infants. *Journal of Child Psychology and Psychiatry, online.*
8. Quigg, A. M., **Candelaria, M.**, Scaletti, L.A., Buckingham-Howes, S., Black, M. M. (2011, January). Healthy Moms: Improving the Quality of Life for Baltimore City Mothers. Baltimore, MD: University of Maryland, Department of Pediatrics, Growth and Nutrition Division. https://childrenshealthwatch.org/healthy-moms-improving-the-quality-of-life-for-baltimore-city-mothers/

9. **Candelaria, M. A.**, O'Connell, M. & Teti. D. (2006). Cumulative psychosocial and medical risk as predictors of early infant development and parenting stress in an African-American preterm sample. *Journal of Applied Developmental Psychology, Vol 27*(6), pp. 588-597.
10. **Candelaria, M.** & Llorente, A. M. (2009). Neuropsychological assessment of Hispanic children. In Reynolds, C.R. & Fletcher-Janzen, E. (Eds.), Handbook of Clinical Child Neuropsychology, Third Edition. New York: Plenum Publishing.
11. Teti, D., Killeen, L. A., **Candelaria, M.,** Miller, W., Hess, C. R., & O'Connell, M. (2008). Adult Attachment, Parental Commitment to Early Intervention, and Developmental Outcomes in an African American Sample at Double Jeopardy. In H. Steele & M. Steele (Eds.), *The Adult Attachment Interview in Clinical Context.* New York: Guilford Press.
12. Teti, D. and **Candelaria, M. A.** (2002). Parental competence. In M. Bornstein (Eds.), *Handbook of parenting*. Baltimore, MD: Paul H. Brooks Publishing Co.
13. Quigg, A. M., **Candelaria, M.A.,** Scaletti, L.A., Buckingham-Howes, S., Black, M. M. (2011, January). Healthy Moms: Improving the Quality of Life for Baltimore City Mothers. Baltimore, MD: UMB, Department of Pediatrics, Growth and Nutrition Division.

NAME Susan C. dosReis, Ph.D., FISPE	POSITION TITLE Professor and Vice Chair for Research, Department of Pharmaceutical Health Sciences, University of Maryland School of Pharmacy
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
University of Rhode Island	BS	1991	Pharmacy
University of Maryland, School of Pharmacy	Ph.D.	1999	Pharmacoepidemiology

Summary of Qualifications

My clinical training and research expertise span the fields of **pharmacy practice, pharmacoepidemiology methods for drug utilization, safety, and outcomes research, patient-centered outcomes research, and quantitative and qualitative (mixed) research methods**. Federally-funded research grants through the National Institute of Mental Health and the Patient Centered Outcomes Research Institute have allowed me to build a foundation of research on psychotropic medication use among children and adolescents. **Over the past 20 years, I developed a program of pediatric pharmacoepidemiology and outcomes research, with publications addressing health system and patient- and family-centered factors that affect psychotropic use for youth treated in community outpatient settings**. My research on psychotropic medication use for children and adolescents has addressed the growing national interest on youth in foster care and has been cited in the New York Times. Collaboration with child-serving agencies has provided an opportunity to integrate large administrative data from individual agencies to assess outcomes for youth treated with psychotropic medication. I accomplished this in naturalistic, quasi-experimental studies using **innovative designs and advanced statistical methods** to control for confounding. I have expertise in stated preference methods using best worst scaling and discrete choice experiments to evaluate trade-offs in decision making with regard to stimulant and antipsychotic medication for youth. I am **applying novel methods to better understand disparities in treatment decisions from a variety of patient groups, and in particular the underserved communities**. My expertise in the content area, methods, and study design will contribute significantly to this proposal. Publications most relevant to the current proposal are listed here, of which for three I was Principal Investigator or Senior Author.

Contributions to Science

1. **Pharmacoepidemiologic Research on Antipsychotic Treatment in Youth**
   a. **dosReis, S.**, Yoon, Y., Rubin, D.M., Riddle, M.A., Noll, E., Rothbard, A. Antipsychotic treatment among youth in foster care. *Pediatrics*. 2011; 128(6):e1459-e1466.
   b. Tai, MH, Shaw, T, **dosReis, S**. Antipsychotic Use and Foster Care Placement Stability Among Youth With Attention-Deficit Hyperactivity/ Disruptive Behavior Disorders. *J Public Child Welfare*. 2016; 10(4): 376-390.
   c. Spence, O., Camelo Castillo, W., Reeves, G., **dosReis, S**. Psychiatric Services Preceding Initiation of Antipsychotic Medication Among Youth in Foster Care. *J Child Adolesc Psychopharm (in press) 2019*.

d. **dosReis, S**, Tai, MH, Camelo Castillo, W, Reeves, G. A National Survey of State Medicaid Psychotropic Monitoring Programs Targeting Medicaid-Enrolled Youth. *Psychiat Serv. 2016*; 67(10):1146-1148.

2. **Pharmacoepidemiologic Outcomes of Mental Health Care Coordination**
   a. Tai, M.H., Lee, B., Onukwugha, E., Zito, J., Reeves, G., **dosReis, S**. Impact of Coordinated Behavioral Health Management on Quality Measures of Antipsychotic Use. *Administration and Policy in Mental Health and Mental Health Services Research*. 2018; 45(1): 174-185.
   b. Tai, M.H., Lee, B., Onukwugha, E., Zito, J.M., Reeves, G.M., **dosReis, S**. Impact of Care Management Entity on Psychiatric Services Among Youth With Severe Mental or Behavioral Disorders. *Psychiat Serv*. 2018; online in advance; DOI: 10.1176.
   c. Wu, B., Bruns, E.J., Tai, M.H., Lee, B., Raghavan, R. **dosReis, S**. Psychotropic Polypharmacy Among Youth with Serious Emotional and Behavioral Disorders Receiving Care Coordination. *Psychiat Serv*. 2018; 69(6): 716-722.

3. **Pharmacoepidemiologic Utilization Studies on Psychotropic Use in Foster Care**
   a. **dosReis, S**. Tai, M.H., Lynch, S., Goffman, D., Reeves, G., Shaw, T. Age-Related Trends in Psychotropic Medication Use Among Very Young Children in Foster Care. Psychiatric Services. 2014; 65:1452-1457.
   b. **dosReis S**, Zito JM, Safer DJ, Soeken KL. Mental health services for foster care and supplemental security income disabled youth. American Journal of Public Health. 2001; 91(7):1094-1099. PMCID: PMC1446701.
   c. Rubin,D., Matone, M., Huang, Y.S., **dosReis, S.**, Feudtner, C., Localio, R. Interstate variation in trends of psychotropic medication use among Medicaid-enrolled children in foster care. Children and Youth Services Review. 2012; 34: 1492-1499.

4. **Research on Psychotropic Medication Safety and Risk Communication**
   a. Sieluk, J., Palasik, B., **dosReis, S.**, Doshi, P. ADHD Medications and Cardiovascular Adverse Events in Children and Adolescents: Cross-national Comparison of Risk Communication in Drug Labeling. *Pharmacoepidemiology and Drug Safety*. 2017; 26: 274-284.
   b. Burcu, M., Zito, J.M., Safer, D.J., Magder, L.S., **dosReis, S.**, Shaya, F.T., Rosenthal, G.L. Concomitant Use of Atypical Antipsychotics with Other Psychotropic Medications and the Risk of Type 2 Diabetes. *Journal of the American Academy of Child and Adolescent Psychiatry*. 201; 56(8):642-651.
   c. Burcu, M., Zito, J.M., Safer, D.J., Magder, L.S., **dosReis, S.**, Shaya, F.T., Rosenthal, G.L. Antidepressant Medications and the Risk of Incident Type 2 Diabetes Mellitus among Medicaid Insured Youth. *JAMA Pediatrics*. 2017;171(12):1200-1207.

5. **Stated Preference Research Involving Pediatric Psychopharmacologic Treatment**
   a. **dosReis, S**, Ng, X, Frosch, E, Reeves, G, Cunningham, C, Bridges, JFP. Measuring Caregivers Preferences for Children's ADHD Treatment Using Best-Worst Scaling – A Pilot. *The Patient*. 2015; 5(8): 423-431.
   b. **dosReis, S**, Park, A, Ng, X, Frosch, E, Reeves, G, Cunningham, C, Janssen, E, Bridges, JFP. Caregiver Treatment Preferences for Children with a New Versus Existing

Attention-Deficit/Hyperactivity Diagnosis. *Journal of Child and Adolescent Psychopharmacology*. 2016; 27(3): 234-242.

c. Ng, X, Bridges, JFP, Ross, MM, Frosch, E, Reeves, G, Cunningham, CE, **dosReis, S**. A Latent Class Analysis to Identify Variation in Caregivers' Preferences for their Child's Attention-Deficit/Hyperactivity Disorder Treatment: Do Stated Preferences Match Current Treatment? *The Patient*. 2017; 10: 251-262.
d. Camelo Castillo, W., Ross, M., Tariq, S., **dosReis, S**. Best-Worst Scaling to Prioritize Outcomes Meaningful to Caregivers of Youth with Mental Health Multimorbidities: A Pilot Study. *Journal of Developmental and Behavioral Pediatrics*. 2018. 39(2): 101-108.

Complete List of Published Work in MyBibliography:

http://www.ncbi.nlm.nih.gov/sites/myncbi/susan.dosreis.1/bibliography/48869274/public/?sort=date&direction=ascending

NAME Deborah Harburger, MSW	POSITION TITLE Clinical Instructor & Maryland Center Director, The Institute for Innovation & Implementation, University of Maryland School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
The Pennsylvania State University	BA	2002	Psychology
University of Maryland, School of Social Work, Baltimore, MD	MSW	2004	Social Work

Summary of Qualifications

- More than 15 years' experience working with public child- and family-serving systems to develop and implement policies and services to serve children and families with high quality, effective home- and community-based services
- Expert in child welfare, financing of services, strategic planning, and implementation science
- Experience as TA provider in multiple states and as a Principal Investigator & Project Director, including for a Children's Bureau-funded Youth At-Risk of Homelessness Grant, two CMS-funded demonstration grants, and, a SAMHSA CSAT grant, as well as multiple state contracts

Professional Positions

2012-Present: The Institute for Innovation & Implementation, School of Social Work, University of Maryland, Baltimore
2012-2016: Project Director
2016-Present: Clinical Instructor & Director, Maryland Center
2007-2012: Project Manager, University of Maryland, Baltimore, School of Medicine, Innovations Institute
2002-2007: State of Maryland
2006-2007: Interim Manager of State Coordinating Council; Manager, Systems of Care Initiatives; Director of Research & Evaluation, Governor's Office for Children
2005-2006: Policy Analyst, Department of Human Services
2003-2005: Social Work Intern (2003), Policy Development Specialist (2004) Governor's Office for Children
2002: Foster Care Worker (Title IV-E Intern), Prince George's County Department of Social Services

Select Peer-Reviewed Publications, Reports, & White Papers

Watrous, J., Lowther, J., DeMaio, J., Gray, C., Gould-Kabler, C., Miller, A., Farrell, J., Kearley, B., & **Harburger, D.S**. (2019). *Maryland Title IV-E Waiver-Funded Evidence-Based and Promising Practices: Summary of Implementation Progress.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland.

Greeno, E. J., Lee, B. R., Tuten, M., & **Harburger, D**. (2018). Prevalence of substance use, housing instability, and self-perceived preparation for independence among current and former foster youth. Child & Adolescent Social Work Journal, doi: 10.1007/s10560-018-0568-y

Greeno, E. J., Fedina, L., Lee, B. R., Farrell, J., & **Harburger, D**. (2018). Psychological Well-Being, Risk, and Resilience of Youth in Out-Of-Home Care and Former Foster Youth. *Journal of Child & Adolescent Trauma.* doi: 10.1007/s40653-018-0204-1

Kearley, B., Lowther, J., Cosgrove, J., Jin, W., Watrous, J. & **Harburger, D.S.** (2017). *Families Blossom Service Array Report: Substance Use Disorder Recommendations.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland.

Harburger, D.S. & Gould-Kabler, C. (2017). *Recommendations to Engage Families and Youth in the Work of Families Blossom/Place Matters and the Title IV-E Waiver.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland.

Lowther, J., **Harburger, D.S.,** Fields, S., Zabel, M., Pires, S.A., & Allen, K. (2016). *Partnering with Medicaid to Advance and Sustain the Goals of the Child Welfare System.* Baltimore, MD: The Institute for Innovation & Implementation, UM SSW.

Pires, S.A., Stroul, B., **Harburger, D.S.,** Boyce, S.P., Fields, S.C., & Zabel, M. (2015). *From Analysis to Implementation: A Financing Toolkit for States, Tribes, and Communities to Support and Sustain Systems of Care.* Rockville, MD: SAMHSA. Toolkit.

Mettrick, J., **Harburger, D.S.**, Kanary, P.J., Lieman, R.B., & Zabel, M. (2015). *Building Cross-System Implementation Centers: A Roadmap for State and Local Child Serving Agencies in Developing Centers of Excellence (COE).* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work. White paper commissioned by the Annie E. Casey Foundation.

Harburger, D. S. & Zabel, M. (2013). *Sustainable financing for* B'More for Healthy Babies: *Commissioned paper for B'More for Healthy Babies by the Annie E. Casey Foundation, the Baltimore City Health Department, and the Family League of Baltimore City.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work. Report.

Harburger, D.S., Zabel, M., & Pires, S.A. (2013). *A Good and Modern Behavioral Health System: Redesigning Kentucky's Services and Supports for Children, Youth and Young Adults and Their Families.* Baltimore, MD: UMB.

Woodruff, K., **Harburger, D.S.,** Bertell, R., West, A., Uretsky, M., & Barth, R.P. (2013). *Evaluation of State Laws on Child Abuse and Neglect: Commissioned Paper for the Institute of Medicine.* Baltimore, MD: UMB.

Harburger, D., Stephan, S., & Kaye, S. (2013). Children's behavioral health system transformation: One State's context and strategies for sustained change. *Journal of Behavioral Health Services & Research.* doi: 10.1007/s11414-013-9339-x

Harburger, D. (2004). Reunifying families, cutting costs: Housing-child welfare partnerships for permanent supportive housing. *Child Welfare, 83(5)*, 493-508.

Select Professional Activities

Teaching

2017 *Children & Social Services Policy. (SOWK 715).* University of Maryland School of Social Work. Fall Semester 2017; Spring Semester 2018; Spring Semester 2019.

2015 *The Ethics of Evidence-Based Practice in Community-Based Care with Children and Families.* Continuing Education Seminar at Kennedy Krieger Institute, Baltimore, MD. Co-taught with B.A. Anthony, K. Keegan & M. Zabel.

Proposal Review Team

2015, 2016, 2017, 2018 — 29th Annual Research & Policy Conference on Child, Adolescent, & Young Adult Behavioral Health, University of South Florida

The Technical Assistance Network for Children's Behavioral Health Faculty

2015-2017 — Innovations in Medicaid Managed Care Meeting (Annual)

2016 — Quality Collaborative on Improving the Use of Psychotropic Medication for Youth in Residential Treatment Facilities

NAME Brook Kearley, Ph.D.	POSITION TITLE Research Assistant Professor, The Institute for Innovation & Implementation, UMB School of Social Work
eRA COMMONS USER NAME Bkearley	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
University of South Florida, Tampa, FL	BA	1994	Criminology
University of Maryland, College Park, MD	M.A.	2002	Criminology and Criminal Justice
University of Maryland, College Park, MD	Ph.D.	2017	Criminology and Criminal Justice

Summary of Qualifications

Brook Kearley is a Research Assistant Professor at the University of Maryland School of Social Work and research faculty at The Institute for Innovation and Implementation. She was a dissertation fellow of the National Institute of Justice and received her Ph.D. in Criminology and Criminal Justice from the University of Maryland in 2017. Dr. Kearley's research interests include criminal and juvenile justice policy and program evaluation with a focus on substance use and delinquency prevention and intervention programs. She has expertise in quantitative and experimental methods, with over 15 years' experience managing randomized field trials and multi-site evaluations. Dr. Kearley is currently Principal Investigator of a long term follow up of a randomized controlled trial of Functional Family Therapy for gang at risk and gang involved youth as well as an evaluation of Harford County's Family Recovery Court. Her recent research has appeared in Prevention Science and Criminology and Public Policy.

Professional Positions

1994-1996: Research Assistant, Operation PAR
1996-1997: Internship, The Stapleford Treatment Centre and Trust
1998-1999: Research Associate, Center for Substance Abuse Research, University of Maryland
1999-2002: Graduate Research Assistant, University of Maryland, Dept. of Criminology
2000: Drug Ethnographer, University of Maryland, Dept. of Anthropology
2003-2004: Faculty Research Assistant, University of Maryland, Dept. of Criminology
2004-2005: Data Analyst, Baltimore City State's Atty.'s Office, Project Safe Neighborhoods Initiative
2005-2007: Evaluation Specialist, Social Solutions International, Inc.
2007-2009: Senior Evaluation Specialist, Social Solutions International, Inc.
2009-2010: Director, Criminal Justice Initiatives, Social Solutions International, Inc.
2010-Present: Consultant, Choice Research Associates
2011: Research Specialist, Maryland Center for Juvenile Justice, University of Maryland
2011-2016: Graduate Research Assistant, University of Maryland, Department of Criminology
2016: Lecturer, Loyola University
2016-2017: Clinical Research Manager, The Institute for Innovation & Implementation, UMB

2017-Present: Research Assistant Professor: The Institute for Innovation & Implementation, UMB

Selected Honors/Relevant State or Federal Committees, Advisory Boards

Dissertation Fellowship, National Institute of Justice
Graduate Assistantship and tuition award, University of Maryland
Demetrious Karamasoukis Scholarship for Outstanding Achievement, University of South Florida
Honors Program, University of South Florida
Professional Affiliation with American Society of Criminology
Professional Affiliation with the Society for Prevention Research

Selected Presentations, Training, Teaching

Peterson, K., Lowther, J., **Kearley, B.** and Mills, S. (2019). "Maryland Social Services Administration's Strategic Approach to Addressing Parental Substance Use Disorders." Presented at the Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health, Tampa, FL.

Kearley, B. (2018). "What Works to Prevent and Intervene in Youth-Perpetrated Gang and Gun Violence: Promising Results from a Randomized Controlled Trial of Functional Family Therapy" Presented at the Project Safe Neighborhoods Conference, Kansas City, MO.

Kearley, B., Gottfredson, D., Thornberry, T., Slothower, M., Devlin, D., and Fader, J. (2017). "Functional Family Therapy for Gang Populations (FFT-G): A Randomized Controlled Trial." Presented at the Blueprints for Healthy Development Pre-Conference, Westminster, CO.

Kearley, B. (2015). "Long Term Effects of Drug Court Participation" Invited Talk, École Nationale de la Magistrature (ENM) Conference on Addiction and Offending: Innovative Judicial Treatment, Paris, France.

Kearley, B. and Gottfredson, D. (2015). "Using an Existing Funding Stream to Test the Effectiveness of Functional Family Therapy Enhanced for a Gang Population." Presented at the Society for Prevention Research Conference, Washington, DC.

Zafft, K. and **Kearley, B.** (2013). "The Impact of Drug Courts on Public Safety: Seeing the Forest for the Trees." Presented at the American Society of Criminology Conference, Atlanta, GA.

Nemes, S., Messina, N. and **Kearley, B.** (2010). "Development of a Comprehensive Training and Model of Care for Women's Addiction and Recovery in Correctional Settings." Presented at the American Public Health Association Conference, Denver, CO.

Hess, L., **Kearley, B.**, Thomas, Z., and James, I. (2008) "Substance Abuse among Older Adults: Risk, Treatment, and Relapse." Presented at the Gerontological Society of America Conference, National Harbor, MD.

Munly, K., Hess, L.S., **Kearley, B.**, James, I., Nemes, S., Pelletier, L., and Moolchan, E. (2006). "Substance Abuse and Older Adults: A Review of the Literature." Presented at the College on Problems of Drug Dependence Conference, Scottsdale, AZ.

Select Peer-Reviewed Publications, Reports, & White Papers

Kearley, B., Cosgrove, J., Wimberly, A., Gottfredson, D. (Accepted July 2019) The Impact of Drug Court Participation on Mortality: 15-Year Outcomes from a Randomized Controlled Trial. Journal of Substance Abuse Treatment

Gottfredson, D., **Kearley, B.**, Thornberry, T. Slothower, M. Devlin, D. and Fader, J. (2018).

Scaling Up Evidence-Based Programs Using a Public Funding Stream: A Randomized Trial of Functional FamilyTherapy for Court-Involved Youth. *Prevention Science,* 19(7): 939-953.

Thornberry, T., **Kearley, B.**, Gottfredson, D., Slothower, M., Devlin, D. and Fader, J. (2018). Reducing Crime Among Youth at Risk for Gang Involvement: A Randomized Trial. *Criminology and Public Policy, 17(4): 953-989.*

Kirk, D., Barnes, G., Hyatt, J. and **Kearley, B.** (2018). The Impact of Residential Change and Housing Stability on Recidivism: Pilot Results from the Maryland Opportunities Through Vouchers Experiment (MOVE). Journal of Experimental Criminology, 14(2): 213-226.

Gottfredson, D., **Kearley, B.**, and Bushway, S. (2010). Substance Use, Drug Treatment, and Crime: An Examination of Intra-Individual Variation in a Drug Court Population. In editor Mangai Natarajan, Drug Abuse: Prevention and Treatment, Volume III; The Library of Drug Abuse and Crime. Ashgate Publishers, Surrey UK.

NAME Jill Farrell, Ph.D.	POSITION TITLE Research Assistant Professor, University of Maryland School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Boston College, Chestnut Hill, MA	BA	1999	Psychology
University of Maryland, College Park, MD	MA	2002	Criminology & Criminal Justice
University of Maryland, College Park, MD	PhD	2009	Criminology & Criminal Justice

Subject Matter Expertise/Personal Statement

Jill Farrell is a Research Assistant Professor at the University of Maryland School of Social Work and research faculty for The Institute for Innovation and Implementation where she **conducts research and provides technical assistance** in the **development and implementation** of a **statewide evidence-based case management model** for the Maryland Department of Juvenile Services (DJS) and serves as the lead evaluator for several **evidence-based programs** implemented with children, youth, and families in Maryland. Dr. Farrell is also a Co-Investigator for a statewide multi-agency data collaborative that focuses on linking and leveraging **administrative data systems to improve policy and practice**. Prior to joining the School of Social Work, Dr. Farrell **conducted applied policy research** at the University of Maryland's Innovations Institute, the Institute for Governmental Service and Research, the Urban Institute, and the Maryland State Commission on Criminal Sentencing Policy. She holds both a Ph.D. and M.A. in Criminology and Criminal Justice from University of Maryland, and a B.A. with distinction in Psychology from Boston College.

Past Professional Positions

2004-2009 Research Assistant, Institute for Governmental Service & Research, University of Maryland College Park

2009-2010 Research Associate, Institute for Governmental Service & Research, University of Maryland College Park

2010-2011 Project Director, Maryland Center for Juvenile Justice, Innovations Institute, University of Maryland School of Medicine

2011-2012 Assistant Professor, Department of Psychiatry, Division of Child and Adolescent Psychiatry, University of Maryland School of Medicine

2012-present Research Assistant Professor, University of Maryland School of Social Work

2015-present Director of Research and Evaluation, The Institute for Innovation & Implementation, School of Social Work, University of Maryland, Baltimore

2016-present Co-Director of the Maryland Center, The Institute for Innovation & Implementation, School of Social Work, University of Maryland, Baltimore

Selected Honors/Relevant State or Federal Committees, Advisory Boards

- Dr. James W. Longest Memorial Award for Social Science Research, University of Maryland (2008)
- Member, Baltimore City Disproportionate Minority Contact Steering Committee & Advisory Board (2012-2014)
- Member, Maryland House of Delegates House Judiciary Committee's Girls Services Workgroup (2012-2013)
- Member, Baltimore City Youth Justice and Equity Council (2015)
- Member, Maryland Crime Research and Innovation Center Advisory Board (2019-)
- Member, School Safety Research Advisory Committee (2016-)

Selected Presentations, Training, Teaching

Farrell, J., Betsinger, A., Irvine, J. (2018, November). *Assessing the impact of a graduated response approach for youth in the juvenile justice system: Preliminary findings.* Paper presented at the American Society of Criminology Annual Conference, Atlanta, GA.

Espinosa, E., & **Farrell, J.** (2018, July). *Juvenile justice and behavioral health diversion: Using the system of care framework to build on and sustain system reform.* Presented at the University of Maryland, Baltimore Training Institutes, Washington, DC.

Farrell, J. (2018, October). *Supporting MST and FFT implementation with CQI and evaluation in Maryland.* 2018 Office of Planning, Research and Evaluation (OPRE) Innovative Methods Meeting, Washington, DC.

Farrell, J., Betsinger, S., Cosgrove, J., Strubler, K., & Irvine, J. (2016, November). *Using evidence-based programs to improve reentry outcomes for youth in the juvenile justice system.* Paper presented at the American Society of Criminology Annual Conference, New Orleans, LA.

Farrell, J., Betsinger, S., & Fanflik, P. (2016, March). *Risk/needs assessment for juvenile justice-involved youth who are transitioning to adulthood.* Paper presented at the Society for Research on Adolescence Biennial Meeting, Baltimore, MD.

Farrell, J., Shaw, T. V., & Betsinger, S., & Stocksdale, B. (2017, October). *Predicting crossover from the child welfare to the juvenile justice system in Maryland.* Presented at the 19th Annual Child Abuse, Neglect and Delinquency Options (CANDO) Judicial Conference, Ocean City, MD.

Shaw, T., & **Farrell, J.,** & Smith, P. (2015, March). *Collaborative data partnerships: The promise and pitfalls of big data in the human services.* Accepted for the Child, Adolescent, and Young Adult Behavioral Health Annual Research & Policy Conference, Tampa, FL.

Shaw, T.V., **Farrell, J.,** Ayer, D., & Irvine, J. (2014, August). *Using linked administrative data to examine involvement in child-serving systems: Linking information to enhance knowledge, Maryland's multi-agency data collaborative.* Workshop presented at the National Association of Welfare Research and Statistics, Providence, RI.

Flanigan, P., Beal, S., & **Farrell, J.** (2013, January 24). *Understanding the Department of Juvenile Services' continuum of care.* Workshop presented at the Maryland Association of Resources for Families & Youth Workshop.

Farrell, J. (2012, October). *Using evidence-based programs to reduce disproportionate minority contact.* Workshop presented at the Disproportionate Minority Contact Conference, Baltimore, MD.

Farrell, J., & Mettrick, J. (2012, October 10). *Evaluating the adoption and reach of evidence-based practices in Maryland's Department of Juvenile Services*. Presented to the Penn State University Prevention Research Center. State College, PA.

Farrell, J. & Mettrick, J. (2012, October 25). *Implementation of evidence-based practices in public systems for youth.* Presented at the UM School of Social Work Research Lunch Time Seminar. Baltimore, MD.

Farrell, J., Bright, C., & Kolivoski, K. (2012, October 15). *Girls' services in Maryland: Results from the 2012 DJS Program Questionnaire.* Presented to the Girls Services Workgroup. Annapolis, MD.

Farrell, J., Kaye, S., & Flanigan, P. (2012, April). *Using standardized assessment to monitor and improve the implementation of evidence-based programs for juvenile offenders*. Workshop presented at the Blueprints for Violence Prevention Conference, San Antonio, TX.

Selected Peer-Reviewed Publications, White Papers, Selected Reports

Taxman, F.S., Henderson, C., Young, D., & **Farrell, J**. (2014). The impact of training interventions on organizational readiness to support innovations in juvenile justice offices. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(2), 177-188.

Young, D.W., **Farrell, J.L.**, & Taxman, F.S. (2013). Impacts of juvenile probation training models on youth recidivism. *Justice Quarterly, 30*(6), 1068-1089.

Farrell, J.L., Young, D.W., & Taxman, F.S. (2011). Effects of organizational factors on use of juvenile justice supervision practices. *Criminal Justice and Behavior, 38*(6), 565-583.

Farrell, J., Young, D., & Betsinger, S. (2010). *Pre-adjudication coordination and transition (PACT) center: Outcome and process evaluation*. Prepared for Family League of Baltimore City, Inc.

Young, D., Yancey, C., Betsinger, S., & **Farrell, J.** (2010). *Disproportionate minority contact in the Maryland juvenile justice system*. College Park, MD: Institute for Governmental Service & Research.

Henderson, C.E., Young, D.W., **Farrell, J.,** & Taxman, F.S. (2009). Associations among state and local organizational contexts: Use of evidence-based practices in the criminal justice system. *Drug and Alcohol Dependence, 103S*, S23-S32.

Young, D.W., **Farrell, J.L.,** Henderson, C.E., & Taxman, F.S. (2009). Filling service gaps: Providing intensive treatment services for offenders. *Drug and Alcohol Dependence, 103S*, S33-S42.

NAME Elizabeth Manley, MSW	POSITION TITLE Faculty & Senior Advisor for Health Care Financing, The Institute for Innovation & Implementation, University of Maryland School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
William Paterson, Wayne, NJ	BS	1986	Health Science
Rutgers University, New Brunswick, NJ	MSW	1994	Social Work
Rutgers University, New Brunswick, NJ	Certificate in Non-Profit Management	2008	Social Work

Summary of Qualifications

Elizabeth Manley is a Clinical Instructor for Health and Behavioral Health Policy at the Institute for Innovation and Implementation. In this capacity, Ms. Manley provides technical assistance to states and communities specific to children's behavioral health innovations with a specific focus on policy, financing and development of service array within a of systems of care. Ms. Manley is the former Assistant Commissioner for NJ's Children's System of Care. In this capacity, Ms. Manley led transformation and implementation of system innovations including integrating individuals with developmental/intellectual disabilities, substance use and integration of physical health into the Children's System of Care. She had direct oversight of the statewide child behavioral health, substance use and development/intellectual disabilities systems. This includes a wide range of home and community-based services, outpatient and residential interventions. Ms. Manley was the DCF representative on the NJ Board of Social Work Examiners and the Governor's Council on Alcohol and Drug Abuse; the Principal Investigator on NJ's Promising Path to Success, a SAMHSA System of Care Expansion Grant with the focus on improving care for youth in need of an residential intervention; Vice Chair of the National Association of State Mental Health Program Directors (NASMHPD); and has presented at several national conferences. Prior to joining DCF Ms. Manley was the CEO of Caring Partners of Morris/Sussex, Inc., a Care Management Organization (CMO) specializing in working with youth with complex behavioral health challenges. Ms. Manley worked for Capitol County Children's Collaboration, the Mercer County CMO, as the Director of Operations, at the time of its inception in 2002. She came to that position after spending 15 years at SERV Behavioral Health, in various positions with her final position at SERV as the Director of Children's Services for SERV Behavioral Health with oversight of residential interventions and partial care services for youth with complex behavioral health needs. MS. Manley earned a B.S. degree in Health Education from William Paterson University and a M.S.W. from Rutgers University in New Brunswick, NJ.

Professional Positions

- Clinical Instructor for Health & Behavioral Health Policy – The Institute for Innovation and Implementation — December 2017 - Present
- Assistant Commissioner, NJ Children's System of Care DCF — August 2015 – December 2017
- Director, NJ Children's System of Care — October 2012- August 2015
- CEO, Caring Partners of Morris/Sussex CMO — November 2005–October 2012
- Director of Operations – Capitol County Children's Collaborative — March 2002-December 2005

- SERV Behavioral Health – Multiple Positions with the last position Director of Children's Services — September 1986-June 2002

Selected Peer-Reviewed Publications, Reports, & White Papers

Manley, E., Schober, M., Simons, D. & Zabel, M. (2018). *Making the Case for a Comprehensive Children's Crisis Continuum.* National Association of State Mental Health Program Directors.

Select Presentations/Expert Convening Experience

- Maryland Training Series – Residential Interventions with Systems of Care, July and September 2019
- National Association of State Mental Health Program Directors Annual Meeting – Making the Case for a Comprehensive Children's Crisis Continuum, July 30, 2018
- Faculty at the Innovations in Medicaid Managed Care for Children, Youth and Young Adults with Behavioral Health Challenge Peer Meeting hosted by The Institute at University of Maryland School of Social Work, Rockville, MD, July 11 & 12, 2017
- Care Integration Opportunities in Primary Care Settings for Children with Behavioral Health Needs hosted by the Institute at University of Maryland School of Social Work, Baltimore, MD, June 7 & 8, 2017
- Morning Keynote for Stark County Ohio Leadership Breakfast "*Preparing for Change & Involving Stakeholders*", June 2, 2017
- Presented at the Association of Children's Residential Centers Annual Conference Portland Oregon, "*The NJ Transformation of Out of Home Treatment,*" April 27, 2017
- Presented at the CWLA Conference, Washington D.C. "*Developing and Supporting Resource Families*," March 29, 2017
- Faculty at the University of Maryland TA Network Mobile Response & Stabilization Peer Meeting, New Brunswick, NJ, April 18 & 19, 2017
- Presented at the Mobile Crisis Response for Children, Grand Rapids, Michigan "*Transforming New Jersey's Behavioral Health: The Role of Mobile Response*", January 25 & 26, 2017
- Faculty at the University of Maryland TA Network Mobile Response & Stabilization Peer Meeting, New Brunswick, NJ, December 7, 2016
- Keynote Speaker at the Transformational Communication Outcomes Management (T-COM) Conference, Princeton, NJ on "*Transforming Children's Behavioral Health: The NJ Story,*" November 2016
- Presenter at the University of Maryland TA Network National Wraparound Implementation Academy – Finance and Policy Track, September 2016
- Keynote at the Delaware Prevention & Behavioral Health Forum – Mental Health Matters, Dover Downs Delaware - "*Transforming Children's Behavioral Health the NJ Experience*," May 2016
- Presenter at the National Association of Public Child Welfare Agencies, Washington, DC – "*NJ Children's System of Care,*" June 2016
- Georgetown System of Care Training Institutes Presenter, July 2014
  Institute – "Customizing Care Coordination in Medicaid for Children with Serious Behavioral Health Challenges"

Institute – "Crisis Response and Stabilization in Systems of Care: Partnering with Youth, Families and Communities"

- Plenary at the 27th Annual Research and Policy Conference on Child, Adolescent and Young Adult Behavioral Health Conference – "*NJ System of Care*", Tampa Florida, March 2014

Grant and Research Experience

Principal Investigator for Promising Path to Success – NJ's Children's System of Care, SOC Expansion Grant through SAMHSA October 2015 – September 2019. This grant focuses on the reduction of reliance on restraint, seclusion and coercion in all treatment programs. Utilizes the Six Core Strategies and the Nurtured Heart Approach. The grant also focuses on Return on Investment for NJ Children's System of Care.

Affiliations/Membership

- Vice Chair of the National Association of State Mental Health Program Directors, Children Youth and Families Division – January 2015 to December 2017
- Vice Chair of NJ Board of Social Work Examiners – January 2015 to December 2017
- University of Maryland System of Care TA Network Steering Committee
- Governors Council on Alcohol and Drug Abuse – January 2014 to December 2017
- NJ Developmental Disability Council – January 2014 to December 2017
- Consumer Advisory Boggs's Center of Excellence - January 2013 to December 2017
- President of System of Care Association – June to October 2012

NAME Shannon Robshaw, MSW	POSITION TITLE System Design and Implementation Coach Senior Advisor for System Design and Implementation
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Trinity University, San Antonio, TX	BA	1985	Biology
Louisiana State University, Baton Rouge, LA	MSW	1992	Social Work

Ms. Shannon Robshaw has over twenty-five years of experience in state government and non-profit executive leadership positions focusing on policy and system reform to improve mental health and health service delivery systems. Since joining the NWIC and TA Network for Children's Behavioral Health, University of Maryland in October 2013, Ms. Robshaw has provided a range of technical assistance to more 17 state level system of care grantees and 20 local community grantees. Ms. Robshaw leads the Rural Mental Health Learning Community and has also served as faculty for TA Network hosted meetings on Integrated Care, Innovations in Medicaid Managed Care, Financing Systems of Care, and at the 2018 UMB Training Institutes and 2016 and 2017 National Wraparound Implementation Academies. She has contributed to the production of array of educational publications and briefing documents from the TA Network. She previously served as Executive Director of the Continuum of Care (COC) in the South Carolina Governor's Office, whose mission is to provide care coordination services for the state's children and youth with the most serious and complex behavioral health disorders. She also served on multi-agency Leadership Team developing South Carolina's statewide Palmetto Coordinated System of Care. She served as the Director of the Louisiana Coordinated System of Care and led planning and start-up efforts for the Governor's cross-departmental initiative to build a new service delivery system for children and youth at risk of out of home placements. The broad-based planning process resulted in the development of the system design, service array and operational structure for the Louisiana CSoC, as well as financing strategies including Medicaid waivers and state plan amendments necessary to leverage funds in support of CSoC implementation. Past service as the Executive Director of the Louisiana Health Care Quality Forum, an Executive Management Officer in the Office of the Secretary of the Louisiana Department of Health and Hospitals and as the Executive Director of the Mental Health Association in Louisiana.

Subject matter expertise includes:

•Child, youth and family mental health through a long term commitment to public mental health children's system reform developed through interning with LA CASSP in graduate school, establishing MHAL as a leader in children's mental health and juvenile justice system reform, leading the development of Louisiana's CSoC, serving on the Leadership Team for South Carolina's SOC.

•SOC system design, planning processes, governance and organizational development through leadership positions in development of Louisiana and South Carolina's Systems of Care.

•Transforming a state agency to become a high fidelity wraparound provider, including staff training needs, management structures, financing and technology support through serving as the Executive Director of South Carolina's Continuum of Care.
•Provision of technical assistance as demonstrated by recent consulting services including providing strategic guidance on state and local level system of care efforts SOC grantees and other state level initiatives. Areas of consultation include system design, governance, cross-agency collaboration, planning structures, Medicaid, managed care, financing, organizational development, family driven practice model and wraparound implementation.

Selected Professional Positions

1993- 2001	Executive Director, Mental Health Association in Louisiana
2003-2004	Director, Grants Division, Office of Mental Health (OMH), Louisiana Department of Health and Hospitals
2004-2005	Director, Strategic Management and Fund Development Office of Mental Health (OMH), Louisiana Department of Health and Hospitals
2005-2008	Executive Management Officer, Office of the Secretary, Louisiana Department of Health and Hospitals
2008-2009	Executive Director, Louisiana Health Care Quality Forum
2009-2011	Project Director, Louisiana Coordinated System of Care
2011-2012	Interim Executive Director Statewide Governance Board, Louisiana Coordinated System of Care
2013- 2014	Executive Director, Continuum of Care, SC Governor's Office
2013-Present	Senior Advisor for System Design and Implementation, TA Network for Children's Behavioral Health, University of Maryland
2018-Present	System Design and Implementation Coach, National Wraparound Implementation Center, University of Maryland

Selected Positions, Honors & Committees

- Co-Chair, *Quality Alliance Steering Committee,* member, National-Regional Implementation Workgroup (2009, 2008)
- Louisiana Team Leader, *Substance Abuse and Mental Health Services Administration Co-Occurring Policy Academy* (2003)
- Member, *National Mental Health Association,* Affiliate Consultant Group (2002)
- Chair, *LA Public Mental Health Review Commission,* Children's Committee (1999-2002)
- *LA Mental Health Planning Council,* Advocacy Committee, Chair 2001; Council Restructuring Committee, Chair 1999-2000; Council Secretary 1998; Child/Youth Plan 2001 Committee, Chair 1997 (1999-2002)
- Review Team Member, *Children's Mental Health Policy Academy*, Georgetown University National Technical Assistance Center for Children's Mental Health (1999)
- Member, *National Mental Health Association, Public Policy Committee* (1999)
- *"Lifetime Advocate"* presented by the Mental Health Association in Louisiana (2005)
- *"Distinguished Service"* accepted on behalf of the Louisiana Mental Health Reform Coalition presented by the American Psychiatric Association (2005)
- *"Leadership in Advocacy"* presented by National Mental Health Association (1998)
- *"Whatever It Takes"* presented by Louisiana Federation of Families for Children's Mental Health (1997)

Selected Presentations, Training & Teaching

- *Perspectives on Implementing Rural Systems of Care for Children and Youth with Significant Behavioral Health Disorders*- Plenary, National Association of Rural Mental Health Annual Conference, June 2016, Portland Main
- *Louisiana's Coordinated System of Care*- Innovative Collaborations: Working Together to Improve Systems of Care For Juvenile Justice-Involved Youth, Pre-conference Session, 23rd Annual State Health Policy Conference National Academy for State Health Policy; Oct 2010, New Orleans, LA.
- *Rebuilding and Redesigning Louisiana's Health Care system*- 2007 World Congress on Public Health Congress, Washington DC, July, 2007.

NAME Dayana Simons, M.Ed.	POSITION TITLE Director, Health Program, The Institute for Innovation & Implementation, University of Maryland School of Social Work
eRA COMMONS USER NAME Not Applicable	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Northeastern University	BS	1986	Economics
University of Massachusetts	M.Ed.	1992	Counseling Psychology

Summary of Qualifications

- Expertise in behavioral health policy and service design, development, and implementation; contract and project management; Medicaid and public sector managed care.
- Extensive background in children's behavioral health, care coordination approaches and Systems of Care.
- Experience in the provision of technical assistance to multiple states; co-lead for national Quality Collaborative on Improving the Use of Psychotropic Medication for Youth in Residential Treatment Facilities; coordinator and lead for TA Network Mobile Response and Stabilization Services Peer Curriculum

Professional Positions

2016-Present: Director, Health Program, The Institute for Innovation & Implementation, School of Social Work, University of Maryland, Baltimore
Member of core leadership team for oversight and implementation of federally funded (SAMHSA) National Training and Technical Assistance Center (NTTAC) contract. Project Director and Co-lead, national Quality Collaborative on Improving the Use of Psychotropic Medication for Youth in Residential Treatment Facilities.

Project Director, Mobile Response and Stabilization Services peer curriculum. Lead Consultant, serving as primary technical assistance resource and coach to SAMHSA System of Care grantee sites in multiple states. Consultant/Subject Matter Expert in two states. Liaison and adjunct faculty to TA Network finance and policy hub.

2017-2019: Lead for Clinical, Wraparound and Workforce Development, National Technical Assistance Network for Children's Behavioral Health (TA Network)
Responsible for coordinating the TA Network's largest work hub, guiding the efforts of multiple core partners and managing cross hub coordination related to clinical best practices, workforce development and wraparound.

2010-2015: Senior Program Officer, The Center for Health Care Strategies, Inc.

2005-2010: Systems of Care Manager, MassHealth Office of Behavioral Health (Massachusetts Medicaid)

1998-2005: Massachusetts Behavioral Health Partnership (MBHP)

2005: Clinical Manager, Child and Adolescent Services; Operations Manager, CFFC

2002-2004: Regional Clinical Supervisor, ICM

1999-2005: Regional Network Manager

1998-1999: Concurrent Reviewer

Select Peer-Reviewed Publications, Reports, & White Papers

P. Nikkel, J. Bergan, **D. Simons**. *Operationalizing and Funding Youth and Parent Peer Support Roles in Residential Treatment Settings.* The TA Network, September 2018.

D. Simons, T. Hendricks, J. Lipper, J. Bergan, B. Masselli. *Providing Youth and Young Adult Peer Support through Medicaid.* The TA Network, August 2016.

D. Simons. *"Taking Wraparound to Scale: Moving Beyond Grant Funding."* The TA Telescope, 1(2), 1-4. Winter 2015

D. Simons, S. Pires, T. Hendricks, Jessica Lipper. *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles.* Center for Health Care Strategies, July 2014.

J. Kallal, J. Walker, L. Lewis, **D. Simons**, J. Lipper, and S. Pires. *Becoming a Medicaid Provider of Family and Youth Peer Support: Considerations for Family Run Organizations.* Center for Health Care Strategies, February 2014.

K. Moses, J. Klebonis, and **D. Simons**. *Developing Health Homes for Children with Serious Emotional Disturbance: Considerations and Opportunities* Center for Health Care Strategies, February 2014.*Utilization Management Considerations for Care Management Entities.* Center for Health Care Strategies, June 2013.

D. Simons and R. Mahadevan. *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs.* Center for Health Care Strategies, May 2012.

Professional Activities

2019 Presenter, *Mobile Response and Stabilization Services for Children: Clinical Best Practices and State Perspectives,* NATCON19, Nashville, TN

Poster presenter, *Meaningful Youth and Family Engagement in Residential Treatment Settings,* USF Annual Research & Policy Conference on Child Adolescent and Young Adult Behavioral Health, Tampa, FL

2018 Lead facilitator/faculty, Mobile Response and Stabilization Services Peer Meeting, New Brunswick, NJ

Panel presenter, *Beyond Beds: Making the Case for a Comprehensive Children's Crisis Continuum of Care*, NASMHPD Annual Commissioners Meeting, Arlington VA.

Presenter, *Institute #7: Mobile Response and Stabilization Services (MRSS): Two State Perspectives On A Key Element of A Statewide Children's System of Care.* University of Maryland Training Institutes, Washington, D.C.

Lead facilitator/faculty, Expanded Mobile Response and Stabilization Services Peer Meeting, Piscataway, NJ

2017 Lead facilitator/faculty, Mobile Response and Stabilization Services Peer Meeting, New Brunswick, NJ

Presenter/faculty, *Advancing Policy and Finance Strategies,* National Wraparound Implementation Academy, Baltimore, MD

Presenter/faculty Innovations in Medicaid Managed Care for Children, Youth and Young Adults with Behavioral Health Challenges convening, Rockville, MD

Presenter/faculty, *Collaborative Financing for Systems of Care: Leveraging Medicaid and Medicaid Managed Care.* Building Systems of Care SAMHSA Grantee Meeting, Rockville, MD

Lead facilitator/faculty, Mobile Response and Stabilization Services Peer Meeting. New Brunswick, NJ

2016 Lead facilitator/faculty, Mobile Response and Stabilization Services Peer Meeting, New Brunswick, NJ

Presenter/faculty, Second Annual National Wraparound Implementation Academy, Rockville, MD

Presenter/faculty, Customizing Medicaid Managed Care for Children, Youth, and Young Adults with Behavioral Health Challenges convening, Rockville, MD

Lead facilitator/faculty, Mobile Response and Stabilization Services Peer Meeting, New Brunswick, NJ.

NAME	POSITION TITLE
Denise Sulzbach, JD	Deputy Director, The TA Network
eRA COMMONS USER NAME	Institute for Innovation & Implementation, University
Not Applicable	of Maryland, Baltimore, School of Social Work

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
Fairfield University, Fairfield, CT	BA	1989	Sociology/Psychology
University of Baltimore, School of Law, Baltimore, MD	JD	1994	Law

Subject Matter Expertise/Personal Statement:

Denise Sulzbach currently serves as the Deputy Director of SAMHSA's National Training and Technical Assistance Center for Child, Youth and Family Mental Health (NTTAC). Ms. Sulzbach is responsible for leadership and oversight to the National Technical Assistance Network for Children's Behavioral Health (TA Network) seventeen core partners and large pool of subject matter experts to ensure high-quality deliverables and outcome-based technical assistance. In this role, Ms. Sulzbach has designed, delivered, overseen, and monitored both targeted and individual technical assistance. She also authored SAMSHA's federal site visit protocol, oversees the assignment of subject matter experts for the visits, and has conducted numerous visits herself. Ms. Sulzbach also serves as the lead for an Interagency Agreement between SAMHSA and the Children's Bureau (CB) with focus on the Family First Prevention Services Act (FFPSA). As part of this work, she leads a group of experts in providing financing, policy and children's behavioral health expertise; serving as a repository for and providing guidance on FFPSA questions; and providing technical assistance on cross-system FFPSA planning and implementation to SAMHSA, the CB and the field. She has over 20 years of experience in program, policy, legal and fiscal analyses of child, youth, and family behavioral health organizations and systems, with specialty in supporting local/state/federal linkages and cross system partnerships. Her experience extends from training law enforcement and judges to leaders at the local, state and federal levels.

Ms. Sulzbach has worked with multiple states including Arkansas, Delaware, Florida, Illinois, Indiana, Kansas, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, and Texas, as well as Guam and the Mariana Islands. In addition to FFPSA planning and implementation, work has included writing, analyzing and implementing Medicaid waivers and State Plan Amendments; drafting regulations and policy to support reform efforts; conducting financial mapping approaches to help states/localities make data-informed decisions; supporting discussions to blend and braid dollars across systems; identifying funds for use as non-federal Medicaid and other federal program match; and supporting states to conduct data analytics on the needs of children and use that data to inform system design.

As a former prosecutor assigned to a child advocacy center, she specialized in child abuse, sexual assault and juvenile law and gained unique expertise in and understanding of the unmet cross system needs of youth with complex behavioral health needs and their families. Her expertise in child welfare, juvenile justice, and substance abuse was expanded while serving as the Deputy Secretary at the Maryland Department of Juvenile Services, as well as other high-level Governor

appointed positions, including Director of Systems of Care and Interagency Policy at the Maryland Governor's Office for Children.

Selected Professional Positions:

2013-present	Deputy Director, NTTAC & TA Network for Children's Behavioral Health
2008-2013	Director, Policy and Strategic Development, University of Maryland, Baltimore, School of Social Work, The Institute for Innovation and Implementation
2007-2009	Owner, Sulzbach Systems Consulting, LLC
2005-2007	Director, Maryland Office of Mental Health Transformation
2004-2005	Director, Systems of Care & Interagency Policy, MD Governor's Office for Children
2003-2004	Deputy Secretary, Maryland Department of Juvenile Services
1997-2003	Assistant State's Attorney, Harford County State's Attorney's Office
1996-1997	Associate Counsel, Law Offices of John E. Kelly, P.A. (Legal Intern,
1992-1994)	
1995-1996	Associate Counsel, Aetna Insurance Company
1994-1995	Judicial Law Clerk, Circuit Court for Harford County (Legal Intern, 1993)
1990-1991	Medicaid Eligibility Technician, State of Connecticut
1989-1990	Victim Advocate, Connecticut Superior Court (Family Law Intern, 1989)

Selected Positions, Honors & Committees:

- Member, Upper Chesapeake Health Foundation Annual Kids for Hope Event Committee (2013-Present)
- Member, Women's Giving Circle of Harford County (2011-Present)
- Member, SAMHSA Center for Mental Health Services, Child, Adolescent and Family Branch (CAFB), Council on Collaboration and Coordination (CCC) (2009-2013)
- Co-Chair, CFAB CCC Technical Assistance, Quality Improvement & Sustainability (2009-2011)
- Family Partnership Award, Maryland Coalition of Families for Children's Mental Health (2008)
- Member, Maryland Children's Cabinet Results Team (2003-2007)
- Member, Maryland Drug Treatment Court Commission (2003-2006)
- Chair, Maryland Systems of Care Initiative (2003-2006)
- Member, Governor's Council to End Forced Custody Relinquishment (2003-2004)
- Member, Governor's Law Enforcement Transition Task Force (2002-2003)

Selected Publications & Presentations:

Sulzbach, D., Manley, E., Lowther, J. (2019) *Family First Prevention Services Act: On-Site Technical Assistance, Nevada.* Carson City, NV.

Sulzbach, D., Cubbon, D., Jackson, W., Stewart, M. Stoltz, C., Tuffor, K., (2018) *Addressing the Multi-System Needs of Youth Involved in Child Welfare and Juvenile Justice Systems.* University of Maryland System of Care Training Institutes, Washington, DC.

Sulzbach, D., Wilkniss, S., Virgo, K., Blackmon, S. (2018) *The Role of Children's Cabinets in Advancing and Sustaining Systems of Care.* University of Maryland System of Care Training

Institutes, Washington, DC.

Espinosa, E., Henke, T., Farrell, J. & **Sulzbach, D.** (2015) *Merging Care with Control Brief I: Why Engage Juvenile Justice in System of Care.* Baltimore, MD: The National Technical Assistance Network for Children's Behavioral Health.

Espinosa, E., Henke, T., Farrell, J. & **Sulzbach, D.** (2015) *Merging Care with Control Brief II: How to Integrate Juvenile Justice into System of Care.* Baltimore, MD: The National Technical Assistance Network for Children's Behavioral Health.

Sulzbach, D. & Harburger, D.S. (2014). *Leveraging Financing Opportunities to Sustain and Expand Systems of Care: The Affordable Care Act and Title IV-E Demonstration Waivers.* Georgetown System of Care Training Institutes, National Harbor, MD.

McGarrie, L., Harburger, D.S., **Sulzbach, D.**, & Estep, K. (2014). *Enhancing Maryland's Public Behavioral Health System of Care for Children & Youth.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work.

Lowther, J., Shannahan, R., **Sulzbach, D.**, Cosgrove, J., Harburger, D.S., & Zabel, M. (2013). *CHIPRA Children, Youth and Families' Crisis Response and Stabilization Report.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work.

Sulzbach, D., Zabel, M., & Harburger, D. (2012). *Maryland's care management model in relation to health care reform & behavioral health integration efforts.* Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work.

Fisher, C., & **Sulzbach, D.** (2009*). Resource planning.* Navigating Change in Child Welfare Regional Forum, ACCWIC, National Child Welfare Training and Technical Assistance Center, a service of the Children's Bureau, U.S. Department of Health and Human Services, Atlanta, GA.

NAME Kate Wasserman, MSW, LCSW-C	POSITION TITLE Co-Director, Parent, Infant, Early Childhood (PIEC) Program, The Institute for Innovation & Implementation, University of Maryland School of
eRA COMMONS USER NAME K_WASSERMAN	

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR	FIELD OF STUDY
The George Washington University, Washington, DC	BA	2004	Political Science
University of Maryland, School of Social Work, Baltimore, MD	MSW	2009	Social Work
University of Maryland, School of Medicine, Baltimore, MD	Post-Graduate Certificate, ECMH	2010	Social Work
University of Illinois at Chicago, School of Public Health	MCH Leadership Development Scholar	2012	Maternal Child Health

Subject Matter Expertise/Personal Statement

At the Institute, Ms. Wasserman oversees program and policy work for all **parent, infant and early childhood** activities. In this role she leads program development, project oversight, workforce training and policy work related to infant and early childhood mental health (IECMH) efforts including: Pyramid Model training, coaching, and statewide implementation; she serves as the Program Director for an IECMH SAMHSA-funded System of Care grant and consultant for a second SOC grant in our state. She is also the **Co-lead for the TA Network's Early Childhood Systems Learning Community**; and a statewide consultant and trainer for Maryland State Department of Education funded IECMHC program. Ms. Wasserman is a licensed clinician with extensive IECMH experience, former mental health consultant in **Early Head Start and pediatric primary care settings**, implemented intimate partner violence protocol within pediatrics, faculty and **curriculum contributor** to the UMB School of Medicine IECMH certificate, and has designed and is currently teaching a PIEC SSW course for our school's MSW program, funded through SAMHSA's **Behavioral Health Curriculum Development Initiative**. She has a background in public policy, and brings expertise in **public health policy**, program development, and direct service perspective to projects. She has extensive experience providing and supporting the implementation of evidence-based practices in a range of disciplines that work with families, including home visitors, educators, early intervention providers and primary care as well as specialty care medical providers. She is a National Trainer of the Fussy Baby Network and served as lead trainer for Maryland's Race to the Top and Project LAUNCH workforce developmental grants, training primary care providers, mental health consultants, and home visitors on trauma-informed, family-focused infant mental health competencies.

Selected Honors/Certifications/Relevant State or Federal Committees, Advisory Boards

2018 - Present: Academy of ZERO TO THREE Fellows Member

2017 - 2018: ZERO TO THREE Community of Practice - Enhancing Mental Health in Home Visiting
2017 - 2018: Baltimore Perinatal Mental Health Professional Study Group, Member
2016 - 2018: ZERO TO THREE National Fellowship
2015 - Present: Maryland SEFEL Pyramid Model State Leadership Committee
2014 - 2017: The Governor's Family Violence Council
2013 - Present: Early Childhood Mental Health Steering Committee, Member
2013 - Present: Fussy Baby National Network, Member & National Trainer
2013 - Present: National Child Traumatic Stress Network Domestic Violence Collaborative Group
2013 - 2017: National Child Traumatic Stress Network Integrated Healthcare Collaborative Group
2011 - 2013: Mayor's Domestic Violence Coordinating Committee (Baltimore)

Professional Positions

- Program Director, Parent, Infant and Early Childhood Program, Institute for Innovation & Implementation, University of Maryland School of Social Work, Baltimore, Maryland April 2017 – Present
- Project Director, BRIDGE Southern Maryland System of Care SAMHSA Funded Grant April 2017 – Present
- Adjunct Faculty, University of Maryland School of Social Work, 2019 – Present
- Lead Counselor, Taghi Modarressi Center for Infant Study, University of Maryland School of Medicine, 2013 – 2017
- Family Support Counselor, Harriet Lane Clinic, Johns Hopkins Children's Center, 2011 – 2013
- Counselor, Taghi Modarressi Center for Infant Study, University of Maryland School of Medicine 2009 –2011
- Government Relations Manager, American Public Health Association, Washington, DC 2005 –2007
- Government Relations Associate, NARAL Pro-Choice America, Washington, DC, 2003 – 2005

Selected Peer-Reviewed Publications, White Papers, Reports

- Heller, S., **Wasserman, K.,** Kelley, A., Clark, R. (2019). "Observational Assessment of the Dyad" in *The Clinical Guide to the Psychiatric Assessment of the Very Young Child*, Harrison, J., Frankel, K, and Njoroge, W., (Eds), Springer, New York.
- Candelaria, M., **Wasserman, K.,** Martoccio, T., & Lipsky, L. (2018). Maryland State Department of Education Social & Emotional Foundations for Early Learning (SEFEL) Infant and Toddler Training and Coaching Activities Report. SEFEL-ITP2018Report
- **Wasserman, K.,** Lowther, J., Candelaria, M., & Harburger, D. (2017). Southern Maryland BRIDGE Finance Plan Executive Report submitted to SAMHSA. BRIDGEfinanceplan2017
- Gilkerson, L., Heffron, M., Steier, A., Imberger, J., Maclean, P., Cosgrove, K., Norris Shortle, C., **Wasserman, K.,** Heller, S., Phillips, C. (2016). "FAN as a Tool to Deepen Trauma-Informed Care for Infants, Toddlers, and Families," *Zero To Three Journal*, 36, 7.

- Harrison, J., **Wasserman, K.,** Steinberg, J., Platt, R., Coble, K., Bower, K. (2016). "The Five S's: A Communication Tool for Child Psychiatric Access Projects." *Current Problems in Pediatric and Adolescent Health Care*, 46, 12, 411–419.
- Leis, J., Solomon, B., **Wasserman, K.,** Carter, T., Mendelson,T., Perry, D., Tandon, S.D. (2015). "Preventing Postpartum Depression in a Pediatric Primary Care Clinic: A Pilot Study," *Clinical Pediatrics*, 54, 487-490.
- DeBoard-Lucas, R., **Wasserman, K.,** Groves, B.M., Bair-Merritt, M. (2012). Sixteen Evidence-Based Recommendations for Advocates Working With Children Exposed to Intimate Partner Violence, (White Paper) Futures Without Violence, San Francisco, California.

Selected Professional Presentations & Training

- **Wasserman, K.,** Andujar, P., Lipsky E., Martoccio T., Hanna T., Candelaria M. Building a Statewide SEFEL Pyramid Model System Including a Cadre of Expert Trainers and Coaches Community of Practice. Poster presented at: The National Research Conference on Early Childhood of The Administration for Children & Families; 2018 June 25-27; Arlington, VA.
- **Wasserman, K.,** Andujar, P., Lipsky E., Martoccio T., Hanna T., Candelaria M. Infant and Early Childhood Mental Health in Schools of Social Work: Preparing the Workforce for Practice with Young Children & Families at Risk, University of Maryland, Baltimore Training Institutes; Washington, DC, July 2018.
- "Supporting a State Workforce in the Pyramid Model" State Day Presentation, National Training Institute, Tampa, Florida, April 2018.
- "Early Head Start Considerations for Understanding Early Childhood Mental Health" Maryland Family Network Staff Development Conference, Timonium, Maryland, November 2017.
- "Early Childhood Mental Health Learning Collaborative for Pediatric Primary Care Providers: Development, Impact and Lessons Learned" Zero to Three 30th National Training Institute, Seattle, Washington, December, 2015.
- "Impact of Trauma in the Classroom" School Health Interdisciplinary Program Conference, Timonium, Maryland, August, 2015.
- "Utilizing Mindfulness" Maryland Family Network Home Visitors Conference, Columbia, MD, March 2015.
- "Reflective Practice In Infant Mental Health: Infusing the Fussy Baby Network Approach" Eleventh Annual Child & Adolescent Mental Health Conference, Baltimore, Maryland, March 2015.
- "A Key To Recovery: Promoting Resilience to Support Children, Parents & Families to Move Forward After Domestic Violence" Expert Witness Training, House of Ruth, Baltimore, Maryland, November 2014.

Mississippi Children's Behavioral Health Needs Assessment

Findings and Recommendations

The Institute for Innovation & Implementation at
the University of Maryland School of Social Work
and the Technical Assistance Collaborative

January 2015

CONTENTS

FIGURES

TABLES

ACKNOWLEDGMENTS

This report was a significant undertaking, particularly for the Department of Mental Health and the Division of Medicaid, who worked within a very short timeframe to identify and assemble documents, and to provide data for the analysis. We want to recognize their cooperation, responsiveness and assistance throughout the process.

We appreciate the candidness of providers and stakeholders who spoke with us; and the flexibility provided us in meeting during our site-visits. The range of issues queried, system challenges discussed, and opportunities identified were possible because of the time offered by providers and stakeholders.

We are indebted to the families and youth who shared very difficult, personal information in an effort to improve the behavioral health system for others. While all who contributed to the report have a valid and valuable perspective, it is the feedback from persons who utilize the system that must guide priorities and actions.

Reports of this nature are difficult, particularly as the purpose is to identify challenges that need to be addressed. Challenges identified in this report should not diminish the work of the dedicated state staff, stakeholders and providers we encountered. Rather, we hope it will provide purpose and direction to the many dedicated people we encountered to cooperatively address those challenges.

EXECUTIVE SUMMARY

INTRODUCTION

In 2011 the U.S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. As it relates to children, DOJ found that Mississippi fails to provide medically necessary services to children with disabilities in violation of the Social Security Act's Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate. As a result, many Medicaid-eligible children do not have access to home and community-based mental health and substance use disorder services and enter psychiatric facilities when they could be served in the community if such services were available. In addition to non-compliance with EPSDT, DOJ found that the state's failure to serve youth in the most integrated settings appropriate to their needs violates Title II of the Americans with Disabilities Act (ADA).

In an August 29, 2014, letter of agreement, Mississippi and DOJ agreed to engage in intensive negotiations for the purpose of reaching a comprehensive settlement agreement to resolve DOJ's claims relating to services for children with mental health conditions. As part of these negotiations, the state agreed to contract with consultants from the Technical Assistance Collaborative (TAC)/The Institute for Innovation & Implementation housed at the University of Maryland (The Institute) to conduct an assessment of Mississippi's children's behavioral health system and identify recommendations for system improvements.

METHODOLOGY

The assessment was conducted over an eight-week period from October 2014 to December 2014. TAC/The Institute's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Medicaid and DMH participant characteristics, claims, and encounters; and 2) An in-depth qualitative analysis of all relevant documents, selected records of youth's care and interviews with stakeholders, youth and adult consumers, family members, associations, advocacy groups, and state personnel. Specific methods included:

- Analysis of populations served, service utilization, Medicaid claims and expenditures, quality data, and other system indicators from DOM and DMH.
- Review of one hundred two (102) state documents.
- Review of eighteen (18) client records.
- Discussions with two hundred eighteen (218) key informants.

LIMITATIONS/CONSTRAINTS

This assessment faced several limitations and constraints. First, the agreement between MS and DOJ required a very rapid timeline for this project. The assessment began in late September 2014, with a first draft of the report due in January 2015, and a final report due in February 2015. While DMH and DOM worked rapidly to provide the range of documents and data requested, the condensed timeframe limited the scope to DMH and DOM expenditures and activities. As a result, a broader cross-system review of other important behavioral health expenditures and activities conducted by the state, in child welfare, juvenile justice, education and public health, could not be included.

Additionally, data related to the uninsured or those privately insured, to physical health and primary care clinician behavioral health screenings, or pharmacy data were also not part of this review. Finally, Medicaid claims data were presented by the Mississippi Division of Medicaid in aggregate form only and were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.). Consequently, data pertaining to behavioral health disparities among underserved and minority populations were not analyzed.

MAJOR FINDINGS

CHAPTER 1: MEDICAID DATA

TAC/The Institute conducted an analysis of five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, coinciding with the implementation of managed care for behavioral health services in Mississippi).

Results of this analysis indicated that, while only a minority of claims is for institutional placements, these claims represent a disproportionately large share of expenditures. It is concerning that spending and utilization of institutional care have increased over the past few years.

Mississippi has the opportunity to serve many more youth in less restrictive and more integrated settings by promoting greater use of services, such as mobile crisis intervention, crisis stabilization, intensive outpatient program (both MYPAC and as a step-down from MYPAC), and peer support. More effective use of these services could help divert youth from placement in costly institutional settings. While utilization and expenditure trends for HCBS services are largely in the right direction, continued work is needed to promote greater uptake of these services in Mississippi.

OVERVIEW OF MEDICAID DATA

- In FY 2014, Mississippi Medicaid spent a total of $184,485,255 on children's and youth's behavioral health services, or $1,183 per child receiving behavioral health care. Nationally, mean expenditure for children in Medicaid using behavioral health services was $4,400 in 2008 (the most recent year for which comparable national data are available).[1]
- Overall spending has decreased over the last four years by about 13% since FY 2010.

INSTITUTIONAL CARE UTILIZATION AND EXPENDITURES

- Forty-nine percent (49%) of Medicaid child behavioral health dollars in FY 14 were spent on services provided in institutional settings. Nationally, in 2008, 28.3% of child behavioral health dollars spent by Medicaid were spent on inpatient or psychiatric residential services.
- Spending for psychiatric residential treatment facilities and inpatient psychiatric hospitals increased by 11% and 6%, respectively, from FY 2010 to FY 2014.
- Among the institutional services, inpatient psychiatric hospitals experienced the greatest increases in the number of unduplicated utilizers. There was an increase of approximately 22% in the number of youth who utilized inpatient psychiatric hospitals from FY 10 to FY 14.
- In FY 10, there was a 10% increase in the number of youth who utilized psychiatric residential treatment facilities. Utilization remained steady from FY 11 to FY 14.

HOME- AND COMMUNITY-BASED UTILIZATION AND EXPENDITURES

- Among the home- and community-based service expenditures, significant amounts (over $1 million in a given year) are spent on assessment, community support, day treatment, individual therapy, intensive home-based treatment (MYPAC), and targeted case management; while relatively small amounts (under $1 million in a given year) is spent on services such as mobile crisis, crisis residential, peer support, and intensive outpatient.
- Despite declines in day treatment utilization, nearly a quarter of HCBS dollars continues to be spent on day treatment.
- There was a 64% increase in spending on MYPAC intensive home-based treatment from FY 10 to FY 14, with declines from FY 13 to FY 14, despite increases in claims and utilizers.
- In FY 14, there were almost $1 million in claims for crisis services, compared to approximately one-quarter of a million dollars in FY 12. This is a positive trend; however, in FY 14, only a small fraction of

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[11] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/

Medicaid beneficiaries' utilized crisis residential or mobile crisis services, suggesting a need to promote availability of these services among potential referral sources, including youth and families.

- An analysis of place of service data for community-based services revealed that in FY 2013, spending on services delivered in the home surpassed spending on services that occurred within the CMHC's offices, increasing by 21% from FY 10 to FY 14. This is an important finding, given the state's goal to increase service provision in homes and other community settings, rather than offices.

CHAPTER 2: EXPANDING THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

Chapter 2 offers an analysis of Mississippi's current HCBS benefit array, including design, operational policies and procedures, and utilization. It goes on to describe services that should be available in robust benefit design for youth, and offers recommendations to improve Mississippi's benefit design and operations. TAC/The Institute's review of Mississippi's HCBS service array found the following:

- While some providers are utilizing functional assessment tools, there is no common system-wide assessment being used to identify the service and support needs of youth or to measure system performance across providers and levels of care.
- A range of services, including some evidence-based practices and best practice approaches, are covered in Mississippi for those that are Medicaid enrolled or receiving DMH funded services. These services include crisis, wraparound, certain outpatient EBPs, respite, and flexible funding from DMH sources through the Making A Plan (MAP) team process. These services need to be grown and expanded further, and their outcomes monitored, so that rapid system and program adjustments can be made to achieve the intended benefit.
- Given how intensive care coordination and intensive family-based therapy are currently defined, it is not clear the extent to which these services are available.
- Services that are not currently covered are therapeutic mentoring, a substance use service continuum for youth, and supported education, vocational, and housing supports for transition-age youth. The availability of these services will help Mississippi achieve its goal to successfully address the behavioral health needs of youth. The benefit array is geared towards mental health treatment, with a limited array of substance use treatment services available.
- Additional infrastructure within the DMH and the DOM, as well as in providers, are necessary to support effective service delivery. These include additional training investment in family-centered EBPs and additional system infrastructure for quality monitoring and data collection and analysis to inform policy decisions.
- Mississippi has worked to meet the needs of special populations, such as transition-age youth and youth experiencing traumatic stress. These efforts are important and the state needs additional resources to expand such efforts to other populations that drive costs in the system, such as the foster care population; and to monitor and address any health disparities based on race, ethnicity, gender, and age.
- The components of the intensive care coordination using wraparound are optional; and the IOP service definition does not fully align with an intensive in-home family-based therapy definition. It is not clear what has been defined to bundle together to make a MYPAC level of care and an IOP level of care. Both MYPAC and IOP use the same state plan definition, yet each service is intended to be a different program, meeting different needs of different populations. Technical assistance and guidance offered to providers to date has not helped them to understand the state's expectations regarding the use of the new rehabilitation services, how to become a provider of these services, and how to bill for these services.
- Referrals to IOP have been slower than estimates of need would indicate. Reasons cited for this include: lack of awareness about the availability of this service among potential referral sources; some referral sources found wait times upon making a referral, thus some sources believed that making further referrals was futile; current level of care criteria and admission processes (specifically the psychiatric evaluation and IQ test requirements) critically delay access to this service; the bundled payment methodology has also created certain disincentives that limit interest of CMHCs and families in participating in IOP.

- The addition of mobile crisis to the service array is a positive development in Mississippi's system; its potential as an intervention to divert youth from more restrictive settings is not yet realized, and additional investments are needed in this critical service area.
- Mississippi's CSU operates similarly to an acute inpatient unit with reported lengths of stay of approximately 14 days, as opposed to a crisis stabilization unit, which would suggest a 2-3 day intervention intended to quickly stabilize the crisis and return the youth to their home and local schools.
- Respite is a service desired by many families, but access and availability of this service is limited. Currently, the Making A Plan (MAP) team process has access to limited funds from the DMH to purchase respite impacting the extent of its use in Mississippi.
- The capacity of institutions to use family-centered practices that ensure connection to family and community varied across the state.
- While providers report great success with peer support in substance use residential programs, crisis stabilization, and mobile crisis services, its use in providing support, systems navigation, and enhancing engagement among caregivers and young adults' remains relatively limited.

CHAPTER 3: PROVIDER CAPACITY

Chapter 3 highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. The assessment of provider capacity included an evaluation of the available behavioral health workforce and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

- The workforce shortage issues facing Mississippi have limited the capacity of community providers to serve youth and families. Child psychiatrists and mental health professionals with child-specific training and expertise were cited as factors contributing to access to care issues for youth and families in community settings. This is further hampered by the rural nature of the state, making it difficult to provide care and reach certain geographic locations.
- While wait time information is an important indicator of provider capacity, the state does not systematically gather information to monitor this issue reported by its stakeholders.
- Telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, yet was used by few behavioral health providers. There was a lack of information and awareness about available opportunities to expand tele-psychiatry among the CMHCs and IOP providers.
- Physicians are prohibited from entering into a collaborative agreement with an advance practice registered nurse (APRN) whose practice location is greater than 40 miles from the physician's practice site, and physicians may not enter into collaborative agreements with more than four APRNs at any one time. Given the rural nature of Mississippi, these requirements may limit the potential of APRNs to provide psychopharmacology to youth who may require it.
- DOM and DMH recently partnered to develop a training center for Wraparound Facilitation Training and Coaching. This is a critically important initiative and one that the state should be commended for undertaking. Stakeholders reported positive experiences with the training provided but expressed that greater family involvement in the design, development, and delivery of these trainings was needed.

- DMH's peer support specialist certification program is another positive area of workforce development. While the certification process established by DMH and the inclusion of peer support in the state's rehabilitation option is extremely positive, efforts need to address caregivers of youth with behavioral health challenges or young adults.

- While there are a total of nine certified providers of Wraparound and eight certified IOP providers, three providers delivered almost 97% of Wraparound facilitation services as of the end of FY 2013. CMHC providers offered that the low reimbursement rates for Wraparound facilitation and IOP have limited their interest in delivering these services.

- Uncompensated care is another issue constraining provider capacity in Mississippi. While the state's network of CMHCs are required by DMH to deliver a number of "core" services, providers report that the funding contributed by the state and the counties do not adequately cover the costs of delivering these services. DOM and DMH have offered to conduct a rate study on services this offer was reportedly declined by the Mississippi Association of Community Mental Health Centers.

- There appears to be great inconsistency and variation across the state with respect to the understanding of the different Medicaid service requirements, how to bill, and what is and is not allowable.

CHAPTER 4: QUALITY

Guided by standards published by the Institute of Medicine, in Chapter 4, TAC/The Institute evaluated Mississippi's approach to ensuring that care delivered to youth is of high quality. Major findings included:

- Mississippi's current approach to quality has largely focused on monitoring provider adherence to regulations established by DMH and DOM. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs. DOM plans to implement an OSCR process across all mental health programs.

- With the exception of MYPAC and PRTF, Mississippi has not yet deployed a systemwide quality improvement process that uses both qualitative and quantitative data to drive changes to the care delivery process. This type of approach requires data infrastructure and staff resources that DOM and DMH do not have at this time. Without this infrastructure, DMH and DOM will be hampered to fully implement needed changes in their system.

- Our review found there is no systematic review of data across child systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

- In sum, Mississippi's performance against many of those key indicators of quality described by the IOM, such as timeliness, effectiveness, efficiency, and family-centeredness, suggests the need for improvements in multiple areas in order to improve outcomes and care for the youth and families served by its public mental health system.

CHAPTER 5: INTERAGENCY COLLABORATION

Interagency collaboration and governance is a prerequisite for building an effective system of care and ensuring that children and youth have the services and supports necessary for remaining at home and in their communities. In Chapter 5, TAC/The Institute reviewed: the extent to which Mississippi's existing policies, structures, and procedures support interagency collaboration and coordination; limitations or barriers to

effective interagency collaboration; and the connection between agency-level policy priorities and client-level barriers and needs identified at a local level. Results of this analysis were:

- Mississippi's System of Care legislation enacted in 2010 provides a clear and impressive framework for establishing a three-tiered interagency governance structure. However, it has not been implemented with the desired intent at the state level.
- DOM is not able to manage a significant cost driver in its program, institutional care. This creates significant challenges for an agency that needs to control the Medicaid budget; and impacts the ability of DMH and DOM to redirect institutional placements with appropriate home- and community-based options. Instead, they manage lower cost services, in which only nominal savings can be achieved.
- There is disparate administration and financing of major components of the system across child welfare, juvenile justice, education, and public health. This has exacerbated the inherent differences between the roles of state agencies, has diffused accountability for the overall performance of the children's behavioral health system, and has perhaps created unintended incentives for cost- or care-shifting between systems and providers.
- The ICCCY, established to align child-specific issues, has not been implemented per the legislation, and the group has not convened since 2012. In addition, the ICCCY does not have authority to impact policy and funding decisions across all public service sectors.

CHAPTER 6: REDIRECTING INSTITUTIONAL CARE

Both institutional settings and home and community-based settings serve important functions in every behavioral health system. Chapter 6 evaluates: the balance of services, access, and utilization across community-based and 24-hour services, what system structures, policies, and procedures are in place to monitor appropriate use of restrictive settings, and whether any cross-system issues impact the use of restrictive settings over community-based options. Major findings included:

- Currently, the behavioral health system in Mississippi is weighted towards institutional settings. The majority of DMH dollars and DMH staffing, along with Medicaid and child welfare expenditures, are locked into maintaining institutions.
- Mississippi spends a greater proportion on institutions compared to national Medicaid expenditure data. In State Fiscal Year 2014, expenditures for psychiatric residential treatment facilities accounted for 26 percent of total Medicaid mental health spending, 7 percentage points higher than the national average.
- The average cost per user of residential was $49,000 in SFY 2014, more than double the national average. Spending on inpatient psychiatric services (including inpatient medical surgical) was greater than the national average, accounting for 24 percent of total mental health Medicaid expenditures in SFY 2014 (compared to 5 percent nationally).
- DMH spent $28.6 million on state mental health hospitals for children and youth, compared to a national average of $11 million. Per capita spending for state hospitals was the second highest in the country. In contrast, only $69 million was spent on community-based programs, compared to a national average of $179 million.
- The average length of stay for children receiving treatment at Oak Circle was 47.2 days in FY 2014, while the average stay for youth receiving psychiatric and substance abuse treatment at the Bradley Sanders Complex in FY 2013 was 125 and 87 days respectively. This level of service utilization exceeds the targeted length of state hospital service in most states.

- Mississippi is the only state in the country where inpatient care is left out of Medicaid managed care when managed care is utilized. This substantially limits the capacity for CCOs to prevent unnecessary hospitalizations, coordinate discharges, and arrange warm hand-offs.

- As previously stated, there is limited community-based alcohol and drug residential treatment beds accessible for publicly funded youth in Mississippi.

- Mobile crisis response was recently expanded, and its potential to divert children from institutional placements has not yet been realized. Additional investments in marketing the service, and supporting provider practice and system infrastructure, are needed.

- The role of courts as an opportunity to engage youth in appropriate treatment was repeatedly mentioned by those interviewed. For families and youth that had such experiences, they frequently indicated that they needed help but were not sure how to get the right help.

RECOMMENDATIONS

TAC/The Institute used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and data analysis to develop a list of actionable short- and long-term recommendations for Mississippi to implement. These recommendations include:

EXPAND THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

Recommendations in this chapter focus on implementing an effective benefit array across Medicaid and DMH. Streamlining and enhancing key components of Mississippi's HCBS benefit, including MYPAC/IOP, mobile crisis response and stabilization services, and other HCBS services based on national models, is necessary to support greater opportunities for youth to thrive in integrated community settings.

1. Review screening policies and data.
2. Implement a standardized assessment tool, and incorporate it into level of care determinations.
3. Further invest and develop a cohesive approach to mobile crisis response and stabilization, including issues related to call center capacity, availability, community education, training in best practices, stabilization capacity, warm-line capacity, allowable providers and other infrastructure.
4. More clearly define intensive care coordination, differentiate services that are bundled together, address MYPAC-specific requirements that impact access, address rate issues and allow reimbursement for coordination, and expand training efforts.
5. More clearly define in-home family-based therapy, differentiate services that are bundled together, address access, address rate issues and allow reimbursement for coordination, and implement an evidence-based training effort specific to in-home family-based models (e.g., multisystemic therapy, or MST).
6. Explore opportunities to expand respite and goods and services (flexible) funding.
7. Establish policies that support family-centered practice and effective transitions from institutional settings, and training for institutional staff in wraparound.
8. Expand SUD services for youth.
9. Further develop caregivers as peer workforce, and implement a caregiver support certification process.
10. Further support efforts for outpatient programs in EBP training and fidelity monitoring.
11. Continue to promote trauma-informed practices across the system.
12. Identify sustainable funding for transition-age youth services.
13. Implement a strategy to ensure access to HCBS for children that are not eligible for Medicaid.

ENHANCE AND EXPAND PROVIDER CAPACITY

1. Develop a provider network management strategy.
2. Review rates to ensure adequate coverage of transportation costs in service rates.
3. Improve access to child psychiatry services in the community.

4. Align staff credentials to their position responsibilities.
5. Review APRN Collaborative Agreement Requirements.

IMPROVE AND MONITOR QUALITY

1. Create a children's behavioral health quality dashboard.
2. Obtain regular feedback from youth and families about system performance.
3. Establish systems to help identify youth in need of services and make families aware of available behavioral health services.
4. Require the UM/QIO and MCOs to engage in at least one children's behavioral health performance improvement project annually.
5. Establish an on-site quality and compliance review process for state hospital facilities.
6. Establish strategies for rapid notification of CCOs and providers about admissions and discharges at 24-hour levels of care.
7. Publish an annual statewide report of findings from MAP teams.

PROMOTE INTERAGENCY COLLABORATION

1. Establish a Children's Cabinet.
2. Facilitate interagency collaboration.
3. Further empower MAP teams.

REDIRECT INSTITUTIONAL CARE

1. Redirect care towards increased use of HCBS and decreased use of institutions.
2. Include the institutional benefit into Medicaid managed care strategies.
3. Conduct an immediate review of all institutionalized youth.
4. Conduct ongoing reviews of youth at risk for institutional placement.
5. Redirect expertise of institutional staff towards needed community-based care.
6. Promote mental health collaboration in youth and chancery courts.
7. Revisit Inclusion of Treatment Foster Care as a Medicaid Benefit

INTRODUCTION

DOJ INVESTIGATION AND FINDINGS

In 2011 the U.S. Department of Justice (DOJ) launched an investigation of the State of Mississippi's system for delivering services and supports to individuals with mental illness and/or developmental disabilities. Their review found that the State of Mississippi failed to meet its obligations under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § § 12131-12134, and its implementing regulations, 28 C. F. R. pt. 35, by unnecessarily institutionalizing individuals with mental illness or developmental disabilities in public and private facilities, and failed to ensure that they are offered a meaningful opportunity to live in integrated settings consistent with their needs. Specifically, DOJ found the state in violation of Olmstead v. L.C., 527 U.S. 581 (1999), which requires that individuals with mental illness and developmental disabilities receive services and supports in the most integrated setting appropriate to their needs.

As it relates to children, DOJ found that Mississippi fails to provide medically necessary services to child with disabilities in violation of the Social Security Act's Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate. As a result many Medicaid-eligible children do not have access to home- and community-based mental health and substance use disorder services and enter psychiatric facilities when they could be served in the community if such services were available. In addition to non-compliance with EPSDT, DOJ found that the state's failure to serve youth in the most integrated settings appropriate to their needs violates Title II of the Americans with Disabilities Act (ADA).

In an August 29, 2014, letter of agreement[2], Mississippi and DOJ agreed to engage in intensive negotiations for the purpose of reaching a comprehensive settlement agreement to resolve DOJ's claims relating to services for children with mental health conditions. These negotiations include counsel for the Troupe plaintiffs[3] and an attempt to resolve the Troupe claims within the agreement. The State also agreed to contract with consultants from the Technical Assistance Collaborative (TAC)/The Institute for Innovation & Implementation housed at the University of Maryland (The Institute) with system expertise in successfully serving children with significant behavioral health needs in community settings. TAC is a national nonprofit organization that provides policy leadership, technical assistance and consultation for many federal, state and local government agencies on such topics as mental health, substance use, developmental disabilities, child welfare, juvenile justice, homelessness, and affordable housing systems. The Institute is a national technical assistance center addressing policy, systems design, financing, training, technical assistance, and evaluation. The Institute works with federal agencies, states and localities, foundations and private organizations to design, implement, and evaluate effective systems and practices to best meet the needs of children and youth with complex behavioral needs and their families.

The primary role of TAC/The Institute identified in the August 29, 2014, letter was to assist the State and DOJ during settlement discussions by assessing the State's current service array, quality, and availability, and make recommendations for necessary improvements. Per the agreement between the State and DOJ, any final settlement would contain provisions that address, at a minimum, the following issues:

- Wraparound facilitation, implemented in fidelity to the national model;
- Flexible, intensive home- and community-based services per national models;

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[2] Letter of Agreement between Mississippi Attorney General and the U.S. Department of Justice, August 29, 2014.

[3] In 2010, a lawsuit was filed in the United States District Court for the Southern District of Mississippi on behalf of the class of Mississippi Medicaid-eligible children with behavioral health disorders. The lawsuit, Troupe v. Barbour, alleged that Mississippi systematically failed to meet the needs of children and unlawfully placed them in institutional settings that did not provide adequate services. It also claimed that Mississippi failed to make available federally mandated and medically necessary home- and community-based behavioral health services and violated the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act.

- Mobile crisis intervention and stabilization for all children who are at serious risk of institutionalization, including those who are receiving intensive home- and community-based services;
- A process through which the State will identify all children who are institutionalized or at serious risk of institutionalization and ensure the availability of these services for the children who need them; and
- Provisions to expand and improve provider capacity.

METHODOLOGY

TAC/The Institute were engaged by Mississippi Leadership to conduct an assessment of Mississippi's children's behavioral health system and identify recommendations for system improvements. This Needs Assessment was conducted over an eight-week period from October 2014 to December 2014. TAC/The Institute's approach to information gathering for this assessment was twofold: 1) A quantitative analysis of Mississippi Medicaid and DMH participant characteristics, claims, and encounters; and 2) An in-depth qualitative analysis of all relevant documents, selected records of youth's care, and interviews with stakeholders, youth and adult consumers, family members, associations, advocacy groups, and state personnel.

TAC/The Institute applied a multifaceted approach to gathering information, including conducting a literature review, synthesizing quantitative and qualitative data, interviewing stakeholders and key informants, and applying TAC/The Institute's extensive expertise analyzing similar data in other states. Specifically, methods included:

- Analysis of populations served, service utilization, Medicaid claims and expenditures, quality data, and other system indicators from DOM and DMH.
- Review of one hundred two (102) state documents.
- Review of eighteen (18) client records.
- Discussions with two hundred eighteen (218) key informants.

The state provided quantitative data from DMH and DOM. Data from DMH included Substance Abuse and Mental Health Services Administration (SAMHSA)-mandated State Mental Health Authority Uniform Reporting System (URS) tables, as well as enrollment and utilization of state psychiatric hospitals, therapeutic group homes and therapeutic foster care, and crisis intervention services.

DOM provided five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, which coincided with implementation of managed care in MS). These data included Medicaid enrollment, utilization, place of service and expenditures for behavioral health services. A listing of claim/encounter fields received can be found in the Attachments.

TAC/The Institute reviewed documents and literature from a variety of sources, including DMH, DOM, Department of Human Services (DHS), Department of Health, and the Department of Education. The State identified and provided numerous legislative and other reports, policy, quality, and procedural documents for review. In total, one hundred two (102) documents were provided from DMH and DOM. These documents offered details on system indicators and issues being tracked by the programs, and policy and quality issues identified and monitored by leaders in various state agencies. A listing of documents provided can be found in the Appendix.

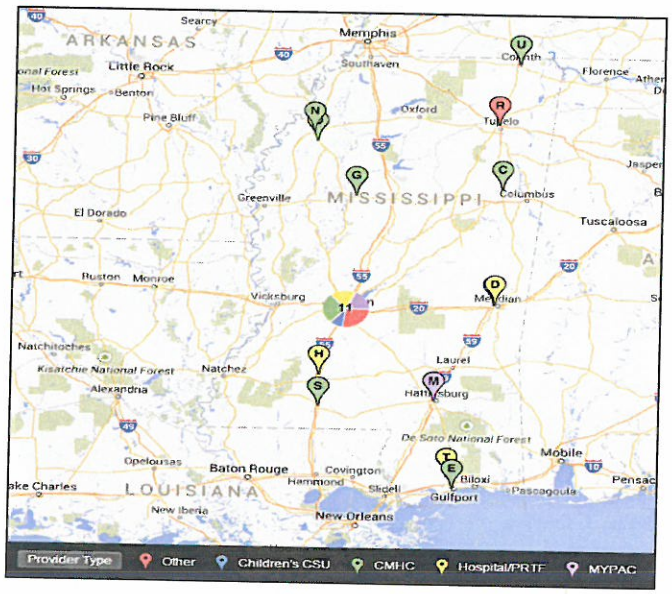
A review of approximately eighteen (18) clinical records of youth served in the behavioral health system was also conducted to evaluate the appropriateness of services utilized by youth, admissions and discharges from services, and coordination across services and child-serving systems. Records selected included samples from children presented to the statewide Making A Plan (MAP) team, children served by each of the three Mississippi Youth Program Around the Clock (MYPAC) providers post the 2012 migration of that service from the Medicaid waiver to coverage under the state plan, and records of children that had at least two

institutional placements and were not enrolled in MYPAC. Records reflected regional variation across the state, and included information from across the provider system for those youth. The sample of records is too small to generalize in an empirical way to the broader system; however, the review did provide a snapshot of system interface, provider response, and planning of care that cannot be gleaned from claims analysis.

A significant part of the qualitative analysis involved engaging and interviewing an exhaustive list of stakeholders. TAC/The Institute conducted interviews with two hundred eighteen (218) people individually or in small focus groups. These individuals included youth, adult consumers and families, providers, state personnel, Medicaid's MississippiCAN vendors called Coordinated Care Organizations (CCOs), and its Medicaid fee for service utilization management and quality vendor (UM/QIO), advocates, and associations. Key informants were identified using a "snowball" identification process, where State officials and DOJ identified an initial group of key informants for each of the identified topic areas, and this initial group of informants identified additional subject matter experts, and so on. Interviews were confidential and were not conducted in the presence of DMH or DOM staff, with the exception of a state hospital site-visit and the CCO interviews. A complete listing of key informants can be found in the Appendix. Please note that names of current consumers and some family members are not included in order to maintain their confidentiality as service recipients; however, they are included in aggregate numbers. Note that during the course of interviews with recipients of care, TAC/Institute did not collect specific information from individuals interviewed, including specific services that were received and the time frame (dates) in which those services were received.

Interviews with key informants took place telephonically and via two site-visits. The first site-visit occurred from October 21 to October 23 and included meetings with state leadership from DMH, DOM, and DHS, MYPAC providers, mobile crisis and stabilization providers, focus group at MS Families as Allies, and Community Mental Health Center (CMHC) leadership. The second site-visit took place from November 1 to November 11 and consisted of visits to a statewide sample of behavioral health service providers, including state psychiatric hospitals, psychiatric residential treatment facilities (PRTFs), MYPAC providers, CMHCs, crisis stabilization units (CSUs), therapeutic group home and foster care providers, and the Mississippi Adolescent Center, a facility that primarily serves children and youth with intellectual and developmental disabilities. In all, TAC/The Institute visited 22 total providers and 25 provider sites located throughout the state. The map below indicates the location of providers visited; and a complete listing of the providers visited can be found in the Appendix. Specifically, providers visited included all three (3) MYPAC providers, 79 percent of CMHCs, both state psychiatric hospitals serving children and youth, the one CSU provider for children, and 25 percent of in-state PRTFs. The themes that emerged from these meetings, interviews, and reviews of written materials are included throughout this report.

Provider Site-Visit Locations



TAC/The Institute used the information learned during the environmental scan, empirical knowledge of best practices, systems expertise, and analysis of MS data to develop a list of actionable short- and long-term recommendations for Mississippi to implement. These recommendations include:

1. *Expanding the Home- and Community-Based Service Array.* Recommendations in this chapter focus on implementing an effective benefit array across Medicaid and DMH. This chapter identifies methods to streamline and enhance key components of Mississippi's HCBS benefit, including IOP, mobile crisis response and stabilization services, and other HCBS services based on national models.
2. *Expanding Provider Capacity.* This chapter also addresses Mississippi's workforce shortages and explores provisions to expand and improve provider capacity, including psychiatry, licensed staff, credentialed staff, and use of peers.
3. *Improving and Monitoring Quality.* This chapter identifies quality priorities, and necessary processes and measures to promote quality across the children's behavioral health system.
4. *Promoting Interagency Collaboration.* This chapter addresses governance structures, interagency priorities and processes to build an effective system that promotes behavioral health for all Mississippi youth.
5. *Redirecting Institutional Care.* This chapter includes recommendations that primarily address DOJ's concern of ensuring a process through which the State identifies all children who are institutionalized or at serious risk of institutionalization, including front door, tracking, and policies with other systems.

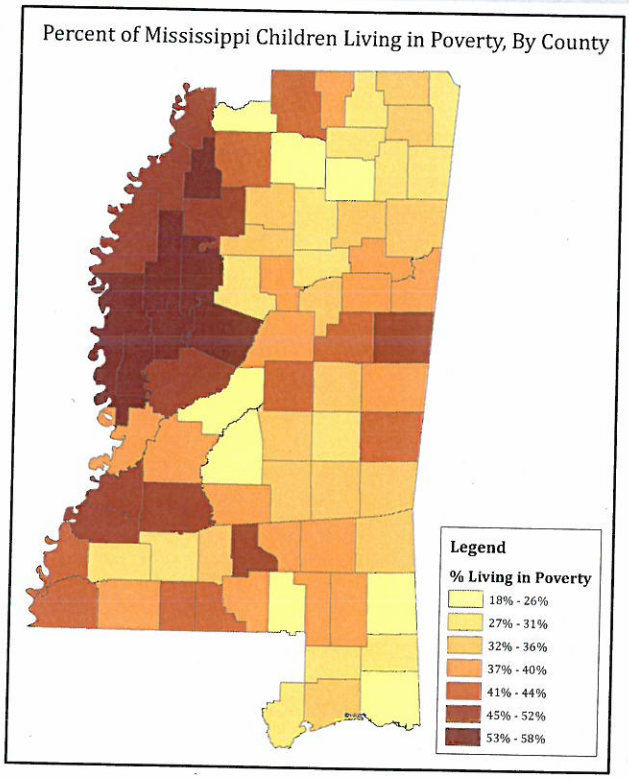
LIMITATIONS/CONSTRAINTS

This assessment faced several limitations and constraints. First, the agreement between MS and DOJ required a very rapid timeline for this project. The assessment began in late September 2014, with a first draft of the report due in January 2015, and a final report due in February 2015. While DMH and DOM worked rapidly to

provide the range of documents and data requested, the condensed timeframe limited the scope to DMH and DOM expenditures and activities. As a result, a broader cross-system review of other important behavioral health expenditures and activities conducted by the state, in child welfare, juvenile justice, education, and public health, could not be included. Additionally, data related to the uninsured or those privately insured, to physical health and primary care clinician behavioral health screenings, or pharmacy data were also not part of this review. Finally, Medicaid claims data were presented by the Mississippi Division of Medicaid in aggregate form only and were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.). Consequently, data pertaining to behavioral health disparities among underserved and minority populations were not analyzed.

STATE CONTEXT

There are 909,608 children and youth ages 0 to 21 residing in Mississippi. An estimated 51 percent of children are male and 49 percent are female. About 49 percent of the childhood population is Caucasian, 43 percent African American, and 4 percent Hispanic or Latino[4]. The unemployment rate among adults is about 9 percent, the third highest in the country[5], and 32 percent of high school students do not graduate on time, the second highest rate in the country[6]. An estimated 44.8 percent of children live in single-parent households. In addition, approximately 34 percent of Mississippi's childhood population lives in poverty, the highest rate in the country, with about 17 percent of children living in extreme poverty (50 percent below the Federal Poverty Line). An estimated 28 percent of children live in areas of concentrated poverty (the highest in the country by 6 percentage points). Minority groups are disproportionately represented in these areas, with 47 percent of African American and 23 percent of Hispanic or Latino children living in high poverty areas, compared to 28 percent of Caucasian children.[7]



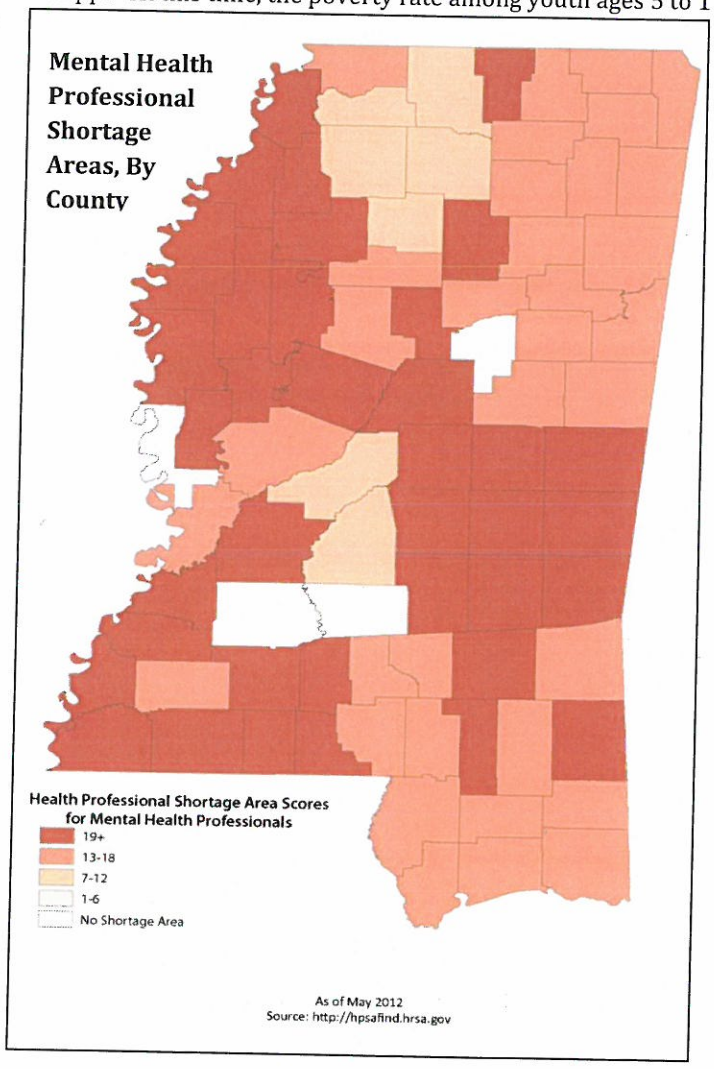
[4]U.S. Census Bureau, [2009-2013] American Community Survey

[5]U.S. Department of Labor, Bureau of Labor Statistics (BLS). Local Area Unemployment Statistics, Annual Average, "Unemployment rates for states" [2013]

[6]Population Reference Bureau, analysis of data from the U.S. Department of Education.
U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), State Dropout and Completion Data, accessible online at http://nces.ed.gov/ccd/drpcompstatelvl.asp.

[7]U.S. Census Bureau, [2009-2013] American Community Survey

To calculate prevalence rates of serious emotional disturbance (SED) among children and youth in Mississippi, we apply methodology issued by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services[8], which uses poverty as a proxy to provide a range of estimates of the prevalence of SED among youth ages 9 to 17. In 2013, there were approximately 369,698 youth between the ages of 9 and 17 living in Mississippi.[9] At this time, the poverty rate among youth ages 5 to 17 was 29.1 percent, the second highest in the United States (note: poverty rates specific to the 9 to 17 age group were not available).[10] This relatively high poverty rate places Mississippi in a group of states with the highest prevalence of SED in the country. It is estimated that 11 to 13 percent of the population ages 9 to 17, or 40,667 to 48,061 youth, have an SED. The estimated prevalence of the more severely impaired group of children and youth is seven to nine percent of the population ages 9 to 17, ranging from 25,879 to 33,273 youth. The prevalence rate of SED among transition-age youth ages 18 to 21, is calculated at 9.2 percent, accounting for a total of 15,840 youth. Please note that prevalence data of SED among youth younger than 9 years old were not available for this assessment.



According to the U.S. Department of Health and Human Services, National Survey of Children's Health, 20 percent of parents of children ages 2 to 17 report that a doctor told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.[11] Further, about 6 percent of Mississippi's youth ages 12 to 14 reported dependence on or abuse of illicit drugs or alcohol in the past year.[12]

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[8]FEDERAL REGISTER, Volume 63, Number 137, July 17, 1998.

[9]U.S. Census Bureau. [2014]. Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2013.

[10]U.S. Census Bureau. [2014]. 2014 Annual Social and Economic Supplement.

[11]U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. [2011-2012] National Survey of Children's Health.

[12]Substance Abuse and Mental Health Services Administration. [2011-2012]. State Estimates of Substance Use from the 2011-2012 National Surveys on Drug Use and Health Report, Appendix B.

With about 51 percent of its population living in a rural area (compared to 19 percent nationally), Mississippi is the fourth most rural state in the country.[13] According to information from Northeast Mississippi Area Health Education Center at Mississippi State University, as of April 2012, approximately 2.1 million Mississippi residents reside in a mental health professional shortage area, with an estimated 1.1 million of those residents considered "underserved."[14] It is estimated that about 279,400 children reside in an undeserved area, accounting for approximately 38 percent of the total childhood population. In addition, Mississippi has only 4.3 child and adolescent psychiatrists per 100,000 youth, the lowest rate in the country.[15]

Mississippi's public community mental health system served 36,990 children and adolescents (0 through 21) with serious emotional disturbance in FY 2012. Of this total number of people, about 96 percent met the federal criteria for an SED. Children and youth served by the public behavioral health system were 36 percent more likely to be African American/Black and male. [16]

In 2012, Mississippi's mental health authority, the Department of Mental Health (DMH), spent about $98 million on mental health services for children ages 0 to 18, compared to a national average of $190 million.[17] Of that total, $69 million was spent on community-based programs, with a per capita spending of $93. Nationally, total spending on community-based programs for youth averaged $179 million, with an average per capita spending of $124.[18] DMH's expenditures for state mental health hospitals among youth totaled $28 million, the fourth highest in the country (the national average was $11 million). Per capita spending in this category was $38, the second highest in the country (compared to a national average of $8).[19] Table 1 on the next page displays total expenditures and per capita spending by state mental health authorities in the Southeast region of the United States.

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[13]U.S. Census Bureau. [2010]. Urban, Urbanized Area, Urban Cluster, and Rural Population, 2010: United States.

[14]Northeast Mississippi Area Health Education Center at Mississippi State University. (n.d.) Healthcare Infrastructure Shortage Areas. Retrieved on November 17, 2014 from: http://nemsahec.msstate.edu/?page_id=437

[15]Substance Abuse and Mental Health Services Administration. [2012]. Behavioral Health, United States, 2012.

[16]Mississippi Department of Mental Health. [2012]. 2012 URS File.

[17]Substance Abuse and Mental Health Services Administration. [2012]. Table 13: SMHA-Controlled Mental Health Expenditures by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

[18]Substance Abuse and Mental Health Services Administration. [2012]. Table 15: SMHA-Controlled Mental Health Expenditures at Community-Based Programs, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

[19]Substance Abuse and Mental Health Services Administration. [2012]. Table 14: SMHA-Controlled Mental Health Expenditures at State Mental Hospitals, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/ Data includes Medicaid match unless otherwise indicated.

Table 1: State Mental Health Authority- Controlled Mental Health Expenditures at State Psychiatric Hospitals and Community-Based Programs for Children and Adolescents (Southeast US)

	State Psychiatric Hospitals		Community-Based Programs	
	Total (in millions)	Per Capita	Total (in millions)	Per Capita
Alabama	$0.00	$0.00	$32.55	$28.95
Arkansas	$7.31	$10.28	$4.35	$6.12
Florida	$0.00	$0.00	$88.56	$22.13
Georgia	$0.00	$0.00	$105.27	$42.28
Louisiana	$14.22	$12.73	$26.64	$23.84
Mississippi	$28.62	$38.39	$69.82	$93.68
North Carolina	$24.72	$10.81	$631.59	$276.22
South Carolina	$15.50	$14.35	$51.30	$47.51
Tennessee	$0.00	$0.00	$180.50	$120.82
Virginia	$9.60	$5.17	$113.70	$61.24

In addition to the aforementioned data from DMH, data was also provided by the Division of Medicaid. According to Mississippi Medicaid claims data for children and youth ages 0 to 21, in 2014 institutional placements accounted for nearly half (49 percent; $91.2 million) of total behavioral health spending, compared to 51 percent ($93.3 million) for home- and community-based services. The largest total amount of spending for any one service in 2014 was for Psychiatric Residential Treatment Facilities (26 percent of total spending). Other inpatient services, including psychiatric hospitalization, outpatient hospitalization, and medical surgical hospitalization, accounted for an additional 24 percent of total spending.

Mississippi served 456 youth (0.6 per 1,000 youth) ages 0 to 17 and 219 (1.6 per 1,000 youth) young adults ages 18 to 21 in state psychiatric hospitals in 2012. Nationally, these rates were 0.2 per 1,000 youth and 0.5 per 1,000 youth, respectively. In addition, the proportion of children and youth served in state hospitals compared to other age groups is higher than the national average, with about 11.8 percent of those served being youth ages 0 to 17, compared to 7.0 percent nationally.

KEY STATE AGENCIES

This next section summarizes the principal agencies (namely the Division of Medicaid and Department of Mental Health) and programs that comprise Mississippi's behavioral health system for children and youth. While it is understood that other child-serving agencies are important elements in every system of care, they will only be described insofar as they interact with the behavioral health system to keep within the scope of this needs assessment. Behavioral health treatment services purchased by agencies other than DMH and DOM were not examined.

DEPARTMENT OF MENTAL HEALTH

Mississippi's public behavioral health system is administered by the Department of Mental Health (DMH). DMH is organized into three components: The Board of Mental Health, the DMH Central Office, and DMH-operated Programs and Community Services Programs. The Board of Mental Health is responsible for governing DMH and includes a physician, a psychiatrist, a clinical psychologist, a social worker with relevant experience, and citizen representatives. The Central Office oversees administrative functions of DMH and implements policies set forth by the State Board of Mental Health. The DMH Central Office is divided into six bureaus, including the Bureau of Administration, the Bureau of Mental Health, the Bureau of Community

Mental Health Services, the Bureau of Alcohol and Drug Services, the Bureau of Intellectual and Developmental Disabilities, and the Bureau of Quality Management.

Established within the Bureau of Community Services, DMH's Division of Children and Youth Services is responsible for determining the behavioral health needs of children and youth in the state and for planning and developing programs to meet those needs. They also allocate budgetary resources and coordinate the establishment of programs. Some federal and state funds for direct community mental health services for youth are provided by grants between the DMH and the regional CMHCs and/or other public or private non-profit mental health service providers.

The components of the behavioral health delivery system include: DMH-operated programs, regional community mental health centers (CMHCs), and other nonprofit/profit service agencies/organizations that provide community services and/or institutional services.

State-operated programs. DMH-operated hospitals and facilities that serve children include:

1. Oak Circle Center at the Mississippi State Hospital, a 60-bed facility that provides acute, short-term inpatient psychiatric treatment for children and adolescents, ages 4 to 17;
2. Bradley A. Sanders Adolescent Complex at East Mississippi State Hospital, a 50-bed short-term (up to 90 days) unit that provides psychiatric and substance abuse treatment to adolescent males.
3. Mississippi Adolescent Center, a 32 -bed facility for youth with intellectual or developmental disabilities that has recently expanded to include youth with behavioral health needs; and
4. The Specialized Treatment Facility, a 48-bed PRTF for youth who have come before Youth Court and have been diagnosed with a mental disorder.

Community Mental Health Centers. The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars, forming the backbone of Mississippi's public, community behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental illness, and emotional and substance use disorders
- Reduce the number of initial admissions to the state hospitals
- Prevent readmissions through supportive aftercare services

CMHCs operating under the authority of regional commissions must provide the following core services for children and youth in each county in the CMHC's entire catchment area:

- Day Treatment Services
- Outpatient Therapy
- Community Support Services
- Psychiatric/Physician Services
- Emergency/Crisis Services, including mobile crisis for youth
- Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over)
- Making a Plan (MAP) Teams
- Targeted Case Management Services
- Peer Support Services for adults
- Support for Recovery/Resiliency Oriented Services

Other nonprofit/profit service agencies/organizations. These programs are certified by and may receive funding from DMH, as well as other sources, to provide additional community-based or institutional services. In addition to the fourteen (14) Community Mental Health Centers, DMH certifies fifteen (15) nonprofit agencies that provide community services to children with mental health needs, and an array of providers

offering community-based substance abuse services and community services for persons with intellectual/developmental disabilities. In addition to DMH operated programs, there are eleven (11) organizations providing acute inpatient and PRTF services. It is important to note that many of these institutional providers are based on a certificate of need that is determined by the health department and approved by the state legislature.

DIVISION OF MEDICAID

The "Mississippi Administrative Reorganization Act of 1984" established the powers and responsibilities of the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program. The duties of the Division of Medicaid Agency are set out by State and Federal legislation and the approved Mississippi State Plan and include setting regulations and standards for the administration of the Medicaid programs, with approval from the Governor, and in accordance with the Administrative Procedures Law.

DOM's Office of Mental Health oversees mental health programs and it is comprised of two divisions, including Mental Health Services Division, which is responsible for:

- Acute freestanding psychiatric facilities,
- Community/private mental health centers,
- Therapeutic and evaluative mental health services for children,
- Outpatient mental health hospital services,
- Pre-admission screening and resident review,
- Psychiatric residential treatment facilities, and
- Psychiatric units at general hospitals.

The other division is the Special Mental Health Initiatives Division, which administers:

- Autism pilot program,
- Federally qualified health centers and rural health clinics,
- In-patient detox for chemical dependency,
- Intellectual disabilities/developmental disabilities,
- Mississippi Youth Programs Around the Clock (MYPAC), and
- Psychiatric services by physician or nurse practitioner.

In 2011, Mississippi implemented a coordinated care program for Mississippi Medicaid beneficiaries called the Mississippi Coordinated Access Network (MississippiCAN) under a 1932(a) State Plan Authority. Managed by the DOM Bureau of Coordinated Care, MississippiCAN employs two coordinated care organizations (CCOs), Magnolia Health Plan and United Healthcare that offer the full range of Medicaid benefits to enrollees. In 2012, mental health benefits, previously offered fee for service, were included. Coverage is available fee for services, outside of this managed care arrangement, for inpatient hospital services, Waiver services, and transportation services. MississippiCAN is available in all 82 counties, and covers 45 percent of Medicaid beneficiaries. This enrollment number is mostly adults with increased enrollment of children in CCOs planned in 2015.

Services that are left out of MississippiCAN (inpatient hospital services, Waiver services, and transportation services) are provided through Mississippi Medicaid's traditional fee-for-service system. Both non-managed care enrolled Medicaid beneficiaries and fee-for-service benefits are managed by eQHealth Solutions (eQHealth), which serves as the state's Utilization Management and Quality Improvement Organization

(UM/QIO). The eQHealth conducts prior authorizations and quality of care reviews for beneficiaries enrolled and services covered in the fee-for-service system.

In State Fiscal Year (SFY) 2014, there were 539,261 children ages 0 to 21 enrolled in Mississippi Medicaid. Of this total, 91,966 (17%) were enrolled in the state's managed care program and 447,295 (83%) were enrolled in the traditional fee-for-service program. Of those enrolled in Medicaid, 156,524 used some type of behavioral health service in SFY 2014. This number is a combined number across both managed care and fee for service, thereby duplicating the count of total utilizers[20].

There are eight hospital-based facilities (six private/nonprofit and two DMH operated) providing acute psychiatric inpatient services for children and adolescents in Mississippi. The Mississippi state legislature has placed a moratorium on the approval of new Medicaid-certified child and adolescent beds within the state. There are also a total of seven psychiatric residential treatment facilities (PRTFs) in the state (six private and one DMH-operated facility.)

Mississippi's preeminent institutional diversion program for children and youth is Mississippi Youth Programs Around the Clock (MYPAC), administered by DOM's Special Mental Health Initiatives Division. MYPAC (begun in 2007) was formerly a 1915(c) Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program and in 2014 was integrated into Mississippi's State Rehab Option as intensive outpatient psychiatric (IOP) services. Its benefit array includes a bundle of services, most notably wraparound facilitation based on a national model.

As noted earlier, along with the state's behavioral health authority, DMH, Medicaid has a significant role in providing behavioral health benefits to children. A critical component to Medicaid for youth is Early Periodic Screening Diagnosis and Treatment (EPSDT), which is designed to ensure the availability and accessibility of health care services and to assist eligible individuals and their families in effectively using their health care resources. The EPSDT program is intended to ensure that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.[21] DOM is currently updating its guidance and requirements for the behavioral health screening component of EPSDT.

Beyond Medicaid enrollees, there are a host of children that are either uninsured or privately insured that do not have access to the same benefits as Medicaid enrollees. For these children, the availability of home- and community-based services through other funding is important. Additionally, there are behavioral health services not allowable under Medicaid that have evidence to their effectiveness. It is for these reasons that opportunities to identify all potential funding streams are identified in this report in order for the state to provide a full continuum of behavioral health care for all Mississippi children and families.

OTHER CHILD-SERVING AGENCIES

Mississippi Department of Education. This agency oversees the State's local education authorities (LEAs) and designates policies to address behavioral health needs in school. Youth presenting with behavioral health or emotional needs are referred to Teacher Support Teams (TSTs), problem-solving units responsible for developing intensive interventions specifically designed to meet students' individual needs. TSTs are comprised of teachers, counselors, and/or school psychologists and engage in a four-step management plan to address behavioral health needs. The steps include functional behavioral assessment and identification, planning, intervention, and referral. TSTs frequently refer youth and families to CMHCs when their needs cannot be met with school supports alone. In addition, CMHCs routinely collaborate with LEAs to provide day treatment and other therapeutic services in the schools.

[20] Please see Chapter 1 *Medicaid Data Analysis* for further discussion of this issue.

[21] http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf

Mississippi Department of Human Services. This agency is responsible for Mississippi's child welfare and juvenile justice programs. DHS requires that all youth involved in the child welfare system receive an initial mental health assessment within 30 days of the opening of their case. To facilitate this requirement, some CMHCs designate a specific day of the week to assess DHS-involved youth. Standards specify that CMHCs must offer services to DHS-involved youth with behavioral health needs (this process is in place to address the Olivia Y. Lawsuit).

The Division of Youth Services (DYS) within DHS administers the community services and institutional programs for juveniles who have been adjudicated delinquent in Mississippi Youth Courts or who are at risk of becoming delinquent. In addition, DYS operates the Adolescent Opportunity Program in partnership with DMH, which serves as a mechanism to coordinate services, share resources, and reduce the number of young offenders placed in state custody. DHS operates one state juvenile facility, called the Oakley Youth Development Center.

Mississippi Department of Health. The Mississippi Department of Health (DOH), Office of Health Facilities Licensure and Certification is the Mississippi regulatory agency responsible for licensing hospitals and psychiatric residential treatment facilities. The office establishes and monitors minimum standards of operation for PRTFs and is authorized to deny, suspend, or revoke a license for failure to comply with requirements established under the law and regulations. The DOH reviews applications for a Certificate of Need (CON) for the establishing, offering, or expansion of acute psychiatric, chemical dependency beds for children and adults, and psychiatric residential treatment beds and services. In its 2014 State Plan, DOH indicated that there were 250 child and adolescent psychiatric beds operating in Mississippi in 2014, and projected a statewide child and adolescent psychiatric bed need of 251 beds (0.55 per 1,000 population aged 7 to 17) in 2015. In addition, DOH projected that Mississippi would need 283 PRTF beds in 2015, 15 fewer than the number of licensed beds in 2014. The Mississippi State Legislature has placed a moratorium on the approval of new Medicaid-certified child and adolescent beds.[22]

Youth and Chancery Courts. Youth Courts are offered in 21 counties that have a County Court and manage issues involving abuse and neglect of children and youth under the age of 18, in addition to offenses committed by juveniles. In the remaining counties that do not have a County Court, a Chancery Judge may hear Youth Court matters, or may appoint a lawyer to act in a judicial capacity as a Youth Court Referee. Once a child is ordered into custody, the Youth Court or Chancery Court has authority to commit the child to DMH or order DHS or any other public agency to provide for the custody, care, and maintenance of the child. As of 2013, there were 83 Youth Courts (82 counties and one municipality), 16 county detention facilities (entirely funded at the local level), 21 County Court judges, 49 chancellors, 62 referees, and one municipal court judge.

[22] MS Department of Health. (2014). Mississippi State Health Plan. Retrieved from http://www.babc.com/files/Publication/102e84c1-78cc-4720-92f3-426c77506093/Presentation/PublicationAttachment/4a031e53-adb6-495a-9a45-e3903ba1669b/2014%20State%20Health%20Plan.pdf

CHAPTER 1: MEDICAID DATA ANALYSIS

INTRODUCTION

The following chapter summarizes an analysis of five years of Medicaid fee for service claims data (2010-2014) and two years of managed care data (2013-2014, coinciding with the implementation of managed care for behavioral health services in Mississippi). These data included Medicaid enrollment, utilization, place of service, and expenditures for all behavioral health services provided to children and youth ages 0-21, including inpatient care and home- and community-based services (HCBS). Lengths of stay data for acute inpatient facilities and the state-run psychiatric residential treatment facility (PRTF) are also provided.

The following categorization of services was used:

- The institutional placement category included psychiatric residential treatment, inpatient psychiatric hospitalization, outpatient hospitalization, and inpatient medical surgical hospitalization.
- All other services comprised the home- and community-based category, including, but not limited to, day treatment, crisis residential, MYPAC services, intensive outpatient psychiatric (IOP), community support services, targeted case management, and partial hospitalization.

When reviewing the data, please note that some services can be provided concurrently and that none of the services are exclusive.

The Medicaid claims data analysis was limited by the condensed timeframe for this report which only allowed for review of Medicaid data in aggregate form. Data were not broken out by demographic variables (e.g., race, ethnicity, gender, age, etc.) and as a result, data relating to behavioral health disparities among underserved and minority populations were not analyzed. In addition, validity of place of service data may be limited due to provider coding and data entry errors. DOM recognizes that increased training is needed in this area.

The chapter is organized into six sections:

- Overview of Medicaid fee for service and managed care spending and utilization for behavioral health services in Mississippi, including lengths of stay data for selected inpatient providers;
- Medicaid expenditure data for each behavioral health service category (institutional and home and community-based);
- Total claims and unduplicated counts of utilizers for each service;
- Analyses on specific home- and community-based services, including day treatment, crisis services and intensive home-based treatment (MYPAC) services;
- Average length of stay data for psychiatric acute inpatient facilities for children and youth under 21 and DMH-operated psychiatric facilities;
- Analyses of place of service codes.

All charts and tables that correspond with this summary can be found in the Data Appendix.

MEDICAID BEHAVIORAL HEALTH EXPENDITURES AND MEDICAID ENROLLMENT

In State Fiscal Year (FY) 2014, Mississippi Medicaid spent **a total of $184,485,255 on children and youth's behavioral health services, or $1,183 per child receiving behavioral health care.** Nationally, mean expenditures for children in Medicaid using behavioral health services was $4,400 in 2008 (the most recent year for which comparable national data are available).[23] Overall spending has decreased by about 13% since FY 2010, from a high of $210 million in FY 2010 to approximately $185 million in FY2014.

[23] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/

This reduction in expenditures is striking given the increase in youth Medicaid covered lives during this same timeframe. Medicaid enrollment went from 455,064 covered youth in FY 2010 to 539,261 covered youth in FY2014.

During this timeframe, the Medicaid penetration rate by children ages 0-21, or the rate of utilization of behavioral health services, decreased from 36% in FY 2010 (164,103 utilizers) to 29% in FY 2014 (156,524 utilizers). **It is important to note that the number of utilizers reported is a duplicated count and overinflates the penetration rate.**

An analysis of expenditure data by service type (institutional or home and community) indicates **an overall decrease in all behavioral health spending during this time period.** From FY2010 to FY2014, spending for community-based services declined from approximately $109 million to $93 million, an approximate 15% decrease. During this time period, spending for institutional services decreased by 11% (from $103 million in FY2010 to $91 million in FY2014).

In terms of the distribution of dollars across institutional settings and home and community based care:

- 49% of Mississippi Medicaid child behavioral health dollars in FY 14 were spent on institutional services.[24] Nationally, in 2005, 24.9% of child behavioral health dollars spent by Medicaid were spent on inpatient or psychiatric residential. [25]

- 51% of Mississippi Medicaid child behavioral health dollars in FY 14 were spent on home-and community-based services (HCBS)26 (98.6% of all claims ; compared to 75.1% of all spending nationally in 2005.[27])

These data reflect that, while only a small number of claims are for institutional placements, these claims represent a disproportionately large share of expenditures. This result mirrors other analyses of Medicaid spending on community-based care.

Specific to certain institutional settings, **spending for residential psychiatric treatment facilities and inpatient psychiatric hospitals increased by 11% and 6%, respectively, from FY2010 to FY2014.** The decrease in overall spending for this category is attributed to inpatient medical surgical hospitals, which saw a 50% decrease in spending. This shift in use of medical-surgical hospital inpatient units was the result of policy decisions to prioritize other provider types, coupled with utilization management to reduce overall institutional utilization. The use of outpatient hospitals for behavioral health care has remained low, representing 1-2% of all spending on institutional placements across years.

Among the home and community based service expenditures, **significant amounts are spent on assessment, community support, day treatment, individual therapy, intensive home based treatment (MYPAC), and targeted case management**. Most of these services, with the exception of day treatment, have capacity to be individualized to meet the different clinical and functional needs of children. Meanwhile,

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[24] Institutional placements include Residential Psychiatric Treatment Facility, Inpatient Psychiatric Hospital, Outpatient Hospital, and Inpatient Medical Surgical Hospital placements.

[25] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/

[26] HCBS include an array of services, including Wraparound facilitation, IOP, crisis stabilization, outpatient psychotherapy, medication management, assessments, peer support, and day treatment. Throughout the document, all services other than the 4 listed as institutional are included in the category of HCBS.

[27] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." *Center for Health Care Strategies*. December 2013. Available at: www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/

relatively small amounts (under $1 million in a given year) are spent on services such as mobile crisis, crisis residential, peer support, and intensive outpatient.

BEHAVIORAL HEALTH SERVICES CLAIMS AND UTILIZATION

There was a decrease in utilization across both the institutional and home and community based service categories[28].

- There were 248 fewer claims for institutional services in FY14 than in FY10, representing a decrease of 2%.
- There were 3,349 fewer claims for HCBS in FY2014 than in FY2010, representing a 17% decrease.

Certain Medicaid-funded behavioral health services are utilized more frequently than others. However, no service was accessed by more than 7% of all Medicaid enrollees. Claims for some services, like day treatment, were much higher than others. **The volume of claims and total expenditures are not consistent with the percent of beneficiaries accessing the services. This indicates that a smaller population of Medicaid beneficiaries are driving service utilization and claims through longer lengths of stay and/or utilization of more expensive services.**

Although expenditures for institutional settings are greater than any one home- and community-based service, **the percent of beneficiaries utilizing institutional settings is less than 1% of all beneficiaries in each of the five years of data reviewed.** The degree of overlap between the youth receiving institutional services and the youth receiving HCBS is unknown given the aggregate data provided.

The number of unduplicated youth that accessed different categories of services.

- The greatest increase in utilization of institutional services was in inpatient psychiatric hospitals. **The number of youth who utilized inpatient psychiatric hospitals increased by 22% from FY10 to FY14.**

- There was a smaller fluctuation in the number of youth who utilized inpatient medical surgical hospitals and/or residential psychiatric treatment facilities compared to inpatient psychiatric hospitals.

- The utilization rate for residential psychiatric treatment facilities has remained steady, in contrast to the increase in the number of claims and the total spending on this service during this time period. **Since FY10, there has been a 10% increase in the number of youth who utilized residential psychiatric treatment facilities. This increase occurred from FY10 to FY11 and utilization remained steady from FY11 to FY14.**

- Most of the HCBS that were available in FY10 experienced a decrease in the number of unduplicated youth who utilized them.

- Injectable medication was removed as a pharmacy service due to safety concerns of beneficiaries and became a new medical service available in 2012. Consequently, medication management and pharmacotherapy experienced a large increase of 451% during this time period.

- There was a sharp decline in the number of youth who utilized skill building services (including day support and psychosocial rehabilitation (PSR available to 18-21 year olds)) during this time period.

- There was a large increase in the use of partial hospitalization from FY10 to FY11, with a high of 60 utilizers in FY12, which has since dropped off to almost no utilizers in FY14 (n=5).

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[28] DOM is aware of this decrease in HCBS claims resulting from UM/QIO contractor prior authorization procedures to reduce improper billing and service delivery.

- MYPAC respite-Waiver also had a large increase in the number of youth utilizing the service from FY2010 to FY2011 and FY202, which has since decreased to fewer youth in FY2014 than in FY10. This decrease occurred because MYPAC respite was only available to youth enrolled in the CA-PRTF Demonstration Waiver as of September 30, 2012.

- More youth utilized peer support, which was added on 1/1/12, in FY2014 than in FY2013.

- Service planning, which includes treatment plan development, MYPAC plan of care development (a required service component of the National CA-PRTF Demonstration Waiver), and community-based wraparound services, has been declining since its peak in FY11.

- In FY2011, school-based services were utilized by more than 8,000 youth, but the service ended on 6/30/12. Utilization of intensive home-based treatment, which includes Wraparound-MYPAC-State Plan, Wraparound-MYPAC-Waiver, and MYPAC-Waiver services, has been increasing since FY2010; over 1,000 youth utilized the service in FY2014.

ANALYSIS OF SPECIFIC HOME- AND COMMUNITY-BASED SERVICES

A closer review was conducted on certain home and community based services. These are: day treatment, mobile crisis and MYPAC. Day treatment was examined as it is a service that both DOM and DMH had concerns with regard to utilization and quality; and intended that the uptake in the new rehab option services would decrease the utilization of this service over time. Crisis services and MYPAC were selected in order to understand the uptake of these new services.

DAY TREATMENT

Medicaid spending on day treatment has declined by 42% since FY10, and there were 48% fewer claims in FY14 than in FY10 for the service. There was a 27% decrease in the total number of unduplicated utilizers of the service from FY10 to FY14. However, **nearly a quarter of HCBS dollars continues to be spent on day treatment.**

The number of youth utilizing day treatment has been declining and, in FY14, represented 0.7% of all Medicaid enrollees in both fee for service and managed care. In FY10, 1.1% of all Medicaid enrollees utilized day treatment. DOM is aware of this decrease resulting from UM/QIO contractor prior authorization procedures to better educate providers about this service, and to reduce any improper billing and service delivery.

CRISIS SERVICES

Mobile crisis and crisis residential services became available through Medicaid during FY2012. Claims for both services have increased sharply since FY12; there were 2,960 claims for crisis services in FY14, an increase of 626% from FY12.

Consistent with the increase in claims, the total spending on crisis services increased from FY12 to FY14, although total spending on crisis services is only about 1% of all HCBS expenses. **In FY14, there were almost $1 million in claims for crisis services, compared to approximately $250 million dollars in FY12.** This is a positive trend, as utilization of crisis services typically suggests lower use of emergency department and inpatient care. However, in FY14, only a small fraction of Medicaid beneficiaries' utilized crisis residential or mobile crisis services, suggesting a need to promote availability of these services among potential referral sources including youth and families. Many more youth utilized one or both crisis services in FY14 than in FY12. However, in FY14, only 0.02% of Medicaid beneficiaries' utilized crisis residential through the fee-for service system and only 0.04% of Managed Care enrollees utilized crisis residential

services. In FY14, 0.21% of Medicaid beneficiaries utilized mobile crisis through the fee for service system and 0.1% of managed care enrollees utilized mobile crisis services.

MYPAC

The MYPAC services migrated from 1915 (c) waiver services to new rehab option services called IOP in FY 2012.

MYPAC included Plan of Care Development (part of Service Planning), MYPAC Intensive Home-Based Treatment, and Respite (MYPAC).

- Plan of Care development was a required component of the National CA-PRTF Demonstration Waiver. Utilization of this service went down to zero in FY14.
- The number of youth receiving Respite (MYPAC) decreased to 24 in FY14, with spending declining by 47%. Children previously enrolled in the Waiver prior to 9/30/12 continued to receive respite services under the Rehab Option service until they were no longer enrolled in the Waiver.
- Intensive home-based treatment includes three types of subservices: 1) MYPAC-Waiver, 2) Wraparound-MYPAC-Waiver, and 3) MYPAC-State Plan Service.
    - A relatively equal number of youth accessed MYPAC-Waiver and Wraparound-MYPAC-Waiver each year. Billing for MYPAC-State Plan Services began in FY13 corresponding with the conclusion of the Waiver demonstration.
    - There was an increase in the number of youth who received MYPAC intensive home-based treatment from FY10-FY14 (either through MYPAC-Waiver, Wraparound-MYPAC-Waiver or Wraparound-MYPAC-State Plan Service).
    - There also was an increase in the number of claims for this service from FY10-FY14 (+128%).
    - The increase in spending was less substantial, only 64% higher in FY14 than in FY10 despite increases in claims and utilizers, reflecting a decline that occurred from FY13 to FY14.

LENGTHS OF STAY

Length of stay information was not available for all Medicaid purchased services, as data were collected and analyzed in aggregate form. However, DMH collects and analyzes lengths of stay data for its state-operated psychiatric hospitals and PRTF and psychiatric acute inpatient facilities. In addition, information was provided by DOM from claims data for the average lengths of stay for youth served in psychiatric acute inpatient facilities. From FY 2010 to FY 2014:

- The average length of stay for Oak Circle Center at Mississippi State Hospital (a state psychiatric hospital serving children and youth[29]) increased by about 4%.
- The average length of stay at the state-run PRTF, Specialized Treatment Facility, increased by 23% during that time.[30]
- The average length of stay for youth served in psychiatric acute inpatient facilities for children and youth under 21 increased in 3 out of the 6 facilities[31] for which data were available for this time frame.[32]

LOCATION OF COMMUNITY-BASED SERVICES

[29] FY14 data were not available for the Bradley A. Sanders Adolescent Complex at East Mississippi State Hospital, and therefore not included. Please refer to the Data Appendix for FY10-FY13 data for this facility

[30] Source: Mississippi DMH State Hospital Admission and Discharge Data

[31] ALOS data were provided for 7 inpatient facilities, however FY14 data were not available for Crossroads Regional Hospital and therefore 6 facilities are referenced above. Please refer to the Data Appendix for FY10-FY13 data for this facility.

[32] Source: Division of Medicaid Acute Inpatient Facilities Data.

Providers bill for a range of services that include information about the location that services occurred. These "Place of service" codes were analyzed as part of the Medicaid data analysis. Place of service codes are not required for claims to be submitted so the data may be unreliable. Given the state's goal to increase service provision in the community versus within offices, it is important to analyze these data to understand where providers are delivering care.

From FY2010 to FY2012, services within the CMHC offices accounted for the greatest percentage of fee-for-service spending. In FY2013, spending on services in the home surpassed spending on services that occurred within the CMHCs offices, increasing by 21% from FY2010 to FY2014. Meanwhile, **as a location of service, spending in CMHC offices fell by 46% from FY2010 to FY2014.** This is an important finding given the state's goal to increase service provision in homes and other community settings rather than offices.

In 2013 and in 2014, approximately one-third of Medicaid fee for service spending was for services received in the home. About 50% of Medicaid fee for service spending was for services received in community mental health centers (25% and 26%) and in schools (21% and 24%). **However, services provided through managed care were more commonly provided in community mental health centers (54% and 49%).** The second most common location for managed care services to be provided was in schools (24% and 26%) followed by in the home (13% both years).

CONCLUSION

Mississippi has the opportunity to serve many more youth in less restrictive and more integrated settings by promoting greater use of services such as mobile crisis intervention, crisis stabilization, intensive outpatient program (both MYPAC and as a step-down from MYPAC), and peer support. More effective use of these services could help divert youth from placement in costly institutional settings. While utilization and expenditure trends for HCBS services are in the right direction, continued work is needed to promote greater uptake of these services in Mississippi.

CHAPTER 2: EXPANDING THE HOME- AND COMMUNITY-BASED SERVICE ARRAY

INTRODUCTION

Developing a clear definition of the service being purchased is an important first step when implementing a new service. This helps purchasers, service providers, family members, and other system partners, understand what the service is supposed to look like "on the ground." It provides clarity about what activities are and are not expected as part of the service

This chapter offers an analysis of Mississippi's current HCBS benefit array, including design, operational policies and procedures, and utilization. It goes on to describe services that should be available in robust benefit design for youth and offers recommendations to improve Mississippi's benefit design and operations.

A critical component to ensuring that youth in Mississippi with serious behavioral health challenges can remain in their homes and local communities and avoid overutilization of restrictive settings such as state hospitals and PRTFs is ensuring that a continuum of treatment options in the community exists. For this assessment, we examined the availability of a broad array of *effective* services and supports (i.e. evidence-based and promising practices) that occur in the home or a community setting.

This chapter is comprised of three sections:

- Evidence-Based Benefit Design defines fifteen (15) service elements informed by scientific knowledge and state experience that successfully address the behavioral health needs of children;
- Mississippi's Benefit Array includes an analysis of current benefits and operational policies, and recommendations for improvements organized by certain evidence-based benefits design elements discussed in section one;
- Financing Beyond Medicaid briefly speaks to the need for home and community based benefits to be available to children that are not eligible for Medicaid.

Several questions drove the quantitative and qualitative aspects of this benefit design analysis. These questions included:

1. What are the array of services available in Mississippi; and how do those service align with evidence on what is effective?

2. How are the services being implemented? To whom are those services available; i.e., Medicaid enrollees, any child in Mississippi regardless of insurance status? How are decisions made about the types of services that children receive?

3. Are there operational or other policy barriers that impact the service design and availability of services?

The next chapter, Chapter 2, considers provider capacity, the availability of a behavioral health workforce[33], and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings. While a robust home and community based service array is closely connected to provider capacity, we have presented that information in a separate chapter in order to better address specific issues and recommendations.

[33] Throughout this report, when discussing the available "workforce" or "practitioners" we are referring to the individuals who deliver mental health and substance use services. Some of these individuals are employed by community mental health centers or other agencies while others (e.g. licensed psychologists or psychiatrists) may operate as a solo practitioner or as part of a small group practice. When using the term "provider" we are referring to agencies.

EVIDENCE-BASED BENEFIT DESIGN

The goal of a behavioral health system benefit design is to provide high quality services to meet the range of clinical, family, age, gender, and cultural needs of the youth. The services that are available in a system should reflect the scientific knowledge that is available. Additionally, services should align with the important role that families, schools and communities have in supporting children's behavioral health.

A number of services and supports have been found effective to support children with behavioral health conditions. As described in the Centers for Medicare and Medicaid May 2013 Informational Bulletin regarding Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions[34], the implementation of home and community-based services for this population has made significant improvement in the quality of life for these children, youth, and families. Findings include:

1. Reduced costs of care – The PRTF Waiver Demonstration evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of$40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program.

2. Improved school attendance and performance - After 12 months of service, 44percent of children and youth improved their school attendance and 41 percent improved their grades as compared to their attendance and grades prior to participating in the program.

3. Increase in behavioral and emotional strengths - 33 percent of youth significantly improved their behavioral strengths after 12 months of service and 40 percent after 24months compared to their strengths as measured prior to participating in the program. Behavioral and emotional strengths include the ability to form interpersonal relationships, positive connection with family members, positive functioning at school, ability to demonstrate self-confidence.

4. Improved clinical and functional outcomes - According to caregiver reports, 40 percent of children served in SAMHSA's Children's Mental Health Initiative (CMHI) showed a decrease in clinical symptoms from when they entered the program.

5. More stable living situations - The percentage of children and youth in CMHI who remained in a single living situation rather than multiple living situations during the previous 6 months increased from 70 percent at intake to 81 percent at 24 months.

6. Improved attendance at work for Caregivers - Caregivers who were employed at intake reported missing an average of 6.2 days of work in the 6 months prior to participation in the program due to their child's behavioral or emotional problems. This decreased to 4.0days at 12 months of program participation, and to 2.8 days at 24 months of program participation.

7. Reduced suicide attempts - Within 6 months of service in CMHI, the number of youth reporting thoughts of suicide decreased from intake into the program by 51 percent and the number of youth reporting a suicide attempt decreased by 64 percent.

8. Decreased contacts with law enforcement - For youth involved in the juvenile justice system, arrests decreased by nearly arrests decreased by nearly 50 percent from intake into the program after 12months of service in CMHI.

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[34] http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html

States that have achieved such robust outcomes have common benefit design elements. We highlight and define the following fifteen components:

Figure 34: Benefit Design Elements

Table 19: Benefit Design Elements

HEALTH PROMOTION, PREVENTION, SCREENING & EARLY IDENTIFICATION
Health promotion, prevention, screening, and early identification are necessary components of a "good and modern" addictions and mental health service system.[35] Health promotion -Health promotion is a significant component of a comprehensive prevention and wellness plan, and plays a key role in efforts to prevent substance abuse and mental illness. Since health promotion efforts have been traditionally community-and school-based in the public sector, there is an opportunity to engage the private sector (particularly employers and insurers) in health promotion initiatives. Prevention- The field of prevention science, well known for advancing the health of people at risk for illnesses such as cancer, diabetes, and heart disease, has also produced effective strategies for the mental health and substance abuse fields. The system must have three levels of prevention practice: Universal, which addresses populations at large; selective, which targets groups or individuals who are at higher risk of developing a substance abuse problem or mental illness; and indicated, which addresses individuals with early symptoms or behaviors that are precursors for disorder but are not yet diagnosable. Prevention efforts can support safer schools and communities, better health outcomes, and increased productivity. Prevention science tells us that a comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavioral or normative change. Health reform recognizes that prevention is a critical element in bending the cost curve and in improving the overall health of all Americans. All health-related prevention efforts

[35] https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/good_and_modern.pdf

should recognize and address the interrelated impact of mental health and substance use on overall well-being.

Screening and early identification- Services should include mental and substance use screens available through Early and Periodic Screening Diagnosis and Treatment (EPSDT). The Bright Futures toolkit developed by the American Academy of Pediatrics is one resource used by some states and localities to support primary care practitioners. The United States Preventative Services Task Force has also developed recommendations regarding screening for various behavioral health conditions among people age 12 years and older. Screening may also be used to identify warning signs for suicide to enable early intervention and suicide prevention. Standardized screening tools are available to support screening for behavioral health conditions in children and youth.

STANDARDIZED ASSESSMENT

Standardized assessment tools gather clinical, functional and environmental information to support clinical decision-making. These standardized tools support the clinical interview process and biopsychosocial assessment documentation. These tools ensure that children receive the appropriate type and amount of service, promote consistency and equity in service provision, and provide objective rationales for service authorization decisions. In addition to informing client specific clinical decision-making, these tools support the monitoring of behavioral health system performance, and inform decisions for improving the quality of care. Examples include Child and Adolescent Functional Assessment Scale (CAFAS), Child and Adolescent Service Intensity Instrument (CASII), Child Behavior Checklist (CBCL) and Youth Self Report (YSR), and Child and Adolescent Needs and Strengths (CANS).

TRAUMA INFORMED SYSTEM

Across the country, behavioral health systems are increasingly aware of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study[36] has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. Examples include Cognitive Behavioral Interventions for Trauma in Schools (CBITS)[37], Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT). [38]

MOBILE RESPONSE AND STABILIZATION

Mobile Crisis Response & Stabilization (MCRS) services includes immediate 24/7 response to urgent mental health needs by a licensed mental health professional or a team approach, as well as access to short-term, individualized services that assist in stabilizing the youth in the home and community. Mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalizations. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise. In newer and more effective models of mobile response, one-to-one crisis stabilizers may work

[36] http://www.cdc.gov/ace/findings.htm

[37] https://cbitsprogram.org/

[38] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

with a child and family over a 30 day or longer period. Crisis stabilization provides intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services. During the time that the child is receiving residential crisis stabilization, there is regular contact between the team and the family to prepare for the child's return to the family.

INTENSIVE CARE COORDINATION: WRAPAROUND PRACTICE MODEL

The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports. The wraparound "facilitator" is the intensive care coordinator who organizes, convenes, and coordinates this process and provides intensive care coordination at low ratios (1:8 or 1:10). Within the wraparound approach, a child and family team is individualized for each youth that includes the child, family members, involved providers, and key members of the child's formal and informal support network, including members from the child serving agencies. The child and family team develops, ensures implementation of, and monitors the service plan. This service is different from intensive in-home family therapy approaches as it is not therapy but a definable approach to care management. It is used in conjunction with therapeutic approaches to address the behavioral health needs of youth.

INTENSIVE IN HOME FAMILY BASED THERAPIES

Intensive in-home services (IIHS) are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placements in inpatient or other settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional. The components of intensive in-home services include individual and family therapy, skills training and behavioral interventions. Typically, staff providing intensive in-home services have small caseloads to allow them to work with the child and family intensively, gradually transitioning them to other formal and informal services and supports, as indicated. Specific examples include, but are not limited to, Flexible Family Therapy, Multi-Systemic Therapy and Brief Strategic Family Therapy. IIHS are designed to be maximally flexible, delivered at times and locations selected by the youth and family. By conducting the assessment, treatment planning, and interventions in the youth and family's home, school, and/or community it allows for customization of services to the youth and their unique familial and environmental contexts. Unlike typical outpatient individual or family therapy that occurs in an office, IIHS services offers the opportunity for trained staff to help youth and families practice skills in "real world" settings, increasing the likelihood that they will be able to apply these skills to a range of "everyday" situations.

RESPITE

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers from the stress of caregiving. Respite services provide short-term safe and supportive environments on a short-term basis for on a planned or unplanned basis. Caring for a child with a behavioral health challenge places unique demands and stresses upon caregivers they must attend frequent meetings with doctors, teachers, therapists, and other helping professionals; and they must engage in highly specialized parenting approaches to support their child's treatment plan, coordinate numerous meetings, work with doctors to monitor side-effects of psychotropic medications, and respond to crises or other critical issues that emerge for their child as he/she grows. Much like parents of children with physical disabilities, parents of a child

with a behavioral health challenge often cannot make use of typical child care arrangements because caregivers need special training or skills to manage the child's emotional and behavioral issues.[39]. The sustained effort it takes to parent a child with behavioral health challenges can be emotionally, financially, and physically taxing, placing the child at increased risk of an out-of-home placement.

FAMILY CENTERED PRACTICES IN INPATIENT/INSTITUTIONAL PROGRAMS

In addition to a range of evidence-based practices to address the clinical treatment needs of youth such as trauma informed CBT, inpatient and other 24 hour programs must also use family-centered practices that ensure connection to family and community, particularly for those programs that have longer lengths of stay. These family-centered approaches are an emerging best practice and include the following elements: [40]

1. Maximizing regular contact between the child and family such as through home visits, telephone calls and electronic communication;
2. Engaging youth and families in all aspects of service planning, including active sharing of information; and treating parents as experts and with respect;
3. Working with youth and families on transitions; and using treatment strategies that families can use in their homes; including culturally appropriate services;
4. Providing ongoing support and aftercare for the child and family, including use of approaches that serve the whole family during and after care.

YOUTH SPECIFIC SUBSTANCE USE DISORDER SERVICES

Given the specific developmental needs of youth, SUD services for youth must be able to address identification, treatment and recovery needs of youth that are developmentally appropriate and incorporate the family. [41] Examples include Screening, Brief Intervention, Referral to Treatment (SBIRT), developmentally appropriate and familial engaging adaptations to family therapy approaches such as Brief Strategic Family Therapy, Adolescent Community Reinforcement Approach, and Medication Assisted Treatments.

PARENT/YOUTH PEER SUPPORT

Providers of peer support services are family members or youth with "lived experience" who have personally faced the challenges of coping with serious mental health conditions, either as a consumer or a caregiver. These peers provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth.

EBP'S IN OUTPATIENT

Psychiatric issues commonly observed in outpatient behavioral health settings for youth such as anxiety, depression, trauma, or conduct problems should be addressed using practices with evidence of their effectiveness. Evidence-based interventions include practices such as Parent Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy, Functional Family Therapy (FFT), Brief Strategic Family Therapy

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[39] Parent/Professional Advocacy League & Massachusetts Department of Mental Health (2013). Respite care: What families say. Boston, MA: Author.

[40] http://www.buildingbridges4youth.org/sites/default/files/BB-Joint-Resolution.pdf

[41] Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about good and modern treatment and recovery services for youth with substance use disorders?* Report of the SAMHSA Technical Expert Panel. Rockville, MD: Center for Substance Abuse.

(BSFT), Strengthening Families, and Triple P – Positive Parenting Program.

HOUSING & EMPLOYMENT –SUPPORTING SUCCESSFUL TRANSITION TO ADULTHOOD

Transition aged youth with serious behavioral health challenges are in need of services specifically geared to support their unique developmental needs as they enter adulthood. Transition services should include a focus on supported education, vocational/employment, and housing support. The Achieve My Plan (AMP) model [42] and the Transition to Independence Process (TIP) model[43] are examples of an evidence-based approaches to supporting youth as they transition to adulthood.

THERAPEUTIC MENTORING

Therapeutic Mentoring offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. Therapeutic Mentoring services include supporting, coaching, and training the youth in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities as part of an individualized plan of care. These services help to ensure the youth's success in navigating various social contexts, learning new skills and making functional progress, while the Therapeutic Mentor offers supervision of these interactions and engages the youth in discussions about strategies for effective handling of peer interactions.

TELE-BEHAVIORAL HEALTH

Tele-behavioral health is the use of telecommunications technology to provide behavioral health services. Tele-behavioral strategies have been used across a range of services including individual therapy, family therapy, medication assessment and management appointments, care plan team meetings and consultations, and primary care appointments and consultations.

GOODS & SERVICES (FLEXIBLE FUNDS)

Customized Goods & Services are flexible funds that can be used to creatively support the strengths and needs of the youth and family and are directly reflected in the goals and strategies of the individualized care plan. Typically, these resources are available to children receiving intensive care coordination as a means to support individualized care planning, engagement with natural supports and to further enable community vs. institutional placement. These funds are used for certain non-recurring expenses such as onetime expenses for a bed for a child returning home, clothing, or memberships to local girls or boys clubs, etc

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MISSISSIPPI'S BENEFIT ARRAY AND RECOMMENDATIONS

The following section provides a descriptive overview of Mississippi's current benefit array across the Department of Mental Health and the Division of Medicaid, analysis of Mississippi's current benefits, including a review of policies and procedures, and qualitative information related to stakeholder experiences; and recommendations for improvements organized by certain evidence-based design elements discussed in section one of this chapter.

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[42] http://www.pathwaysrtc.pdx.edu/proj-3-amp

[43] http://www.tipstars.org/

OVERVIEW OF CURRENT BENEFITS

As Table 20 indicates below, Mississippi has a wide array of behavioral health services for youth across Medicaid and DMH funding.

Table 20: Medicaid and DMH funded behavioral health services for youth

Service	DMH	DOM
Inpatient hospital	X	X
Partial		X
Community Support Services*		X
Crisis response	X	X
Crisis stabilization (crisis residential)	X	X
Day treatment*		X
Emergency/crisis services*	X	X
Family education	X	
Individual, family & group psychotherapy*		X
Wraparound facilitation	X	X
IOP (MYPAC)		X
Other IOP		X
Making a Plan (MAP) team*	X	
Peer support*		X
Psychological evaluation	X	X
Psychosocial assessment	X	X
Treatment plan development & review	X	X
Pre-evaluation screening for civil commitment (ages 14 and up)*	X	
Psychiatric Residential Treatment Facilities (PRTF)	X	X
Psychiatry*, including medication management	X	X
Psychosocial rehabilitation (ages 18 and up only)		X
Residential Treatment for Substance-Abusing Adolescents	X	
Support for recovery/resilience-oriented services*	X	
Therapeutic foster care	X	
Therapeutic group home	X	+

**Indicates DMH core service. +For therapeutic group home, DOM covers the therapeutic services that are delivered within the therapeutic group home. Note: Physical health services, including primary care screenings and nursing assessments, are not listed.*

A review of benefits listed in the Medicaid state plan, and available through DMH funding, indicate a range of services, including some evidence-based practices and approaches, are covered in Mississippi for those that are Medicaid enrolled or receiving DMH funded services. These services include crisis, wraparound, and outpatient EBPs investments, and respite and flexible funding from DMH sources through the Making A Plan (MAP) team process. Some of these services and investments, such as mobile crisis, are newer, and their effect and outcomes have not yet been experienced by the system. These services need to be grown and expanded further, and their outcomes monitored so that rapid system and program adjustments can be made to achieve the intended benefit. Some services may not be new to the system but have not been taken up fully across the system for various reasons. These services, such as MYPAC and telehealth, are needed across the system more broadly. These services need to be reviewed to see why they are not being taken up, and to identify what barriers may exist to their full implementation. Services that are not currently covered are therapeutic mentoring, training investment in institutional family centered EBPs, a substance use service continuum for youth, and supported education, vocational and housing supports for transition age youth. The availability of these services will help Mississippi achieve its goal to successfully address the behavioral health needs of youth. Finally, as will be discussed, it is not clear to what degree intensive in home family based therapies, separate from intensive care coordination, is occurring.

The efforts to make available a range of home and community based services has been an important step. In addition to the presence or absence of certain services in the system, we also examined the implementation and execution of the services. It is in this area that we see significant opportunity for Mississippi to align its goals to achieve the outcomes it seeks. Our review indicates that there are several implementation decisions that should be modified or augmented that will better support the state's goals of improved service access, utilization, quality and outcome. We see these issues as easily rectifiable.

HEALTH PROMOTION, SCREENING, AND EARLY IDENTIFICATION

Mississippi EPSDT requirements include screening for developmentally appropriate social and behavioral issues. While the scope of our assessment did not include an analysis of this physical health data regarding screening for behavioral health conditions, we raise here the importance of a review of the policies and utilization of this vital service. Given the states goal to ensure that children get access to needed behavioral health care, understanding positive screens for behavioral health need, and working with primary care to understand where to refer for services, is vital. Given the estimated prevalence of behavioral health conditions among Mississippi's youth, we anticipate that there is additional need for behavioral services than current service utilization indicates. Establishing early identification as a policy priority can support children in getting services earlier, leading to the use of less costly services.

Notwithstanding the requirements under EPSDT, numerous groups endorse the use of screening of behavioral health for children during well-child visits including the US Preventive Services Task Force, and the American Academy of Pediatrics' (AAP) Bright Futures. Other states including North Carolina, Colorado, South Carolina, and Massachusetts have worked to improve their behavioral health screening efforts. North Carolina's Assuring Better Child Health and Development (ABCD) program has greatly increased the number of behavioral health screenings occurring in primary care offices. By working closely with local community care networks and pediatricians the state improved communication about the need for screening, identified standardized screening tools and trained doctors on how to use them during the course of a pediatric visit. The Massachusetts Medicaid program, MassHealth, has required primary care clinicians seeing youth under 21 to use one of several approved screening tools during well-child visits. The state updated its regulations, published guidance on how to obtain reimbursement for conducting a screening, and convened trainings on how to use the various screening tools. More information including additional state examples is located in the March 2013 guidance on prevention and early identification of mental health and substance use conditions published by the Centers for Medicare and Medicaid Services.[44]

[44] Centers for Medicare and Medicaid Services, (March, 2013). Prevention and early identification of mental health and substance use conditions. Retrieved on March 1, 2015 from: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf

RECOMMENDATION

1. REVIEW SCREENING POLICIES AND UTILIZATION DATA

Data regarding the screening of children's behavioral health by primary care providers should be reviewed to assess the need for any additional communication, education and/or training for providers. Consider any additional need for notification and information to enrollees regarding screening for behavioral health needs as a Medicaid benefit Once this review is complete, the state should consider how the Center for Advancement of Youth (CAY) and/or the Children's Collaborative group could be used to provide training and support to pediatricians, nurse practitioners, and family practice physicians on behavioral health screening in primary care settings.

STANDARDIZED ASSESSMENTS

An underpinning to all behavioral health services is the need for a consistent standardized assessment tool across all services. DMH requires that certified providers conduct functional assessments; and has invested in training and data efforts to support providers to adopt this practice. Over two years ago, DMH began training and implementation of a specific standardized assessment tool- the Child and Adolescent Functional Assessment Scale (CAFAS).

Certain programs, such as MYPAC, use functional tools as part of the practice. Some providers are using tools more broadly to help inform individual decisions about a youth's care or evaluating the performance of their own program (i.e. CAFAS, CANS). The DMH Operational Standards require children/youth mental health providers to conduct a functional assessment within 30 days of admission and six months thereafter to measure client's progress. In FY 2013, DMH introduced a web-based version of the Child and Adolescent Functional Assessment Scale (CAFAS) to serve as the required assessment.

Many state examples exist on the use of standardized assessment tools to support screening, level of care decisions, care planning and outcomes. The state of Washington has adopted the CANS instrument to screen for the need for services within 10 days of receiving a referral, as well as to support care planning decisions. This data is also used to monitor how the system is performing.[45] Massachusetts also uses the CANS instrument for screening, care planning and system and child level outcomes. [46]

DMH intends for full statewide implementation of the CAFAS by 2016. We fully support DMHs decision to move towards statewide adoption of a standardized tool across providers. Data from standardized tools will make it possible for DMH and DOM to be able to monitor how well the current system of services and supports is meeting the needs of Mississippi's youth.

RECOMMENDATION

1. IMPLEMENT A STANDARDIZED ASSESSMENT TOOL ACROSS ALL PROVIDERS

This will allow for a broader use of data across all providers (institutional and community-based) including eligibility, clinical decision making, care planning and service provision and intensity; client outcomes, provider quality and system outcomes. A common system-wide assessment instrument is needed to identify the service and support needs of a youth and measure system performance across providers and levels of care (e.g. outpatient, inpatient, day treatment, MYPAC, etc.). Without this, DMH, DOM and other system partners have limited ability to use data to help service providers; and to design, augment and adjust their system to meet emerging needs, and to inform other policy makers, such as the legislature on agency needs.

[45] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

[46] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/child-and-adolescent-needs-and-strengths-cans/

The implementation of a common instrument across the system will also help DMH and DOM address provider variability in service delivery. While a standardized tool does not replace clinical judgment it can help create a common language among providers, payers, families/youth and lead to a more uniform process for making placement and treatment decisions. The current variability with respect to the information collected about the needs of youth makes it difficult to draw an accurate picture of who is being served by the system and how the system is performing.

2. INCORPORATE THE STANDARDIZED TOOL IN LEVEL OF CARE DETERMINATIONS

It is recommended that Mississippi build on this existing infrastructure and expand the use of the CAFAS as a standardized assessment throughout the behavioral health delivery system as children seek services, for service planning, for level of care determinations, for ongoing assessment, and to support outcomes tracking.

Mississippi's current level of care criteria would benefit from the inclusion of a standardized assessment tool. Standardized assessment tools should be utilized to support recommendations regarding the level of intensity of the services needed by particular youth at specific points in time. Assessment tools can be used at various points of time, including with those youth who have been given a diagnosis based on a psychiatric evaluation or comprehensive psychosocial assessment or who have been referred to an out-of-home or restrictive level of service provision, such as MYPAC or IOP. A tool will support clear service eligibility guidelines, and ensure that youth who are most in need of services can access care. Providers must then seek authorization from the youth's managed care entity which is ultimately responsible for determining eligibility for services. We recommend that standardized tools be used more frequently than every six months.

Some states, including Georgia and Michigan, use the CAFAS to screen for eligibility for their intensive care coordination programs. In Georgia, the CAFAS is used for eligibility screening for their Community Based Alternatives for Youth Program, Alternatives to Psychiatric Residential Treatment demonstration waiver, Money Follows the Person, ad 1915(c) waiver. They use a tiered approach, where youth who score 140 or above on the CAFAS are eligible for the aforementioned programs, while youth who score 110 or above are eligible for the state's non-waiver CME program. In Michigan, the CAFAS is used to determine the level of functional impairment and to assist with eligibility determination for SED criteria. Further, given its utility for effectively assessing level of care, it is recommended that the CAFAS be employed to determine eligibility for MYPAC and IOP, as well as to inform acute inpatient hospitalizations and PRTF placements.

An additional benefit of DMHs decision to expand the use of the CAFAS throughout the behavioral health system is that it can serve as a foundation for a coordinated statewide evaluation system. The CAFAS should be utilized for intake, periodic review, and at discharge for all children receiving publically funded behavioral health services, with providers being required to input CAFAS scores into the web-based system currently operated by DMH. Wholesale use of the CAFAS as an eligibility determination and outcomes monitoring tool will help promote accountability in the public behavioral health system and ensure that children and youth are receiving the appropriate services and supports.

MOBILE CRISIS & STABILIZATION

Mobile crisis response and stabilization is an effective mechanism for preventing unnecessary placement in institutions and increasing access to HCBS. Mobile crisis and stabilization is a DOM rehabilitation option service that CMHCs are required to provide. DMH has invested in developing the mobile crisis infrastructure through grants to the CMHCs.

DMH began plans for mobile crisis capacity several years ago and conducted a tour of the State of Georgia's system and met with Behavioral Health Link, a private company that specializes in providing crisis call center and crisis intervention services. DMH decided to have its initial grant investment focus on building provider's capacity to offer mobile crisis; with future investments planned for crisis infrastructure such as centralized triage or crisis number capacity.

The addition of mobile crisis to the service array is a new and positive development in Mississippi's system, so it's potential as an intervention to divert youth from more restrictive settings has not yet been realized and needs further development. Providers are in the process of ramping up access, and deploying and training staff. Expectations for mobile crisis are new and providers have not yet fully transitioned from historical uses of phone triage to a "in-vivo crisis intervention approach." A specific model is needed to guide the clinical intervention that occurs as variation was evident from interviews in how providers are responding to crisis calls. Some are providing phone triage and follow-up the next day at the child's school; while others were going out to homes and other community-settings. There was also variation in the CMHCs approach used to staff crisis response. Some providers did deploy child trained clinicians while many used generalist teams serving both adults and youth. DMH recognizes the need for training support for mobile crisis providers and plans to require that providers ensure that staff are trained in best practices for responding to youth and their families in crisis.

Although mobile is offered in the state, it is an underutilized service that needs to be better marketed to youth and families, system partners, and the general community. As interviews indicated, it appears to be mostly communicated at this point to existing CMHC clients. Numerous family stakeholders, advocates, and non-CMHC behavioral health providers that we interviewed stated that they were not aware of the mobile crisis service and its availability for children.

We also found that locating the mobile crisis number was not always easy, with some mobile crisis numbers not readily found on the CMHC website. Some CMHCs had different mobile crisis numbers for each county that they covered, meaning one CMHC could be operating several different numbers. For families experiencing a crisis, ready access to a number to call is critical to avoiding use of emergency departments and 911 systems.

Promoting the availability of crisis response to the community-at-large would assist to divert children and families from seeking help in emergency departments or police departments; and would potentially lead to decreases in admission rates to 24 hour programs. Many CMHCs noted that many crisis calls (for youth) they received were for existing clients. This indicates the need for enhanced clinical planning for clients already engaged in services, and a review of the marketing and clinical orientation of the crisis response service. In other words, there is a need to more clearly define requirements for an urgent response/triage system for existing CMHC clients, versus a crisis response system for those youth experiencing a behavioral health crisis that has the potential to lead to an out-of-home placement.

To assist the state in considering ways to promote clearer delivery of mobile crisis, two states definitions are provided below.

Arizona defines it service as meeting the following requirements[47]:

> *Crisis Services stabilize individuals as quickly as possible and assist them in returning to their baseline of functioning; assess the individual's needs, identify the supports and services that are necessary to meet those needs, and connect the individual to appropriate services; provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more segregated setting; utilize the engagement of peer and family support services in providing crisis services; coordinate with all clinics and case management agencies to resolve crisis situations for assigned members;*
>
> *Crisis Services-Mobile Crisis Teams maintain the following capabilities: Ability to travel to the place where the individual is experiencing the crisis; ability to assess and provide immediate crisis intervention; have the capacity to serve specialty needs of population served including youth and children, hospital rapid response, and developmentally disabled; stabilize acute psychiatric or*

[47] http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-111.pdf

behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs; respond on site within the average of ninety (90) minutes of receipt of the crisis call.

Massachusetts defines Mobile Crisis as[48]:

Mobile Crisis Intervention is the youth-serving component of an Emergency Services Program (ESP) provider. MCI teams provide a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week, and 365 days a year. Between the hours of 10pm and 7am, Mobile Crisis Intervention staff may be on-call and dispatched by pager. Each encounter, including ongoing coordination following the crisis assessment and stabilization intervention, may last up to 7 days, based on the individual needs of the youth served.

The service includes a crisis assessment; engagement in a crisis planning process, which may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including on-site, face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology Intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff coordinates with the youth's ICC care coordinator throughout the delivery of the service. With consent, Mobile Crisis Intervention also coordinates with the youth's parent(s)/caregiver(s), primary care clinician, any care management program provider, other behavioral health providers, and/or any state agencies that are providing services to the youth throughout the delivery of the service.

Mobile crisis intervention services are designed to optimize clinical interventions by meeting clients in home or school settings where they are more comfortable, where strengths and cultural differences are more apparent, and where caregivers are more available. Community-based crisis interventions provide a highly effective alternative for de-escalation and resolution of a crisis event, allowing many youth and families to bypass the stigma of hospital settings, as well as the trauma and disruption of an emergency out-of-home placement. This is accomplished by safety planning in an actual site where long-term safety will most matter, and with the people who are crucial to the plan. MCI services optimally produce more holistic evaluations, solutions and referrals. They are also intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intrusive manner. The nature and anticipated benefits of a community-based crisis intervention should be discussed with the youth and parent at the earliest stages of the MCI encounter, in order to ease anxiety or safety concerns, support informed consent and decision-making by the youth/caretaker, and clarify the intended purpose of the service.

DMH recognizes this need for marketing of this new service more broadly. DMH plans to work with mobile crisis providers to market the service to local school districts, colleges/universities, social services, and other community organizations to ensure that more children and families, providers and stakeholders are informed about this important service.

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[48] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html
https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx?id=1

Crisis stabilization units are another essential component of a crisis response system and are critical to reducing 24 hour placement. They are designed to actively engage in crisis intervention work with families to stabilize the crisis and ameliorate the situation that led to the crisis. These services are significantly lower in cost, can be developed across the state to address current access issues resulting from the constellation of providers in two areas in the state, and allow for closer interaction between CSU team and the IOP service.

As an example, Arizona defines its Crisis Stabilization Services as[49]:

> *Crisis Stabilization Settings offer twenty-four (24) hour substance use disorder/psychiatric crisis stabilization services including twenty-three (23) hour crisis stabilization/observation capacity; short-term crisis stabilization services (up to seventy-two (72) hours) in an effort to successfully resolve the crisis and returning the individual to the community instead of transitioning to a higher level of care.*

Currently there is only one crisis stabilization unit for adolescents in the state. This CSU provides a range of services including mobile crisis and in home therapy. These are very important elements for crisis stabilization units. We observed that the CSU operates similarly to an acute inpatient unit with reported lengths of stay of approximately 14 days, as opposed to a crisis stabilization unit which would suggest a 2-3 day intervention intended to quickly stabilize the crisis and return the youth to their home and local schools. Given there is only one child CSU, it's model is to operate mobile and in-home capacity independent of the providers that the system has invested in operating those same services. These structures makes it difficult to expand CSU capacity. CSU capacity could be more easily expanded, and offered consistent with a 2-3 day stabilization approach if certain service elements, such as mobile crisis and intensive in-home therapy, were not duplicated by every CSU provider but rather provided by a designated mobile crisis team or a designated in-home therapy team for that child's home area in the state. Billing restrictions that do not allow for reimbursement of the CSU and any ongoing treatment providers should be lifted to allow for active treatment planning. A CSU will be able to provide rapid stabilization of 2-3 days when the CSU and ongoing service providers work "hand and glove" to identify and develop an effective plan; and support the family to ensure that the child can safely return home. Without the availability of an integrative approach across services, the current CSU will continue to operate by default as an acute inpatient service.

RECOMMENDATIONS:

1. FURTHER INVEST AND DEVELOP A COHESIVE APPROACH TO MOBILE CRISIS RESPONSE AND STABILIZATION

The development of mobile crisis response and stabilization, while underutilized by youth, is a positive step in enhancing Mississippi's service system. Additional investment in and policy priority of mobile crisis and stabilization is needed to improve access to this service, expand knowledge of its availability, implement best practices approaches, and monitor for quality. Mississippi should consider newer generation approaches to mobile crisis that allow for one-to one crisis stabilizers to work with youth and families over an extended period (e.g., 30 days). Outcomes associated with these approaches include not only reduced use of institutional placements but also reduced placement disruptions in child welfare. Given its rural nature, Mississippi also should consider use of tele-behavioral health to augment its mobile crisis response. While telehealth is currently allowed as a billable service, the state would benefit from actively encouraging its use to address needed crisis capacity in hard to reach areas of the state.

2. CONSOLIDATE 24/7 CRISIS CALL CAPACITY

We recommend that Mississippi consolidate 24/7 crisis call capacity to one centralized function. Currently, crisis call capacity is spread across 14 CMHCs. Centralized capacity would allow the state to better ensure triage, tracking and access to mobile crisis. Following triage, if a mobile intervention as needed, this one statewide crisis triage function would then mobilize the local CMHC teams as needed to conduct the crisis

[49] http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-111.pdf

intervention in the community. Consolidation of this function would allow CMHCs to focus on crisis intervention, support consistency in response across the state, and provide oversight of this important function. Additionally, one call center could be more easily tied to warm-line/support capacity with peers/family partners. This could be a provider contracted capacity or potentially a role for a CCO or UM/QIO vendor, particularly since those vendors have some type of 24/7 call capacity currently. If capacity does not allow a statewide centralized function, consider reducing the number of call lines that CMHCs advertise and use to assist community stakeholders, who also serve people across different counties, in knowing how to access the service.

3. EFFECTIVELY COMMUNICATE THE AVAILABILITY OF CRISIS SERVICES FOR CHILDREN AND FAMILIES

We support DMHs plan to further communicate the availability of mobile crisis response as a Medicaid-billable service for children and families. In addition to DMHs plans to work with community providers, the state could also consider EPSDT notification and information materials for Medicaid enrollees and other Medicaid providers.

4. REQUIRE AN UPDATED COMMUNITY EDUCATION PLAN FOR CRISIS SERVICES

Provide additional guidance and oversight to CMHCs regarding a community education plan of crisis service availability, including mobile crisis services, to schools, pediatricians, church groups, hospitals, police and other community organizations. Teams are currently developing specific education and outreach plans to local school districts. This provides an opportunity for the state to ensure consistency in approach across providers, and to model best practice outreach and education efforts that can be used with other important referral sources.

5. IMPLEMENT A BEST-PRACTICE MODEL FOR CRISIS RESPONSE

Design and execute a statewide, child and family focused crisis response training and coaching model that is focused on crisis resolution and trauma informed competencies. Drawing upon the state's investments made in trauma informed approaches and wraparound, address clinical practice issues impacting mobile crisis service delivery. Require that providers use standardized triage methods that allow for the accurate determinations of intensity of services. Drawing from the IOP/MYPAC quality approach, develop and implement a quality and network management strategy for this important service. Use peer specialists in training to reduce stigma, increase insight into lived experience, what helps/harms in a crisis, and the limitations to services like hospitalization. Examine the data regarding place of service for mobile crisis interventions to inform any practice, policy and training supports for providers.

6. EXPAND CSU CAPACITY

Expand CSU capacity, restructuring approach to a shorter term model connected to IOP and/or in-home therapy options for rapid intervention in the home. Address barriers to billing for CSU services when concurrent with MYPAC/IOP or other intensive community-based treatment services. Although the addition of CSU capacity is important, priority should be given to expansion of effective mobile response teams and their infrastructure and training first. We suggest that the need for CSU capacity be considered after additional investment in crisis response infrastructure in the state.

7. ADD A STATEWIDE "WARM LINE"

Add a statewide "warm line" capacity that would be staffed by parents/caregivers and attached to the crisis service capacity, with the necessary funding to support the infrastructure and staffing for this type of position. Warm lines reduce calls to crisis centers, can reduce visits to emergency departments for behavioral reasons and serve as a source for community resources. By employing parents/caregivers in this professional capacity, MS will direct the limited licensed staff time to crisis intervention services, expand its commitment to family and recovery directed approaches, enhance its support to families, and engage persons with lived experience as an important workforce solution. Typically warm lines are covered through state-only funds (i.e., general state revenue funds). We suggest that the need for warm line be considered after additional investment in crisis response infrastructure in the state.

8. CONSIDER EXPANDING ALLOWABLE PROVIDERS BEYOND CMHCs

Selection of providers for mobile crisis is best made on their capacity to deliver this type of services. Many states contract with child welfare and juvenile justice providers who are not historically part of Medicaid networks but who have the experience and skills to provide rapid intervention in homes and communities. In terms of rural models, one state manages mobile crisis by contracting for single crisis teams (meaning single clinician or clinician/peer specialist team available around the clock--sometimes on-call rather than "on the clock") within a number of treatment agencies rather than one agency with a team that is based in a big population center and traveling out to smaller places (with smaller places getting slower response time and less local relationship development). This capacity is tied to a centralized 24/7 crisis line that triages requests, dispatches teams, supports resource linkage and follow-up. This model means that teams serve areas in which they live, are familiar and have relationships. It means the little population centers get as much attention as the big population centers. Additionally, consider the use of a 2 person teams to encourage home and community based interventions, particularly at nighttime. If using 2-person response, pair clinician and peer specialist so that there is diversified response. To some degree, some CMHCs are using this approach by the nature of the counties they serve; but combined with the potential to add providers other than CMHCs in the pool, more in-reach to rural communities could be achieved.

9. CRISIS SYSTEM INFRASTRUCTURE RESOURCES

DMH grant funds are able to be used for important aspects of mobile crisis response infrastructure such as community marketing and education about the service, cell phones, laptops and tracking tools. It is important to ensure that these initial investments meet the needs; and can be augmented as this new service grows in its capacity.

INTENSIVE CARE COORDINATION

It is difficult to analyze Mississippi's benefits for intensive care coordination and intensive in-home family based therapies separately as both services are linked in Mississippi's current benefit array. The Mississippi service known as Intensive Outpatient Program (IOP) contains elements of both the intensive care coordination and the intensive in-home family based therapy best practice design elements discussed in section one of this chapter. The section below will discuss IOP as it relates to the best practice benefit element of Intensive Care Coordination; and the next section will discuss IOP related to the best practice design element of intensive in-home family based therapy approaches.

Mississippi has experience providing intensive care coordination through wraparound as one of nine states to participate in the 1915(c) Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program, a 5-year demonstration waiver in effect from 2007 to 2012 that enabled states to provide home and community-based services to children as alternatives to PRTFs. In Mississippi, this program was referred to as Mississippi Youth Programs Around the Clock (MYPAC). The special services offered by MYPAC through the Demonstration waiver included intensive case management, wraparound facilitation based on a national model, and respite care. These services were provided by three organizations, including Mississippi Children's Home Services, Youth Villages, and Pine Belt Mental Healthcare. Enrollment in the waiver ended September 30, 2012. A total of 1,484 youth enrolled in the waiver, accounting for the second highest total among participating states, or about 28 percent of the total national 1915(c) waiver population.

When the state migrated the MYPAC service from the waiver to the rehab option, some of the MYPAC components were written into the rehab option under Intensive Outpatient Program (IOP) and wraparound facilitation, and under another service called Community Support Services (CSS). IOP and CSS already existed as services but were used for a different population and with different requirements. These historical uses for these defined services continue and also now include this new use for these defined services.

In terms of intensive care coordination using a wraparound approach, both the Intensive Outpatient Program (IOP) and Wraparound Facilitation are defined in the rehabilitation option to serve these functions.

The IOP rehabilitation option definition states:

a. treatment provided in the home or community to individuals up to the age of twenty-one with serious mental illness for family stabilization to empower the individual to achieve the highest level of functioning. Based on a wraparound model, this service is a time-limited intensive family intervention to diffuse current crisis, evaluation its cause, and intervene to reduce the likelihood of a recurrence. "

b. the clinical purpose is to is to stabilize the living arrangement, promote reunification and prevent the utilization of out-of-home therapeutic resources to allow the individual to remain at home and in the community.

c. The components are based on an all-inclusive model that covers all mental health services the individual may need, [and] may include:

1. Treatment plan development and review
2. Medication management
3. Intensive individual and family therapy provided in the home
4. Group therapy
5. Day treatment
6. Peer support services
7. Skill building groups
8. Wraparound facilitation

The Wraparound Facilitation definition states:

a. the development and implementation of a treatment plan which addresses the prioritized needs of an individual up to the age of twenty-one (21). The treatment plan empowers the individual to achieve the highest level of functioning through the involvement of family, natural and community supports.

b. the clinical purpose of wraparound facilitation is to assist an individual to function at the highest level at home, school and the community through the intensive individualized treatment plan.

c. The service components may include:

1. Treatment plan development and review
2. Identifying providers of services and other community resources to meet [the] family and the individuals needs
3. Making necessary referrals for the individual

In terms of how services are defined, the definitions in the state plan amendment for wraparound facilitation and IOP are clear but the expectations for how each is used in the system, and how each is paired together with other services to support an evidence-based practice approach to intensive care coordination is confusing.

The IOP service is intended to fulfill three service system needs:

1. Intensive care coordination for children that meet PRTF level of care-this is what is referred to as the MYPAC program;
2. A step-down intensive care coordination program for children that need intensive care coordination but are not PRTF level of care-this is called IOP;
3. No matter if the service is MYPAC or IOP, the service is supposed to provide the element of intensive in-home family based therapy.

To differentiate IOP in the claims data for when it is used for children that are PRTF level of care (called MYPAC) and when used for children as a step-down (just referred to as IOP), a modifier is used to indicate MYPAC. This is added by DOM when a child has been determined eligible for that service through a MYPAC specific assessment process.

The IOP service is billed as an all-inclusive service using one procedure code. The all-inclusive package of services defined are supposed to meet the needs of enrolled children. Separate behavioral health services cannot be billed when a child is designated with the MYPAC modifier. However, when a child is not designated with the MYPAC modifier, the provider may bill other service codes on days that the provider does not bill the IOP code, such as individual or family therapy. Providing intensive care coordination using wraparound is an optional component of IOP and not a requirement. Providers of IOP are required to use appropriate evidence-based practices to address the intensive in home family therapy needs of youth.

For some functions, the state has maintained the prior waiver processes for MYPAC, including program requirements, assessment processes and provider certification requirements. Some of these processes do not apply to IOP for non PRTF level of care children. For example, children enrolled in IOP with the MYPAC claim modifier are required to use wraparound but when IOP is not designated for use with PRTF level of care children, wraparound is optional. As another example, providers assessing a child for the MYPAC designation are required to follow assessment processes that include collection of reports from past and current providers, other agencies and the child's school.

Analysis of the data as discussed in Chapter One of this report indicates that the majority of IOP claims include the modifier, and therefore are used as part of the MYPAC program. Only a small amount of utilization exists without the modifier, indicating little usage of IOP for children that do not meet PRTF level of care. Given that IOP can be used as a step-down service, as well as for its historical uses such as outpatient therapy for mental health or substance use needs, understanding the purpose of those IOP services cannot be understood through a claims analysis. Review of records and interviews would be needed. Additionally, as indicated in chapter one, analysis of data indicated service codes for "service planning" but it is unclear of that utilization what may be specific to the wraparound facilitation rehabilitation option service.

Referrals to IOP have been slower than estimates of need would indicate. Several reasons for this issue were noted. As of this writing, the two Demonstration Waiver providers and one CMHC offer this service. DOM has sought to expand this service to other providers; however, the state has received limited interest by providers. Second, providers report that the IOP rate is insufficient to cover the required elements, and that they are confused about the required service elements, and have been slow to offer that service. The IOP rate offered to new providers is significantly less than the MYPAC rate that continues to be paid to the original MYPAC providers. A rate differential between MYPAC and IOP is appropriate if the services are really differentiating intensity of population. Given the low utilization of IOP, it is not clear what populations are being served in the programs. DOM and DMH offered to conduct a rate study but that offer was declined by the Mississippi Association of Community Mental Health Centers. DOM is meeting with providers to address these issues. Additionally, some CMHCs reported no interest in providing this type of service no matter the rate established.

Third, families and other child serving system staff interviewed reported no or little knowledge of IOP. Stakeholders and providers had inconsistent knowledge of and understanding of the service or a misconception that it was a "waiver" service and not available to any Medicaid child. The state has made efforts to provide written information and to train other agencies. Given this reported lack of knowledge and misinformation, a review of the training approach is recommended to identify ways to augment and promote greater knowledge of this important service.

Fourth, with a limited pool of providers, capacity was limited and referral sources found wait times, thus some referral sources believed that making further referrals was futile. As previously mentioned, DOM would like to see more providers offer this service.

Fifth, eligibility criteria and processes impact rapid access to this service. Children must meet the following criteria to be determined eligible:

1. The youth must have been diagnosed by a psychiatrist or licensed psychologist in the past 60 days with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for SED specified with the DSM on Axis I;

2. The youth has a full scale IQ of 60 or above, or, if IQ score is lower than 60, there is substantial evidence that the IQ scores is suppressed due to psychiatric illness; and

3. The evaluating psychiatrist or licensed psychologist advises that the youth meets criteria for PRTF level of care. The youth meets the same LOC for admission to a PRTF, but can be diverted to MYPAC as an alternative to residential treatment; or the youth is currently a resident of a PRTF or acute care facility, who continues to meet the LOC for residential treatment, but who can be transitioned back to the community with MYPAC services.

4. The youth needs specialized services and supports from multiple agencies including community support services or targeted case management, and an array of clinical interventions and family supports.

Current level of care criteria and admission processes for MYPAC and IOP (specifically the psychiatric evaluation and IQ test requirements) critically delay access to this service with stakeholder reports ranging from 2-6 months for enrollment. The majority of states in the country do not limit the capacity to diagnose behavioral health conditions to only psychiatrists or psychologists. Mississippi does not restrict this practice within their licensing requirements of other "practitioners of the healing arts" such as independently licensed social workers. The scope of independently licensed practitioners such as social workers includes the ability to diagnose behavioral health conditions. By limiting the pool of practitioners, particularly to the severely limited number of psychiatrists and psychologists available, impacts access to this service. The requirement for IQ testing on all children referred was migrated from the CMS waiver requirements but is not necessary for rehab option services. This holdover procedure results in unnecessary delays to care, unnecessary expenditures, and discourages families from pursuing this service. Operating within the scope of their license, independently practitioners are able to ascertain whether an intellectual disability may be present that could impact the ability of a youth to benefit from this service. In those instances when an intellectual disability may be present, IQ testing would be warranted; however, to carry out IQ testing when youth and family interviews, school information and other and historical information can corroborate the absence of an intellectual disability is unnecessary. Rapid assessment and admission is key to maintaining a child in the home and community. Delays from referral to enrollment can be costly for both families and the state, resulting in disengagement from care and/or decompensation in functioning.

The current service definition for IOP also bundles most mental health services together. The package includes medication management, day treatment, skills groups, and individual, group and family therapy, peer support, and wraparound. In states that use bundling approaches of such a range of different behavioral health services, it is used in conjunction with population based enrollment and capitated risk (or similar) arrangements. An example would be paying a health plan for a population of children (e.g., SED population) a monthly per member per month to provide a range of services that children may need. In this instance, Mississippi is not asking providers to manage a population of children with different needs. It is asking providers to provide intensive in-home family therapy, and optional intensive care coordination using wraparound. One of the reasons for this bundling approach by DOM was out of concern regarding the amount and quality of day treatment services children were receiving. While the state worked diligently to find a solution to address day treatment quality concerns, they may have inadvertently created a lack of clarity that could lead to other quality and provider issues.

The inclusion of all of the other mental health benefits under this description does not support individualized approaches to care; not does it provide clarity on what the state wants to purchase from providers. A bundling approach for effective intensive care coordination should involve what it takes for providers to

deliver this service effectively. This would include components like travel time, telephone consultation, care plan teams development, care plan team convening, care planning, assessment of needs and strengths, and resource linkage and referral.

As an example, below is Montana's 1915(i) definition for Intensive Care Coordination. Please note we abbreviated the description table for space[50].

> *High Fidelity Wraparound Facilitation Wraparound Facilitation services are comprehensive services comprised of a variety of specific tasks and activities designed to support the family and youth in identifying, prioritizing, and achieving their goals using the wraparound process within a team of the family's choosing. Wraparound facilitators work under the supervision of a licensed mental health professional.*
>
> *The following table provides a breakdown of billable/non-billable activities. Wraparound Facilitator duties include:*

FACE-TO-FACE (billable per 15 minute code)	***COORDINATION (billable per 15 minute code with modifier)***	***PAPERWORK (not billable; activities are included in the rate)***
Engaging the family	*Engaging the family*	
Completing the Strengths, Needs and Cultural Discovery with the family Review completed SNCD with family for editing	*Completing the Strengths, Needs and Cultural Discovery with the family (can possibly occur multiple times as family dynamics/circumstances change)*	*Completing the Strengths, Needs and Cultural Discovery with the family; Edits to the SNCD; typing and updating*
	Assembling the wraparound team (mostly coordination; some face-to-face)	*Agenda for meeting and progress notes (meeting overview minutes)*
Facilitating family team meetings and developing a crisis plan (mostly, some coordination)	*Updating/coordinating w/ team members not present at the meeting; Gathers information from team members who will not be at the meeting/reminder calls of meeting time and date.*	*Typing/writing the meeting overview*
Convening regular meeting with family and team to review accomplishments and progress towards goals and to make adjustments	*Convening regular meeting with family and team to review accomplishments and progress towards goals and to make adjustments*	*Preparing agenda for meeting, updating ground rules, etc*
	Calls to team members to elicit information/updates if member will not be in attendance and ensuring follow through of role on team responsibilities	*Documenting and maintaining all information regarding the, approved service plan including revisions approved by the regional manager*
	Presenting the team's suggested service plan changes to the regional manager for approval	
Providing copies of the current approved service plan to the youth and family/ legal representative and to professional and agency team members	*Providing copies of the current approved service plan to the youth and family/guardian and to professional and agency team members*	*Making copies of current approved service plan and mailing out copies to those not present and/or after revisions have been made and approved by the regional manager*

[50] https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

	Monitoring the service plan to ensure services are provided as planned; ongoing with Regional Manager	
	Consulting with family to ensure services received continue to meet identified needs	
	Maintaining communication between all wraparound team members	
	Preparing family for transition out of formal wraparound 1915(i) HCBS State Plan	*Documenting proposed team revisions to service plan to support transition and providing this to the regional manager for approval and revision of the service plan*
Complete MT CANS (to occur at admission, every 3 months, and at discharge)	*Complete MT CANS (to occur at admission, every 3 months, and at discharge)*	*Complete MT CANS (data entry; report activities)*

This definition provides one example that clearly defines intensive care coordination, and the service components required to effectively deliver care consistent with evidence-based practices for care coordination. This example was also selected because it is from a state that has a separate definition for intensive in home family therapy; clearly differentiating the intent and purpose of both of these different services in their systems.

In addition to the issues discussed above with the current bundling approach, some services such as individual therapy, family therapy and day treatment can no longer be provided by the existing providers or in the case of children with the MYPAC designation, must be purchased by the MYPAC provider directly. During interviews, both the MYPAC providers and the CMHCs indicated little purchasing by the MYPAC providers of these bundled services since the migration of this service to a rehab option benefit from the waiver. This results in youth being discharged from the care of any existing providers and creates disincentives for existing providers to refer. While CMHCs do make referrals to IOP, many voiced preference to not refer because they thought their quality of care was better, or out of concern in disrupting relationships. This is further complicated by the fact that the state allows these other billing codes to be used for IOP enrolled children that do not have the MYPAC designation.

While the IOP definition shares components of a best practice definition for intensive in home therapy and intensive care coordination, the definitions do not fully align with practices that are specific to each. Additionally, allowing providers to bill other "like" services on days that IOP is not billed does not support evidence-based approaches for intensive care coordination or intensive in home family therapy. A service definition should support an evidence-based approach, and allowing for other individual or family therapy to be provided outside of the IOP services that by its definition is supposed to provide those very services undermines effective service delivery.

For providers, this leads to confusion on what model and approach they are using when; and when they can use a certain service alone and when it can only be used in conjunction with two other services (CSS and wraparound facilitation). This also creates challenges for DMH and DOM to monitor provider performance. Given the concerns that DOM and DMH have about provider performance, the use of definitions that are not differentiated and have optional components vs required components makes oversight of service delivery difficult. Clearer definitions that explicitly state what is expected to be delivered, when and how, will aid the state in ensuring quality of care, will decrease the likelihood of services being used inappropriately and will increase the likelihood that providers will perform to expectations. Clearer service definitions also need to align with staffing requirements. Wraparound facilitators are responsible for facilitation of the planning process and should coordinate an array of services and supports. They are not required to have a master's degree in a mental health field; therefore, wraparound facilitators should not and cannot deliver individual or family therapy. The facilitator role and the clinician role should be separate and distinct.

Based on discussions with providers, it appears that technical assistance and guidance offered to providers to date has not helped them to understand the state's expectations regarding the use of the new rehabilitation services, how to become a provider of these services, and how to bill for these services. For example, some providers thought of IOP as only a substance use treatment service. Others described IOP as "MYPAC light" to be used for children who do not need MYPAC. Others report they use wraparound facilitation in lieu of targeted case management for children that do not need the intensity of MYPAC but need some type of coordination. The fact that the state continues to offer a per diem rate to the two providers who delivered MYPAC under the waiver, while suggesting that other providers would need to bill a combination of Wraparound facilitation, IOP, or CSS does in order to achieve the same level of intensity as MYPAC further contributes to a lack of clarity and potential interest by the CMHC providers in delivering IOP.

We applaud DOM for their effort to invest in IOP and increase use of an evidence-based practice in their system; particularly to encourage a system to move from a traditional use of day treatment to a more evidence-based group therapy approach. We further support MS efforts to use innovative financing approaches such as bundling to incent the use of certain services in their system. We do see, however, unintended consequences from the implementation of these efforts that are impacting access to care.

RECOMMENDATIONS:

1. CLEARLY DEFINE SERVICES TO ENSURE THE PROVISION OF INTENSIVE CARE COORDINATION USING WRAPAROUND

Revise service definitions to more clearly differentiate services that are intended to do different things for different populations, and to include required instead of optional elements. Consider separate rehabilitation option definitions for the intensive care coordination function and the intensive in-home family therapy function. Given that it is not clear from claims data when a code indicates intensive care coordination using wraparound, intensive family therapy or both services, separate service definitions would ensure the delivery of effective services and that a review of data would indicate services provided. If the state does not want to consider separately defined benefits for intensive care coordination and intensive in-home family therapy, then the service definition should be revised to indicate that both are required (vs allowing intensive care coordination using wraparound to be optional.) Both services need to be available in a system; and as discussed in the next section on intensive in-home family therapy, not all children will require both services at the same time-that is why many states define them as separate benefits and why we are recommending separate benefit definitions.

Within the effort to more clearly define services, reconsider the use of two levels of IOP- one for PRTF level of care and one as a step-down from PRTF level of care. The differentiation of PRTF level of care is no longer needed now that the service is approved under the rehabilitation option. The state's efforts to ensure that IOP is available as a step-down are laudable. IOP is an essential service for children with serious mental health needs whether or not they are at a PRTF level of care. Because IOP services are expected to be individualized to the unique needs of a child, training staff in the evidence-based practice, and authorization and quality oversight can ensure that the appropriate amount of care is delivered to meet the individualized needs of each child.

As service definitions are fine-tuned, it will be important to ensure that participation in care planning team meetings for non-IOP Medicaid providers that are part of a child's treatment plan are reimbursable. This will necessitate a review of other rehabilitation option service descriptions to ensure that those services allow for clinicians to participate in the care plan teams. Having IOP be the point of coordination in the system even when a child is admitted to a 24 hour service will further align policy with best practice. Currently, when a child is admitted to a 24 hour service, the child must be discharged from IOP and later reenrolled following that hospitalization. This leads to wait times for the child to resume IOP when re-referred but also prohibits IOP from continuing to coordinate care. In other states where the intensive care coordination provider

continues to be involved when a child is hospitalized, systems see shorter lengths of stay by having this service continue to coordinate care.
Further, re-examine the purpose for a service called wraparound facilitation separate from a newly defined intensive care coordination service definition.

2. REVIEW THE BUNDLED APPROACH TO SERVICE DEFINITION

Aside from the issue of IOP defined to meet both intensive in home family therapy and intensive care coordination, the current IOP definition includes services such as day treatment, medication management, individual, family and group therapy, peer support, wraparound facilitation and skill building groups. This constitutes most of the behavioral health benefits under one service definition.

Wraparound provides a unique opportunity to manage care by identifying strategies that align with a family/child's strengths and needs. The state should consider eliminating the current bundling of disparate services and consider a limited bundled approach that supports individualized approaches to care and evidence based practices. Specifically, combining day treatment, skills groups, medication management and other components previously discussed in the bundle do not align with the clinical purpose of intensive care coordination.

Rather than bundling services of concern (e.g., day treatment), use other utilization and quality approaches to address quality issues. Additionally, consider a single plan of care approach for children enrolled in an intensive care coordination approach through which other behavioral health services are approved. This ensures that all services are coordinated, that the range of services children need concurrently make sense and are not duplicative. This could be tied to the authorization processes of Medicaid vendors such as the CCOs and UM/QIO. This approach poses an additional opportunity for MYPAC to be the point of coordination in the system even when a child is admitted to a 24 hour service.

3. EXPAND ACCESS TO AND PROVISION OF IOP SERVICES

The state needs to continue its efforts to expand the number of providers that deliver IOP services. The state currently has limited capacity with three providers. Given the state's intent that IOP provide care to children that are "a step-down" from PRTF level of care, additional capacity is needed to ensure that this service is more widely available to more children.
Clearer communication, in writing, to providers and referral services is needed about the population for referral to IOP. Many providers and stakeholders do not understand the range of children's issues that could be referred to this service.

4. ENSURE RAPID ACCESS TO MYPAC

The process for referral, document collection and approval to MYPAC is very labor intensive and time consuming. The state has maintained processes used under its waiver program which are not needed under the rehabilitation option. Families often seek such services in times of heightened need and it is critical that they access services quickly, otherwise they may become discouraged or frustrated and rely on more traditional types of care. Intake staff are typically the family's initial contact with the program and as a result, quality consumer service is essential. A positive first experience can promote engagement with and attrition to the program and enhance the program's image in the community. The use of standardized assessment tools discussed previously and the reduction or elimination of these historical requirements can ensure that this service is rapidly available to families.

Mississippi could consider use of data from their CCOs or UM/QIO to streamline and ensure appropriate admissions to intensive home- and community-based services. MCOs have capacity, expertise, and leverage with providers to facilitate rapid enrollment in intensive home- and community-based services. By reviewing data, children that may benefit from this service could be triaged quickly. Additionally, Louisiana's eligibility determination process for their Coordinated System of Care included presumptive eligibility and may be beneficial to Mississippi to consider.

5. ELIMINATE THE REQUIREMENT FOR IQ SCORE FOR MYPAC ENROLLMENT

Among states implementing intensive care coordination programs, Mississippi is the only state to require IQ testing in its eligibility criteria. It is recommended that the requirement for IQ score be eliminated and replaced with clinical judgment of absence of an IQ issue with testing required for uncertain clinical scenarios, as other states have done. This will reduce unnecessary testing, wait times and unnecessary costs in the system.

6. RE-EVALUATE REQUIREMENT FOR PSYCHIATRIC DIAGNOSIS BY A PSYCHIATRIST OR PSYCHOLOGIST

Re-evaluate requirement for psychiatric diagnosis by a psychiatrist or a psychologist given the lengthy wait times reported for appointments with these two disciplines; and allow independently licensed staff of other discipline to perform this function as allowed within the scope of their license. We understand that this is currently under review.

7. USE COORDINATION SERVICES AND BILLING CODES THAT ALLOW FOR IOP AND INSTITUTIONAL PROVIDERS TO COORDINATE CARE

To facilitate treatment and transitions, establish service definitions and billable codes, policies and practices that emphasize warm "hand-offs", joint care planning and the active exchange of information. Children would benefit from system incentives that encouraged institutional providers and community providers to more rapidly exchange information, and engage in informed care planning. For example, many Medicaid programs reimburse for one warm "hand-off" (face to face meeting) that includes the community provider, institutional provider, youth and family in order to support successful transitions. Another successful strategy is the reimbursement for telehealth, allowing for a "virtual" transition meeting. Additionally, other states allow for reimbursement to participate on the child and family teams.

8. ADDRESS RATE ISSUES AND PROVIDER CONFUSION

Medicaid is currently meeting with providers to address concerns about the IOP rate. As stated previously, DOM and DMH have also offered to conduct rate studies on services. In other chapter, we discuss and recommend that a range of provider communication approaches be used to facilitate policy issues including regular meetings specific to children's behavioral health policy issues, active dialogue with providers, written communication to all providers of behavioral health services, and an increased focus in translating individual provider questions into more frequent policy communications to all behavioral health providers.

9. TRAINING AND INFORMATION

Mississippi has made an introduction to wraparound training available to behavioral health service providers (in addition to providers delivering MYPAC), and to system partners such as child welfare staff. Given that wraparound engages all involved systems in the plan of care, we recommend that a system-wide coordinated training plan be developed to address ongoing training needs across all child serving systems and other behavioral health service providers. Information and training on wraparound and their role in the wraparound process is vital to successful outcomes for this evidence-based practice. In addition to a coordinated interagency effort on joint training, written materials geared towards schools, child welfare and juvenile justice would be beneficial as part of that ongoing effort. The state has partnered with the University of Southern Mississippi to provide training infrastructure for wraparound across the state. USM could provide this additional planning and training support.

INTENSIVE IN-HOME FAMILY BASED THERAPIES

DOM has indicated that IOP is intended to be the intensive in-home family therapy model in Mississippi. As mentioned in the previous section, it is difficult to analyze Mississippi's benefits for intensive care coordination and intensive in-home family based therapies separately as both services are linked in

Mississippi's current benefit array. Given how it is defined, and that the same definition is used to also address intensive care coordination, it is not clear if a separate service called intensive in-home family therapy is available for children in Mississippi (and likewise if a separate service called intensive care coordination is available.)

As part of the 2012 Medicaid rehabilitation option revisions, DOM submitted an intensive in home family therapy definition for approval by CMS but it was denied by CMS due to a perceived duplication to IOP. In response, DOM added clarification to the IOP service description including family therapy as part of that service. We commend DOM for recognizing the importance of intensive in home family therapy approaches, and attempting to resolve this Medicaid benefit issue by including family therapy as part of IOP.

Combining two separate services into one service has created system challenges. First, providing wraparound is an optional component of IOP and not a requirement. While the IOP definition shares many components of a best practice definition for intensive in home therapy and intensive care coordination, allowing one service definition to be used interchangeably-either for intensive in home or intensive care coordination, is confusing. It creates challenges for DMH and DOM to monitor provider performance and to clearly understand the services that are being provided when data is reviewed. Given the concerns that DOM and DMH have about provider performance, clearer definitions that explicitly state what is bought, when and how, will aid the state in ensuring quality of care and decrease the likelihood of services being used inappropriately.

The components of intensive in-home family based services include individual and family therapy, skills training, and behavioral interventions."[51] This array of interventions is meant to be used flexibly and delivered where the youth and family choose. One substantial benefit of this benefit is that trained staff can help youth and families practice skills in "real world" settings, which increases the likelihood that they will be able to apply these skills in a variety of situations they face every day. As stated in the discussion about care coordination, the current definition does not clearly align with delivery of in home family based therapy; and bundles an array of mental health benefits together that are not consist with family based therapy models. Given that many in home family based therapies such as Multi-Systemic Therapy (MST) involve team approaches, further clarification of expectations to provide a therapeutic mentoring like components would also help differentiate the type of clinical intervention being provided in IOP. Components of therapeutic mentoring exist in several rehabilitation option definitions including IOP, Community Support Service (CSS), and Peer Support.

As an example, Massachusetts defines In-Home Family Therapy[52] as:

> *In-Home Therapy Services: This service is delivered by one or more members of a team consisting of professional and paraprofessional staff, offering a combination of medically necessary In-Home Therapy and Therapeutic Training and Support. The main focus of In-Home Therapy Services is to ameliorate the youth's mental health issues and strengthen the family structures and supports. In-Home Therapy Services are distinguished from traditional therapy in that services are delivered in the home and community; services include 24/7 urgent response capability on the part of the provider; the frequency and duration of a given session matches need and is not time limited; scheduling is flexible; services are expected to include the identification of natural supports and include coordination of care. In-Home Therapy is situational, working with the youth and family in their home environment, fostering understanding of the family dynamics and teaching strategies to address stressors as they arise. In-Home Therapy fosters a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family. Interventions are designed to enhance and improve the*

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[51] United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved on June 20, 2014 from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[52] http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/home-and-community-based-behavioral-health-srvcs.html

family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. The In-Home Therapy team (comprised of the qualified practitioner(s), family, and youth), develops a treatment plan and, using established psychotherapeutic techniques and intensive family therapy, works with the entire family, or a subset of the family, to implement focused structural or strategic interventions and behavioral techniques to: enhance problem-solving, limit-setting, risk management/safety planning, communication, build skills to strengthen the family, advance therapeutic goals, or improve ineffective patterns of interaction; identify and utilize community resources; develop and maintain natural supports for the youth and parent/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention.

Montana defines In-Home Family Therapy as[53]:

In-Home Therapy In-home therapists provide face-to-face, individual, and family therapy for youth and parent(s)/legal representatives in the residence of the youth at times convenient for the youth and family. As part of the provision of the therapy and for the purposes of the service plan, the in-home therapist must: (a) communicate with the department regarding the status of the youth and their treatment; (b) develop and write an individual treatment plan with the youth and parent(s)/legal representative specific to mental health therapy; (c) provide crisis response during and after working hours; (d) assist the youth with transition planning; and (e) attend family and team meetings and other activities pertinent to support success in the community. The in-home therapist and high fidelity wraparound facilitator cannot be employed by the same agency when serving on the treatment team and providing services to a specific youth enrolled in the 1915(i) HCBS State Plan program.

Both of these examples are important for two reasons. While these state plan definitions are different in scope, both clearly define intensive in home family therapy, provide a definition that is consistent with evidence-based practices, and state how providers are expected to perform/deliver care. These examples were also selected because they are two of many states that also have separate definitions for intensive care coordination; clearly differentiating the intent and purpose of both of these different services in their systems.

Not all children need both intensive care coordination and intensive in home family therapy at the same time. By bundling the two together, the state may not be fully realizing effective quality and efficient financing that could be realized if these services were defined separately.

Families and providers highlighted the need for an intensive in-home therapy model. Providers reported that engaging families in treatment could be "difficult" and that, "there is no way to deal with problems in the home." Clinicians reported little time and ability to provide the type of family therapy they knew was needed to help a child; from the lack of reimbursement for travel time to safety concerns about being in a family's home, clinicians and managers reported frustration with not being able to meet the needs of families.

Time did not allow our review of the intensive in-home family therapy service descriptions submitted to CMS; therefore, we cannot speak to any apparent duplication between those proposed services. However, other states have received CMS approval of both intensive care coordination and intensive-in home therapy including Georgia, Massachusetts, and Montana. Additionally, the joint informational bulletin released in May 2013 by the Centers for Medicaid and CHIP Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), which provided guidance to states on establishing benefit designs

[53] https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

intended to help youth with behavioral health challenges remain in their homes and local communities, clearly defined Wraparound facilitation and intensive-in home therapy as distinct services[54].

RECOMMENDATIONS:

The recommendations made in the previous section on intensive care coordination are also applicable to intensive in home family based therapy. There is a need to more clearly define in-home family based therapy consistent with evidence-based practices and addressing bundling of other services with a family based definition; address expanded access to the service, coordination with other services, and rate and provider issues. In addition, we also recommend:

IMPLMENTATION OF EVIDENCE-BASED PRACTICE SPECIFIC TO INTENSIVE IN HOME FAMILY BASED THERAPY

We recommend that a system-wide coordinated training and fidelity effort be developed specific to at least one evidence- based in-home family based therapy model. While providers are required to use EBPS, it is not clear what specific models are being consistently used. If the state invested in at least one model, the state would be better able to realize its system goals for this service. As an example, the state could select Multi-Systemic Therapy (MST) that was previously introduced to providers in Mississippi.

RESPITE

Respite services are intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite services provide safe and supportive environments on a planned or unplanned short-term basis for children with mental health conditions when their families need relief. Respite services are provided either in the home or in approved out-of-home settings. Currently, the Making A Plan (MAP) team process has access to limited funds from the Department of Mental Health to purchase respite. While a review of MAP Team processes and expenditures was beyond the scope of our work; DMH reports that a small amount of dollars, approximately $ 722,696 is able to be allocated to MAP teams; thereby impacting the extent of its use in Mississippi. Additionally, DOM supported the purchase of respite services through the waiver that covered MYPAC services.

In April 2013 DMH and the Strategic Planning and Best Practices Committee established as part of the Rose Isabel Williams Mental Health Reform Act, conducted a survey of external stakeholders to identify needed or desired revisions to the core services that CMHCs and other DMH approved and certified mental health service providers offer. Recommendations from this survey for additional core services for youth included: respite care, family support, and supportive housing options for young adults, prevention services, and creative therapies such as art or music.[55] Additionally, interviews conducted with stakeholders for this assessment identified the need for similar additions to the service array for youth. Respite care, (not just crisis or overnight respite but respite care a family could access even for a few hours in the afternoon or evening) was mentioned repeatedly by families as a service that could help them to maintain their child at home and avoid placement in PRTF and/or hospitals.

States are using a variety of funding streams for this service, often blending general revenue and certain federal dollars from other child-serving agencies such as child welfare and juvenile justice. In addition, some states are using Medicaid as a sustainable funding source for respite care, employing a variety of different Medicaid authorities. Indiana which had a 1915(c) Community Alternatives PRTF Demonstration Grant, leveraged the Money Follows the Person (MFP) Rebalancing Demonstration Grant, which helps states rebalance their Medicaid long-term care systems, to support youth transitioning from PRTF settings into the

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[54] United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved on June 20, 2014 from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[55] Rose Isabel Williams Mental Health Reform Act of 2011 Strategic Planning and Best Practices Committee. Report to the Legislature. (June, 2013). Retrieved on November 17, 2014 from: http://www.dmh.ms.gov/wp-content/uploads/2012/08/SPBP-Final-Report_Scanned-Version.pdf

community. Montana used the 1915(i) HCBS State Plan authority to include respite along with several other services in its state Medicaid plan. Through its Coordinated System of Care (CSoC) effort, Louisiana uses the 1915(b)(1) mandatory managed care enrollment combined with a 1915(c) HCBS waiver to cover short-term respite care for youth with serious behavioral health challenges. Louisiana also uses managed care savings under the Medicaid 1915(b)(3) authority to pay for respite services for youth who meet eligibility criteria for enrollment in the CSoC but who do not meet the institutional level of care criteria under its 1915(c) waiver.

While CMS does not allow coverage of respite through a Rehabilitation Option, there are other viable options that Mississippi is encouraged to explore to fund this service. As an example, Indiana, also a former 1915(c) Community Alternatives PRTF Demonstration Grant state, leveraged the Money Follows the Person (MFP) Rebalancing Demonstration Grant, a program that helps states rebalance their Medicaid long-term care systems to support youth transitioning from PRTF settings into the community. Respite providers in Indiana bill in 15 minute increments when respite is provided for less than seven hours in any one day; or at a daily rate when respite is provided from seven to 24 hours. Indiana also allows crisis respite care to be provided for a minimum of eight to 24 hours billable at a daily rate.

Montana used the 1915(i) HCBS State Plan authority to include respite along with several other services in its state Medicaid plan. Montana respite providers who deliver care for less than 24 hours bill in 15 minute units, also using the Healthcare Common Procedure Coding System (HCPCS) code S5150, while those providing overnight respite bill a daily rate using code S5151. In addition, through its Coordinated System of Care (CSoC) effort, Louisiana uses the 1915(b)(1) mandatory managed care enrollment combined with a 1915(c) HCBS waiver to cover short-term respite care for youth with serious behavioral health challenges. Louisiana also uses managed care savings under the Medicaid 1915(b)(3) authority to pay for respite services for youth who meet eligibility criteria for enrollment in the CSoC but who do not meet the institutional level of care criteria under its 1915(c) waiver. Like Montana, providers in Louisiana bill for respite services in 15 minute increments using HCPCS code S5150.

Montana defines respite as[56]:

> *Respite Care is the provision of supportive care to the youth when the unpaid persons normally providing day to day care for the youth will not be available to provide care. Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods. Respite Care services may be provided in the place of residence of the youth, another private residence or other community setting, excluding psychiatric residential treatment facilities. The provider of respite care must ensure that its employees providing respite care* services are: (a) physically and mentally qualified *to provide this service to the youth; (b) aware of emergency assistance systems and crisis plans; (c) knowledgeable about the physical and mental conditions of the youth; (d) knowledgeable about common medications and related conditions of the youth; and (e) capable to administer basic first aid. Respite care cannot be billed at the same time as Crisis Intervention Service. Per federal regulation, the cost for room and board furnished in a residential setting is excluded.*

Louisiana defines respite as:[57]

> "Short term respite care provides temporary direct care and supervision for the child/youth in the child's home or a community setting that is not facility-based (e.g., not provided overnight in a provider-based facility). The primary purpose is relief to families/caregivers of a child with a SED or relief of the child. Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. Respite may either be planned or provided on an emergency basis. Normal activities of daily living are considered to be included in the content of the service when providing respite care and cannot be billed separately. These include support in the home, after school or at

[56] https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/1915%28i%29HomeandCommunityBasedServicesProviderPolicyManual.pdf

[57] http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv4b.pdf

night, transportation to and from school/medical appointments or other community-based activities and/or any combination of the above. The cost of transportation is also included in the rate paid to providers of this service. Short term respite care can be provided in an individual's home or place of residence or provided in other community settings, such as at a relative's home or in a short visit to a community park or recreation center. Respite services provided by or in an Institution of Mental Disease (IMD) are not covered. The child must be present when providing short-term respite care. Short term respite care may not be provided simultaneously with crisis stabilization services and does not duplicate any other Medicaid State Plan service or service otherwise available to recipient at no cost.

It is important to note that room and board costs cannot be included in the rate for Medicaid funded respite services. To account for this, Louisiana leverages funding from other agencies that from the Louisiana Behavioral Health Partnership, such as the Office of Juvenile Justice and the Department of Children and Family Services, to cover the costs of room and board for overnight respite care.

RECOMMENDATION: EXPAND RESPITE SERVICES

TAC/The Institute recommends that DOM and DMH continue to explore various avenues to expand funding for respite care, including how Medicaid could be utilized in order to draw down additional federal dollars. In addition to expansion of funding, a certain portion of MAP team funds could be designated to specifically support youth and families who need respite. Depending on related efforts to reduce institutional care, some capacity may be able to be repurposed for respite care. This would require training and other policy changes to ensure that any repurposed capacity met its new goals.

GOODS & SERVICES

As mentioned in the aforementioned respite section, DMH is able to allocate limited dollars to the MAP teams for use in purchasing goods and services. As with respite care, states have several options to make this service available. Most states blend dollars across child-serving agencies to make flexible funding available for high need children receiving intensive care coordination. Chapter 4 in this report on Interagency Collaboration discusses opportunities for Mississippi's child serving agencies to better meet the behavioral health needs of children, including blending or braiding of funding to collectively pool dollars together, compensating for certain funding rules/restrictions. As with respite care, states have several options to make flexible funding available to families. Maryland is implementing use of customized good and services as part of its 1915(i) Medicaid state plan amendment. Other jurisdictions including Milwaukee County, Wisconsin, Cuyahoga County, Ohio and New Jersey have leveraged state dollars for flexible funding.

Wraparound Milwaukee defines its flexible funds as:[58]

> *Funds intended for the purchase of a service or commodity that is needed to meet a specific client mental health need. The disbursement of those funds by a Care Coordinator must be directly related to achieving a specific need in the Plan of Care for the child or family enrolled in Wraparound Milwaukee. The following categories should be used to identify specifically what the discretionary request is for. Incentive Money, Rent, Security Deposit, Utilities, Phone, Household Supplies, Groceries, Clothes, Shoes, Classes, Books, Workshops, Miscellaneous Memberships (i.e., YMCA), Recreation.*

The Maryland definition is[59]:

[58] http://wraparoundmke.com/wp-content/uploads/2013/07/015-Discretionary-Funds.pdf

Customized Goods and Services are those used in support of the child and family's POC for a participant receiving care coordination from a CCO. All customized goods and services expenditures must be used to support the individualized POC for the child and family and are to be used for reasonable and necessary costs. A reasonable cost is one that, in its nature and amount, does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. Necessary costs have been generally determined to be those that are likely to improve outcomes or remediate a particular and specific need identified in the POC. This item or service must aim to decrease the need for other Medicaid services, promote inclusion in the community, or increase the participant's safety in the home environment. A participant may access the service only if the individual does not have the funds to purchase the item or service, or the item or service is not available through another source. Experimental or prohibited treatments are excluded.

RECOMMENDATION: EXPAND FUNDING FOR GOODS AND SERVICES (FLEXIBLE FUNDING)

DMH has made efforts to ensure that flexible funding is available to the MAP teams. Additional funding is needed to expand flexible funding availability. The state should explore how other resources from DOM, child welfare, or juvenile justice, can be used to increase access to flexible good and services. Chapter 4 of this report on Interagency Collaboration discusses opportunities for Mississippi's child serving agencies to better meet the behavioral health needs of children, including blending or braiding of funding to collectively pool dollars together, compensating for certain funding rules/restrictions.

FAMILY-CENTERED PRACTICE IN INSTITUTIONAL PROGRAMS

The focus on our analysis in this section was the capacity of institutions to use family-centered practices that ensure connection to family and community. These include maximizing regular contact between the child and family such as through home visits, telephone calls and electronic communication; engaging youth and families in all aspects of service planning, identifying and building on the families' strengths; assisting families with transportation to visit their children at the hospital if the family has no options; educating families about their child's illness and any medications if prescribed/revised from the time of admission; working with youth and families on transitions; and using treatment strategies that families can use in their homes, including culturally appropriate strategies. Institutions varied in their capacity to support connection to families and communities through these various means.

Geographic distance hampers the ability of institutions to engage some families; particularly given the rural nature of Mississippi and that many of the institutions are located centrally in the state. Many programs had established requirements for monthly or bi-monthly family meetings; several used day and overnight passes home as part of transitioning. Many states have found the use of family or youth (young adult) peers as a key way to engage families, and support a successful transition. All providers would benefit from additional support to engage families and support transitions.

RECOMMENDATIONS

1. ESTABLISH POLICIES AND PRACTICES THAT SUPPORT TRANSITION FROM INSTITUTIONAL SETTINGS

Successful transition from institutional settings requires policies and practices that can divert re-entry, and support engage with needed services. Strategies discussed throughout this report, including increased use of telehealth approaches, allowing the concurrent billing of Medicaid between institutional and community providers to support warm 'hand-offs" and successful transitions, the hiring of persons with lived experience as part of institutional teams, and transportation reimbursement so families can participate in family meetings, are best practice approaches. We discuss other institutional setting issues in greater deal in Chapter 5 of this report.

[59] http://dhmh.maryland.gov/bhd/SitePages/1915%28i%29%20Intensive%20Behavioral%20Health%20Services%20for%20Children,%20Youth%20and%20Families.aspx

2. TRAIN INSTITUTIONAL STAFF IN WRAPAROUND

TAC/The Institute recommends that all institutional settings participate in wraparound training. This will further support involvement of institutional staff on care planning teams, and institutional staff focus on community integration. Much like the effort to engage CMHCs in the importance of family driven care, methods to engage families in their youths care, institutional settings should also be expected to identify needs, develop individualized plans of care, and engage families to those same standards. Given that many of these children are involved with the child welfare system, successful transitions requires alignment with child welfare policies and procedures, and coordination across agency staff and providers.

YOUTH SPECIFIC SUD SERVICES

The benefit array is geared towards mental health treatment, with limited substance use treatment services available. Certain services are funded by Medicaid and DMH including IOP and residential services. A January 2015 CMS Informational Bulletin regarding *Coverage of Behavioral Health Services for Youth with Substance Use Disorders* [60] cites the need for a comprehensive benefit design covering vital evidence-based treatment and best practices to identify and treat SUD in the youth and adolescent population. Most states have expanded their SUD benefit array for youth as required under EPSDT provisions.

As an example, the state of Louisiana[61] defines a full continuum of services specific to substance use treatment for youth according to the criteria established by the American Society of Addiction Medicine (ASAM). The state follows the ASAM criteria that includes an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance abuse symptoms and behaviors. Services for adolescents must be separate from adult services, be developmentally appropriate, involve the family or caregiver and coordinate with other systems (such as child welfare, juvenile justice and the schools). These services are designed to help youth achieve changes in their substance abuse behaviors.

RECOMMENDATION

EXPAND AVAILABLE SUD SERVICES

Mississippi should expand the availability of SUD services for youth and build the capacity of providers to deliver this service. This includes screening, brief intervention and referral to treatment opportunities, greater use of outpatient, community-based, residential settings, and Medication Assisted Therapies specific to the developmental needs of this population.[43] [62]

PARENT AND YOUTH PEER SUPPORT

Between July 2013 and June 2014, approximately 178 individuals received Medicaid funded peer support services.[63] While providers report great success with peer support in substance use residential programs, crisis stabilization, and mobile crisis services, its use in providing support, systems navigation, and enhancing

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[60] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf

[61] http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/LBHPSvcsManv4b.pdf

[62] Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about good and modern treatment and recovery services for youth with substance use disorders?* Report of the SAMHSA Technical Expert Panel. Rockville, MD: Center for Substance Abuse.

[63] Only represents claims for peer support on behalf of Medicaid beneficiaries under 21.

engagement among caregivers and young adults' remains relatively limited. Despite the enthusiasm for peer support expressed by providers, they cited the low reimbursement rate for this service as a barrier to developing greater capacity and utilization, particularly for providers serving more rural areas. DOM and DMH offered to conduct a rate study; the Mississippi Association of Community Mental Health Centers declined such a study. The use of peer support for caregivers and young adults has largely been in the SAMHSA funded MTOP program. Given severe workforce shortages, expansion to appropriately credentialed persons with lived experience would allow for effective access to care and redirection of licensed workforce towards functions that only licensed persons can provide. Additionally, persons with lived experience are an invaluable resource to engaging youth and families in treatment; and supporting successful transitions from treatment.

States have used different approaches to define this service though all share the common element of hiring persons with lived experience as a primary caregiver of a child with a behavioral health need. For example, Massachusetts defines this as a separate free-standing service that is to be incorporated across all levels of care.

> *Family Support and Training is s service provided to the parent/caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings. FS&T is a service that provides a structured, one-to-one, strengths-based relationship between a Family Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent/caregiver to parent the youth so as to improve the youth's functioning as identified in the outpatient or in-home therapy treatment plan or individual care plan and to support the youth in the community or to assist the youth in returning to the community. Services may include education, assistance in navigating the child serving systems (child welfare, education, mental health, juvenile justice, etc.), fostering empowerment, including linkages to parent/peer support and self-help groups; assistance in identifying formal and community resources (e.g., after-school programs, food assistance, summer camps, etc.) support, coaching and training for the parent/caregiver.*

Arizona defines the service as:[64]

> *Home care training family services (family support) involve face-to-face interaction with family member(s) directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family. Parent staff who provide this service also utilize a wide array of other billing codes i.e. case management, peer support, behavioral health prevention and promotion, transportation, translation.*

Many states are pursuing opportunities to expand this important role. Maryland is working to integrate peer support services for caregivers of children with complex behavioral health needs with other State-sponsored services and to increase Medicaid reimbursement. Georgia is both developing a peer support training curriculum and certification process for caregivers of children with complex behavioral health needs and identifying ways to increase Medicaid reimbursement. Utah and Idaho are engaging "parent partners" to provide peer support and advice on quality improvement activities in pediatric practices participating in the CHIPRA quality demonstration medical home efforts. [65]

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[64] http://www.azdhs.gov/bhs/documents/covserv/covered-bhs-guide.pdf

[65] Agency for Health Care Research and Quality. (2014). *The National Evaluation of the CHIPRA Quality Demonstration Grant Program.* http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/highlight07.pdf

RECOMMENDATION

DEVELOP THE PEER WORKFORCE AND IMPLEMENT A CAREGIVER SUPPORT CERTIFICATION PROCESS

We recommend that DMH expand its efforts to certify peers and implement caregiver/peer support certification process. We would recommend some adaptations of a caregiver certificate process from the current peer certificate process as the current peer application packet is very labor intensive which could serve to discourage potential applicants.

EVIDENCE-BASED PRACTICES IN OUTPATIENT SETTINGS

As indicated in chapter one, claims analysis indicates that individual therapy is among the top services utilized based on percent of Medicaid enrollees receiving services. As such, it is a critical opportunity to ensure that these children receive evidence-based practices that support successful outcomes. All providers reported use of EBPs in outpatient settings. Providers of outpatient services are working to incorporate EBPs into practice but the infrastructure and fidelity monitoring that reinforces consistent use of EBPs needs to be addressed. Opportunities include selection of a couple of additional system wide EBPs that address clinical needs, in addition to the investment already made in trauma and wraparound. Given that a majority of children receiving care are using outpatient, efforts made by the state to ensure the quality of care in IOP should be extended to other outpatient services as well. Further, gathering of fidelity data on the use of EBPs in outpatient is recommended to provide invaluable information on both the individual and system level related to improved outcomes.

RECOMMENDATION

CONTINUE TO SUPPORT INVESTMENTS IN EBP TRAINING AND FIDELITY MONITORING

DMH has made investments in Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARC), and Wraparound Facilitation. Each of these requires three intensive learning sessions, bi-monthly technical assistance calls, and implementation of fidelity measures, all of which is provided at minimal cost to providers. We recommend that DMH continue to provide this infrastructure for evidence-based practices in both outpatient and institutional settings. Providers of outpatient services, in particular, are working to incorporate EBPs into practice but the infrastructure and fidelity monitoring that reinforces consistent use of EBPs needs to be addressed. Opportunities include selection of a couple of additional system wide EBPs that address clinical needs other than trauma and wraparound, for further focus and statewide infrastructure support.

TRAUMA-INFORMED SYSTEMS APPROACHES

Across the country, behavioral health systems are increasingly aware of the impact of trauma. Children and youth with the most challenging mental health needs often have experienced significant trauma in their lives. The Adverse Childhood Experiences (ACE) study[66] has reported short and long-term outcomes of childhood exposure to certain adverse experiences that include a multitude of mental health, health and social problems. Mississippi has been investing in trauma informed practices since 2007. Mississippi has been recognized by the National Child Traumatic Stress Network for its learning collaborative approach for Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Mississippi implemented a learning collaborative approach in several of its institutions; and has conducted three out of state trainings and numerous in state trainings that have included parents and youth. The state was selected to participate in a web based video tool available through Georgetown University's Center for Child and Human Development. The state also participated in a national learning collaborative hosted by the National Council. Recently, the MTOP grant

[66] http://www.cdc.gov/ace/findings.htm

evaluation produced a report on the outcomes from the trauma informed trainings, conferences and workshops which will guide future planning efforts.

RECOMMENDATION

PROMOTE USE OF TRAUMA INFORMED CARE PRACTICES

Mississippi can build on its successful efforts and expand its trauma informed care practices across all institutional care providers. Training staff in these settings on how to adapt their environments and work with youth with trauma histories could reduce restraint and seclusion practices and reduce length of stay in these environments. To deepen its efforts among community-based providers, the state will also need additional resources to support the broader use of TF-CBT among outpatient practitioners.

TRANSITION TO ADULTHOOD

Transition aged youth with serious behavioral health challenges need services specifically geared to support their unique developmental needs as they enter adulthood. Transition services should include a focus on supported education, vocational/employment, and housing support. The Achieve My Plan (AMP) model [67] and the Transition to Independence Process (TIP) model[68]are examples of evidence-based approaches to supporting youth as they transition to adulthood. The Mississippi Transition Age Youth (MTOP) program, funded through a grant from SAMHSA, was highlighted as a well-regarded program that has helped support young adults with serious behavioral health challenges in areas such as employment, housing, and recovery.

RECOMMENDATION

IDENTIFY SUSTAINABLE FUNDING SOURCES FOR TRANSITION AGE YOUTH SERVICES

Currently, there is limited access for transition-aged youth to support employment or housing opportunities, outside of the SAMHSA grant funding. DMH and DOM should work collaboratively to ensure there is a sustainable source of funding for supported employment, education, and housing for the young adult population once the SAMHSA funding ends.

FINANCING BEYOND MEDICAID

Throughout this assessment process we also heard from numerous advocates, providers, and family stakeholders that community-based services for those youth who were either uninsured or underinsured (e.g. typically those with commercial insurance) were extremely limited or non-existent. This dearth of community-based service options for youth lacking Medicaid was cited by stakeholders and family members as one of the factors contributing to the out-of-home placement of their child. Supporting access to a continuum of community-based services for youth with serious behavioral health challenges regardless of payer is integral to stemming the tide of youth entering state hospital and PRTF facilities. The state has invested in growing its Medicaid behavioral health benefits to meet the needs of Medicaid eligible children. It is equally important to meet the behavioral health needs of children that are not covered by Medicaid. Mississippi could achieve this through a coordinated purchasing plan across the various funders of behavioral health including child welfare, juvenile justice, public health and education.

[67] http://www.pathwaysrtc.pdx.edu/proj-3-amp

[68] http://www.tipstars.org/

RECOMMENDATION

IMPLEMENT A STRATEGY TO ENSURE ACCESS TO SERVICES REGARDLESS OF CHILD'S INSURANCE.

Other states and localities have created financial arrangements that combine funding streams in order to accomplish this objective of serving children who are not Medicaid-eligible. For example, in New Jersey providers of care management and mobile crisis can make Medicaid presumptive eligibility determinations. This means that if a youth is in need of mobile crisis services and is not a current Medicaid beneficiary, the provider can make that youth eligible for Medicaid on a short-term basis (30 days or until a formal Medicaid eligibility determination can be made) so providers can bill and service delivery is not delayed. For youth who are not found to be eligible for Medicaid, the youth is issued a "look-alike" number. This allows service providers to submit claims to the state's Medicaid fiscal agent who pays the claim(s)(for services provided to non-Medicaid eligible youth) with state only dollars. This reduces administrative burden on providers by having claims submission and payment for both Medicaid beneficiaries and non-Medicaid beneficiaries be a single entity. It also ensures access to the range of home and community-based services available under the state's Children's System of Care for youth who are not Medicaid eligible. In developing this arrangement, New Jersey has successfully created a system that is easy for both families and providers to navigate; and has allowed for greater access to a range of services to help youth in need of behavioral health treatment. The New Jersey system was financed with a combination of Medicaid, block grant, and state general revenue from the behavioral health and child welfare systems. Mississippi has recently implemented presumptive eligibility with hospitals; this effort could serve as a foundation for other providers to also provide that function.

Louisiana's Behavioral Health Partnership (LBHP) offers another example of a funding approach designed to support access to a continuum of behavioral health services. Medicaid and non-Medicaid adults and children who require specialized behavioral health services, including those children who are at risk for out of home placement under the state's Coordinated System of Care (CSoC) initiative can accessed services through the LBHP. Several state agencies comprised the LBHP including the Office of Behavioral Health, Medicaid, the Office of Juvenile Justice, the Department of Children and Families, and the Department of Education. A Statewide Management Organization had responsibility for coordinating care, provider contracting, and claims processing. With funds contributed by the different partners, the LBHP allowed youth who are found eligible for services available as part of the CSoC: wraparound facilitation, parent support and training, youth support and training, short-term respite care, and crisis stabilization access to these services regardless of their eligibility for the Medicaid program. It also helps to pay for aspects of services that cannot be paid for with Medicaid funds such as room and board costs for respite care. While Louisiana has recently decided to shift from this approach, other localities are considering such approaches based on the Louisiana design.

Finally, as Mississippi explores opportunities that redirection of institutional dollars provides, discussed in detail in a later chapter, this would further allow DMH appropriations to be used to address the community behavioral health needs of children that are not enrolled in Medicaid.

CHAPTER 3: PROVIDER CAPACITY

INTRODUCTION

This chapter highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. The assessment of provider capacity included an evaluation of the available behavioral health workforce[69] and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

In addition to the services that are available in a system, another critical component to ensuring that youth in Mississippi with serious behavioral health challenges can remain in their homes and local communities requires sufficient community-based provider capacity to deliver those services. An assessment of provider capacity included an evaluation of the available behavioral health workforce[70] and its ability to competently deliver services and supports to youth with behavioral health challenges in home and community-based settings.

PROVIDER LANDSCAPE

This section highlights critical provider capacity issues facing Mississippi, details provider and workforce capacity information and trends, and discusses results of the various key informant interviews. Several questions drove both the quantitative and qualitative aspects of this provider capacity and workforce analysis. These questions included:

1. To what extent are providers delivering services able to meet the community support needs of youth and their families?
2. Are there limitations or barriers to expanding community-based provider capacity?
3. To what extent are caregivers of youth with behavioral health challenges being utilized in the provision of mental health and substance use services?
4. What structures exist to support workforce development and provider capacity building?

It should also be noted that determining providing capacity is incredibly challenging. Much of the data that is available to assess capacity are proxy measures such as numbers of certified providers licensed/certified practitioners, or beds that do not reveal much about the true capacity of the system to serve youth and families. For example, budgets often limit the number of people who can be hired to perform the work. Data from licensing or certification boards are limited in that the numbers only reflect the total number of licensed/credentialed staff and not those who are specifically trained or interested in working with youth and families. These staff too may be working in other settings such as child welfare or juvenile justice. These numbers therefore overinflate the actual number of practitioners available to serve youth and families. These limitations must be taken into consideration when reviewing these data.

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[69]Throughout this chapter, when discussing the available "workforce" or "practitioners" we are referring to the individuals who deliver mental health and substance use services. Some of these individuals are employed by community mental health centers or other agencies while others (e.g. licensed psychologists or psychiatrists) may operate as a solo practitioner or as part of a small group practice. When using the term "provider" we are referring to agencies.

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Mississippi's behavioral health service provider system consists of three major components: 1) state-operated facilities, 2) regional community mental health centers, and 3) private behavioral health providers. It should be mentioned here that the discussion below largely focuses on the capacity of those providers who offer services in home and community-based settings rather than those offering acute inpatient or PRTF services. Information specific to the use of institutional settings will be discussed in chapter 5.

STATE-OPERATED FACILITIES

There are four facilities operated by DMH that provide inpatient treatment for youth with serious emotional disturbance and/or intellectual disabilities:

- **East Mississippi State Hospital in Meridian** has a 50-bed unit that serves adolescent males between the ages of 12-17 for "short-term" treatment (up to 90 days). The unit also has capacity to provide alcohol and drug treatment for youth with substance use disorders.
- **Mississippi State Hospital in Whitfield** (Oak Circle Center) has capacity to serve youth between the ages of 4-17 in its 60-bed facility.
- **Mississippi Adolescent Center in Brookhaven** serves adolescents with intellectual or developmental disabilities in its 32 bed facility.
- **Specialized Treatment Facility in Gulfport** has capacity to serve up to 48 adolescents between 13 and 18, and gives priority to those that have some involvement with the judicial system and are diagnosed with a psychiatric disorder.

COMMUNITY MENTAL HEALTH CENTERS

The Regional Commission Act provides the structure for Mississippi's mental health service system and program development by authorizing the 82 counties to form multi-county regional commissions on mental health. Regional commissions are authorized to plan and implement mental health and intellectual or developmental disability programs in their respective areas, delivered through community mental health centers (CMHCs). There are currently 14 CMHCs operating in the State, funded by a combination of local, state, and federal dollars forming the backbone of Mississippi's public behavioral health service delivery system. DMH certifies the centers to provide services and monitors state and federal dollars allocated to them via DMH. The primary goals of the CMHCs are to:

- Provide accessible services to all citizens with mental and emotional problems
- Reduce the number of initial admissions to the state hospitals
- Prevent re-admissions through supportive aftercare services

The CMHCs provide a range of services and supports for youth. All CMHCs are required by DMH to offer certain core services (see Chapter 1 for specific services) for youth. Some offer additional services and supports beyond the core services typically as part of special grant funded initiatives such as Mississippi Transitional Outreach Project (MTOP) or the Adolescent Opportunity Program (AOP). A CMHC provider (Region 1) operates the one adolescent residential substance use program in the state.

PRIVATE BEHAVIORAL HEALTH PROVIDERS AND CENTERS

There are a number of private mental health providers throughout the state who offer certain specialized treatment services such as acute inpatient care, therapeutic group home, therapeutic foster care, PRTF, crisis stabilization, and IOP (MYPAC). These programs are certified by and may receive funding from DMH, in addition to other sources, to provide community-based services such as community-based substance abuse services, community services for persons with intellectual/developmental disabilities, and community

services for children with behavioral health needs. DOM added these providers to the Medicaid network of providers to address access issues and increase service capacity across the state.

WORKFORCE CHALLENGES

It has been widely recognized that that there are serious challenges facing mental health and substance use systems, both nationally and in Mississippi, with regard to the available workforce.7[71] Behavioral health systems all over the country are lamenting the lack of qualified and trained practitioners not only for today, but also for the future.79F[72]The health care workforce treating mental and/or substance-use (M/SU) conditions is not equipped uniformly and sufficiently in terms of knowledge and skills, cultural diversity and understanding, geographic distribution, and numbers to provide the access to and quality of M/SU services needed by consumers. This has long been the case and has been persistently resistant to change despite recurring acknowledgments for major improvements to address them (p. 286).

Behavioral health, as all human services, is a human resource dependent industry. Human resource costs often represent 80 percent or more of a behavioral health provider's or program's budget. The ability to recruit and retain adequate staff numbers of the right kind of professionals and the ability to assure those staff not only have but are able to continue learning the necessary information and skills to provide high quality care, is core to the success of the behavioral healthcare field and to the individuals and families it serves. Much is known about the difficulties facing the public behavioral health workforce, including: low salaries, poor working conditions, the aging workforce, high caseloads, lack of adequate training and graduate preparation programs, limited opportunities for advancement, lack of ethnic and linguistic diversity, and regulatory and scope of practice issues that limit who can provide reimbursable services. However, making headway resolving these issues has been slow in Mississippi and nationally.

Certainly the rural nature of the state impacts the ability of providers to meet demand. Indeed, Mississippi has the 4th largest rural population in the nation which presents the state with many challenges in terms of its workforce and provider capacity. Rural areas are particularly hard hit by shortages of mental health professionals. Rural areas experience unique challenges in the recruitment and retention of qualified mental health and substance use practitioners such as having a small pool of available workers, limited local educational opportunities, and geographic barriers such as transportation.

The workforce shortage issues facing Mississippi have limited the capacity of community providers to serve youth and families. While wait time information is an important indicator of provider capacity the state does not systematically gather information to monitor this issue reported by its stakeholders. However, most stakeholders lamented the lack of board-certified child psychiatrists in particular citing long appointment wait times. This shortage of child psychiatrists impacts both institutional and community based providers but is particularly felt in rural areas of the state as the majority of psychiatric capacity is centrally located in the larger communities. Mississippi needs to adopt policy priorities that support the recruitment and retention of psychiatrists in Mississippi. For example, psychiatry is not included as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program.

While telehealth in Mississippi has grown with respect to its use in primary care and other medical specialties, its reach is limited for the vast majority of youth in need of community psychiatric care. At the time of this writing, only a couple of providers are actively utilizing tele-psychiatry for youth. While there is reportedly grant funding available for the purchase of telehealth hardware and mechanisms for billing the Medicaid program for tele-psychiatry services, there was a lack of information and awareness about these opportunities among the CMHCs. DOM is looking at ways to expand telehealth capacity, including developing a revised state plan amendment to address this service.

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[71]The Annapolis Coalition on the Behavioral Health Workforce (2007). An action plan for behavioral health workforce development: A framework for discussion. Cincinnati, OH: Author.

[72] National Council of Community Behavioral Healthcare Annual Survey, 2001: National Association of State Mental Health Program Directors as reported in Mental Health Weekly, 12(15), 1,4, and 6.

In addition to the lack of child psychiatrists, many stakeholders noted a shortage of mental health professionals with child-specific training and expertise in working with youth with serious behavioral health challenges. Licensed mental health professionals in particular were described as very difficult to recruit and retain in community mental health settings. Again, long wait times for services including IOP were reported by families and other stakeholders but statewide data on wait times were not available.

Providers also noted that the few licensed staff members they do have are not well utilized given that an increasing amount of their time is spent certifying treatment plans and obtaining treatment authorization from the CCOs. DMH responded to this shortage by creating a certification process for non-licensed individuals working within the "state mental health system." The DMH Professional Licensure and Certification (PLACE) program was a creative attempt to appropriately respond to the shortage of licensed mental health clinicians. It allows individuals without specific training in a behavioral health field to work in the public mental health system in Mississippi. In order to receive certification, individuals must participate in a core training program developed by DMH and pass a written exam. The table below shows the number of individuals holding a DMH professional credential as of October 2014. These numbers represent all individuals, not just those providing services to children. The numbers below are in addition to individuals with other credentials such as licensed social workers or counselors. Numbers of licensed staff were not available at the time of this report, though even if available, it would not likely reveal much about the capacity of the system to serve youth with behavioral health challenges.

Table 21: Number of individuals holding a DMH professional credential

Credential	Number as of 10/14/14
Mental health therapist	1,276
Community support specialist	964
IDD therapist	231
Licensed DMH administrator	79
Addictions therapist	111
TOTAL	**2,661**

Finally, in Mississippi it is required that Advance Practice Registered Nurses (APRNs) practice according to conditions specified in a Mississippi Board of Nursing-approved agreement, indicating that the collaborating physician's practice is compatible with the APRN's practice. Collaborative agreements also define the scope of practice, including mutually agreed upon guidelines for the health care provided and designate the agreed upon medication formulary to be used by the APRN and physician in practice. Physicians are prohibited from entering into a collaborative agreement with an APRN whose practice location is greater than 40 miles from the physician's practice site and physicians may not enter into collaborative agreements with more than four APRNs at any one time.

WORKFORCE DEVELOPMENT ACTIVITIES

It is well known across the behavioral health arena that few people come to their jobs adequately prepared to do the work with youth and families. Development of state structures to support training and provider capacity building are a critical component to ensuring the workforce has the necessary skills and competencies to deliver high quality care.

Numerous stakeholders mentioned the need for improved capacity and training in functional assessment, diagnostic capability, treatment/care planning, best practice and evidence-based approaches to working with

youth and their families. This further points to the need for a strong workforce development infrastructure that can support providers in training and coaching staff to deliver best practice services to youth and families.

Over the past few years, the University of Maryland's Institute for Innovation & Implementation has provided training and coaching in Wraparound facilitation. DOM and DMH recently partnered to develop the in-state capacity to do this work by jointly funding the University of Southern Mississippi, School of Social Work to develop a training center for Wraparound Facilitation Training and Coaching. This is a critically important initiative and one that the state should be commended for undertaking. Stakeholders reported positive experiences with the training provided but expressed that greater family involvement in the design, development, and delivery of these trainings was needed.

DMH's peer support specialist certification program is another positive area of workforce development. Use of persons with lived experience in the provision of services is a strategy more states are using to augment traditional mental health services and support better engagement in treatment. Growing this underutilized workforce is a key to developing greater capacity to serve adults and families with behavioral health challenges. While the certification process established by DMH and the inclusion of peer support in the state's rehabilitation option is extremely positive, efforts have focused primarily on adults with lived experience as opposed to caregivers of youth with behavioral health challenges or young adults. In FY 2014, Medicaid data suggest low utilization of peer support for youth under 21 in both managed care (50 utilizers) and the fee-for-service system (128 utilizers).

REIMBURSEMENT AND BILLING CONSTRAINTS FOR COMMUNITY-BASED SERVICES

Notwithstanding the real workforce challenges facing Mississippi that require creative solutions, it must be stated that if providers have the right incentives and enough youth needing and wanting services, they can typically grow to meet demand. We found disincentives limiting the growth of community-based interventions for children. CMHC providers offered that the low reimbursement rates for Wraparound facilitation and IOP have limited their interest in delivering these services. As of September 2014, there were nine providers certified by DMH to provide Wraparound facilitation and eight certified to deliver IOP. It should be noted here that simply because a provider is certified to deliver a service does not necessarily mean that they are. As the table below reflects, three providers delivered almost 97% of Wraparound facilitation services as of the end of FY 2013.

Table 22: DMH-Certified Wraparound facilitation providers

Service provider	# of trained staff as of 7/2014	# of youth served between 7/1/12 & 6/30/13
Region 2/Communicare	2	0
Region 14/Singing River	2	9
Region 6/Life Help	5	0
Region 4/Timber Hills	10	17
Region 7/Community Counseling	11	9
Region 10/Weems	31	6
Region 12/Pine Belt	42	267
Youth Villages	98	476
Mississippi Children's Homes Services	114	443
Total	**318**	**1,227**

While the state has made investments in developing Wraparound training and coaching capacity, some providers have been reluctant to dedicate staff to participate in these trainings. Almost 80% of the trained staff in the state represent three providers. Several CMHC providers endorsed their support for the Wraparound model, however, they stated they simply cannot provide the service due to the low reimbursement rate combined with the intensive service requirements. They cite the requirement that Wraparound involves meeting with families in their homes and other community-based locations yet the rate does not adequately account for travel time or mileage costs. As noted earlier, the rural nature of most of Mississippi means that time spent in transit is considerable. The failure of the rates to accurately account for the time lost delivering face to face activities due to time spent traveling to home and community-based settings is a significant barrier to increasing the capacity of providers to serve youth and families in their homes.

Providers are reportedly finding it difficult to become an IOP provider because the pathway to certification is providing Wraparound facilitation. However providers report that the rate for Wraparound facilitation is too low and with the caseload capped at 10 and no ability to bill for time spent in training, doing paperwork or for travel, CMHC providers cannot "make the numbers work." The existing IOP/MYPAC providers began delivering services as part of the state's 1915(c) PRTF demonstration waiver and were paid (and continue to be paid a per diem for each enrolled youth). This funding arrangement offered them greater flexibility with respect to travel, training, and paperwork time. Without support to cover these types of costs, the capacity to deliver these services to a greater number of youth will remain limited.

Uncompensated care is another issue constraining provider capacity in Mississippi. While the state's network of CMHCs are required by DMH to deliver a number of "core" services, providers report that the funding contributed by the state and the counties do not adequately cover the costs of delivering these services. DMH grants and county contributions only account for a very small overall percentage of any CMHCs overall budget. The Medicaid program is the single largest payer for care delivered by the CMHCs. A combination of Medicaid managed care cost containment priorities and decreases in available federal block grant dollars has further limited the ability of CMHCs to serve youth and their family members with behavioral health challenges. CMHCs report they have had to lay-off staff due to budgetary constraints and one CMHC had to close its doors. At the same time providers have reported that the number of referrals has increased, resulting in large caseloads for staff. With Medicaid billing comprising the majority of CMHCs budgets, they are particularly vulnerable to cost containment efforts such as service authorization denials and rate reductions. Furthermore, absent adequate sources of funding to pay for "core services", and care for people without health insurance, the ability of CMHCs to continue to provide access to community-based care will diminish.

Medicaid billing limitations which constrain efficient community-based service delivery efforts were also noted by providers. For example, providers cannot bill for a psychiatric visit and an individual therapy visit on the same day. This places an unnecessary burden on families who may have to travel long distances to come to the clinic, requiring them to expend extra time and money on transportation. Providers, who appropriately respond to a request for an urgent outpatient and psychiatric appointment on the same day in an attempt to stabilize a crisis, are in fact penalized for providing this type of care.

DOM and DMH have offered to conduct a rate study on services; this offer was declined by the Mississippi Association of Community Mental Health Centers. We recommend that rate studies occur. We understand that there are concerns that rate studies open up discussions about both rate increases and decreases. We recommend that rate analyses occur from a systems level perspective on how services fit together to achieve client and system level outcomes, including how to incent the use of more effective services, decrease the use of less effective services, and promote greater coordination. While rate analysis occurs service by service, final rate determinations need to include a systems level perspective on what is being incented, how services fit together to achieve the best health outcomes, what services need to be grown, and the cost of providing care.

PROVIDER NETWORK MANAGEMENT ISSUES

Throughout our meetings with providers we observed great inconsistency and variation across the state with respect to the understanding of the different Medicaid service requirements, how to bill, and what is and is not allowable. For example as described above, while some providers were offering telehealth, others did not appear to know that this option was available to them. Another example of this confusion or misinformation was with respect to IOP. While IOP is in the state plan under the rehabilitation option many of the CMHC providers stated they understood IOP as only MYPAC or as a substance use treatment service. Providers report that communication with the CCOs and UM/QIO are infrequent and not always clear in terms of medical necessity, service requirements and allowable billable activities. In general, our meetings with stakeholders revealed there is a marked distrust between DMH, DOM (including the CCOs and UM/QIO) and the behavioral health provider community in the state. Most providers described the primary role of DOM and its vendors as cost containment rather than promoting access to care or quality of care. DOM and DMH leadership have voiced concerns about some provider's ability to deliver quality services. This has furthered DMH and DOM's interest in including more private behavioral health providers in the network; and to deploy the CCOs and UM/QIO to implement various management strategies in an effort to ensure quality care. DOM and DMH report regular meetings with providers in the state, including webinars, face to face meetings and conference calls. Regular communication to Medicaid providers is conveyed through Medicaid Provider Bulletins and a daily document titled Late Breaking News. Providers reported periodic "all Medicaid provider meetings" but noted little behavioral health specific communication outside of compliance reviews. This difference in perspective provides an opportunity to review the communication approach and methods with behavioral health providers.

RECOMMENDATIONS

A necessary component of ensuring that youth with behavioral health challenges can access care in home and community-based settings is improving the capacity of the provider network to serve youth and their families. Below are several recommendations intended to support the development of greater provider capacity.

1. DEVELOP A PROVIDER NETWORK MANAGEMENT STRATEGY

DOM, its vendors and DMH should develop a joint behavioral health network management plan to include a particular focus on child behavioral health. This is beyond simply holding a meeting or conducting compliance reviews or recovery audits, but a strategy for how they will actively engage and communicate with providers regarding policy decisions, offer technical assistance, and support more effective and judicious use of Medicaid and DMH resources. This will require additional resources for DMH and DOM to implement. It is a necessary step to support communication of purchaser expectations for provider performance , to support monitoring of provider performance and to achieve outcomes(see Quality Management chapter for more information about possible performance and outcome metrics) A component of this network management strategy could include individual meetings with providers to review certain metrics such as access to care or follow-up after hospitalization and help policy makers better understand what barriers might exist. This could open up more opportunities for dialogue between policy makers and the provider community and promote a better working relationship. Good network management is transparent, and gives the provider community confidence that the state is a partner in ensuring that high quality care is delivered to the youth and families of Mississippi.

2. REVIEW RATES TO ENSURE ADEQUATE COVERAGE OF TRANSPORTATION COSTS IN SERVICE RATES

Given the rural nature of the state and the states goal to increase home and community based care, it will be important to review rates for services to ensure that time spent in transit and mileage costs are accounted for. Without adequate reimbursement for transportation time and mileage costs, the workforce will not be available to provide home and community-based interventions and uptake by providers of interventions such as IOP will remain limited. While travel time is not currently a billable activity under current CMS regulations, CMS does not preclude states from developing rates that incorporate time spent in transit. DOM and DMH have offered to conduct a rate study of services.

3. IMPROVE ACCESS TO CHILD PSYCHIATRY SERVICES IN THE COMMUNITY

DOM should continue its efforts to expand access to telehealth and continue its work to revise the state plan to support better use of this approach. Medicaid, DMH, and UMMC Center for telehealth should host a joint meeting with CMHC providers to discuss opportunities for the expansion of telemedicine and to clarify any issues related to billing and equipment use. Medicaid and DMH should set a joint goal of expanding use of telemedicine across all 14 CMHCs by the end of 2015.

To improve access to psychiatry in the community, Mississippi should consider a community psychiatry residency rotation where psychiatric residents from institutional settings are rotated through the CMHCs. As the state moves forward with reducing use of institutional settings for children, the capacity to deploy child psychiatry in this way will increase.

Mississippi should also consider developing a Child Psychiatry Access Program which uses child psychiatrists who can consult to pediatricians and family physicians so that they can serve as the lead prescribers for youth with less complex medication needs. Consultation models where psychiatrists consult to physicians and nurse practitioners about use of psychiatric medications for "routine" cases so as to free up psychiatrists for patients who require more complex medication regimes have been used successfully in states across the country. The state may wish to explore how the Center for the Advancement of Youth at UMMC could be used to support this type of consultation model. 3. Support workforce development and training activities

As described above, DOM and DMH have partnered to support the University of Southern Mississippi, School of Social Work to develop a training center and certification process for Wraparound Facilitation Training and Coaching. Increased financial support to expand the training center is key to ensuring providers have the capacity to deliver high-quality Wraparound. It will also be critically important for USM, DOM, and DMH to consider how to further include family members and youth in the design, development, and delivery of training activities. It would be very beneficial to include family's experiences in booster trainings and/or small presentations.

Further expansion of the activities of this center to support other workforce training initiatives could help address some of the concerns we heard with respect to the skills and competencies of the available workforce. For example, DMH could contract with USM to strengthen the current PLACE certification and/or develop a certification specifically for those interested in working with youth and families. Furthermore, if the state identifies some EBPs they would like to promote in outpatient settings, USM could become an intermediary purveyor of these EBPs similar to what they have done with Wraparound as a way to ensure sustainability of these practices in the state.

Partnering with local colleges and universities to create a pipeline of licensed staff is another strategy that could help address some of the workforce challenges the state is experiencing. Delta State University's Division of Counselor Education and Psychology was recently awarded a Behavioral Health Workforce Education and Training for Professionals and Paraprofessionals grant from the federal Health Resources and Services Administration for $1,125,278 over the next three years. This funding will provide internship stipends for 83 master's level counseling students who, following their training, will focus on youth at risk for developing, or who have developed, a behavioral health disorder. Grant funds will also provide support for University staff to conduct recruiting activities over the three-year project period. The USM School of Social Work has included Wraparound into their curriculum; and the university is looking to add this to the curricula of other behavioral health disciplines. This is a much needed infusion of support to increase the number of licensed clinicians available to work with youth with serious behavioral health challenges in Mississippi. DMH could offer this type of support for internships at a more modest scale as a way to increase the number of individuals who commit to working in the public mental health system after graduation.

With respect to child psychiatry, we understand that there was a loan forgiveness program approved by the legislature that was not funded. Developing and funding this type of program could help stimulate the pipeline of child psychiatrists. Including psychiatry as one of the medical specialties eligible for the Mississippi Rural Physician Scholarship program is also a potential option.

Another key workforce development activity for consideration is to adapt or building upon the existing peer support certification program to promote greater use of parents of youth with behavioral health challenges in the delivery of Medicaid reimbursable peer support services. Continuing partnerships with a family organization to assist in the development of a family peer support certification process would help bring legitimacy to the process and foster collaboration. . We note that the current peer support specialist application is complex and the associated fees and training costs were reportedly a burden for some. This is an area DMH should review so as to ensure these issues do not hinder expanded capacity of this service.

Finally, the state should consider how to utilize the Center for Advancement of Youth (CAY) and the Children's Collaborative group to provide training and support to pediatricians, nurse practitioners, and family practice physicians on behavioral health screening.

4. ALIGN STAFF CREDENTIALS TO THEIR POSITION RESPONSIBILITIES

Current DMH regulations require only a GED or high school equivalent for staff hired as Wraparound facilitators. We understand that DMH is in the process of raising this requirement to a bachelor's degree as part of its development of a certification process. . We fully support this effort to raise this requirement. Additionally, experience with youth with SED should be added as a preferred qualification. This would help bring Mississippi more in line with the credentials for this service nationally. Louisiana for example requires its Wraparound facilitators to have a bachelor's degree in a human services field or a BA in any field with a minimum of 2 years of full-time experience working in a relevant family, children/youth or community service capacity. Relevant alternative experience may substitute for the BA on a case by case basis. Georgia, Nebraska, and Oklahoma also require its Wraparound facilitators to have a minimum of a BA.

5. REVIEW APRN COLLABORATIVE AGREEMENT REQUIREMENTS

Many states are easing their scope of practice restrictions for advanced practice registered nurses (APRNs) as a way to increase access to primary care. It is well documented that APRNs perform a subset of primary care services at a level comparable to physicians and have the potential to offset critical physician shortages, especially in historically underserved areas. State laws and regulations governing APRN practice fall into three categories:

- **Full Practice**: State practice and licensure law provides for APRNs to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications—under the exclusive licensure authority of the state board of nursing. This is the model recommended by the Institute of Medicine and National Council of State Boards of Nursing.
- **Reduced Practice**: State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of APRN practice. State requires a regulated collaborative agreement with an outside health discipline in order for the APRN to provide patient care.
- **Restricted Practice**: State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of APRN practice. State requires supervision, delegation, or team-management by an outside health discipline in order for the APRN to provide patient care.

Mississippi is characterized as a reduced practice state due to the requirement that APRNs must establish individualized collaborative agreements with physicians. Current trends indicate that more states are removing such requirements and becoming full practice states. There are 19 full practice states and the District of Columbia[73], many of which include such rural and frontier states such as Alaska, Arizona, Iowa, Montana, Nevada, New Mexico, North Dakota, and Wyoming. Full practice states find that the removal of formal collaborative agreements grants APRNs greater flexibility and improves access to care. In a rural state with few physicians such as Mississippi, collaborative agreements, especially those with proximity requirements, can significantly impede APRNs' ability to provide care. APRNs cite difficulty finding collaborating physicians that the Board of Medical Licensure would approve and that are located within a 40-

[73] Full practice states include AK, AZ, CO, CT, HI, ID, IA, ME, MN, MO, NV, NH, NM, ND, OR, RI, VT, WA, and WY.

mile catchment area of their practice. While Mississippi has made strides to ease these requirements in recent years, including an amendment to authorize a 90-day grace period for APRNs who cannot secure a collaborative physician, the geographic component of collaborative agreements is a major barrier that limits access to care. It is recommended that this requirement be removed to grant greater flexibility for Mississippi's 2,718 APRNs.

Mississippi is one of the few states that still place geographic limitations on its collaborative agreements, whereas other reduced and restricted practice states are increasingly eliminating such requirements. For example, Georgia allows APRNs to establish collaborative agreements with physicians whose practices are either located within the state or outside the state but within 50 miles of the APRN. In 2013 Texas, a restricted practice state with otherwise very austere APRN requirements, removed its proximity requirements and permitted APRNs to be supervised by a physician located anywhere in the state. Previously the supervising physician had to be located within 75 miles of the APRN's practice. Missouri's collaborative agreement regulations allow APRNs to provide services outside the geographic proximity requirements if the collaborating physician and advanced practice registered nurse use telehealth in the care of the patient and if the services are provided in a rural area of need. We understand that legislation has been introduced related to these requirements.

CHAPTER 4: QUALITY

INTRODUCTION

Guided by standards published by the Institute of Medicine, in this chapter, TAC/The Institute evaluated Mississippi's approach to ensuring that care delivered to youth is of high quality.

In its seminal document on improving quality in health care settings titled, *Crossing the Quality Chasm,*[74] the Institute of Medicine (IOM) identified six areas that should define how health care services are delivered. Health care should be:

- **Safe** - injuries and harm to those accessing health care services must be avoided.
- **Effective** –services with evidence of their effectiveness should be provided to those who need them and avoid offering services to those who are not likely to benefit (avoiding both over and under utilization of care).
- **Patient/family-centered** – care should be respectful, inclusive, and responsive to the preferences, needs, values, and beliefs of the individual/family receiving care.
- **Timely**- delays and long wait times to receive needed services must be avoided.
- **Efficient** – resources (both human and financial) should not be wasted.
- **Equitable**–quality of care should not vary due to factors such as gender, race/ethnicity, geography, or socioeconomic status.

TAC/The Institute used the framework to guide our assessment of Mississippi's children's behavioral health system as well as to inform our recommendations for potential improvements. In addition to the IOM quality areas, TAC/The Institute also considered the following:

- Both process and outcome measures should be developed to measure/monitor the behavioral health system and the quality of care provided.
- There should be a mix of indicators that address quality of care issues for service recipients, at the provider/service level, and at the larger system level.
- Feedback from multiple informants with different perspectives on the system including caregivers and youth, providers, and other system partners should be solicited.
- A mix of qualitative and quantitative information about system performance must be collected.
- Families should be included in the design and development of quality activities.
- Data should not sit on a shelf. Information should be made public and should be connected to quality improvement strategies and initiatives.

CURRENT CONTEXT

Mississippi's current approach to quality has largely focused on monitoring provider adherence to regulations established by DMH and DOM. The exception to this is the On-Site Compliance Review (OSCR) process established to monitor provider compliance and quality of care in the MYPAC and PRTF programs.

[74]Institute of Medicine (2001).Crossing the Quality Chasm. Washington, DC: National Academy Press.

DOM plans to implement an OSCR process across all mental health programs. DMH monitors the quality of services provided to both children and adults through the following mechanisms:

1. Through the provider certification process, DMH ensures a network of credentialed and qualified providers in the state
2. Tracking and resolving both quality of care and access to care/services grievances
3. Tracking and resolving provider serious incidents
4. Conducting on-site compliance/quality assurance reviews both annually and when triggered by grievance/serious incident report data

Provider adherence to regulations is only one of many factors that should be used to evaluate provider performance. Patient experience of care, access, and improvement in youth functioning, are also critically important variables that should be used to evaluate provider and system performance. With the exception of MYPAC and PRTF, Mississippi has not yet deployed a system-wide quality improvement process that uses both qualitative and quantitative data to drive changes to the care delivery process. This type of approach requires data infrastructure and staff resources that DOM and DMH do not appear to have at this time.

TAC/The Institute found that across DOM, DMH, and provider organizations there is limited use of data for planning purposes, to identify service gaps, or to assist managers in making day-to-day operational decisions. There is very little outcome data collected outside of federal grant programs or waivers. The data that is available is often outdated or has significant lags (i.e. claims data) making its utility for making operational decisions limited. With a few exceptions, providers have limited data infrastructure and reporting systems are outdated and continue to rely heavily on paper and pencil reporting methods. In short, our review found there is no systematic way of looking at data across systems to inform statewide planning or to identify quality of care issues requiring attention. There is an obvious need for investments in establishing data collection and reporting mechanisms, identifying key quality indicators and metrics that can be used to evaluate performance, and connecting results to performance improvement activities and initiatives.

In many of our interviews with family members, state agency staff, advocates, and providers, concerns came up with respect to the quality of care. This is an issue described by all constituents- those that fund care, provide care or receive care. Family members and other stakeholders described barriers accessing needed services and supports, delays in obtaining necessary treatment leading to exacerbation in symptoms, lack of coordination among services, and ineffective care resulting in repeated hospitalizations or juvenile justice involvement. Families expressed that their opinions, beliefs, and values were not solicited or considered in the design and development of treatment interventions nor did they feel valued as partners in their child's care. In sum, Mississippi's performance against many of those key indicators of quality described by the IOM, such as timeliness, effectiveness, efficiency, and family-centeredness suggests the need for improvements in multiple areas in order to improve outcomes and care for the youth and families served by its public mental health system.

Recently, DMH was able to hire an Information Technology Director. This role will provide infrastructure and leadership on the identification and analysis of data that will support policy decisions and quality initiatives. Currently, DMH engages the University of Southern Mississippi's School of Social Work (USM) to administer annual client satisfaction surveys for both adult and youth mental health services. (Another entity was used prior to 2012.) In 2014, the third annual client satisfaction surveys were administered and questionnaires were completed by clients in each of the 14 Community Mental Health Center (CMHC) regions. The questionnaires include demographics and lykert style ratings for domains including access to services, treatment participation, appropriateness and quality of services, social connectedness, and skills improvement. Respondents also have the opportunity to answer open-ended questions regarding their satisfaction with the service system. In 2014, A total of 248 Youth Consumer Satisfaction Questionnaires were completed by parents of youth clients receiving services in the 15 CMHC regions in Mississippi.

RECOMMENDATIONS

1. CREATE A CHILDREN'S BEHAVIORAL HEALTH QUALITY DASHBOARD

TAC/The Institute recommends that the state collect and report on a variety of system development measures (i.e. process measures) and program outcome measures that will be used to monitor system performance and determine gaps in the service system for youth. Additional resources will likely be required by DMH and DOM to implement a quality dashboard.

A list of recommended measures is located below. It should be noted that some of the indicators are already being collected in some fashion. What is missing is:

1. the use of the data to inform policy, planning, operational decisions and
2. a single place where relevant information is put together to offer a comprehensive picture about system functioning and performance.

It should also be noted here that publicly reporting on these types of indicators would help create an environment of greater transparency which could build trust among state agency partners and important stakeholder such as families and consumer groups.

To the extent possible data should be reported out by region and broken out by gender and race/ethnicity where relevant. This will help focus attention on one of the areas of quality identified by the IOM, equity. By reporting out by region, race, and gender policy makers can determine if there are variations in quality due to these factors and more readily consider strategies to address inequities. Further, once a baseline report is established these data should be trended across several years to help evaluate progress over time.

Given these data may come from multiple sources, the state may want to contract with an independent entity such as a university or a UM/QIO to analyze the data and prepare a public report that must be presented to the ICCCY on a regular basis but not less than annually. The information from this data dashboard can be used to identify performance improvement projects and other quality improvement initiatives that the state may wish to include in the CCO and UM/QIO contracts. Establishing a set of indicators helps DMH, DOM and other key stakeholders determine where to focus improvement efforts and how to allocate available human and financial resources.

2. OBTAIN REGULAR FEEDBACK FROM YOUTH AND FAMILIES ABOUT SYSTEM PERFORMANCE

An important aspect of changing the culture in Mississippi's children's behavioral health service delivery system is for front line staff and leaders to hear directly from families about the experience of parenting a youth with a serious behavioral health challenge. Greater inclusion of families in this role will enhance the training activities and help build trust between families, providers, and the state.

Understanding how the system is performing from the point of view of those for whom it is intended to help is absolutely critical. Collecting data from multiple informants and through a variety of mechanisms (e.g. claims data, family survey, provider reports, focus groups, etc.) can offer a more complete picture of how the system is working for youth and families. Gathering information from youth and families offers an important perspective on the system and can help "bring life" and a new level of understanding to the quantitative data that is collected. It often can help provide the "why" behind some of the numbers and can also be useful in identifying those issues that require a more thorough investigation or analysis.

Engaging families in the collection of this information is also important. Many families who have had negative experiences with the system may not respond to a survey from the state or a service provider but may feel more comfortable offering honest opinions and feedback to a peer. Thus TAC/The Institute recommends that the state build upon its current survey efforts include: provider responsiveness, improvements in ability to cope with/manage their child's behavior, improvements to overall well-being and quality of life. Understanding families' perceptions of how their opinions, values, and beliefs were solicited and considered throughout the service delivery process should also be assessed as a way of measuring if care is being

delivered in a family-centered manner. We recommend that results be included in the data dashboard described above and presented publicly at an ICCCY meeting and at provider forums; and that results be used to identify possible performance improvement projects.

Additionally, some states use a "secret shopper" approach to better assess access to care issues and wait times for services. Using families to perform these activities is preferred as there is likely to be greater buy-in and trust from stakeholders if the calls and a report of findings are performed by families as opposed to state staff. A transparent approach to this process is key to its success. When done in partnership with providers to inform critical system issues, it provides access to real-time information which is otherwise difficult to obtain. The state could also establish processes to solicit feedback from youth, providers and system partners such as child welfare through structured interviews, focus groups or other survey methods.

Table 23: Proposed Children's Behavioral Health Dashboard Measures

Area (s)	Measure(s)
Effectiveness **Efficiency**	Unduplicated count of youth who receive the following Medicaid services (across FFS and each CCO) • Community support services • Crisis stabilization • Day treatment • Individual, family, and group outpatient psychotherapy • Inpatient hospital • IOP • MYPAC • Mobile crisis • Peer support • PRTF • Psychiatry • Psychosocial rehabilitation (for youth 18-20) • Tele-behavioral health
Effectiveness **Efficiency**	Penetration rates for the following Medicaid services (across FFS and each CCO) • Community support services • Crisis stabilization • Day treatment • Individual, family, and group outpatient psychotherapy • Inpatient hospital • IOP • MYPAC • Mobile crisis • Peer support • PRTF

	• Psychiatry (including tele-psychiatry) • Psychosocial rehabilitation (for youth 18-20)
Effectiveness **Efficiency**	Unduplicated count of youth who receive the following DMH services • Mobile crisis • Pre-evaluation screening for civil commitment • Residential treatment for Substance Abusing Adolescents • Respite • State hospital • PRTF • Therapeutic foster care • Therapeutic group home
Effectiveness **Efficiency**	% of Medicaid dollars spent on community services for youth under 21 % of DMH appropriation spent on community services for youth under 21
Effectiveness **Efficiency**	% of Medicaid dollars spent on day treatment and partial hospital for youth under 21
Effectiveness **Efficiency**	% of Medicaid dollars spent on 24-hour settings % of DMH appropriation spent on 24-hour settings
Effectiveness **Patient/family-centered** **Timely**	Number of grievances (formal complaints) related to: • Access and availability • Effectiveness/appropriateness of care • Quality of care
Effectiveness **Efficiency**	Ability to successfully respond to and manage crises in community settings as measured by: • N of youth reviewed by MAP who are diverted from out-of-home placement • N of youth diverted from 24-hour care (data from mobile crisis teams) • 30 and 180 day readmission rates for acute psychiatric inpatient, state hospital, and PRTF • N of emergency department visits for youth in behavioral health crisis

	• % of mobile crisis for youth under 21 that occur in the following locations: ○ CMHC ○ Group home ○ Home ○ Hospital emergency department ○ Office ○ Other ○ School
Effectiveness **Efficiency**	Ability to provide access to home and community-based services as measured by: • # of service units for youth under 21 per month for: ○ Community support services ○ IOP ○ MYPAC ○ Peer support ○ Psychosocial rehabilitation (for transition age youth)
Effectiveness **Efficiency** **Timely**	Number of EPSDT screenings that identify behavioral health Number of referrals for a behavioral health assessment following a positive behavioral health screen in primary care
Efficiency	Average and median length of stay, admission rate, and readmission rate for children discharged from the following settings: ○ Acute inpatient psychiatric facilities ○ Crisis stabilization units ○ Group home ○ PRTF ○ State hospital ○ Residential treatment for Substance Abusing Adolescents
Patient/family-	% of families who report satisfaction with or improvements in:

centered	• Provider responsiveness to treatment request • Ability cope with/manage their child's behavior as a result of the behavioral health services they have received • Overall well-being and quality of life • Improved coping • Family-centered approach to care
Efficiency **Patient/family-centered**	Number of certified family peer-support specialists
Safety	Number of patient deaths in 24-hour settings (state hospital, acute psychiatric inpatient, PRTF, hospital)
Safety	Physical restraint per 1000 patient days for state and acute psychiatric inpatient facilities Physical restraint per 1000 patient days for PRTF facilities
Safety	Average duration of restraint for state and acute psychiatric inpatient facilities Average duration of restraint for PRTF facilities
Safety	Seclusion per 1000 patient days for state and acute psychiatric inpatient facilities Seclusion per 1000 patient days for PRTF facilities
Safety	Average duration of seclusion for state and acute psychiatric inpatient facilities Average duration of seclusion for PRTF facilities
Safety	Patient injuries per 1000 patient days for state and acute psychiatric inpatient facilities Patient injuries per 1000 patient days for PRTF facilities
Safety	Medication errors (i.e. missed dose, incorrect medication given) per 1000 patient days for state and acute psychiatric inpatient facilities Medication errors (i.e. missed dose, incorrect medication given) per 1000 patient days for PRTF facilities
Timely	% of mobile crisis evaluation for youth under 21 that are responded to within 1-hour
Timely	Average time to first appointment for psychiatric clinician
Timely	Average time to first appointment for IOP
Timely	Average time to first appointment for an outpatient behavioral health assessment
Timely	% of youth under 21 who received follow-up appointment within 4days and 14 days for an initial assessment

3. ESTABLISH SYSTEMS TO HELP IDENTIFY YOUTH IN NEED OF SERVICES AND MAKE FAMILIES AWARE OF AVAILABLE BEHAVIORAL HEALTH SERVICES

Many families (and providers) that we spoke with for this assessment were unaware of the types of behavioral health services and supports available to support youth in the community. We also heard examples of providers who were not facilitating referrals for more intensive services and supports such as IOP even when it might have been indicated for the youth. TAC/UMD recommends that the state identify and seek to notify the parent/caregiver of any youth that claims data reveals could potentially benefit from an intensive home and community-based behavioral health service such as IOP. These approaches are being widely adopted through health home and patient-centered medical home approaches but are also applicable to youth behavioral health. Through these approaches, data is analyzed to identify youth that meet certain criteria and then deploying a managed care vendor, provider or a letter from the state Medicaid office to contact families to see if additional services could be helpful.

Indicators or flags that would identify youth include:

- Acute inpatient or PRTF psychiatric admission
- Poly-pharmacy
- Two or more mobile crisis intervention encounters
- Two or more emergency department visits with a primary mental illness or substance use diagnosis on the claim

Additionally, some states routinely notice all family members of youth via letters that provide information on benefits that are available in the Medicaid program. As an example, Vermont has developed specific EPSDT notices tailored to different ages in order to inform families about developmentally appropriate EPSDT screens[75]. These letters, newborn through age 20, are sent yearly, reminding families and youth about specific health issues tailored to their ages. This type of identification and outreach would help raise awareness among Medicaid members about benefits available to youth under 21 as part of the EPSDT benefit and support more timely access to services. It is also a more efficient strategy than relying on providers alone to facilitate referrals. This letter would be in addition to notifications about behavioral health services for youth under 21 made available to families upon enrollment.

Further, given that many families may not necessarily respond to a letter, consideration should be given to how family support partners could be utilized to conduct further outreach to families to help them understand how to access services and supports for their child. As an example, Maryland uses its Family Support workers to serve as system navigators, to outreach and engage families directly. Some families may need this type of personal assistance and system navigation support due to low literacy or cognition or simply because of prior bad experience with behavioral health services. Family support partners could serve as that critical bridge to support engagement in treatment services.

4. REQUIRE THE UM/QIO AND MCOS TO ENGAGE IN AT LEAST ONE CHILDREN'S BEHAVIORAL HEALTH PERFORMANCE IMPROVEMENT PROJECT ANNUALLY

The selection of these projects should be stakeholder informed and data driven and agreed upon by the ICCCY so that the selected projects do not overlap or place undue burden on providers without requisite support. Examples of projects could be facilitating a learning collaborative on engagement and retention strategies in outpatient behavioral health clinics, reducing 30 day readmission rates, developing same-day or urgent capacity at CMHCs, implementing an EBP, or decreasing mobile crisis response times. These projects should include an evaluation component and could be tied to bonus payments for successful completion and/or outcomes.

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[75] http://healthvermont.gov/family/toolkit/tools%5CG6%20Summary%20of%20recommendations%20included%20in%20EPSDT%20Informing%20Letters.pdf

5. ESTABLISH AN ON-SITE QUALITY AND COMPLIANCE REVIEW PROCESS FOR STATE HOSPITAL FACILITIES.

As stated earlier, with the exception of MYPAC and PRTF, DMH and DOM's approach to quality has primarily focused on provider compliance. The OSCR process included a review of provider's administrative operations, overall approach to treatment, and an evaluation of how services are working for enrolled youth and families. This process involves not only a review of client records and program documentation but also interviews with staff, observation of child and family team meetings, and interviews with families. At the end of this process, providers are offered a debriefing and if deficiencies are found the provider must submit a corrective action plan. The inclusion of information from multiple sources, the solicitation of feedback from families, and the connection to a quality improvement process in the form of the correction action plan makes the OSCR a model process. TAC/The Institute recommend that this approach be adopted (and adapted) for use in the other institutional settings for youth. The state will need to use some criteria to determine which programs to review first and establish a timeframe for review of all programs using this new framework. For example, those facilities with high rates of seclusion and restraint, longer than average lengths of stay, or other performance issues should be reviewed in the first wave.

6. ESTABLISH STRATEGIES FOR RAPID NOTIFICATION OF CCOS AND PROVIDERS ABOUT ADMISSIONS AND DISCHARGES AT 24-HOUR LEVELS OF CARE

With inpatient behavioral health care carved out of the managed care benefit, CCOs are often not aware when one of their member's is admitted to an inpatient facility. While a report detailing inpatient admissions is generated by the UM/QIO and sent to the CCOs, it relies on claims data creating a long lag time between the discharge and the receipt of the report. In this way, youth may fall through the cracks and not get connected with important aftercare services that could help prevent another hospitalization. If the UM/QIO obtains information about admissions though some mechanism (i.e. notification by the hospital, concurrent review of care) UM/QIO could send a daily report to the CCOs of those members to inform them of inpatient psychiatric admissions. The CCOs could use this information to contact the family and offer support/assistance in connecting the family with needed post-hospital services and supports. This is another opportunity to use family support partners to help families navigate the system and offer a bridge to other treatment services.

TAC/The Institute recommends that DMH and DOM expand its current efforts related to providers crisis management and safety plan. The development and availability of crisis plans is important to diverting crisis placements. As Mississippi's mobile crisis system grows and more children present for that service, the system would benefit from proactive communication about potential crises. Many states with centralized crisis response teams are able to place "on alert" , with guardian permission via a release of information, a crisis safety plan so that if a child presents in crisis, the mobile crisis team that is not familiar with that child, has access to that crisis safety plan. With parent/caregiver permission, this plan should be sent to the local mobile crisis team and the behavioral provider(s) responsible for "after care" prior to discharge, to supply them with information about the youth and family that could be used to stabilize a behavioral health crisis.

7. PUBLISH AN ANNUAL STATEWIDE REPORT OF FINDINGS FROM MAP TEAMS

As the local "eyes and ears" about issues impacting youth with behavioral health challenges and their families, MAP teams are an invaluable resource to identify emerging system challenges and resource needs and solutions. TAC recommends that DMH build upon its quarterly data gathering and report process to include an annual report for submission to the ICCCY detailing the findings from local MAP teams. This report should include information about numbers of youth reviewed and outcomes of these reviews, but more importantly it should discuss the barriers and challenges faced by local teams in supporting youth and families in the community. It should also include examples of best practices or successful strategies used to support families. This report should be used for action planning and to inform state policy makers about system gaps as well as those best practice strategies that have the potential for replication in other areas.

CHAPTER 5: INTERAGENCY COLLABORATION

INTRODUCTION

In this chapter, TAC/The Institute reviewed the extent to which Mississippi's existing policies, structures, and procedures support interagency collaboration and coordination; limitations or barriers to effective interagency collaboration; and the connection between agency level policy priorities and client-level barriers and needs identified at a local level.

Interagency collaboration and governance is a prerequisite for building an effective system of care and ensuring that children and youth have the services and supports necessary for remaining at home and in their communities. Defined as decision making entities with oversight at a policy level that has legitimacy, authority, and accountability, governance structures vary in configuration and may be established in several ways, such as by legislation, executive order, or memoranda of agreement. As with all behavioral health systems in the country, Mississippi's children's behavioral health system is impacted by decisions made in other child-serving systems.

Several questions drove this interagency collaboration analysis. These questions included:

1. To what extent are policy priorities, structures and procedures established across child-serving agencies in Mississippi?
2. Are there limitations or barriers to interagency collaboration?
3. What is the connection between agency level policy priorities and client-level barriers and needs identified at a local level?

Strong governance structures are essential because they establish the strategic direction for activities, tasks, and functions associated with building, implementing, and sustaining systems of care and providing oversight for their implementation. They also provide a mechanism to ensure that systems of care values and principles are communicated and operationalized by all child-serving agencies.

MISSISSIPPI SYSTEM OF CARE FOR CHILDREN AND YOUTH

In 2010, Mississippi enacted legislation to amend Section 43-14-1, Mississippi Code of 1972 to provide for the development, implementation and oversight of a coordinated interagency system of necessary services and care for children and youth, called the Mississippi System of Care (MSCC), for children with serious emotional/behavioral disorders. The legislation defines three primary interagency components along with their membership and functioning requirements, including:

- ***The Interagency Coordinating Council for Children and Youth (ICCCY).*** Established to serve in an advisory capacity and to provide state level leadership and oversight to the development of the MSCC, the ICCCY invites the participation of the Executive Directors from each child-serving agency, including the Department of Mental Health, Department of Health, Superintendent of Public Education, Department of Human Services, Division of Medicaid, Department of Youth Services, and the Attorney General.
- ***The Interagency System of Care Council (ISCC).*** Also at the state level, the ISCC serves as the management team for the ICCCY and is tasked with developing the MSCC by collecting and analyzing data and funding strategies, coordinating local MAP teams, and applying for grants from public and private sources. The ISCC is comprised of a member from each state agency, a family member representing a family education and support organization, two special organization representatives, and a family member appointed by Mississippi Families as Allies.

- ***Multidisciplinary Assessment, Planning and Resource (MAP) Teams.*** The MAP teams are the local arms of the Mississippi Statewide System of Care required to work with individual cases to ensure children and youth receive services and supports in the least-restrictive setting possible.

Although this legislation provides a clear and impressive framework for establishing a three-tiered interagency governance structure, it has not been implemented with the desired intent at the state level.

There are many examples of ongoing cooperation between DOM and DMH. Both agencies share a commitment to a service system and benefit array that supports children with behavioral health needs and their families. The sharing of policy changes before enactment, regular meetings to address child specific placement issues, interagency agreements and memorandum of understanding are in place. Aside from a shared commitment to improved care for children, agency goals are not always aligned which is impacting the behavioral health system.

Specifically, DOM is under tremendous pressure to manage costs in the Medicaid program. In an effort to meet that across the board directive, certain policies are implemented to meet that goal. However, these can have inadvertent impact on the behavioral health delivery system. DOM can be hampered by directives outside of its agency's control. . As a specific example, DOM is not able to manage a significant cost driver in its program which is institutional care. This creates significant challenges for an agency that needs to control the Medicaid budget; and impacts the ability of DMH and DOM to redirect institutional placements with appropriate home and community based options. As such, DOM is required to control costs but cannot manage a key cost driver for the program. Instead, they manage lower cost services, in which only nominal savings can be achieved. These types of push-pulls on both of these agencies impact the continuum of care.

Looking beyond DMH and DOM, there is disparate administration and financing of major components of the system across child welfare, juvenile justice, education and public health. This has exacerbated the inherent differences between the roles of state agencies, has diffused accountability for the overall performance of the children's behavioral health system, and has perhaps created unintended incentives for cost or care-shifting between systems and providers. These systems influence access to institutional levels of care and purchase other behavioral services and supports. In most instances the same children may be receiving services across all of those entities, common system goals, client goals, clarity on roles and decision-making, and alignment of agency policy and procedures is needed to ensure a systemic approach to home and community based care. The state language regarding the purview of ICCCY to align child specific issues is strong; however, this body has not been implemented per the legislation and the group has not convened since 2012. The state needs to renew its commitment to that legislation, and enact provisions that lead to accountability across the system. In addition, The ICCCY does not have authority to impact policy and funding decisions across all public service sectors. This is an important component to strengthen this coordinating body.

RECOMMENDATIONS

1. ESTABLISH A CHILDREN'S CABINET

It is recommended that Mississippi establish a Children's Cabinet level position to serve as an organizational locus of system of care management at the state level to implement policy, administrative and regulatory changes. A children's cabinet level position can ensure that governmental agency priorities, policies and financial decisions are aligned toward ***one common set of goals for all Mississippi children*** including shared accountability, alignment of spending, development of communication protocols across agencies, and alignment of agency procedures to facilitate access to services, institutional placement redirection and discharges, and provider capacity. This approach offers greater ability to align with Governor established priorities, addresses that some agencies are already cabinet level while others are not; and provides clearer accountability. The role of ICCCY could remain and become the operational group. We understand that

discussions have commenced with the Governor's office to establish a Children's Cabinet and commission a study to inform the right approach for Mississippi. This group should be empowered to develop a comprehensive and uniform purchasing plan for children's behavioral health, and implement system-wide performance measures and quality indicators that could be incorporated into a comprehensive approach.

2. FACILITATE INTERAGENCY COLLABORATION

The State of Mississippi and specifically child-serving agencies must reaffirm their commitment to the 2010 Mississippi Systems of Care statute and develop interagency structures that reflect a shift to a more child-centered, family-focused and youth guided service delivery system .It is recommended that DMH and DOM introduce new legislation to expand current ICCCY language to empower ICCCY to identify and implement one shared set of goals detailing each agency's accountability and responsibilities towards those goals. This offers the ability to capitalize on existing language and to use the ICCCY structure as originally intended. However, given that ICCCY is not operational and appears to have limited coordination and policy influence; changes would be necessary to ensure that ICCCY could fulfill this purview. Revised legislation should be introduced to mandate staffing and resources to support the ICCCY and methods to ensure the accountability of participating agencies, such as a requirement that annual reports be submitted to the Governor and the Mississippi legislature that includes a summary of activities, any statutory reporting responsibilities, proposals to reduce redundancies, highlights of successes, and meeting minutes with rosters of attendees at each ICCCY meeting. To promote transparency, a web-site that shares the activities of the ICCCY and its participants, provides up-to-date, relevant information, and allows community stakeholders to provide input. For an example, see Louisiana's Coordinates System of Care website, located at www.csoc.la.gov.

TAC/The Institute also recommends that Mississippi implements a cross-agency data sharing protocol and interagency agreements that outline system responsibilities, including actions to ensure system representation on local MAP teams, training of respective agency staff, and cross-agency commitments for policies on diversion of children from placement. The potential use of MAP teams for system wide review on placement considerations should also be considered. In addition, it is recommended that Mississippi consider an interagency funding approach to services that cross multiple agency funding streams and to meet the priorities of the ICCCY. Such an approach would ideally require contributions from each participating agency and would be managed via a comprehensive performance-based budget plan to ensure that interagency funds result in benefits for specified target populations. This cross-agency planning and data sharing strategy could also lead to designating funds to help cover the cost of indigent care. Shared goals and priorities, and redirected funds from reduced institutional placements, could be redirected to cover services for youth without insurance.

3. FURTHER EMPOWER MAP TEAMS TO ADDRESS SYSTEM LEVEL ISSUES

DMH, DOM and other agencies recognize the importance of MAP teams to the system. It is recommended that DOM and DMH implement methods to further empower local MAP teams and ensure an effective communication mechanism between the ICCCY/ISCC so that systems of care policy is understood and achieved at all levels.

The MAP teams have served as a source of interagency youth level reviews to address "stuck" situations and coordinate resources across agencies to meet the needs of specific youth. As intensive care coordination using Wraparound is expanded and utilized by more children, the care planning teams for those youth will be the process to address the needs of youth and to coordinate resources. This will allow the MAP teams to focus their expertise on system level issues that can further support the effectiveness of those care plan teams. As the local "eyes and ears" about issues impacting youth with behavioral health challenges and their families, MAP teams are an invaluable resource to identify emerging system challenges and resource needs and solutions. A greater connection between MAP teams and the needs and challenges identified by the care plan teams convened in IOP will further support this work.

TAC/Institute recommends that DMH build upon its quarterly data gathering and report process to include an annual report for submission to the ICCCY detailing the findings from local MAP teams. This report should include information about barriers and challenges faced by local teams in supporting youth and families in the community. It should also include examples of best practices or successful strategies used to support families. This report should be used for action planning and to inform state policy makers about system gaps as well as those best practice strategies that have the potential for replication in other areas.

Given variation in MAP teams, a systematic approach for convening local MAP team members should be devised to promote participation in peer-to-peer learning activities. In addition, DOM and DMH should regularly conduct trainings and webinars and provide written information that communicate proposed and actual changes in policies and recommendations. Finally, with support of the ICCCY and ISCC, MAP teams should engage in a public-relations campaign to promote the activities of the Mississippi System of Care and to educate and encourage the participation of community stakeholders.

CHAPTER 6: REDIRECTING INSTITUTIONAL CARE

INTRODUCTION

This final chapter in the report evaluates the balance of services, access and utilization across community-based and 24 hour services, what system structures, policies, and procedures are in place to monitor appropriate use of restrictive settings, and whether any cross system issues impact the use of restrictive settings over community-based options.

Both Institutional settings and home and community-based settings serve important functions in every behavioral health system. It is essential for Institutional services to be viewed as part of a continuum of care with a defined role. The National Association of State Mental Health Program Directors recently issued a white paper which describes a shared vision for the role that state psychiatric hospitals can play.[76] State hospitals should serve as a treatment setting which assures health and safety for individuals whose symptoms and behavior, resulting from a mental health disorder, cannot be treated and managed safely in a community setting. In addition, the paper states that 'state psychiatric hospitals should not be a solution or default system for an underfunded or fragmented community system.[77] The lack of a fully-developed and adequately-funded community-based system has contributed to an over-reliance on Institutional care for children and youth in Mississippi.

Several questions drove the quantitative and qualitative aspects of the institutional care analysis. These questions included:

1. What is the balance of services, access and utilization across community-based and 24 hour services?
2. What are the system structures, policies, and procedures in place to monitor appropriate use of restrictive settings?
3. Are there any cross system issues that impact the use of restrictive settings over community-based options?

CURRENT CONTEXT

As indicated in chapter one, the current behavioral health system expenditures is weighted towards institutional settings. The majority of DMH dollars and DMH staffing, along with Medicaid and child welfare expenditures, are locked into maintaining institutions. Additionally, institutions require significant capital investment. Facilities tend to become aged and fall into disrepair resulting in quality of care issues. The state will need to continually budget for capital expenditures. Without commitment to dedicate state staff and state dollars towards HCBS, institutional redirection will not occur.

Disproportionate spending on institutional care is not unique to Mississippi. Nationally, about 19 percent of total Medicaid expenditures are for residential treatment settings, accounting for the highest proportion of spending of any service and averaging nearly $22,000 per child per year. Inpatient psychiatric treatment accounts for an additional 5 percent of total Medicaid spending.[78]

Mississippi spends a greater proportion on institutions compared to national Medicaid expenditure data. In State Fiscal Year 2014, expenditures for psychiatric residential treatment facilities accounted for 26 percent

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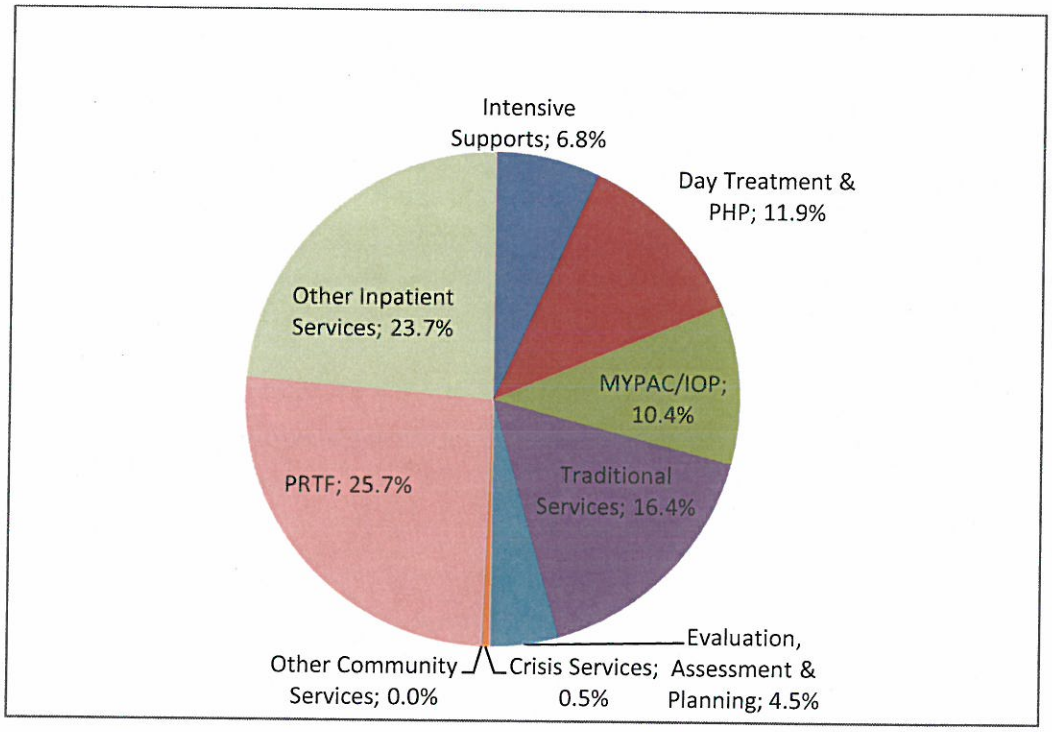
[76] http://www.nasmhpd.org/publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

[77] Ibid.

[78] Center for Health Care Strategies, (2013).Examining Children's Behavioral Health Service Utilization and Expenditures. Retrieved from http://www.chcs.org/media/Faces_of_Medicaid_Examining_Childrens_Behavioral_Health_Service_Utilization_and_Expenditures.pdf

of total Medicaid mental health spending, 7 percentage points higher than the national average. Further, the average cost per user of residential was $49,000 in SFY 2014, more than double the national average. From SFY 2010 to SFY 2014, spending on PRTFs trended upward, increasing by 11 percent. Spending on inpatient psychiatric services (including inpatient medical surgical) was exceptionally greater than the national average, accounting for 24 percent of total mental health Medicaid expenditures in SFY 2014 (compared to 5 percent nationally).

Figure 35: Distribution of Medicaid Payments in FY 2014 (FFS & MC)



Although states spend a significant amount on residential treatment and inpatient care, the evidence base for their long-term effectiveness is mixed. Many states are prioritizing investment in home- and community-based alternatives to ease reliance on institutions, prevent readmissions, and reduce lengths of stay. This trend is influenced by two major factors:

- Greater evidence of cost-savings and better return on investments from home- and community-based interventions, and
- Emerging evidence for the efficacy of a myriad of home and community-based interventions with replicable models.

In states that are purposefully redirecting use of institutional care, expenditures saved by diverting children from residential care into community treatment are often re-allocated to child-serving agencies with the goal of enhancing intensive home and community services.[79]

[79]Ireys H.T., Pires, S. & Lee, M. (2006). Public Financing of Home and Community Services for Children and YOuth with Serious Emotional Disturbances: Selected State Strategies. Retrieved from http://aspe.hhs.gov/daltcp/reports/2006/youthSED.pdf

In their bulletin issued in 2013, SAMHSA/CMCS highlighted the cost-savings potential of home- and community-based alternatives to PRTFs, in which they reference findings from the evaluation of the PRTF-Waiver Demonstration: "The PRTF evaluation showed that state Medicaid agencies reduced the overall cost of care. For example, home and community-based services provided to children and youth in the PRTF demonstration cost 25 percent of what it would have cost to serve the children and youth in a PRTF, an average savings of $40,000 per year per child. State Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program."[80] Such savings are prime reinvestment opportunities to enhance the home- and community-based service array.

The SAMHSA/CMS bulletin also pointed to findings from the national evaluation of the Children's Mental Health Initiative (CMHI) that consistently demonstrate improved outcomes and per capita savings across child-serving systems for children and youth with serious emotional disturbance enrolled in systems of care. In 2010, SAMHSA reported a 47 percent decline in inpatient costs and a 42 percent decline in child arrest costs.[81] In 2011, they indicated a 21 percent reduction in psychiatric inpatient costs and a 32 percent reduction in child arrest costs.[82]

More recently in 2013, an expanded analysis was conducted to investigate outcomes and cost-savings among children and youth receiving home- and community-based services in 76 CMHI-funded system of care communities. The analysis found that children enrolled in systems of care, particularly those that incorporated intensive care coordination using a Wraparound approach for high needs children, demonstrated improved outcomes which translated into measurable cost-savings to taxpayers. In particular, decreases in inpatient hospitalizations result in a cost-savings of $37 million, decreases in psychiatric emergency room visits resulted in a cost-savings of $15 million, and decreases in child arrests resulted in a cost-savings of $10 million.[83]

In addition to the national evaluation discussed above, there are a myriad of individual state, community, and provider evaluations that further bolster claims that home- and community-based services reduce costs among children and youth with serious behavioral health needs. For example, Choices Inc., a care management organization that serves children and youth with multi-system needs in District of Columbia, Florida, Indiana, Louisiana, Maryland, and Washington reported that 98 percent of the youth they served were diverted or returned from residential treatment facilities. They found that this resulted in a cost-savings of nearly $36,000 per youth.

Similar savings were demonstrated by an evaluation of PRTF-Waiver youth in Georgia, which found that reductions in inpatient utilization and residential stays due to Wraparound involvement translated into an average annual savings of $44,000 per youth. Further, the cost of serving youth in juvenile correction facilities decreased by 45 percent as a result of Wraparound involvement and recidivism for youth in the juvenile justice system who received Wraparound services was 23 percent lower than the overall rate for Georgia.

In addition to the potential for cost-savings, home- and community-based services are becoming a more attractive option to policymakers due to increasing evidence that they are as or more effective than residential and impatient treatment for similar populations of youth at a lower per capita cost. Although some studies have demonstrated that residential treatment can be successful for many youth, particularly during program involvement, there is a dearth of research that evaluates the effectiveness of specific program components. In addition, the literature lacks operational definitions of residential treatment

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[80]CMCS & SAMHSA. (2013). Joint CMCS and SAMHSA Information Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[8181]SAMHSA. (2010). The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings – Annual Report to Congress, 2010.

[82]SAMHSA. (2011). The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings – Annual Report to Congress, 2011.

[83]Stroul, B. A., Pires, S. A., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on Investments in Systems of Care for Children with Behavioral Health Challenges (Data source: Agency for Healthcare Research and Quality). Retrieved from http://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf

and success. These factors conspire to make successful residential programs and practices difficult to replicate and scrutinize.[84] In contrast, many evidence-based or promising home- and community-based practices achieve their designations through a highly rigorous practice and are manualized, standardized, replicable, and consistently monitored to ensure fidelity.

Additionally, as the PRTF Waiver Evaluation demonstrated, states are able to achieve similar or improved outcomes to PRTFs with home- and community-based services at lower per capita costs. The national evaluation of the CMHI program also found that home- and community-based services improved outcomes across multiple domains, including improved school attendance and performance, increases in behavioral and emotional strengths, improved clinical and functional outcomes, more stable living situations, improved attendance at work for caregivers, reduced suicide attempts, and decreased contacts with law enforcement.[85]

It is important to reiterate that residential treatment and inpatient care serve a critical need within an overall continuum of care. These services provide care to those children and youth whose needs are too severe to treat at home or those who have not improved via community-based services alone. It is however incumbent upon residential treatment and inpatient providers to take steps to maximize their role within a system of care. This can be accomplished by:

- Ensuring that children and youth who enroll in residential programs are ideally matched to the intervention, preferably through the use of standardized assessment tools. Children with severe levels of functional impairment may be more amenable to residential treatment then their lower-need counterparts, where in some cases residential treatment may be iatrogenic (e.g., due to peer contagion).

- Effectively coordinating discharge from the residential or inpatient program by ensuring the availability of needed services and participating in wraparound child and family teams.[86]

- Creating an internal culture that imbeds a sense of urgency to develop individualized and program-wide strategies to reintegrate youth back into their home sand communities rather than assuming longer lengths of stay

- Adopting systems of care values and principles and tenets of the Building Bridges Initiative (See: CHIPRA Webinar: Reengineering Residential Treatment, available at www.chcs.org).

Many states have closed or dramatically decreased their use of state hospitals for children and adolescents; instead relying on community hospitals for any inpatient care. Unlike in other states where state hospital capacity is directed towards forensic or other special populations, state psychiatric hospitals in Mississippi appear to operate similarly to other acute hospitals in terms of the types of populations described as admitted to the facilities during interviews. Any institutional capacity needs to be integrated with a continuum of robust community services. Some states have pursued inclusion of treatment foster care [87] in their Medicaid benefit array to increase their use of effective practices that better integrate and maintain a child in their community. States are incorporating this service because it is a less-restrictive alternative to

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[84]Brown, et al., (2011).Outcomes monitoring after discharge from residential treatment for children and youth. *Residential Treatment for Children and Youth, 28,* 303-310.

[85] SAMHSA/CMCS Bulletin

[86]Lyons, J. S., Woltman, H., Martinovich, Z., & Hancock, B. (2009).An outcomes perspective of the role of residential treatment in the system of care.*Residential Treatment for Children and Youth, 26* (71). 71-91.

[87] Substance Abuse and Mental Health Services Administration. (2013). What does the research tell us about services for children in therapeutic/treatment foster care with behavioral health issues? Report of the SAMHSA, CMS and ACYF Technical Expert Panel, September 27–28, 2012. HHS Publication No. (SMA) 14-4842. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

more restrictive settings such as group care, psychiatric residential treatment facilities, and long-term residential programs. As an example, Montana defines its benefit as:

> *Therapeutic Foster Care (TFOC) is a home based treatment Care alternative for youth with a serious emotional disturbance requiring specific and frequent treatment alternatives and/or supports. TFOC is provided in therapeutic foster homes in two levels: moderate and permanency. TFOC room and board costs are not reimbursed by Montana Medicaid. Medicaid reimburses for 14 therapeutic home visits per state fiscal year for youth in moderate level TFOC. Permanency level TFOC is an intensive therapeutic intervention for the foster family, intended to support the foster placement to become an adoptive home.*

As previously mentioned in Chapter 1, DMH spent $28.6 million on state mental health hospitals for children and youth, compared to a national average of $11 million. Per capita spending for state hospitals was the second highest in the country. In contrast, only $69 million were spend on community-based programs, compared to a national average of $179 million.[88][89]

The average length of stay for children receiving treatment at Oak Circle was 47.2 days in FY 2014 while the average stay for youth receiving psychiatric and substance abuse treatment at the Bradley Sanders Complex in FY 2013 was 125 and 87 days respectively. As reflected in the table below, this level of service utilization exceeds the targeted length of state hospital service in most states. It should be noted that 35 states do not rely on any state hospitalization to treat children and 30 states do not rely on state hospitalization to treat adolescents. For those that do admit children and adolescents to state hospitals, more states target the services for Acute and Intermediate Care as opposed to Long-Term Care in excess of 90 days.

Table 24: Number of States with State Psychiatric Hospitals Providing Specific Inpatient Services by Age and Targeted Length of Inpatient Services

Target Population	Acute Care (less than 30 days)	Intermediate Care (30-90 days)	Long-Term Care (greater than 90 days)
Children	15	13	11
Adolescents	20	20	16

Source: NRI 2013 State Mental Health Agency Profiling System

Currently, admissions to inpatient and other institutional settings that do not involve the Chancery Courts are decided by the institutional provider where the client presents; this provider is frequently rendering decisions based on the presented information, with little or no input from current treaters. The exclusion of inpatient benefits from MississippiCan contributes to this problem. Mississippi is the only state in the country where inpatient care is left out of Medicaid managed care when managed care is utilized. The CCOs have no ability to offer alternatives to, or coordinate the delivery of, the most disruptive and intrusive level of care for children and youth in Mississippi. Not only are the CCOs unable to coordinate inpatient care for their members they are also not funded to create alternative home and community-based services and supports that could help divert youth from unnecessary hospitalization. Many stakeholders and providers report concern that there are no HCBS alternatives that could successfully divert admission/re-admission. Inpatient psychiatric services are provided through the traditional fee-for-service while other home- and community-based behavioral health services are managed by MississippiCAN. Consequently, CCOs are unable to track consumers when they are admitted to inpatient settings in real-time and instead must rely on retroactive reports submitted by UM/QIO. This process substantially limits the capacity for CCOs to prevent unnecessary hospitalizations, coordinate discharges, and arrange warm hand-offs. As previously stated, there are no community-based alcohol and drug residential treatment beds accessible for publicly-funded youth in Mississippi.

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[88]Substance Abuse and Mental Health Services Administration. [2012]. Table 15: SMHA-Controlled Mental Health Expenditures at Community-Based Programs, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/

[89]Substance Abuse and Mental Health Services Administration. [2012]. Table 14: SMHA-Controlled Mental Health Expenditures at State Mental Hospitals, by Age Group and State: FY 2012. Retrieved from http://www.nri-incdata.org/

Access to mobile crisis response and stabilization is an effective mechanism for preventing unnecessary placement in institutions and increasing access to HCBS. While the addition of mobile crisis to the service array is a positive development in Mississippi's system, its potential as an intervention to divert youth from more restrictive settings is underdeveloped. These services are significantly lower in cost, can be developed across the state to address current access issues resulting from the constellation of providers in 2 areas in the state, and allow for closer interaction between CSU team and the IOP. Crisis stabilization units, in addition to mobile response capacity, can also provide observation capacity when it is not known if redirection from inpatient will be effective or when a 23 hour or less placement intervention is appropriate. Mobile crisis services are intended to be delivered where the person in crisis is experiencing the crisis, in order to avoid the individual/family from needing to go to the ED or police department for stabilization. Crisis workers report trying to identify a neutral location where they can meet the person/family but this often ends up being the ED which defeats the purpose of de-escalating and stabilizing the crisis where it is occurring.

Youth and chancery courts were identified as a primary referral source to state and private inpatient facilities. In some cases, children involved with the court are committed to a hospital without parental consent or knowledge. In addition, approximately 85 percent of children detained at the state-run detention center, Oakley Training School, have a mental health disorder (not including conduct-related disorders).

Twenty (20) counties in the state have a full-time judge assigned to youth court; however the remaining 62 counties (mostly rural) have part-time "referees" appointed to the chancery's court. These areas lack the capacity for adequate collaboration with mental health providers to inform the courts' recommendations as to whether the youth should be diverted to community services or referred for formal processing to state hospitals or detention centers. As a result, court-involved youth with mental health needs are inappropriately detained or hospitalized.

RECOMMENDATIONS

1. REDIRECT CARE TOWARDS INCREASED USE OF HCBS AND DECREASED USE OF INSTITUTIONS

Residential treatment is the most expensive per episode child and adolescent behavioral health intervention option. Given that total treatment dollars for youth with behavioral health needs are scarce, the more that states spend on residential and other out-of-home care, the less they have for intensive home and community services. As a result, many states recognize that expansion of home- and community-based services is tied to the reduction of the number of residential beds and average lengths of stay in residential settings.

To reduce Mississippi's present overreliance on institutional placements, 24-hour services must be repurposed to build the home- and community-based service array and limit opportunities for restrictive placements. We understand that there is currently a moratorium on PRTF beds, and this should continue. In addition, it is recommended that DHS, DMH and DOM require PRTFs and state hospitals to submit plans for reconfiguring a portion of their beds and redirecting staff and resources towards alternate treatment modalities more conducive to a home- and community-based service array.

In the United States, residential centers are increasingly reengineering their services by re-training staff to provide intensive home and community services. They are also espousing a broader view of their mission, focusing on a range of services that vary in intensity and delivery site while still providing residential treatment. For example, some PRTFs are providing crisis intervention services by reconfiguring their beds to serve as short-term crisis stabilization units. Some are implementing best-practice and evidence-based models to include wraparound and other treatment services provided in the home, school, detention centers, or other community settings.

2. INCLUDE THE INSTITUTIONAL BENEFIT INTO MEDICAID MANAGED CARE STRATEGIES

In order to better manage and coordinate services for children and youth with intensive behavioral health needs, states have implemented managed care plans that include both inpatient and outpatient behavioral

health services. For example, in 2012 Louisiana launched the Louisiana Behavioral Health Plan under a 1915(b) authority that includes the Louisiana Coordinated System of Care. In 2006, Georgia introduced Georgia Families, a managed care plan under a 1932(a) authority that includes primary care, acute, and specialty services including both inpatient and outpatient behavioral health services, dental, and transportation.

Managed care plans that include both inpatient and outpatient services are better able to promote and make available lower-cost alternatives to more restrictive levels of placement. Further, uniting inpatient and outpatient services under one plan will position CCOs/UMQIO to reliably perform independent initial certifications of need and recertification of need for members seeking admission or who have been admitted to a psychiatric inpatient facility or psychiatric residential treatment facility, in which they are able to reasonably determine that:

- Less restrictive, ambulatory care resources available in the community do not meet the treatment needs of the member;
- Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician; and,
- The services can reasonably be expected to improve the member's condition or prevent further regression, so that the services will no longer be needed.

In addition, including the inpatient services into managed care would enable CCOs/UMQIO to develop and provide daily admission and discharge reports to CMHCs and private providers, developed and provided to CMHCs and private providers to ensure timely notification of service changes and more efficient coordination of care. CCOs should use the information from daily reports to create standards and expectations for care coordination to be implemented by providers. This process would greatly improve continuity of care for children and youth in the behavioral health system.

After carving inpatient care into managed care, it is also recommended that CCOs/UMQIO serve as a single point of accountability for admission to any 24 hour level of care, including acute psychiatric inpatient settings, PRTFs, state hospitals, and CSUs. In addition, CCOs/UMQIO should develop emergency services gatekeeper capacity within the State's current crisis response effort to serve as single point of accountability for screening, redirection from any 24 hour psychiatric placement. This should be firewalled from 24 hour service providers either through separate provider selection or contracting and team composition requirements.

In this regard, there are numerous managed care options to explore including implementing an authorization process for all 24-hour levels of care, care coordination plan for all children presented to crisis team to ensure tracking and immediate connection to services, reporting functions, and quality and network management strategies with its' providers.

It has been demonstrated that integrated managed care approaches that include both home- and community-based services and inpatient services reduce lengths of stay and prevent admissions and readmissions through improved coordination of care and reduced fragmentation. This occurs when the managed care entity also is charged with developing appropriate home and community based service capacity. Without this infrastructure, assigning institutional gatekeeping to managed care vendors can result in children discharged due to lack of medical necessity for the service, without access to appropriate aftercare services in the home and community. This can be particularly problematic for children in child welfare for whom a living arrangement may also be needed. It is anticipated that by following suit with the rest of the country and carving inpatient into their managed care plan, along with other infrastructure, Mississippi could realize cost-savings through the reductions in the excessive use of inpatient services.

3. CONDUCT AN IMMEDIATE REVIEW OF ALL INSTITUTIONALIZED YOUTH

A first step to reducing the number of institutionalized youth is to conduct a review of youth admitted to institutional facilities to determine whether youth are being unnecessarily institutionalized. Given that approximately 6300 children are driving 49% of the Medicaid behavioral health costs, there is significant opportunity to review the clinical needs of these children, and identify systemic opportunities to improve care. A best example of this type of activity comes from New Jersey. They conducted a review targeting children and youth with the longest stays in residential treatment who did not have any clear rationale for being admitted and who were potentially discharge ready. They stratified youth placed in a range of residential placements using two criteria: 1) Exceedingly long length of stay, and 2) Low levels of need according to CANS assessments. The review was focused on children with lengths of stay that were more than three standard deviations above the mean for the specific service type and low levels of clinical and functional impairment according to the CANS, therefore indicating no readily apparent need for continued level of care.

After identifying potentially discharge ready children, lists were provided to care management organizations who then conducted meetings with residential treatment staff, families, and child-welfare workers if necessary to determine whether there was a continued need for residential treatment, and if so, to better understand that need, identify and address barriers to discharge, and develop appropriate discharge plans. At the start of the review in June, 2005, 830 PDR children were in residential placement and at its completion a year later only 38 of those remained, resulting in a 95 percent decrease in the number of potentially discharge ready youth admitted to residential treatment.[90] It is important to recognize that New Jersey had in place a broad continuum of benefits, such as intensive in home and intensive care coordination to help support the movement of children back into the community.

As Mississippi begins its efforts to reduce the number of youth admitted to residential treatment, it is recommended that DOM and DMH implement a similar approach to determine the number of potentially discharge ready youth in residential care and to initiate their transition to home- and community-based services. The review should encompass all youth who are in out-of-state residential care, in-state hospital facilities longer than the average length of stay, and in PRTF facilities longer than the average length of stay to identify barriers to discharge and to develop appropriate transition plans. The CAY and/or the Children's Collaborative could be used to conduct these reviews and a process should be determined for conducting independent reviews of care of all youth who meet the criteria described above. This could be done as part of the statewide MAP team process, the ICCCY, or via contract with the CAY or the Children's Collaborative.

4. CONDUCT ONGOING REVIEWS OF YOUTH AT RISK FOR INSTITUTIONAL PLACEMENT

In addition to conducting an immediate review of youth in out-of-home settings, we recommend that Mississippi develop an identification and referral protocol for those youth who are at risk of an out-of-home placement. The methodology below can be used for two purposes. First, to develop an estimate of the number of youth who could benefit from MYPAC/IOP in each of the 14 CMHC regions. Second, this methodology can be used in an ongoing way to identify those youth who should be screened for MYPAC/IOP eligibility.

Claims and encounter data should first be used to identify Medicaid enrolled youth under 21 with a mental health service need. TAC/The Institute recommends using the definition of mental health service need developed as part of the *T.R. v. Dreyfus* settlement agreement in Washington State. Mental health service need was defined as having one or more of the following:

- A psychiatric diagnosis in the following categories: psychotic disorders, mania and bipolar disorders, depressive disorders, anxiety disorders, adjustment disorders, and other childhood psychiatric disorders including ADHD.[91]
- Filled a prescription for medication in one or more of the following therapeutic classes: anti-psychotic, anti-mania, anti-depressant, anti-anxiety, and ADHD.

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[90]Center for Health Care Strategies. (2006). ValueOptions New Jersey: Shortening Residential Care Stays for Teens. Retrieved from http://www.chcs.org/resource/valueoptions-new-jersey-shortening-residential-care-stays-for-teens/

[91] Please see Appendix D of the T.R. v. Dreyfus settlement agreement for a list of the ICD code values within each diagnostic category. The full settlement agreement is located at: https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/documents/cbhtrfullagreement.pdf

- Receipt of a behavioral health service. In Mississippi this would include receipt of any Medicaid behavioral health service or behavioral health screening.

That state also uses a data analytic approach; and has developed algorithm to identify children that could potentially benefit from the states intensive care coordination service. [92] Washington selected a standardized assessment tool called the Child and Adolescent Needs and Strengths (CANS), and developed an algorithm to guide provider decision-making.

Once the larger pool of youth with a mental health service need is defined, the list should be further refined using the indicators below to identify those youth with who should be screened for IOP eligibility using a standardized assessment tool.

- Inpatient psychiatric admission
- PRTF admission
- Psychotropic medication poly-pharmacy where the child was holding at least 4 psychotropic medications. The count of 4 or more includes anti-psychotic, anti-mania, anti-depressant, anti-anxiety, ADHD, sedatives and anticonvulsants.
- Two or more medical inpatient admissions with a primary mental illness on the claim
- Two or more medical outpatient Emergency Department visits with a primary mental illness diagnosis on the claim
- Mental health service use at/above the 90th percentile based on count of outpatient encounters
- Drug overdose diagnosis in a medical claims or encounters
- Anorexia/bulimia diagnosis in medical claim or encounter
- Suicide attempt or self-injury in medical claim or encounter
- Possible suicide attempt or self-injury in medical claim or encounter
- Medical claim or encounter with diagnosis of a substance use disorder

Furthermore, referral protocols with child welfare, juvenile justice, DMH, education, and the CMHCs should be created to promote access to IOP for youth with the following profiles:

- Youth involved with child welfare who have experienced three or more out of home placements
- Youth exiting the Oakley Youth Development Center who have been identified as having a behavioral health condition
- Youth experiencing homelessness as defined by the McKinney-Vento Homeless Education Act (via local school district homeless liaisons)
- Youth reviewed by local MAP teams
- Youth exiting PRTF facilities
- Youth exiting state hospital facilities
- Youth with a mobile crisis intervention encounter

Specific guidance can be developed for partners and stakeholders to assist them in identifying children that may be eligible for IOP (or other needed HCBS services), how to refer and what to expect upon referral. The State of Washington, as part of their recent agreement, will be developing written materials, communication plans and trainings for fifteen different categories of stakeholders including child welfare, education, juvenile justice, primary care. [93]

In order to accommodate those youth identified through the screening process as needing IOP, Mississippi will need to ensure there is adequate provider capacity to deliver the service. Based on the utilization targets, DMH and DOM will need to work closely with the Wraparound Facilitation Training and Coaching Center at the University of Southern Mississippi (USM) and the CMHC providers to create a plan for CMHCs to become

[92] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

[93] http://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20manual%20v%201.3%20FINAL.pdf

certified IOP providers. Using the methodology described above, DOM and USM should be able to estimate the number of staff who will need to be trained in each region of the state and the approximate timeframe for doing so. This will aide in determining how long it will take for providers to "ramp-up" to full capacity[94] and develop a clear plan for how they will do this.

5. REDIRECT EXPERTISE OF INSTITUTIONAL STAFF TOWARDS NEEDED COMMUNITY-BASED CARE

As states and communities build home- and community-based services and reduce their reliance on institutional care, downsizing of staff in state psychiatric hospitals and residential treatment centers is a common concern. Many states repurpose the traditional roles for state hospital staff as providers of the new types of services being introduced to the system. To this end, state behavioral health authorities are able to expand the availability of low-cost alternatives to psychiatric inpatient placements while capitalizing on the expertise of the professionals currently employed by those institutions.

It is recommended that DMH expand the current and historical functions of staff in its state hospitals to include the provision of home- and community-based services. Given current demands on CMHCs, the services provided by redeployed state hospital staff would complement the role of CMHCs and other providers without duplication. DMH can manage the provision of lower cost alternatives to institutional treatment that CMHCs lack the capacity to provide. For example, the state could redeploy hospital staff to increase mobile crisis response capacity, to provide emergency services and crisis triage functions, to provide one:one crisis stabilization services, and to staff crisis stabilization units. In addition, hospital staff would be ideal for providing in-home therapy, care coordination and warm hand-offs, and for serving special populations such as forensic populations and children placed out-of-state for treatment. Further, psychiatrists currently serving children and youth in state hospitals could be redeployed to enhance access to and capacity for community psychiatric services.

6. PROMOTE MENTAL HEALTH COLLABORATION IN YOUTH AND CHANCERY COURTS

In order to effectively divert youth with behavioral health needs away from detention centers and other restrictive placements, it is necessary for Mississippi to implement a widespread and systematic approach to identifying those needs as they become involved with the court system. Building behavioral health screening and assessment capacity within youth and chancery courts is necessary to identify and respond to behavioral health needs, allowing courts to make informed and appropriate decisions regarding the necessary types of services, proper levels of treatment intensity and degrees of security. Many of these efforts are underway including efforts to adopt a common standardized risk assessment, revisions to state Juvenile Detention Standards, and efforts to improve access to behavioral health services and the collection and use of data with this population of youth. Currently, there are five counties participating in the Juvenile Detention Alternatives Initiative (JDAI), and two more counties are in planning to implement JDAI.

In partnership with DYS, DMH should designate the behavioral health screenings and assessments to be used throughout the state. Some juvenile justice systems employ the CAFAS, which may have utility for Mississippi given that it is currently required to be performed by CMHCs. Depending on the risk assessment instrument used, this may also be a useful behavioral health screening tool.

In addition, DMH should further explore opportunities for expanding Judge Broome's mental health collaboration model beyond Rankin County. This model, which assigns mental health liaisons in-house at Rankin County's youth court, sheriff's department, and detention center, was cited as a best practice in Mississippi that could have utility for other youth courts. Additionally, DMH with its state partners, should continue efforts to promote the lessons learned from current JDAI sites, and seek expansion of such efforts throughout the state.

[94] Full capacity or the utilization target is defined as the number of youth who could benefit from IOP using the methodology described above.

7. REVISIT INCLUSION OF TREATMENT FOSTER CARE AS A MEDICAID BENEFIT

Several states have included treatment foster care in their Medicaid benefits. Mississippi tried to include this service in their benefit array but it was denied by CMS. We recommend they revisit this benefit, and review prior decisions regarding eligible populations for this service. Inclusion of this service is a successful strategy to enhance community based treatment and could help the state divert unnecessary institutional care. We did not review the draft SPA submitted but through dialogue with the state we understand that the SPA was denied as the population defined was restricted to foster care youth only. This service, when implemented with screening and other management strategies to ensure that the appropriate clinical population is identified, will further help the state address the needs of children and reduce use of institutional settings.

CONCLUSIONS

This report has described the Mississippi children's mental health and substance use service systems from a variety of perspectives. As noted in the introduction, the central focus of the report is The Department of Mental Health and the Division of Medicaid. However, these two agencies do not exist in a vacuum, and many of the recommendations contained in the report will require a coordinated effort across all child-serving state agencies, including child welfare, juvenile justice, education and public health.

The report includes quantitative and qualitative information about behavioral health recipients, home and community based services, institutional services, providers and workforce, quality, and interagency collaboration. All of these factors affect the quality and performance of Mississippi's behavioral health system for children.

NOTABLE STRENGTHS

The results of our analyses identified several notable strengths. These are areas that should be built upon and leveraged to further the work of DMH and DOM and other child-serving agencies in meeting its goals and priorities.

AUGMENTATION OF MEDICAID BENEFIT ARRAY IN 2012

In 2012, Mississippi expanded their home- and community-based benefit array to include essential services that are nationally recognized for leading to improved outcomes among children and youth with intensive behavioral health needs. These services include:

- *IOP.* Previously offered as a Demonstration Waiver service, MYPAC, which includes Wraparound facilitation, was migrated to the State Rehab Option. This was an important step to ensure the sustainability of a vital service for children and youth who are at-risk for institutional placement.
- *Crisis Response Services.* DMH has made noteworthy investments towards establishing a robust mobile crisis response and stabilization system in Mississippi. They continue to provide grants, supports, training, and technical assistance to community providers to build this service with the goal of reducing emergency room visits and unnecessary psychiatric hospitalizations. In addition, DOM added crisis response services, which include crisis residential services, to the State Rehab Option in 2012, evidencing a statewide commitment to ensuring the viability of this intervention.
- *Peer Support.* This federally-endorsed service was also added to the State Rehab Option in 2012. While these services are targeted to individuals 18 years of age and older, Peers provide much needed support for youth transitioning to adulthood.

EVIDENCE-BASED AND PROMISING PRACTICE IMPLEMENTATION

Mississippi has made considerable effort to invest in evidence-based, trauma informed approaches. In 2008, Trauma Recovery for Youth and DMH joined forces with the National Center for Child Traumatic Stress to start a statewide Learning Collaborative in Mississippi designed to enhance the implementation of TF-CBT. DMH continues to provide TF-CBT training for clinical staff through the learning collaborative model. As of 2013, there were 90 CMHC staff who completed training in TF-CBT, SPARCS, or other evidence-based practices through Learning Collaboratives. Additionally, the Division has also promoted use of TF-CBT in several of its institutions.

QUALITY MONITORING OSCR PROCESS WITH MYPAC AND PRTF

The Division of Medicaid's On-Site Compliance Review (OSCR) Process for MYPAC providers and PRTFs is a highlight of Mississippi's quality monitoring system; it is very thorough in its scope. The OSCR process consists of a blend of direct observation, document review, staff interviews and participant and family interviews. The robust OSCR tool verifies both that the provider is in compliance with applicable state and

federal requirements for mental health treatment and investigates the quality of treatment being provided to service recipients. The tool also enables compliance reviewers to provide clear, specific feedback regarding findings to provider staff. This process also allows the Division to reliably identify and address non-compliance and enhance the delivery of these important services.

CREDENTIALING OF PEERS

DMH has made considerable investments for training Certified Peer Support Specialists (CPSS). In FY2014, CPSS Trainers held three trainings attended by 62 individuals who identify as a family member or an individual who received or is currently receiving mental health services. Mississippi's CPSS training and certification program prepares specialists for helping families enhance community living skills, community integration, rehabilitation, resiliency, and recovery.

DEVELOPMENT OF STATE TRAINING INFRASTRUCTURE

In 2012, a State Wraparound Council was formed with USM School of Social Work, DMH and DOM to plan for sustainable Wraparound training infrastructure in Mississippi. USM is funded by DMH and DOM to provide High-Fidelity Wraparound training and coaching. As of this writing, there are a total of four certified Wraparound coaches in the state and trainings are planned through December, 2015. Mississippi is well on their way to building a network of certified coaches and trainers as a result of state-level investments and support, which will be vital to ensure adequate capacity for meeting growing demand for wraparound services.

MAP TEAMS

These local multidisciplinary teams have served as a review team concerning children and youth who are at immediate risk for institutionalizing and meet on a monthly basis to identify community-based services and resources that may divert children away from inappropriate out-of-home placements. Families reported satisfaction with the MAP team process, indicating that they have had a positive impact in the system. Because of their local systems knowledge, they can serve an expanded role to address local system level gaps and issues that will improve and support the work of IOP care planning teams.

ICCCY/ISCC STRUCTURES

The legislation enacted in 2010 to provide for the development, implementation and oversight of a coordinated interagency system of necessary services and care for children and youth contains commendable systems of care language. As stated previously, this legislation, which establishes the ICCCY and ISCC structures, provides a clear and impressive framework for establishing a interagency governance structure and appropriately delineates how a statewide coordinated system of care should function. While the ISCC meets regularly and elicits commitment from mid-level agency staff, the ICCCY has not been implemented as intended.

SYSTEM CHALLENGES

The challenges and recommendations identified in the report are intended to focus the state's efforts on both immediate gaps in the system and long-term investments to strengthen and improve the system. Each chapter identifies specific challenges and recommendations related to each of the five content areas: home and community based services, provider and workforce capacity, quality, interagency collaboration, and institutional care. Many of the recommendations are operational in nature, augmenting, modifying or fine-tuning what Mississippi has already built in order to improve its system performance. At the core of recommendations are the following challenges that will impact the state's ability to move forward with the recommendations.

RESOURCES

Mississippi DMH and DOM need additional resources in order to be prudent purchasers of mental health and substance use services. These resources are needed for service delivery and for infrastructure, particularly in the areas of data, quality improvement, and interagency collaboration. While our recommendations do address the need to redirect certain resources from high cost and less-effective care, redirection of funding alone will not provide the resources needed. Both DMH and DOM need the ability to be more nimble, to be able to more rapidly identify system gaps and deploy resources to solve problems. This requires access to data, quality indicators, staff to conduct joint reviews and analysis of outputs and internal flexibility to respond to indicators for needed change.

COORDINATED PURCHASING AND POLICY STRATEGY

Mississippi is hampered by the disparate administration and financing of major components of their children's behavioral health system. DMH, DOM, child welfare, juvenile justice, the courts, education and public health all play a significant role in children's behavioral health. A coordinated effort around system goals, planning and purchasing, as well as policies is needed. A common planning and purchasing approach that addresses critical system functions including results and outcomes for beneficiaries, equity of access to services, best practice benefit array, clarity of responsibilities across state agencies, and improved access to and use of data to guide decision-making are approaches needed to improve the behavioral health system.

PARTNERSHIP WITH YOUTH AND FAMILIES

There is a voiced perception among some stakeholders that Mississippi leadership is disengaged from the voice and will of youth and families. Consequently there is little trust of efforts for system transformation. In order for systems changes to have the desired benefits, decisions by leadership at DMH and other state agencies must align with the goals and values of youth and families. This can only be achieved through sustained outreach, engagement and collaboration with families and advocacy organizations.

REDUCE RELIANCE ON INSTITUIONAL SOLUTIONS

Mississippi leadership has made significant efforts to improve home and community based services however considerable work remains to fully transform a system historically oriented towards institutional care. Institutional options are a known entity and some purchasers and families are comfortable with these services. However, most children and youth can be served effectively and appropriately within their own homes and communities if the right mix and intensity of services is available. Family choice is crucial, but families are not making a true choice when their only option is institutional care or no care. Families, youth, and providers—as well as funders—need to work together to grow Mississippi's service array so that it is comprehensive and based on what national best practice, research, and families have said works. The shift to serving children and youth in the community instead of in institutional settings will not happen overnight; it is a process that will require the collective commitment of all parties to retrain the workforce to provide high quality and effective services to children and youth in their homes and communities. It will also require that the compensation structure that is established for providers is equitable and commensurate with the expertise of their staff and the resources required. This is in no way is to say PRTFs and other institutions will no longer serve an important role in Mississippi's system. Rather, our recommendations will help ensure that Mississippi's limited number of beds are available only to those who need them most.

APPENDIX- INTERVIEW LIST

IN-PERSON INTERVIEW LIST

Name	Organization	Site-Visit
Steven Allen	Boswell Regional Center	Provider
Amy Turner	Catholic Charities	Provider
Angela Griffin	Catholic Charities	Provider
Angela Hudson	Catholic Charities	Provider
Carol Warfield	Catholic Charities	Provider
Linda Raff	Catholic Charities	Provider
Lisa McBride	Catholic Charities	Provider
Michelle Hamilton	Catholic Charities	Provider
Monica Meunger	Catholic Charities	Provider
Nadia Gaynor	Catholic Charities	Provider
Valeria Mapiella	Catholic Charities	Provider
Amanda Keel	Communicare (Region 2)	Provider
Darlene Petit	Communicare (Region 2)	Provider
Kerry McKnatt	Communicare (Region 2)	Provider
KippHeatherly	Communicare (Region 2)	Provider
Meagan Taylor	Communicare (Region 2)	Provider
Melody Copp	Communicare (Region 2)	Provider
Rachel Alcorn	Communicare (Region 2)	Provider
Sandy Rogers	Communicare (Region 2)	Provider
Terri Hall	Communicare (Region 2)	Provider
Tiffany Lewis	Communicare (Region 2)	Provider
Africa Shirley	Community Counseling Services (Region 7)	Provider
Angela Johnson	Community Counseling Services (Region 7)	Provider
Brook Minton	Community Counseling Services (Region 7)	Provider
Carnette Hudson	Community Counseling Services (Region 7)	Provider
Christi Hayes	Community Counseling Services (Region 7)	Provider
Felicia Fort	Community Counseling Services (Region 7)	Provider
Gwen Gray	Community Counseling Services (Region 7)	Provider
Jackie Edwards	Community Counseling Services (Region 7)	Provider
Janice McGee	Community Counseling Services (Region 7)	Provider
Juliette Reese	Community Counseling Services (Region 7)	Provider

Karen Frye	Community Counseling Services (Region 7)	Provider
Kelvin Knowles	Community Counseling Services (Region 7)	Provider
Lakesha Shelton	Community Counseling Services (Region 7)	Provider
Lina Beall	Community Counseling Services (Region 7)	Provider
Lori Latham	Community Counseling Services (Region 7)	Provider
Martha Wallis	Community Counseling Services (Region 7)	Provider
Meomia Gant	Community Counseling Services (Region 7)	Provider
Nikki Nicholson	Community Counseling Services (Region 7)	Provider
Phasun King	Community Counseling Services (Region 7)	Provider
Ray Evans	Community Counseling Services (Region 7)	Provider
Rose Coffee	Community Counseling Services (Region 7)	Provider
Shanta Lawrence	Community Counseling Services (Region 7)	Provider
Sharon Bell	Community Counseling Services (Region 7)	Provider
Stephanie Taylor	Community Counseling Services (Region 7)	Provider
Tiffany Williams	Community Counseling Services (Region 7)	Provider
Toni Jackson	Community Counseling Services (Region 7)	Provider
Trina Cotton	Community Counseling Services (Region 7)	Provider
Trudy Buckhalter	Community Counseling Services (Region 7)	Provider
Amy Winn	Fairland Center	Provider
Stephen Johnson	Fairland Center	Provider
Jaqueline Dedeaux	Gulf Coast Mental Health Center (Region 13)	Provider
Jeff Bennet	Gulf Coast Mental Health Center (Region 13)	Provider
Julie Forrest	Gulf Coast Mental Health Center (Region 13)	Provider
Lisa Crain	Gulf Coast Mental Health Center (Region 13)	Provider
Mary Romero	Gulf Coast Mental Health Center (Region 13)	Provider
Michael Maxey	Gulf Coast Mental Health Center (Region 13)	Provider
Robin Berry	Gulf Coast Mental Health Center (Region 13)	Provider
Shelley Foreman	Gulf Coast Mental Health Center (Region 13)	Provider
Tom Pritchard	Gulf Coast Mental Health Center (Region 13)	Provider
Madolyn Smith	Life Help (Region 6)	Provider
Phaedre Cole	Life Help (Region 6)	Provider
CARES Staff	MCHS	Provider
Cynthia Undesser	MCHS	Provider
Denny Hydrick	MCHS	Provider
Shea Hutchins	MCHS	Provider

Wanda Thomas	MCHS	Provider
BathshebоDompeer	MS Adolescent Center	Provider
Bobby Alsworth	MS Adolescent Center	Provider
Donna Horton	MS Adolescent Center	Provider
Douglas McDonald	MS Adolescent Center	Provider
Henrietta Bey	MS Adolescent Center	Provider
William Gates	MS Adolescent Center	Provider
Amy Baskin	MS State Hospital	Provider
Barbara Fishgrab	MS State Hospital	Provider
Billy Walton	MS State Hospital	Provider
Carolyn Tingle	MS State Hospital	Provider
Chandra Beston	MS State Hospital	Provider
Chris Allen	MS State Hospital	Provider
Deena Mullins	MS State Hospital	Provider
Demetria Horton	MS State Hospital	Provider
Dirk Hosschel	MS State Hospital	Provider
Genevieve Garrett	MS State Hospital	Provider
James Chastain	MS State Hospital	Provider
Jeane Dillon	MS State Hospital	Provider
Kathryn Ford	MS State Hospital	Provider
Kathy Denton	MS State Hospital	Provider
Regina Lacking	MS State Hospital	Provider
Robert Maddux	MS State Hospital	Provider
Rose Casano	MS State Hospital	Provider
Carol Brown	Pine Belt Mental Healthcare (Region 12)	Provider
Donna English	Pine Belt Mental Healthcare (Region 12)	Provider
Felecia Coleman	Pine Belt Mental Healthcare (Region 12)	Provider
Jean Robertson	Pine Belt Mental Healthcare (Region 12)	Provider
Jeanne Baykeu	Pine Belt Mental Healthcare (Region 12)	Provider
NaymudTalakdon	Pine Belt Mental Healthcare (Region 12)	Provider
Rita Porter	Pine Belt Mental Healthcare (Region 12)	Provider
Roger Anas	Pine Belt Mental Healthcare (Region 12)	Provider
Karen Corley	Region One Mental Health Center	Provider
David Cook	Region One Mental Health Center	Provider
Diane Youngblood	Region One Mental Health Center	Provider

Karen Corley	Region One Mental Health Center	Provider
Lisa Phelps	Region One Mental Health Center	Provider
Shane Garrard	Region One Mental Health Center	Provider
Shirley Long	Region One Mental Health Center	Provider
Jody Herring	Southwest MHC	Provider
Karen Graves	Southwest MHC	Provider
Pamela Barman	Southwest MHC	Provider
Sherelene Vince	Southwest MHC	Provider
Steve Ellis	Southwest MHC	Provider
Bryan Vyverberg	Specialized Treatment Facility	Provider
Charles Harris	Specialized Treatment Facility	Provider
Kim Peterman	Specialized Treatment Facility	Provider
Scott Turner	Specialized Treatment Facility	Provider
Shannon Bush	Specialized Treatment Facility	Provider
Stacy Miller	Specialized Treatment Facility	Provider
Stephanie May	Specialized Treatment Facility	Provider
Valerie Joiner	Specialized Treatment Facility	Provider
Bridgett Hancock	Sunflower Landing	Provider
Martinese Fitzpatrick	Sunflower Landing	Provider
Nicole Garrard	Sunflower Landing	Provider
Charlie Spearman	Timber Hills Mental Health Services	Provider
Nikki Tapp	Timber Hills Mental Health Services	Provider
Henry Cooper	Youth Villages	Provider
Jameeka Williams	Youth Villages	Provider
Kayla Virgil	Youth Villages	Provider
Sheneeta Benson	Youth Villages	Provider
Cynthia Eubank	Attorney General's Office	Week One
Patti Marshall	Attorney General's Office	Week One
Lori Garrott	Catholic Charities	Week One
Vivian Walker	Catholic Charities	Week One
Dixie Church	Communicare (Region 2)	Week One
Angie Williams	Department of Human Services	Week One
Kim Shackelford	Department of Human Services	Week One
Sandra McClendon	Department of Human Services	Week One
James Maccarone	Department of Human Services, Division of Youth Services	Week One

Melonie Taylor Gore	Department of Human Services, Division of Youth Services	Week One
Diana Mikula	Department of Mental Health	Week One
Mark Lewis	Department of Mental Health	Week One
Jerri Avery	Department of Mental Health, Division of A&D Services	Week One
Mark Stovall	Department of Mental Health, Division of A&D Services	Week One
Melody Winson	Department of Mental Health, Division of A&D Services	Week One
Sandra Parks	Department of Mental Health, Division of Children & Youth	Week One
Andrew Day	Department of Mental Health, Division of Community Services	Week One
Kris Jones	Department of Mental Health, Division of Quality Management	Week One
Jake Hutchins	Department of Mental Health, Division of Community Services	Week One
Charlene Toten	Division of Medicaid	Week One
David Dzielak	Division of Medicaid	Week One
Sharon Jones	Division of Medicaid	Week One
Will Crump	Division of Medicaid	Week One
Bonlitha Windham	Division of Medicaid, Bureau of Mental Health	Week One
Jennifer Grant	Division of Medicaid, Community Programs	Week One
Joy Hogge	Families as Allies	Week One
Laura Smith	Families as Allies	Week One
Randy Weeks	Grenada Crisis Stabilization Unit (Region 6)	Week One
August Patton	Hinds Behavioral Health Services (Region 9)	Week One
Ophelia Kelly	Hinds Behavioral Health Services (Region 9)	Week One
Angela Ables	Life Help (Region 6)	Week One
Donna Theriot	Life Help (Region 6)	Week One
Jonathon Grostham	Life Help (Region 6)	Week One
Zandrea Ware	MACMHC	Week One
John Damon	MS Children's Home Services	Week One
Al Cervantes	Pine Belt Mental Healthcare (Region 12)	Week One
Mona Gauthier	Pine Belt Mental Healthcare (Region 12)	Week One
Emile Craig	Region 8 Mental Health Services	Week One
Richard McMillan	Region 8 Mental Health Services	Week One
Stephanie Berry	Region 8 Mental Health Services	Week One
Ron Earl	Region One Mental Health Center	Week One
Pamela Bowman	Southwest MS Mental Health (Region 11)	Week One
Sherlene Vince	Southwest MS Mental Health (Region 11)	Week One
Bobby Barten	Warren-Yazoo Mental Health Services (Region 15)	Week One

Suzanne Lancaster	Warren-Yazoo Mental Health Services (Region 15)	Week One
Hon. Tom Broome	Youth Court Judges Association/Rankin County Youth Court	Week One
Amy Adams	Youth Villages	Week One
Katja Russell	Youth Villages	Week One

TELEPHONE INTERVIEW LIST

Name	Organization
Therese Hanna	Center for MS Health Policy
Ann MacLaine	Disability Rights MS
Kristi Plotner	Division of Medicaid
Otis Washington	Division of Medicaid
Charlene Toten	Division of Medicaid
Jennifer Grant	Division of Medicaid
eQHealth Staff	eQHealth
Joy Hogge	Families as Allies
Laura Smith	Families as Allies
Cliff Davis	Human Service Collaborative
Magnolia Staff	Magnolia Healthplan, Inc.
John Damon	MS Children's Home Services
Terry Hight	MS Children's Home Services
Pam Dollar	MS Coalition for Citizens with Disabilities
MS DOE Staff	MS Department of Education
Carnette Hudson	Nfusion
Marshia Moody	Nfusion
Ellen Reddy	Nollie Jenkins Family Center
Jerry Mayo	Pine Belt Mental Healthcare
Mona Gauthier	Pine Belt Mental Healthcare
Elissa Johnson	Southern Poverty Law Center
David Elkin	UMC
United Healthcare Staff	United Healthcare, Inc.
Elizabeth McDowell	USM
Tamara Hurst	USM
Tim Rehner	USM
Katja Russell	Youth Villages

PROVIDER SITE-VISIT LIST

Provider Name
Catholic Charities
Catholic Charities CSU
Community Counseling Services
East MS State Hospital
Gulfport
Hinds Behavioral Health Services
Life Help
MS Adolescent Center
MS Children's Home Services - Lakeland
MS Children's Home Services - CARES Center
MS Families as Allies
MS State Hospital - Adult Psychiatric
MS State Hospital - Oak Circle Center
Pinebelt MHC
Region 1 Mental Health Center (Clarksdale)
Region 1 Mental Health Center (Tutwiller)
Region 8 Mental Health Services
Southern Christian Services (Jackson)
Southern Christian Services (Tupelo)
Southwest MHC
Specialized Treatment Facility
Timber Hills
Warren-Yazoo Mental Health Services
Weems Community Mental Health Center
Youth Villages

MISSISSIPPI BEHAVIORAL HEALTH CONSUMER INTERVIEW TOTALS

These are interviews in addition to the stakeholders listed. These are service recipients, and their names are withheld to protect their confidentiality at their request.

Forum	Number
Provider site-visit	17
Week One site-visit	15
Telephone	6
Total	38

APPENDIX- DOCUMENTS

DOCUMENT REVIEW LIST

Author	Title	Year
eQHealth Solutions	MYPAC Services Provider Manual	2013
Human Service Collaborative	An Assessment and Study of the Mississippi System of Care	2009
Legislature of the State of Mississippi	Miss. Code Ann. § 43-13-107	2014
Legislature of the State of Mississippi	Miss. Code Ann. § 43-14-1(Mississippi System of Care)	2010
MS DMH	A&D ADAPT Project Narrative	2014
MS DMH	Alcohol and Drug Treatment Program Directory	2014
MS DMH	Certified Peer Support Specialist Application	2014
MS DMH	Certified Peer Support Specialist Information Gathering Form	2014
MS DMH	Certified Peer Support Specialist Program: Quick Glance	Unknown
MS DMH	Crisis Intervention Service Utilizaiton, FY 2014	2014
MS DMH	Crisis Stabilization Unit Utilization Totals	2014
MS DMH	Division of Children & Youth Services Directory	2012
MS DMH	DMH State Plan Implementation Report	2013
MS DMH	DMH Strategic Plan, FY15-17	2014
MS DMH	East Mississippi State Hospital Admissions and Discharges, 2010-2013 [Data File]	2014
MS DMH	FY 2014 Adolescent Opportunities Programs	2014
MS DMH	FY 2014 School-Based Services	2014
MS DMH	ICCCY Internal Organizational Procedures	2011
MS DMH	ICCCY Meeting Minutes	2010-2012
MS DMH	ICCCY Membership Roster	2013
MS DMH	ICCCY Memoranda of Understanding (SFY11-12)	2011-2012
MS DMH	IOP Children and Youth Provider Listing	2014
MS DMH	ISCC Meeting Minutes	2010-2014
MS DMH	ISCC Membership Roster	2013
MS DMH	Juvenile Outreach Program Updates	2014
MS DMH	MAP Team and SLCR Youth Served Data	2010-2014
MS DMH	MAP Team Case Summary Form	Unknown

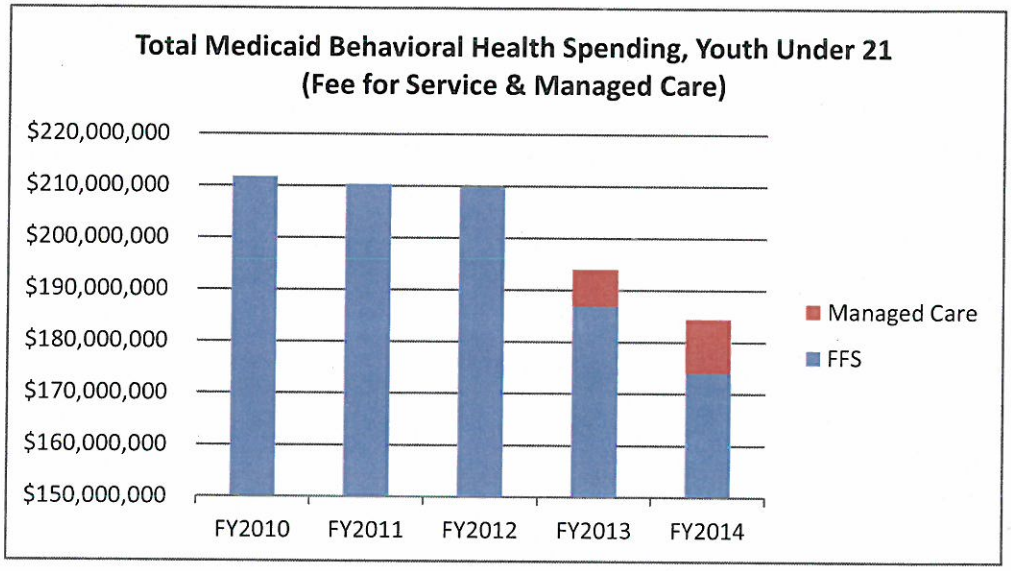
MS DMH	MAP Team Guidance	2014
MS DMH	MAP Team Initial Case Referral Form	2008
MS DMH	MAP Team Monthly Form	2012
MS DMH	MCeRT Utilization Totals (January-September, 2014)	2014
MS DMH	Mississippi Adolescent Alcohol and Drug Services Wish List	2014
MS DMH	Mississippi Mental Health National Outcomes Measures (NOMS): CMHS Uniform Reporting System, 2011-2012	2014
MS DMH	Mississippi State Hospital (Oak Circle Center) Admissions and Discharges, 2010-2014 [Data File]	2014
MS DMH	Mississippi SYT-ED Youth Treatment Workplan	2014
MS DMH	Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers	2013
MS DMH	Peer Support Specialist Professional Standards and Requirements	2012
MS DMH	PRTF Seclusion and Restraint Numbers, January 2012-December 2013 (Southern Poverty Law Center RFI)	2013
MS DMH	SmartTrack Data Brochure	2013
MS DMH	Specialized Treatment Facility Admissions and Discharges, 2010-2014 [Data File]	2014
MS DMH	Therapeutic Group Home and Foster Care Utilization	2014
MS DMH	Wraparound Provider Listing	2014
MS DOH	Mississippi State Health Plan	2014
MS DOM	Acute Facilities - Admissions and Expenditures (SFY10-11) [Data Files]	2010-2011
MS DOM	Administrative Code Title 23, Part 202: Inpatient Hospital	2012
MS DOM	Administrative Code Title 23, Part 206: Mental Health Services	2014
MS DOM	Administrative Code Title 23, Part 300: Appeals	2012
MS DOM	Appeal Request Data, SFY11-13	2014
MS DOM	Application for a 1915c Home- and Community-Based Services Waiver	2007
MS DOM	CMHC Billing Guidelines and Procedure Codes	2012
MS DOM	CMHC Office Address List	2014
MS DOM	CMHC Provider Policy Manual	2001
MS DOM	CMHC Services and Fact Sheets	2010-2011
MS DOM	Contract Between DOM and Magnolia Healthplan, Inc.	2014
MS DOM	Contract Between DOM and UnitedHealthcare of Mississippi, Inc.	2014
MS DOM	EPSDT Anticipatory Guidance	2006
MS DOM	Guidance for Becoming a MYPAC Provider	2013
MS DOM	HCBS FY2016 Budget Request	2014

MS DOM	HSM Year End Reports: Inpatient Programs, SFY10-14	2010-2014
MS DOM	Intensive Outpatient Psychiatric Administrative Code (Draft)	2014
MS DOM	Mississippi Medicaid Fee-for-Service and Managed Care Claims Encounter Data, SFY10-14 [Data Files]	2010-2014
MS DOM	MSCAN Provider Surveys	2014
MS DOM	MYPAC Critical Incident Reporting, SFY10-14	2014
MS DOM	MYPAC Freedom of Choice Form	2010
MS DOM	MYPAC Initial Screen Form	2014
MS DOM	MYPAC Legislative Report	2008-2012
MS DOM	MYPAC On-Site Compliance Review (OSCR) Tool	2009
MS DOM	MYPAC Provider Policy Manual (prior to Administrative Code - Title 23, Part 206, Chapter 2)	2009
MS DOM	MYPAC vs. PRTF Reports	2010-2013
MS DOM	OSCR Summary for MYPAC Demonstration Waiver	2013
MS DOM	Provider Reference Guide for MYPAC	Unknown
MS DOM	PRTF Administrative Code (Draft)	2014
MS DOM	PRTF Incident Reporting Requirements	Unknown
MS DOM	PRTF Incident Reports: Numbers and Types (SFY10-13)	2014
MS DOM	PRTF Provider Policy Manual	2009
MS DOM	Request for Proposals: Utilization Management and Quality Improvement Services	2008
MS DOM	Sample MYPAC OSCR Exit Interview Documents for Provider	2013
MS DOM	Sample MYPAC OSCR Notification Letter	2013
MS DOM	Sample MYPAC OSCR Status Letter to Provider	2013
MS DOM	Sample MYPAC Provider Corrective Action Plan	2013
MS DOM	SPA04-012: Title XIX Inpatient Hospital Reimbursement Plan	2005
MS DOM	SPA08-063: Inpatient Psychiatric Services	2008
MS DOM	SPA10-006: Rate Computation for State-Owned PRTFs	2010
MS DOM	SPA12-003: Rehabilitative Services	2012
MS DOM	SPA12-009: Outpatient Hospital Services	2012
MS DOM	SPA14-005: Treatment Foster Care Services	2014
MS DOM	SPA14-016: Title XIX Inpatient Hospital Reimbursement Plan	2014
MS DOM	Substance Use Disorder Treatment Administrative Code (Draft)	2014
MS DOM	Therapeutic and Evaluative Mental Health Services for Children Provider Policy Manual	2009

MS DOM	Therapeutic and Evaluative Mental Health Services: Legislative Data (2010-2013)	2013
MS DOM	Updated Billing Guidelines for Therapeutic and Evaluative Mental Health Services for Children	2014
MS Families as Allies	Family Survey	2010
MS Families as Allies	Focus Group Findings	2013
MS Families as Allies	Letter to the Governor	2014
Specialized Treatment Facility	Admission, Discharge, and Continued Stay Policies	2010
University of Southern Mississippi	Evaluation of MYPAC Participant Outcomes and Family Satisfaction	2014
University of Southern Mississippi	Evaluation of MYPAC Wraparound Fidelity	2014
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Final Evaluation	2012
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Local Evaluation Report #1	2010
University of Southern Mississippi	Mississippi Youth Programs Around the Clock: Local Evaluation Report #2	2011
Youth Villages	MYPAC Program: Length of Time from Referral to Program Placement	2014
Youth Villages	MYPAC Program: Parent Satisfaction at Discharge	2014
Youth Villages	Telemedicine Consent Form and Policy	2014

APPENDIX DATA REFERENCED IN CHAPTER 1

FIGURE 1: TOTAL MEDICAID BEHAVIORAL HEALTH SPENDING (FFS & MC), FY10-FY14



Note: Lower totals in FY 2014 may be attributed to claim lag.

TABLE 2: TOTAL MEDICAID COVERED LIVES, YOUTH 0-21

	FY10	FY11	FY12	FY13	FY14
Fee for Service	455,064	466,559	467,891	463,588	447,295
Managed Care*	N/A	N/A	N/A	70,655	91,966
Total	455,064	466,559	467,891	534,243	539,261

*CCOs did not include outpatient mental health services until late 2012.

FIGURE 2: TOTAL MEDICAID COVERED LIVES, FY10-FY14

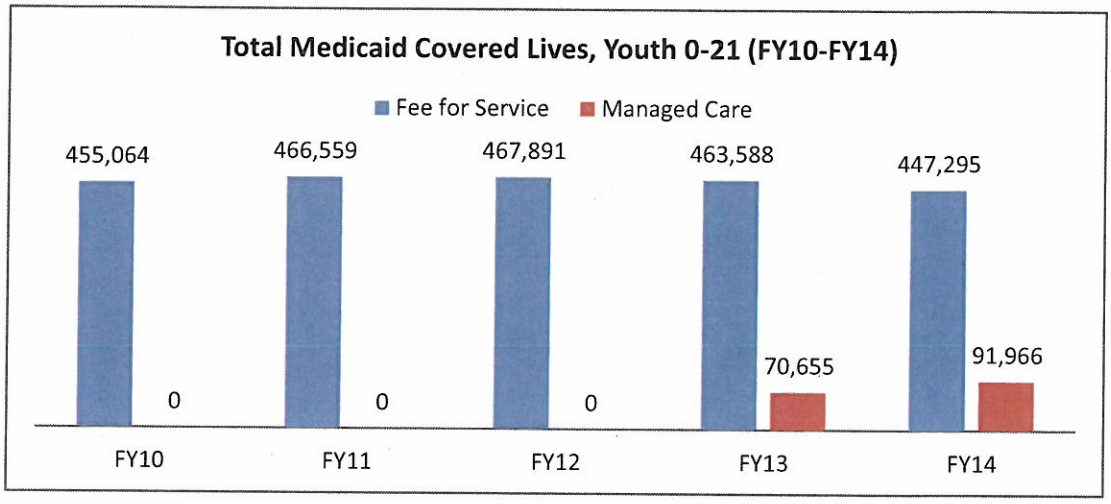


TABLE 3: COVERED LIVES & UTILIZATION

	FY10		FY11		FY12		FY13		FY14	
	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)	Covered Lives	Utilizers (% CL)
FFS	455,064	164,103 (36%)	466,559	177,429 (38%)	467,891	189,446 (40%)	463,588	165,137 (36%)	447,295	134,607 (30%)
MC	0	0	0	0	0	0	70,655	16,580 (23%)	91,966	21,917 (24%)
Total	455,064	164,103 (36%)	466,559	177,429 (38%)	467,891	189,446 (40%)	534,243	181,717 (34%)	539,261	156,524 (29%)

TABLE 4: AVERAGE LENGTHS OF STAY (DAYS) IN MISSISSIPPI STATE PSYCHIATRIC HOSPITALS AND STATE-OPERATED PRTF FOR CHILDREN AND YOUTH (0-18)

	FY10	FY11	FY12	FY13	FY14
Oak Circle Center (MSH)	45.1	45.2	48.9	42.9	47
Specialized Treatment Facility*	142.6	175.2	182.5	170.1	184.4
Bradley Sanders Complex (EMSH)	120	127	120	125	N/A

*PRTF Source: Mississippi DMH State Hospital Admission and Discharge Data

TABLE 5: ALOS (DAYS) IN PSYCHIATRIC ACUTE INPATIENT FACILITIES FOR CHILDREN AND YOUTH UNDER 21

	FY10	FY11	FY12	FY13	FY14
Brentwood Acquisition INC	15.29	14.37	14.53	12.91	12.49

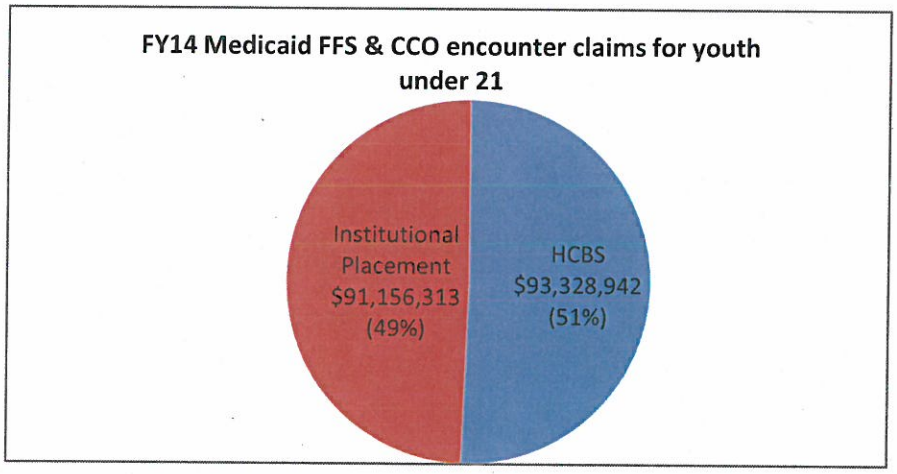
Crossroads Regional Hospital*	15.77	13.55	13.05	13.97	N/A
Diamond Grove Center	22.27	22.63	21.84	15.09	11.83
Lakeside Behavioral Health Systems*	15.35	15.44	14.15	15.83	15.55
Liberty Healthcare Systems*	7.08	7.54	10.12	10.78	10.09
Oak Circle Center	28.71	33.95	29.84	31.24	36.48
Parkwood Behavioral Health System	14.60	14.30	13.92	12.79	13.06

*Out-of-State Facility Source: Division of Medicaid Acute Inpatient Facilities Data

TABLE 6: FY14 FFS & CCO CLAIMS

FY14 FFS & CCO, Youth Under 21	Total Encounter Claims ($)	% of Total Medicaid BH Spending	% of Total Medicaid BH Claims	Number of Medicaid Beneficiaries Utilizing Services[95]
Institutional Placements	$91.2 million	49%	1.4%	6,394
HCBS	$93.3 million	51%	98.6%	150,130

FIGURE 3: MEDICAID FFS AND CCO ENCOUNTER CLAIMS FOR YOUTH UNDER 21



[95] The utilizer figures are likely duplicated by services, with a youth counted each time he or she accessed a different HCBS or institutional service. Data were unduplicated *within* service types only and in aggregate, so a child-level analysis is not possible.

TABLE 7: TOTAL MEDICAID SPENDING, INSTITUTIONAL & HCBS, BY SERVICE, FEE FOR SERVICE & MANAGED CARE

Service Category	FY2010	FY2011	FY2012	FY2013 (MC & FFS)	FY2014 (MC & FFS)
Assertive Community Treatment (FY2010-2011, MIMS service)	$325,903.45	$285,484.50	$168,269.76	$2,557.50	$7,375.50
Assessment	$5,101,559	$5,579,513	$5,876,878	$5,450,954	$5,047,024
Community Support Services#	N/A	N/A	$6,568,173	$12,276,726	$10,591,244
Crisis Residential #	N/A	N/A	$228,214	$687,158	$546,475
Day Treatment	$38,142,091	$27,715,326	$24,308,241	$20,386,276	$21,975,081
Electroconvulsive Therapy*	$0	$0	$0	$1,130	$224
Evaluation and Management	$7,913,792	$8,120,609	$8,155,530	$5,480,911	$2,980,184
Family Therapy	$5,818,368	$6,344,031	$6,562,359	$6,706,638	$6,240,469
Group Therapy	$1,001,014	$1,430,785	$1,862,678	$2,842,947	$3,018,738
Individual Therapy	$15,640,281	$18,237,131	$18,700,398	$20,034,952	$20,631,898
Individual Therapeutic Support*^	$32	$64	$124	N/A	N/A
Inpatient Medical Surgical Hospital	$35,161,427	$32,588,874	$32,194,633	$21,367,994	$17,479,844
Inpatient Psychiatric Hospital	$24,576,115	$25,017,217	$24,580,512	$27,243,428	$26,159,344
Intensive home-based treatment (MYPAC)	$11,535,974	$15,863,100	$18,568,700	$21,061,611	$18,947,865
Intensive Outpatient Psychiatric (CMHC/PMHC service) #	N/A	N/A	$6,582	$5,741	$102,637
Interactive Complexity%	N/A	N/A	$4	$16,669	$72,119
Medication Management$	$1,864,820	$2,271,746	$2,692,499	$1,217,019	$139,087
Mobile Crisis Service#	N/A	N/A	$40,403	$166,414	$367,802
Outpatient Hospital	$8,947	$6,551	$11,851	$15,099	$15,515
Partial hospitalization	$38,002	$97,439	$69,402	$19,411	$8,735
Peer Support #	N/A	N/A	$689	$17,354	$45,520
Pharmacotherapy (including Medication Assisted Treatment)	$6,218	$8,593	$10,864	$143,187	$266,957
Prolonged Service*	$9,511	$24,239	$66,892	$78,503	$4,876
Residential Psychiatric Treatment Facility	$42,851,133	$44,153,413	$45,535,965	$46,374,799	$47,501,610
Respite (MYPAC)&	$150,400	$343,600	$426,000	$403,600	$80,400
School Based Services^	$2,033,266	$2,482,602	$2,122,565	N/A	N/A
Screening and Brief Intervention for Tobacco Cessation*	$0	$0	$0	$0	$21
Service Planning	$641,528	$697,306	$565,472	$327,224	$315,160
Skill Building	$1,483,440	$1,939,699	$1,777,801	$1,242,798	$909,216

Specialized evaluations (Neuropsychological Evaluation)*	$12,700	$12,550	$10,830	$23,043	$8,197
Targeted Case Management	$17,488,464	$17,140,844	$8,589,530	$464,186	$1,021,638
Therapeutic Foster Care*+	N/A	N/A	$153,888	N/A	N/A

*Indicates a service that was not included in graphs depicting HCBS claims, utilization or services below

^Indicates a service that ended in FY2012

# Indicates a service that began in FY2012

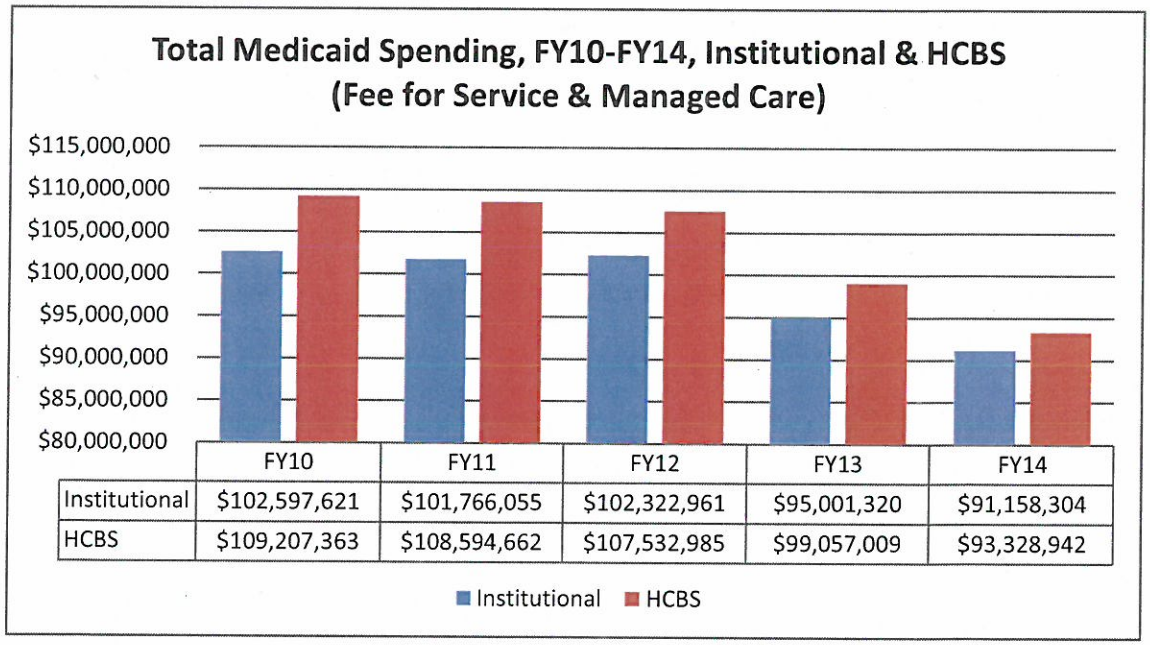
% Indicates a service that began in FY2013

$ CMS removed the procedure code in FY2014. Services provided as an E&M code or as a HCPS code.

& MYPAC respite did not continue for newly enrolled MYPAC recipients for admission dates after 9/30/2012. This was only allowed for CA-PRTF Demonstration Waiver participants.

+ Treatment Foster Care (TFC) was opened in FY2012 for billing while DOM requested approval of the service in the Rehab Option of the State Plan Amendment (SPA). Based on informal questions received from CMS, DOM felt the service would not be approved and requested providers stop billing TFC until approval or denial was received from CMS. Although various revisions were made to this draft SPA TFC was ultimately denied by CMS.

FIGURE 4: TOTAL MEDICAID SPENDING BY CATEGORY OF SERVICE



	FY10	FY11	FY12	FY13	FY14
Institutional	$102,597,621	$101,766,055	$102,322,961	$95,001,320	$91,158,304
HCBS	$109,207,363	$108,594,662	$107,532,985	$99,057,009	$93,328,942

FIGURE 5: TRENDS IN MEDICAID INSTITUTIONAL SPENDING

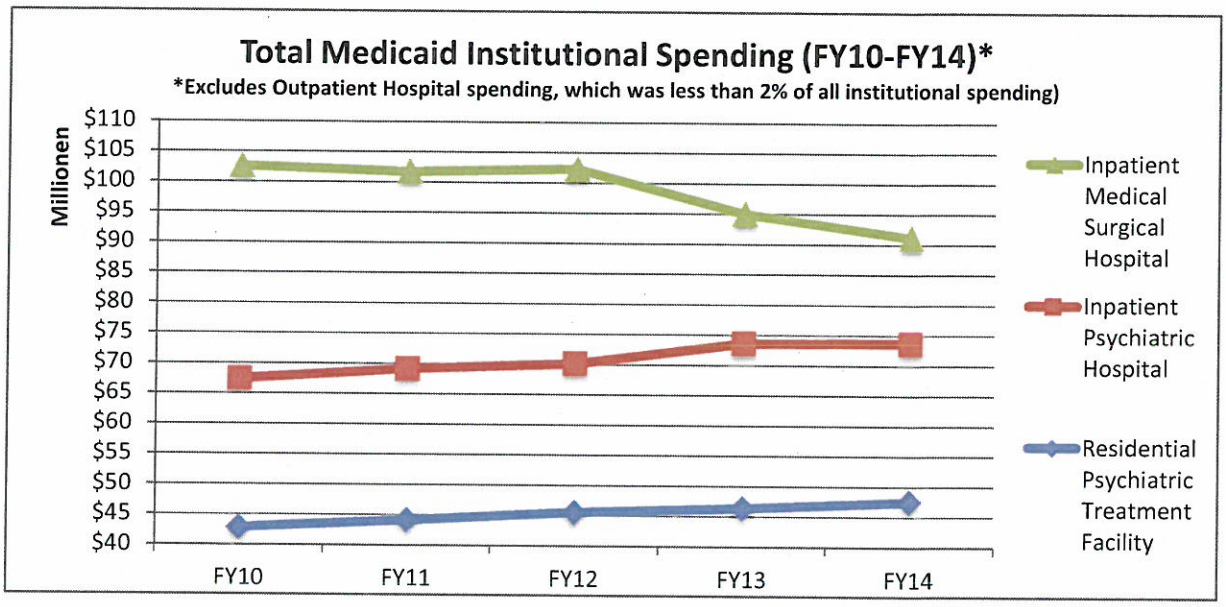


FIGURE 6: TRENDS IN HCBS MEDICAID SPENDING, FY10-14 (SERVICES WITH $1 MILLION OR MORE IN A GIVEN YEAR)

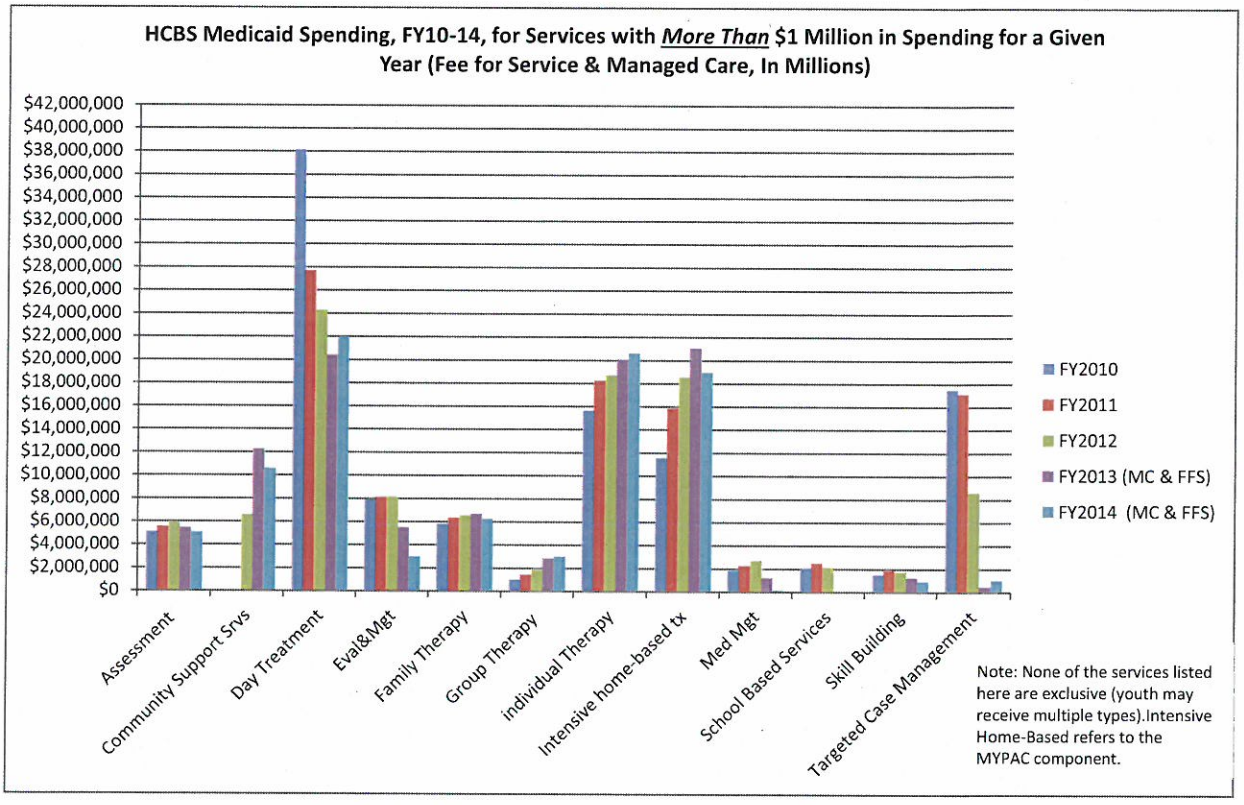
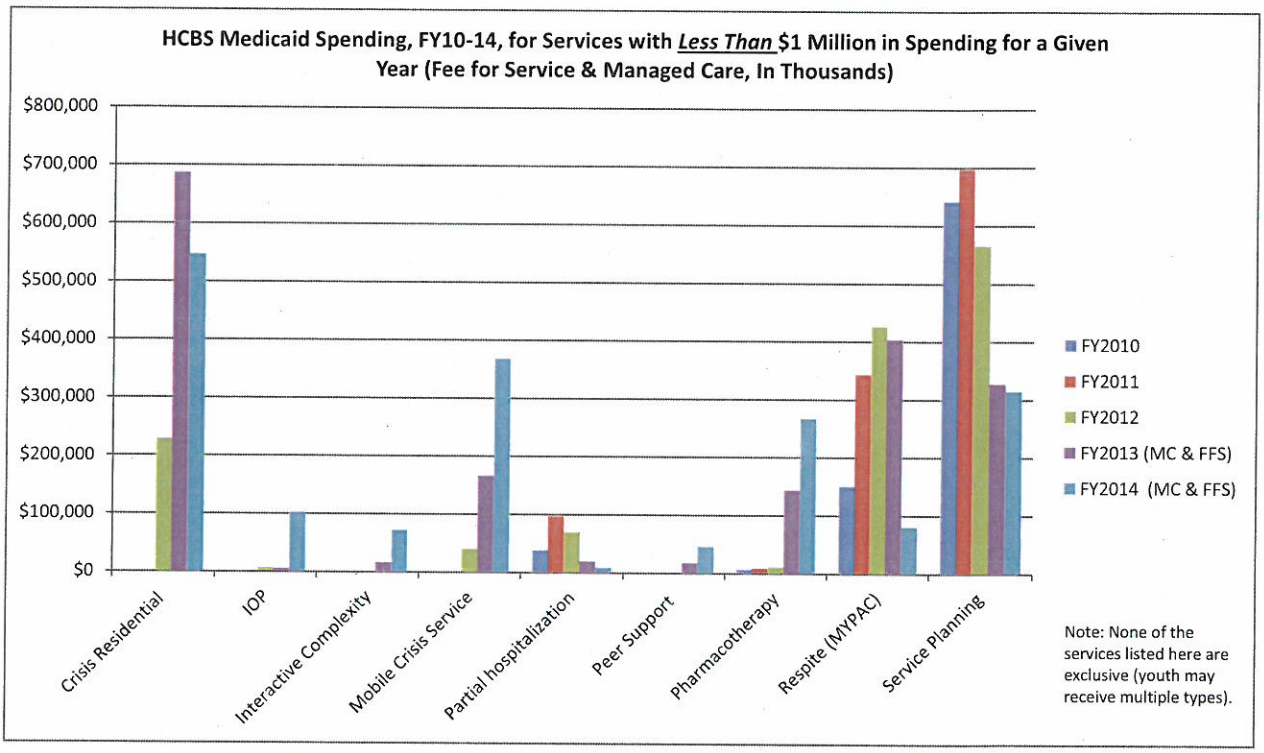


FIGURE 7: TRENDS IN HCBS MEDICAID SPENDING, FY10-14 (SERVICES WITH LESS THAN $1 MILLION IN A GIVEN YEAR)



Note: Although the data provided to TAC by DOM grouped Institutional, Inpatient, and Outpatient Hospital services together, it was not DOM's intent to have hospital outpatient service considered as institutional services. Hospital Outpatient services are considered the same type services that would be provided in an office setting, such as psychiatrist, LCSW, or CMHC, therefore should not be considered inpatient or institutional.

TABLE 8: BEHAVIORAL HEALTH SERVICES UTILIZED BY THE HIGHEST PERCENTAGE OF MEDICAID ENROLLEES[96]

Top Services	FY2012 FFS	FY2013 FFS	FY2013 Managed Care	FY2014 FFS	FY2014 Managed Care
1	Evaluation & Management (6.8%)	Evaluation & Management (6.4%)	Individual Therapy (4.8%)	Individual Therapy (5.8%)	Individual Therapy (4.9%)
2	Individual Therapy (6.1%)	Individual Therapy (6.1%)	Assessment (3.6%)	Assessment (5.6%)	Assessment (4.2%)
3	Assessment (5.7%)	Assessment (5.7%)	Evaluation & Management (3.4%)	Family Therapy (4.3%)	Evaluation & Management (3.6%)
4	Family Therapy (4.4%)	Family Therapy (4.4%)	Community Support Services (3.2%)	Evaluation & Management (3.2%)	Family Therapy (3.1%)
5	Medication Management (3.5%)	Medication Management (2.6%)	Family Therapy (2.8%)	Community Support Services (2.7%)	Community Support Services (2.6%)
6	Service Planning (3.3%)	Community Support Services (2.9%)	Service Planning (1.6%)	Service Planning (2.1%)	Service Planning (1.9%)

TABLE 9: NUMBER OF CLAIMS PER SERVICE, FY10-FY14, INSTITUTIONAL & HCBS

Service Category	FY2010	FY2011	FY2012	FY2013 (MC & FFS)	FY2014 (MC & FFS)
Assessment	76,363	80,995	87,548	85,948	81,098
Community Support Services#	N/A	N/A	108,311	196,744	169,944
Crisis Residential#	N/A	N/A	354	879	709
Day Treatment	337,541	268,264	261,438	210,019	174,508
Electroconvulsive Therapy*	0	0	0	7	2
Evaluation and Management	82,893	83,399	85,600	68,417	46,850
Family Therapy	64,420	68,981	74,579	82,420	86,073

[96]Based on % of Enrollees Receiving Service

Group Therapy	29,661	38,379	48,227	63,312	76,659
Individual Therapy	191,415	217,076	231,528	251,255	235,372
Individual Therapeutic Support*^	1	2	4	N/A	N/A
Inpatient Medical Surgical Hospital	2,928	2,935	2,826	2,834	2,820
Inpatient Psychiatric Hospital	4,086	4,137	4,130	3,967	3,908
Intensive home-based treatment (MYPAC)	2,873	3,913	4,553	5,472	6,549
Intensive Outpatient Psychiatric (CMHC/PMHC service)[#]	N/A	N/A	43	44	280
Interactive Complexity[%]	N/A	N/A	1	3,063	10,985
Medication Management[$]	40,273	44,586	51,517	24,917	3,170
Mobile Crisis Service[#]	N/A	N/A	310	1,256	2,251
Outpatient Hospital	199	165	156	164	151
Partial hospitalization	350	880	615	178	59
Peer Support[#]	N/A	N/A	21	648	1,346
Pharmacotherapy (including Medication Assisted Treatment)	978	995	974	1,301	1,308
Prolonged Service*	107	162	203	422	49
Residential Psychiatric Treatment Facility	4,837	4,849	4,934	5,000	4,923
Respite (MYPAC)[&]	57	144	186	188	37
School Based Services^	33,735	40,742	36,038	N/A	N/A
Screening and Brief Intervention for Tobacco Cessation*	0	0	0	0	4
Service Planning	34,637	37,650	30,442	17,780	16,029
Skill Building	21,258	28,516	27,210	17,165	8,926
Specialized evaluations (Neuropsychological Evaluation)*	24	35	25	51	25
Targeted Case Management[!]	238,705	236,568	120,355	20,614	39,709
Therapeutic Foster Care*[+]	N/A	N/A	60	N/A	N/A

*Indicates a service that was not included in the graphs
^Indicates a service that ended in FY2012
[#]Indicates a service that began in FY2012
[%]Indicates a service that began in FY2013
[$]CMS removed the procedure code allowed for Medication Management in FY2014. Services were to be provided as an E&M code or as alternate HCPS code that DOM implemented.
[&]MYPAC respite did not continue for newly enrolled MYPAC recipients for admission dates after 9/30/2012. This was only allowed for CA-PRTF Demonstration Waiver participants.
[+] Treatment Foster Care (TFC) was opened in FY2012 for billing while DOM requested approval of the service in the Rehab Option of the State Plan Amendment (SPA). Based on informal questions received from CMS, DOM felt the service would not be approved and requested providers stop billing TFC until approval or denial was received from CMS. Although various revisions were made to this SPA and multiple follow-up questions from CMS were answered, TFC was ultimately denied by CMS.
[!]SFY '10. '11 and '12 included traditional Case Management services during this time. Community Support Services was added in FY2012 to distinguish managing the case from managing the person.

FIGURE 8: MEDICAID CLAIMS FOR INSTITUTIONAL SERVICES, FY10-14

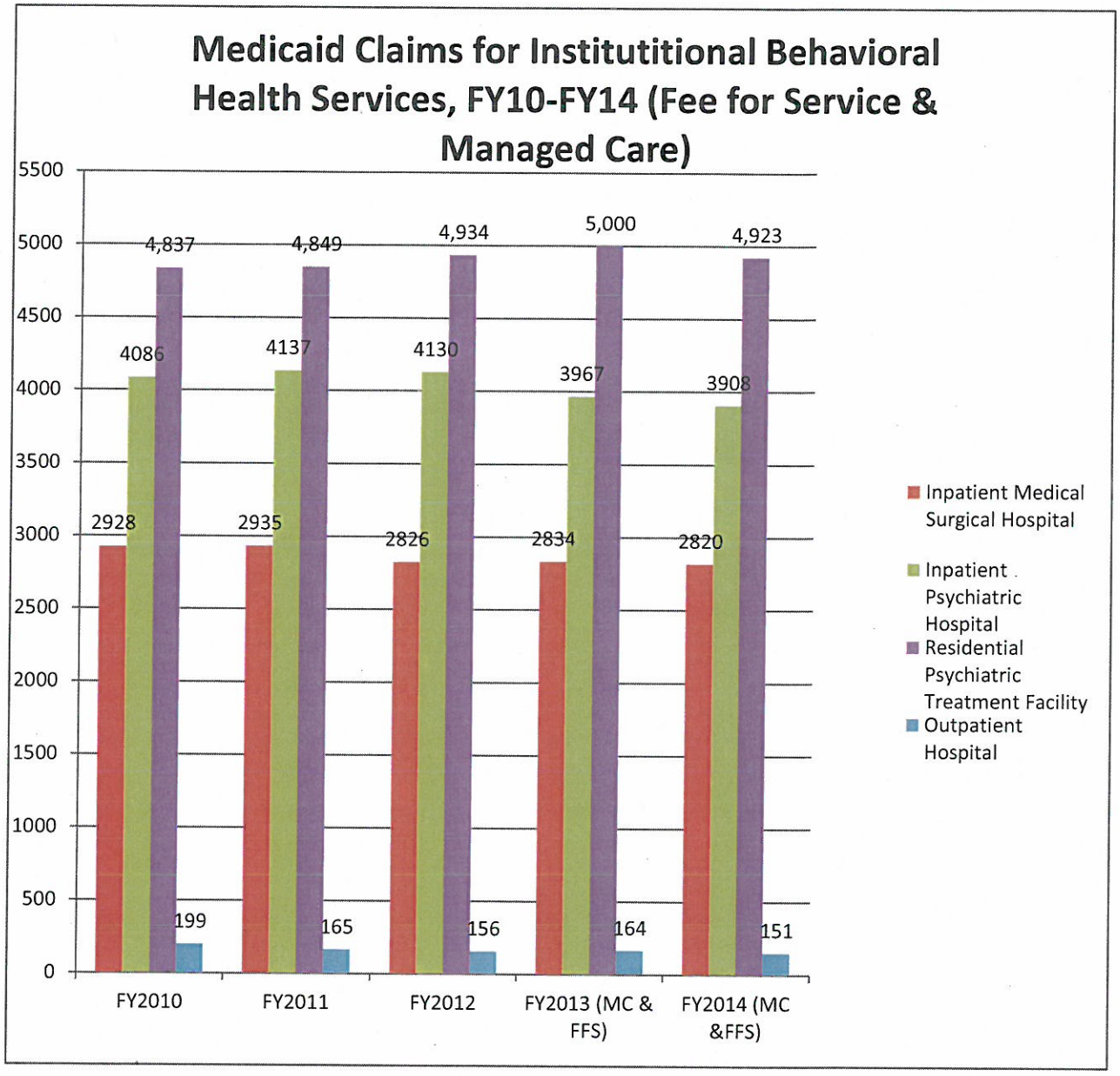


FIGURE 9: HCBS MEDICAID CLAIMS, FY10-14: SERVICES WITH GREATER THAN 10,000 CLAIMS

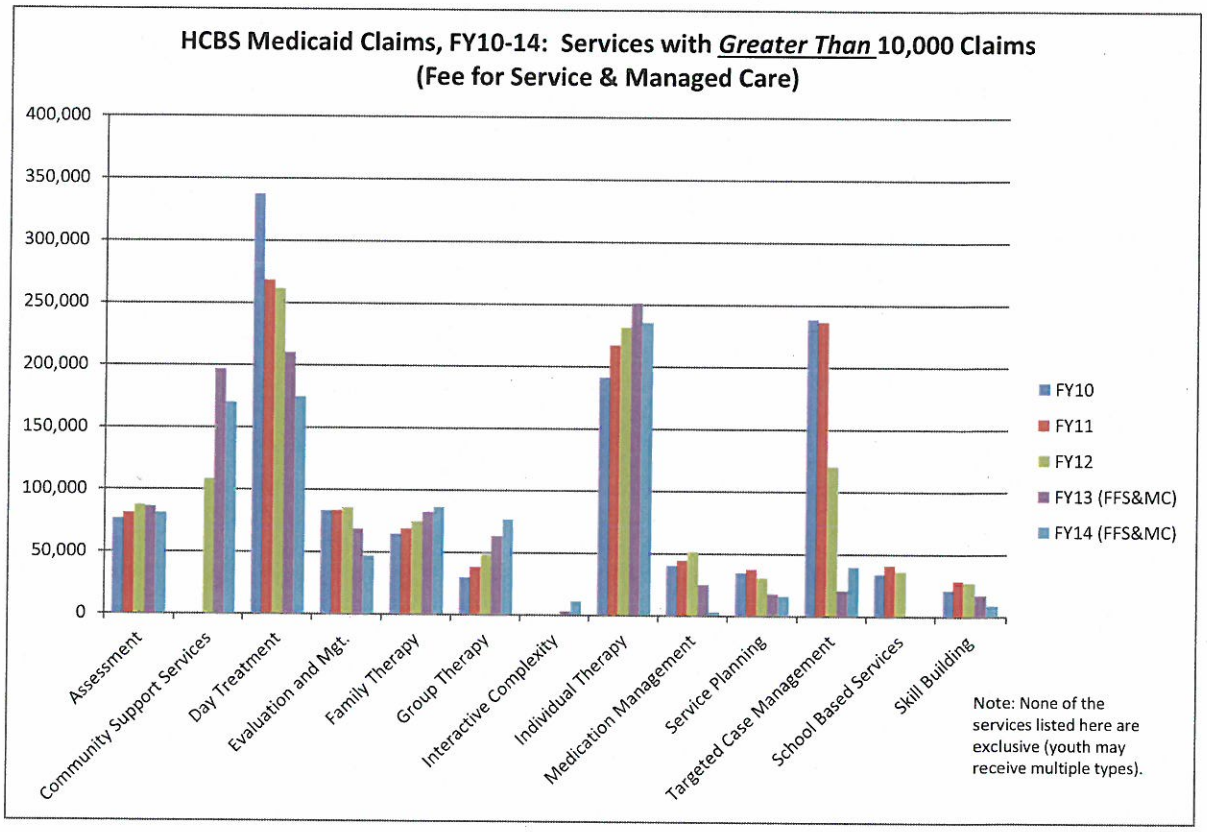


FIGURE 10: HCBS MEDICAID CLAIMS, FY10-14: SERVICES WITH FEWER THAN 10,000 CLAIMS

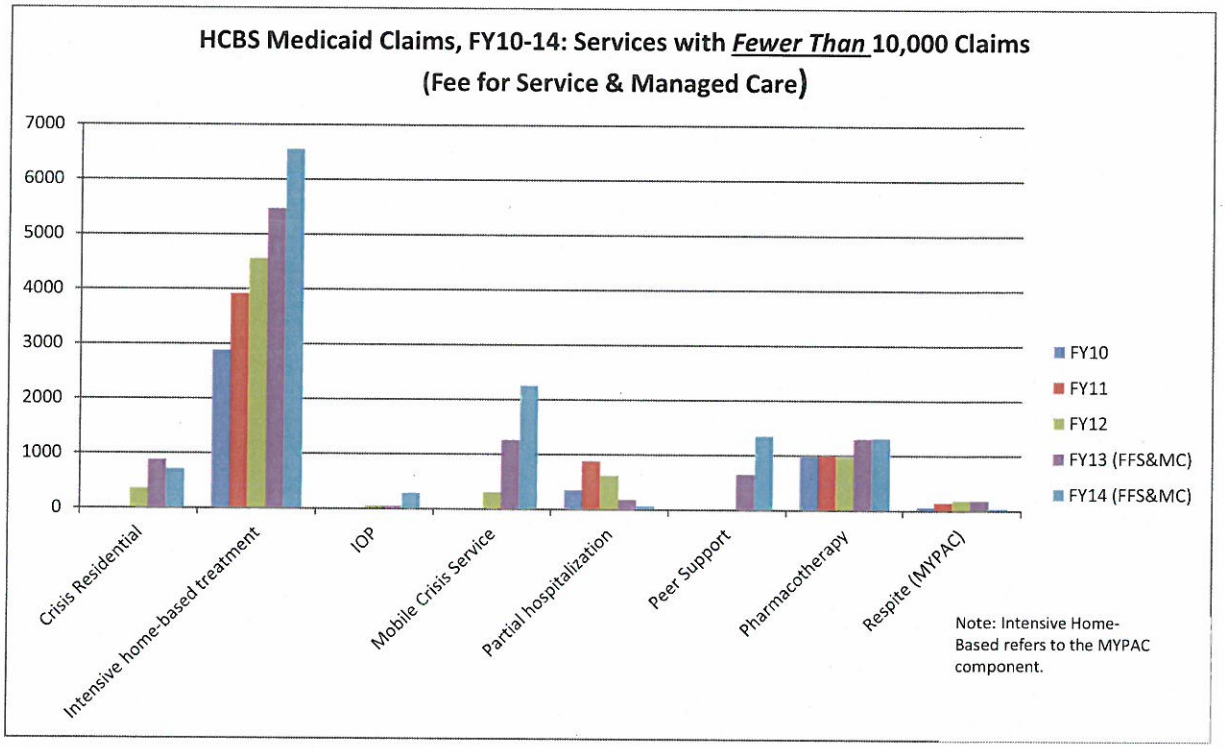
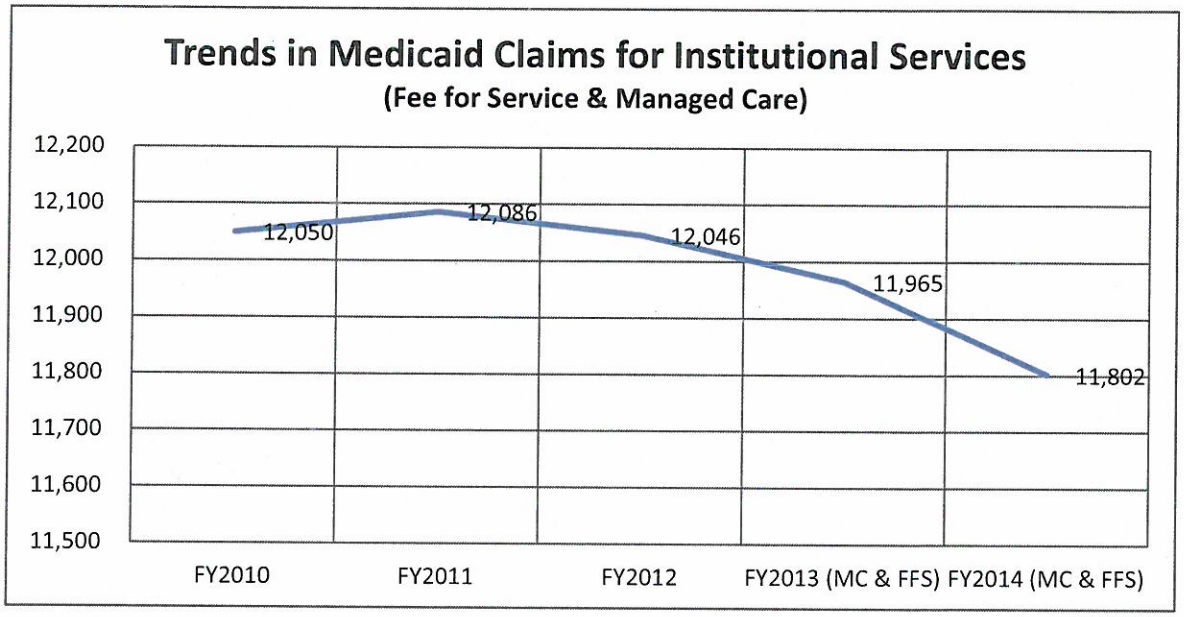


FIGURE 11: TRENDS IN MEDICAID CLAIMS FOR INSTITUTIONAL SERVICES



Note: Although the data provided to TAC grouped Institutional, Inpatient, and Outpatient Hospital services together, it was not DOM's intent to have hospital outpatient service considered as institutional services. Hospital outpatient services are considered the same type services that would be provided in an office setting, such as psychiatrist, LCSW, or CMHC, therefore should not be considered inpatient or institutional.

FIGURE 12: TRENDS IN MEDICAID CLAIMS FOR HCBS

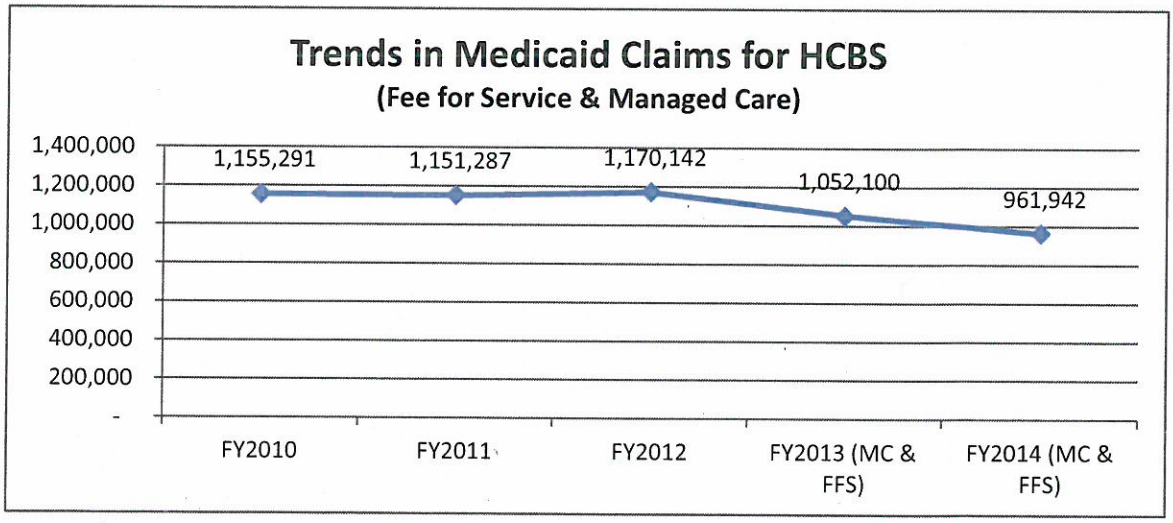


FIGURE 13: UNDUPLICATED COUNT OF UTILIZERS, INSTITUTIONAL SERVICES, FY10-FY14

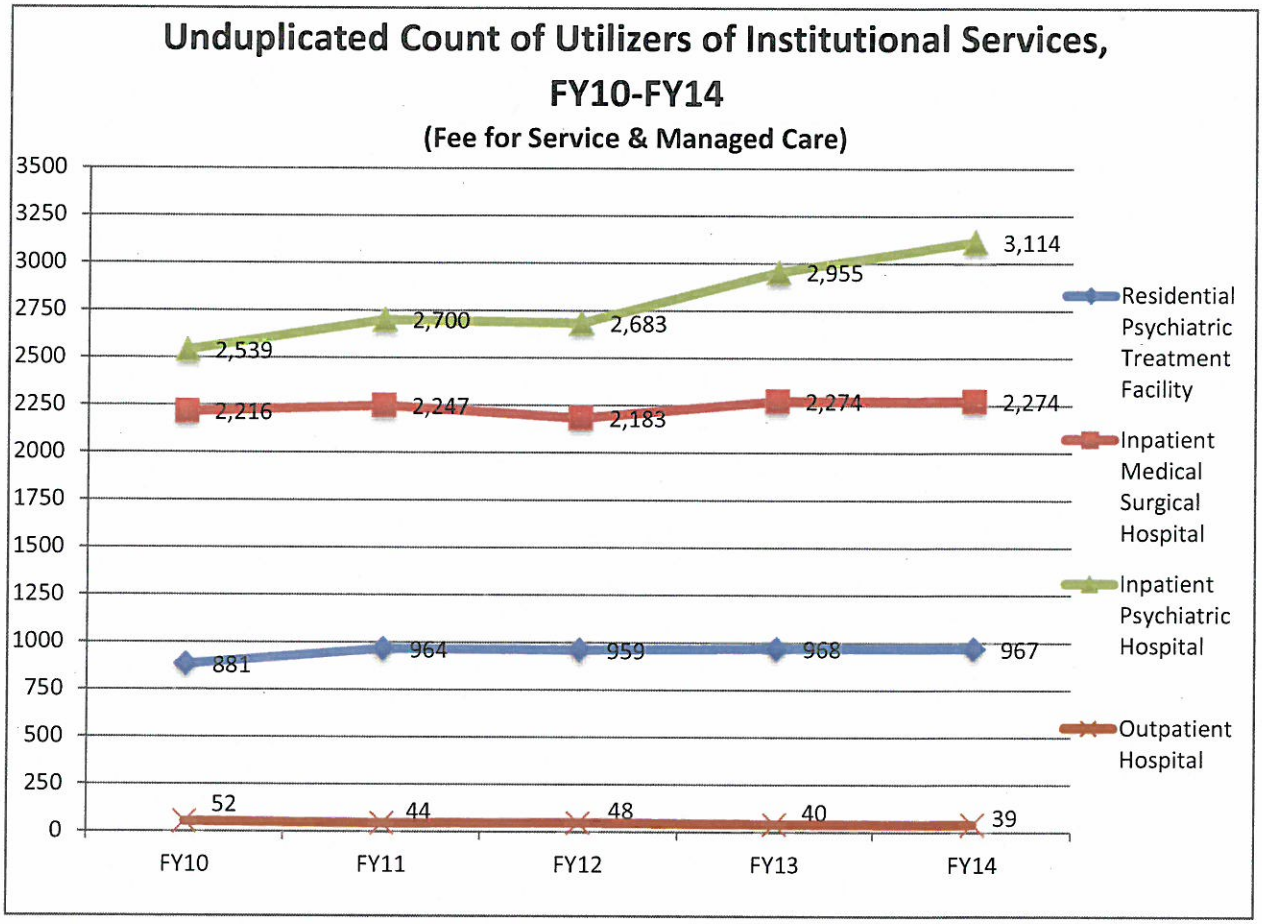


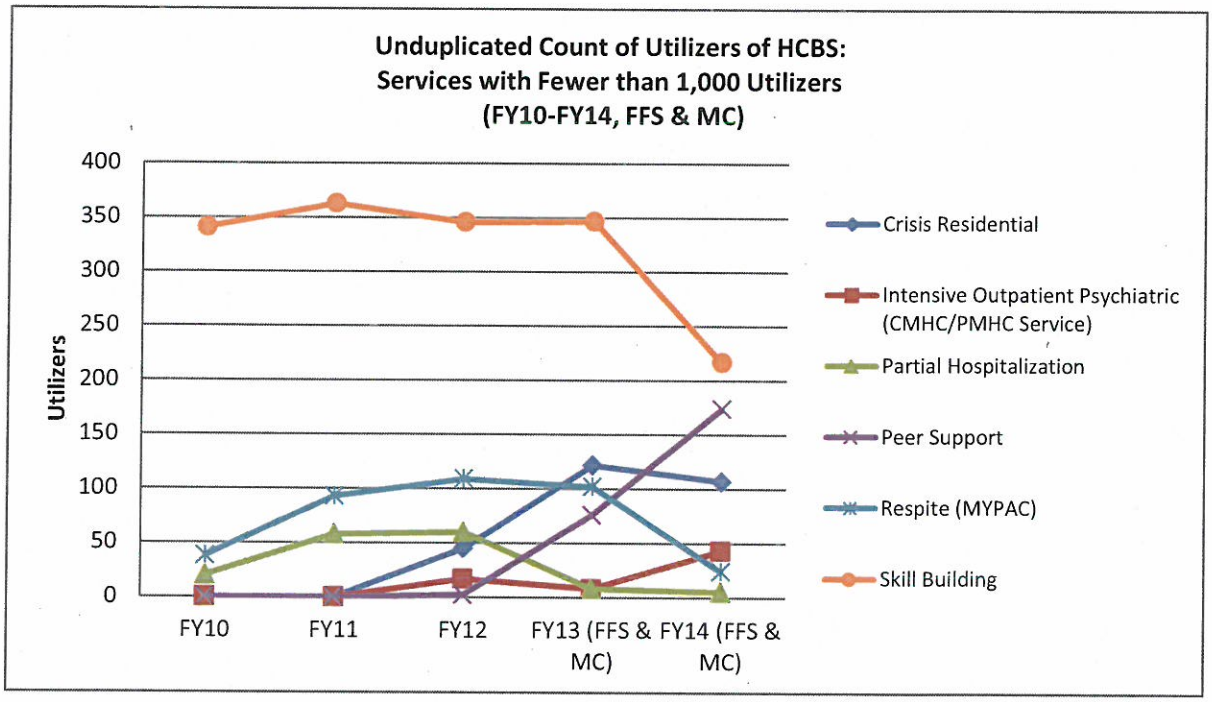
TABLE 10: CHANGES IN UTILIZATION, HCBS, FY10-FY14

Service	% Change from FY10-FY14
Assessment	18%
Community Support Services	26%*
Crisis Residential	138%*
Day Treatment	-27%
Evaluation & Management	-41%
Family Therapy & Group Therapy	-39%

Individual Therapy	22%
Intensive home-based treatment (MYPAC)	111%
Intensive Outpatient Psychiatric (CMHC/PMHC Service)	153%*
Interactive Complexity	69%~
Med Management & Pharmacotherapy	451%
Mobile Crisis Service	360%*
Partial Hospitalization	-75%
Peer Support	129%*
Respite (MYPAC- Waiver)	-37%
School Based Services	-100%
Service Planning	-22%
Skill Building	-36%
Targeted Case Management	-46%

*Indicates service that was not available until FY12; % change is calculated from FY12-FY14
~Service began on 1/1/13, but only 1 youth utilized it in FY12; calculation was for FY13-FY14.

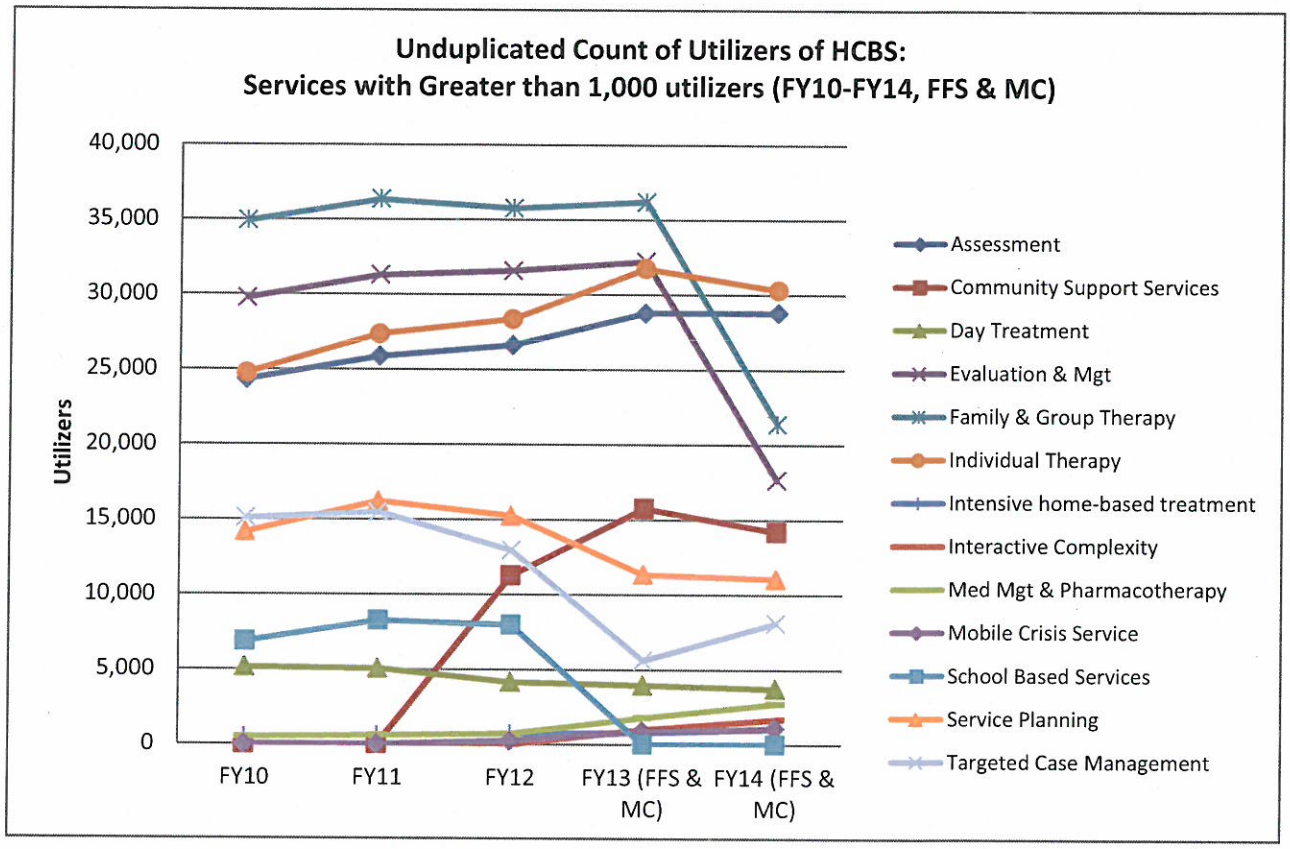
FIGURE 14: UNDUPLICATED COUNT OF UTILIZERS-HCBS WITH FEWER THAN 1,000 UTILIZERS



	FY10	FY11	FY12	FY13 (FFS & MC)	FY14 (FFS & MC)
Crisis Residential	N/A	N/A	45	122	107
Intensive Outpatient Psychiatric (CMHC/PMHC Service)	N/A	N/A	17	8	43
Partial Hospitalization	20	58	60	8	5
Peer Support	N/A	N/A	2	76	174
Respite (MYPAC)	38	93	109	102	24
Skill Building	341	363	346	347	217

Note: Crisis Residential, IOP and Peer Support were not available until FY2012. In FY2013 and FY2014, respite was only available to participants still enrolled in the CA PRTF Demo (MYPAC Demo).

FIGURE 15: UNDUPLICATED COUNT OF UTILIZERS OF HCBS WITH GREATER THAN 1,000 UTILIZERS

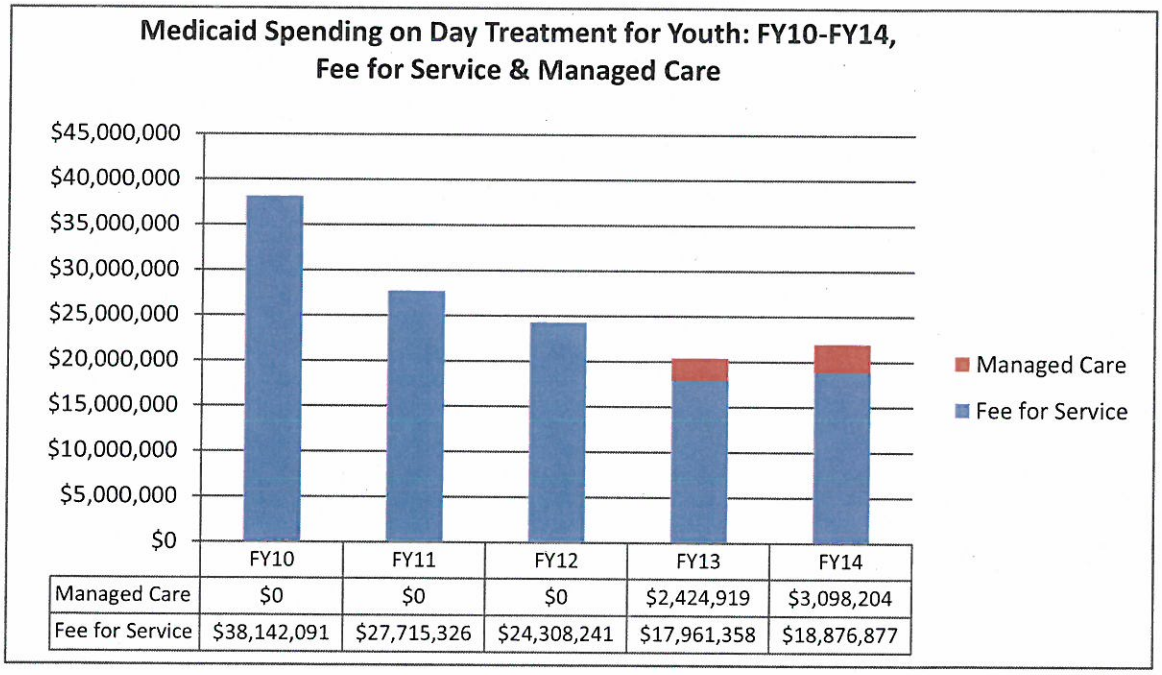


	FY10	FY11	FY12	FY13 (FFS & MC)	FY14 (FFS & MC)
Assessment	24,341	25,873	26,635	28,794	28,797
Community Support Services	N/A	N/A	11,274	15,769	14,208
Day Treatment	5,147	5,059	4,168	3,970	3,735
Evaluation &Mgt	29,777	31,302	31,597	32,236	17,649
Family & Group Therapy	34,924	36,361	35,765	36,206	21,384
Individual Therapy	24,769	27,374	28,382	31,760	30,329
Intensive home-based treatment (MYPAC)	495	601	713	790	1,043
Interactive Complexity	N/A	N/A	1	998	1,686

Med Mgt& Pharmacotherapy	495	601	714	1,788	2,729
Mobile Crisis Service	N/A	N/A	237	881	1,090
School Based Services	6,873	8,267	7,980	N/A	N/A
Service Planning	14,169	16,227	15,263	11,354	11,062
Targeted Case Management	15,089	15,483	12,961	5,605	8,113

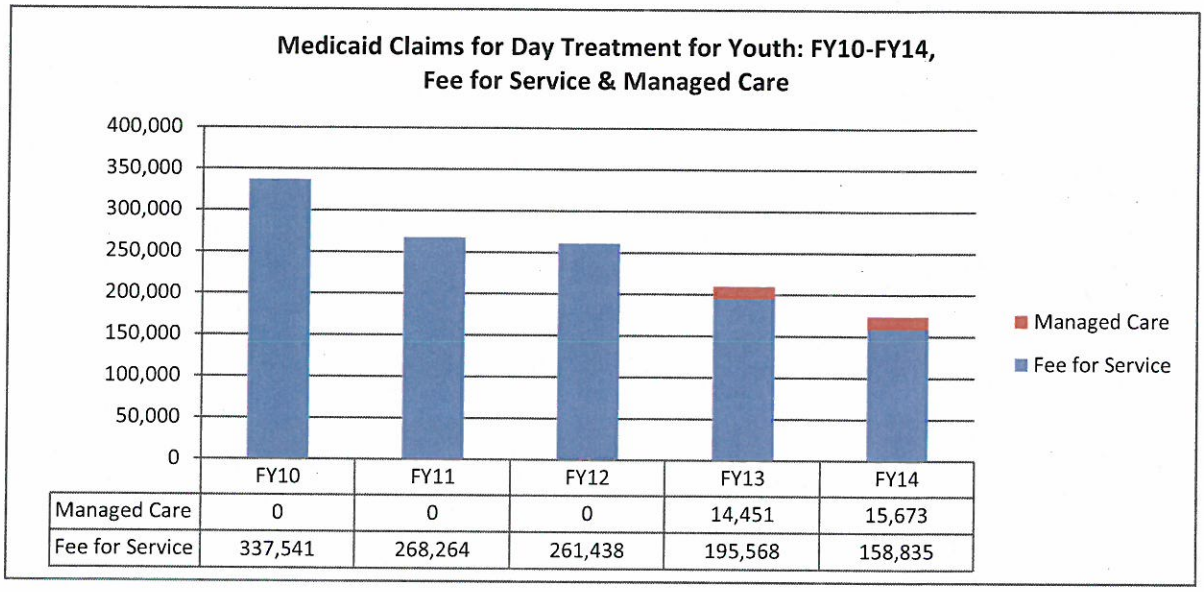
Note: Community support services and mobile crisis services began in FY2012. Interactive complexity began in FY2013. School-based services ended in FY2012.

FIGURE 16: DAY TREATMENT MEDICAID SPENDING



	FY10	FY11	FY12	FY13	FY14
Managed Care	$0	$0	$0	$2,424,919	$3,098,204
Fee for Service	$38,142,091	$27,715,326	$24,308,241	$17,961,358	$18,876,877

FIGURE 17: MEDICAID CLAIMS FOR DAY TREATMENT



	FY10	FY11	FY12	FY13	FY14
Managed Care	0	0	0	14,451	15,673
Fee for Service	337,541	268,264	261,438	195,568	158,835

FIGURE 18: UNDUPLICATED UTILIZERS OF DAY TREATMENT

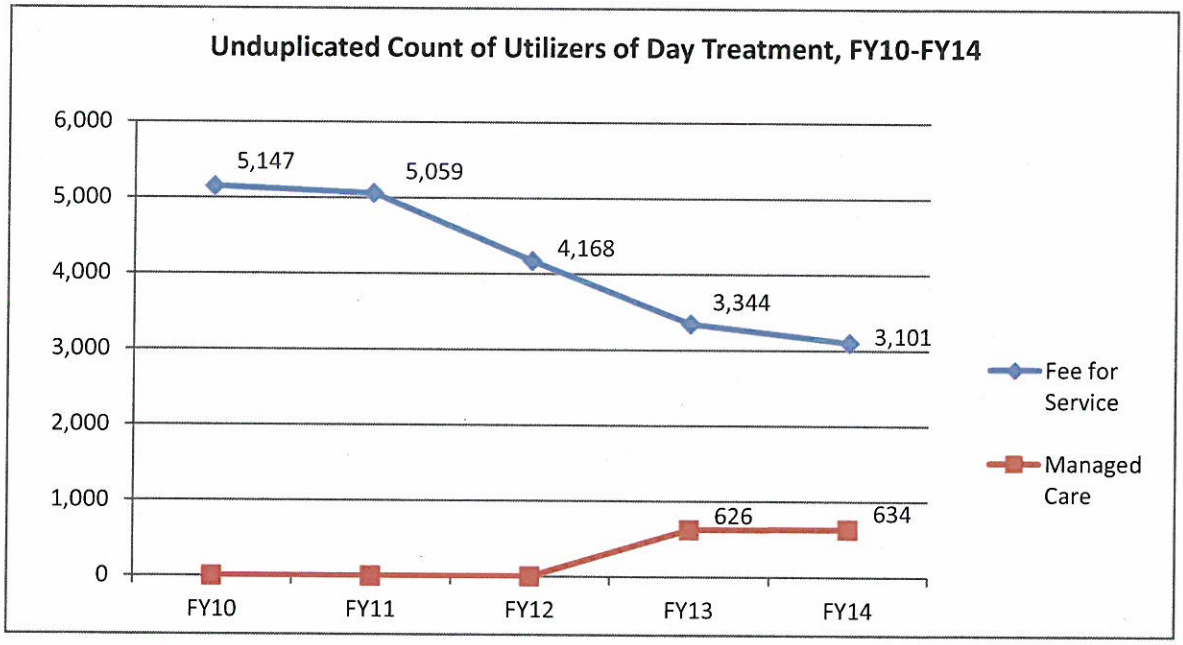


FIGURE 19: MEDICAID CLAIMS FOR CRISIS SERVICES

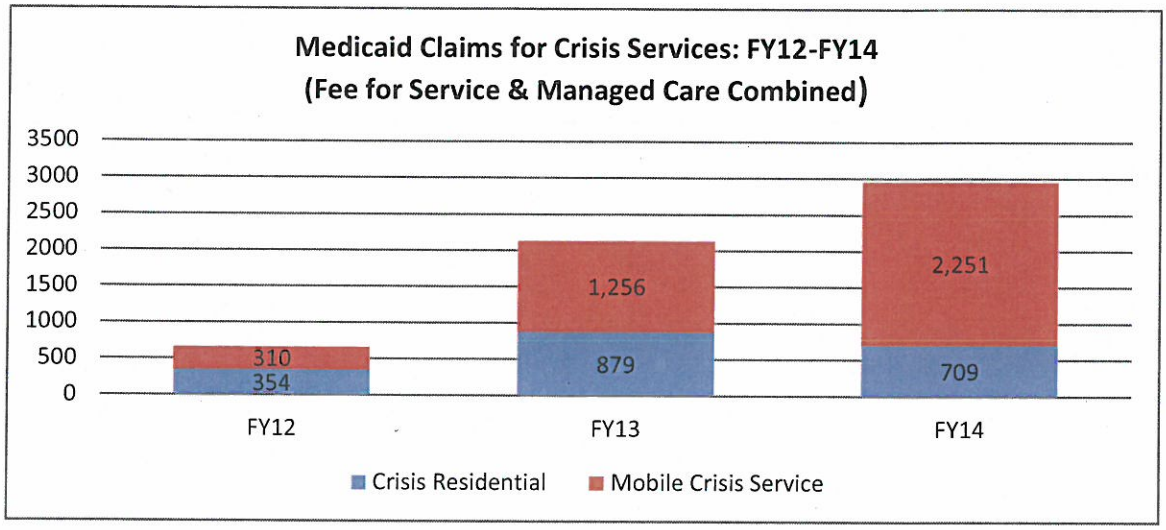


FIGURE 20: MEDICAID SPENDING ON CRISIS SERVICES

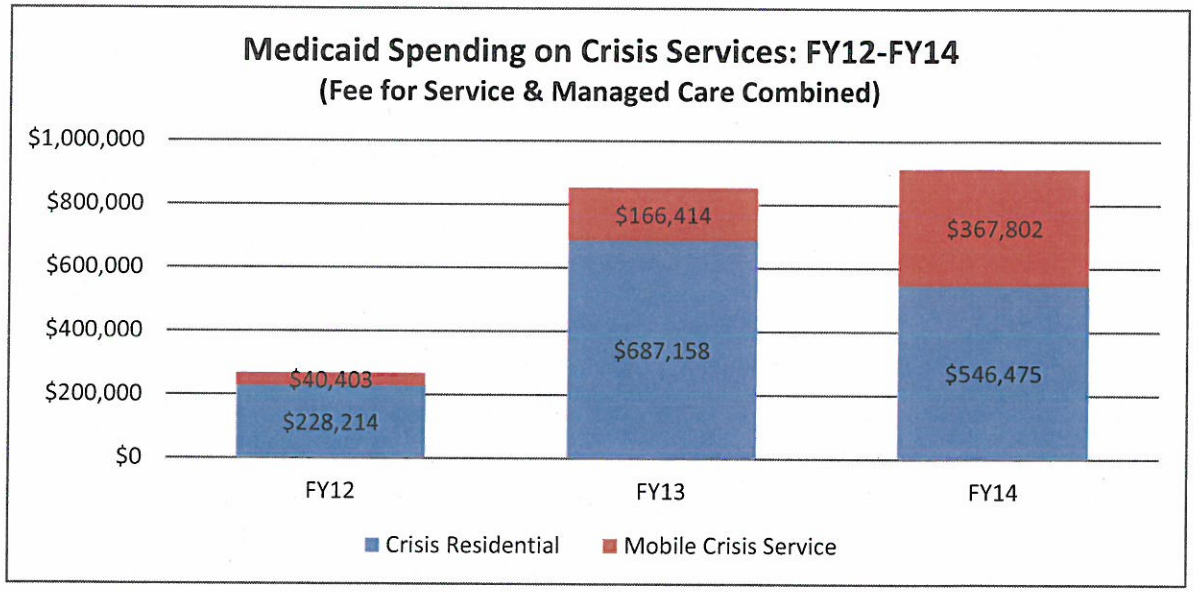
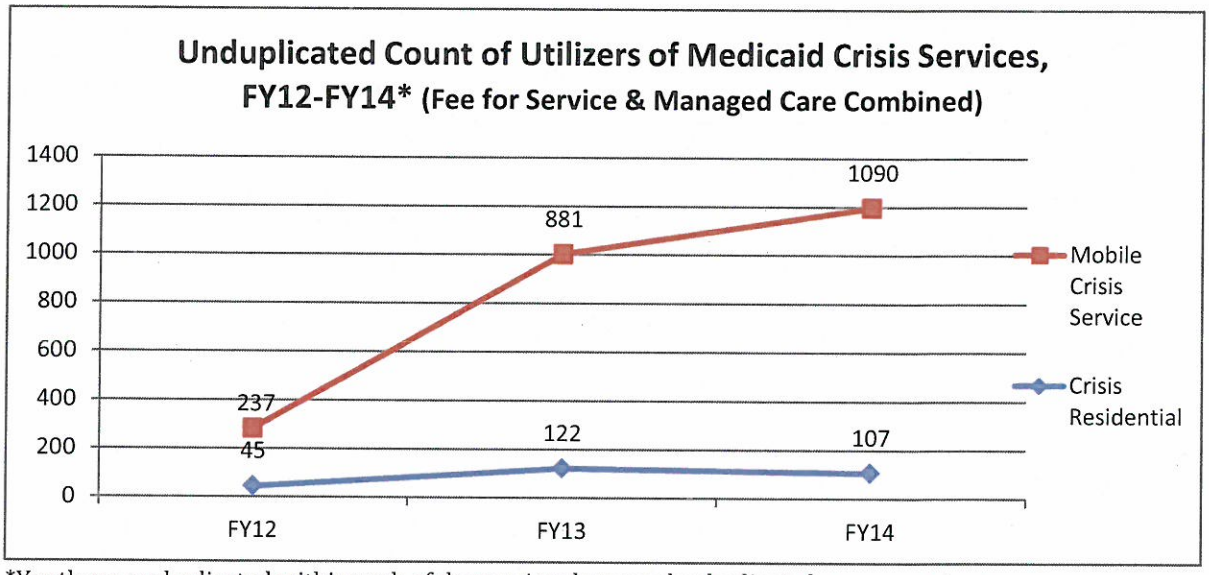
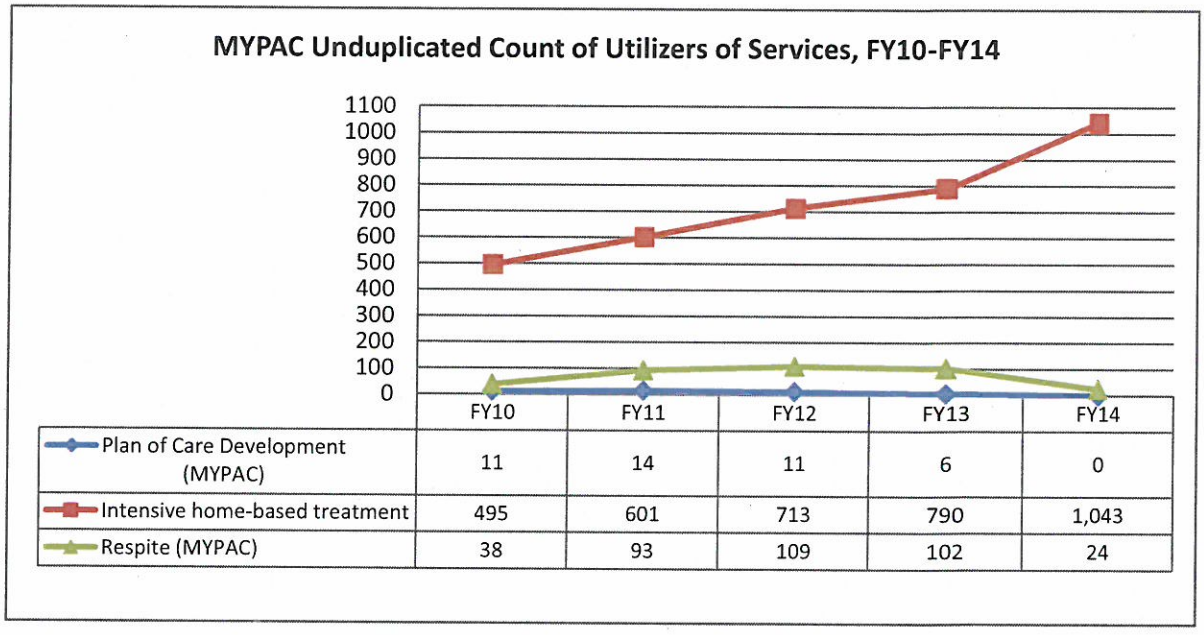


FIGURE 21: UNDUPLICATED COUNT OF UTILIZERS OF MEDICAID CRISIS SERVICES



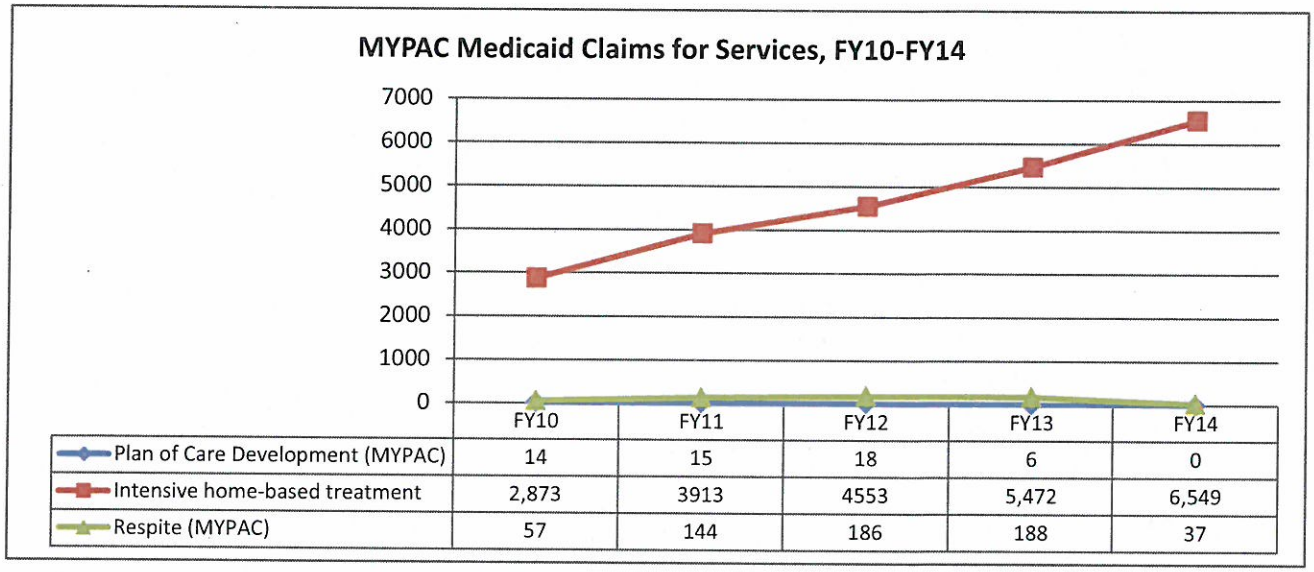
*Youth are unduplicated within each of the services but may be duplicated across services.

FIGURE 22: MYPAC UNDUPLICATED COUNT OF UTILIZERS OF SERVICES, FY10-FY14



	FY10	FY11	FY12	FY13	FY14
Plan of Care Development (MYPAC)	11	14	11	6	0
Intensive home-based treatment	495	601	713	790	1,043
Respite (MYPAC)	38	93	109	102	24

FIGURE 23: MYPAC MEDICAID CLAIMS FOR SERVICES, FY10-14



	FY10	FY11	FY12	FY13	FY14
Plan of Care Development (MYPAC)	14	15	18	6	0
Intensive home-based treatment	2,873	3913	4553	5,472	6,549
Respite (MYPAC)	57	144	186	188	37

FIGURE 24: TOTAL MEDICAID SPENDING ON PLAN OF CARE DEVELOPMENT (MYPAC), FY10-14

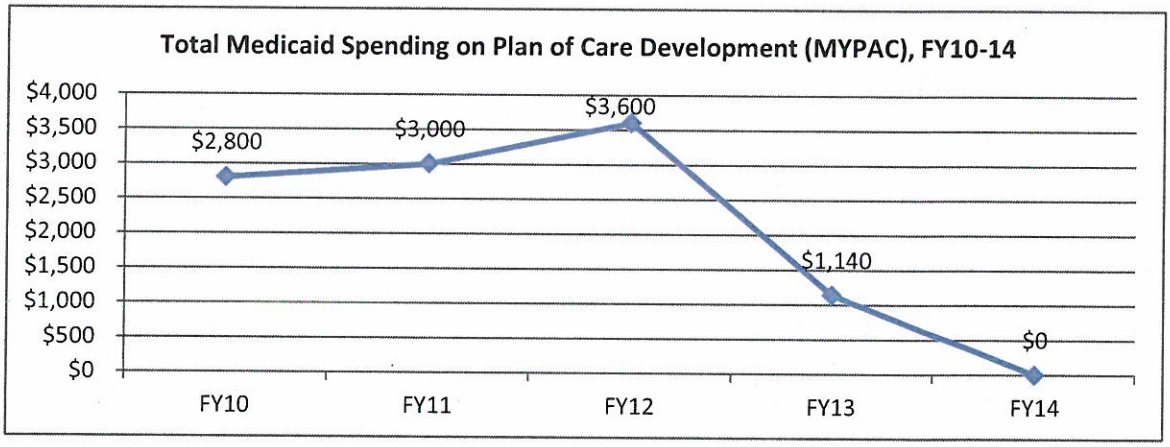


FIGURE 25: TOTAL MEDICAID SPENDING ON MYPAC INTENSIVE HOME-BASED TREATMENT COMPONENT, FY10-14

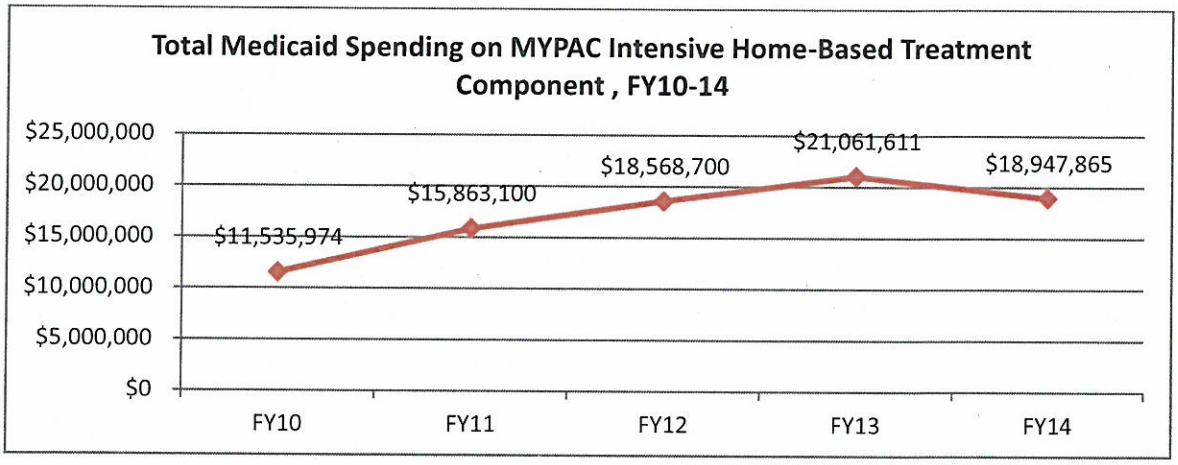


FIGURE 26: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING FOR INTENSIVE HOME-BASED TREATMENT, FY10-14

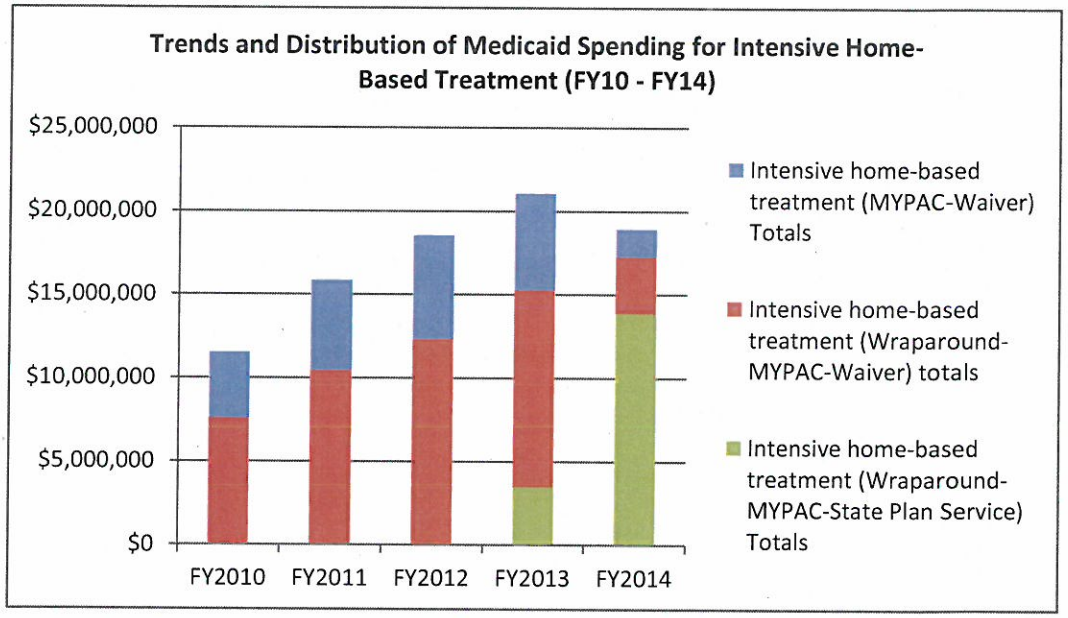


FIGURE 27: TOTAL MEDICAID SPENDING ON RESPITE (MYPAC), FY10-14

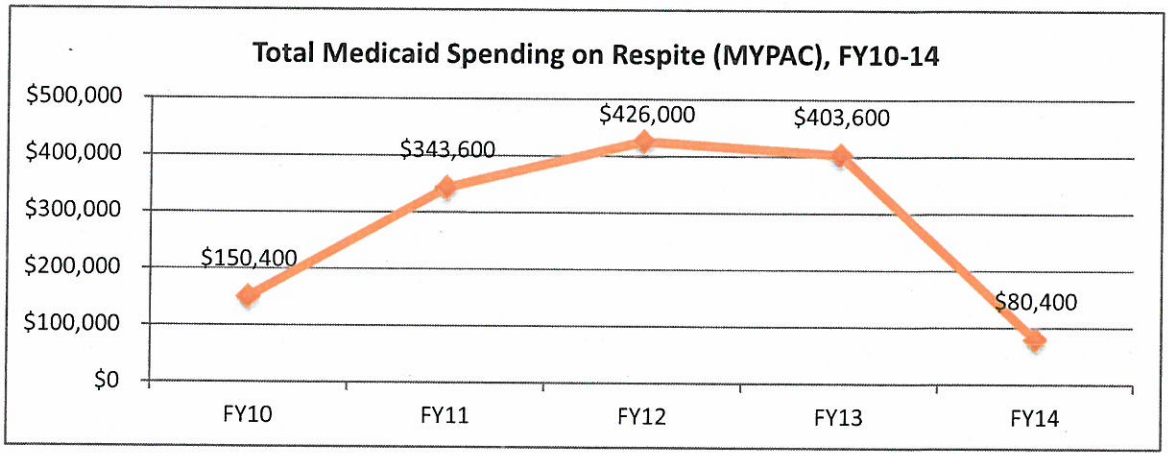


FIGURE 28: MEDICAID SPENDING BY PLACE OF SERVICE, 2013, FEE FOR SERVICE

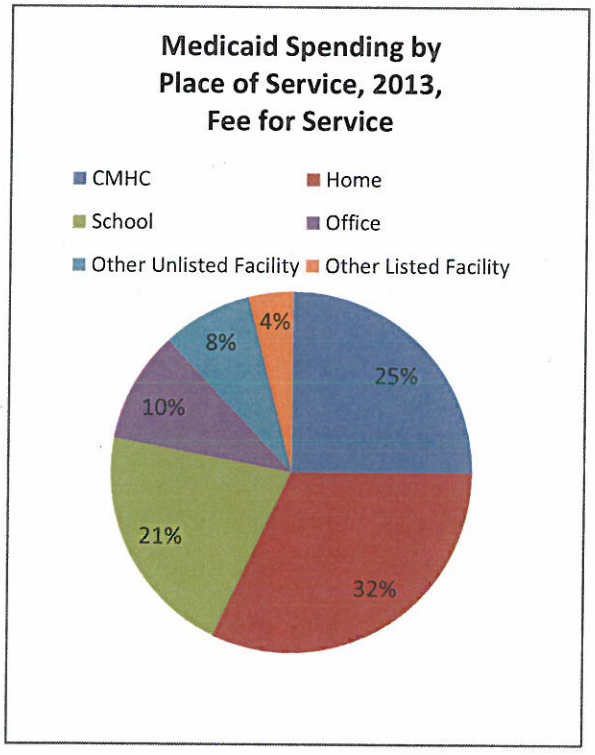


FIGURE 29: MEDICAID SPENDING BY PLACE OF SERVICE, 2013, MANAGED CARE

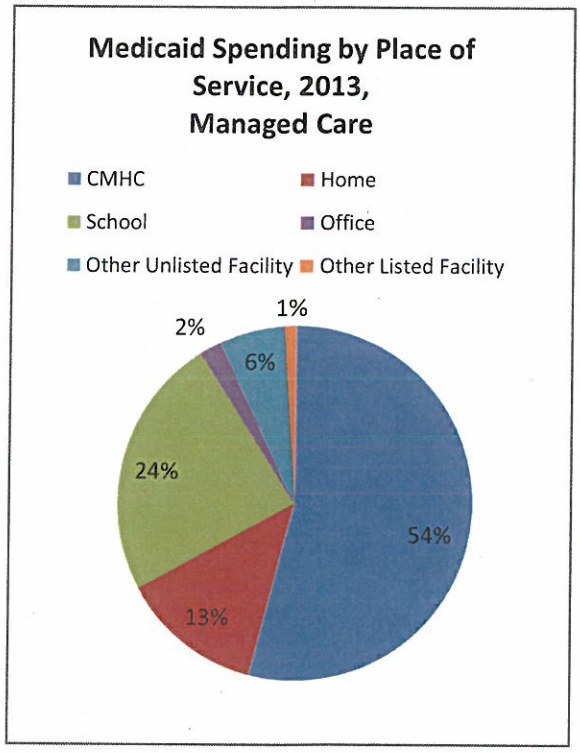


FIGURE 30: MEDICAID SPENDING BY PLACE OF SERVICE, 2014, FEE FOR SERVICE

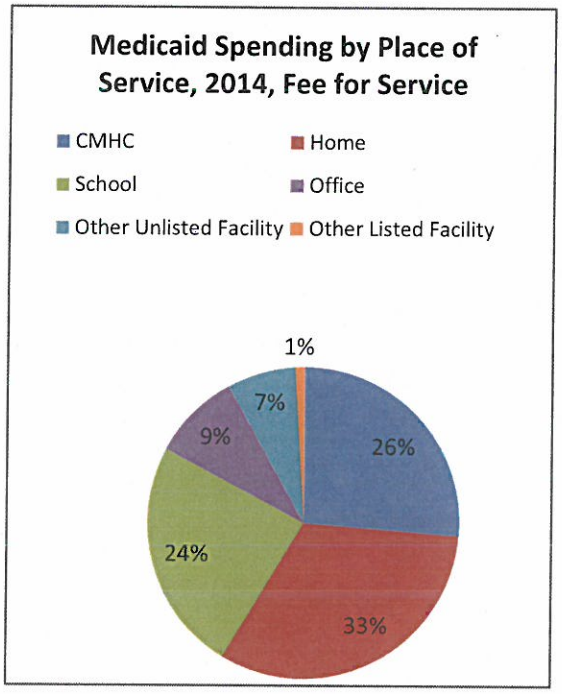


FIGURE 31: MEDICAID SPENDING BY PLACE OF SERVICE, MANAGED CARE

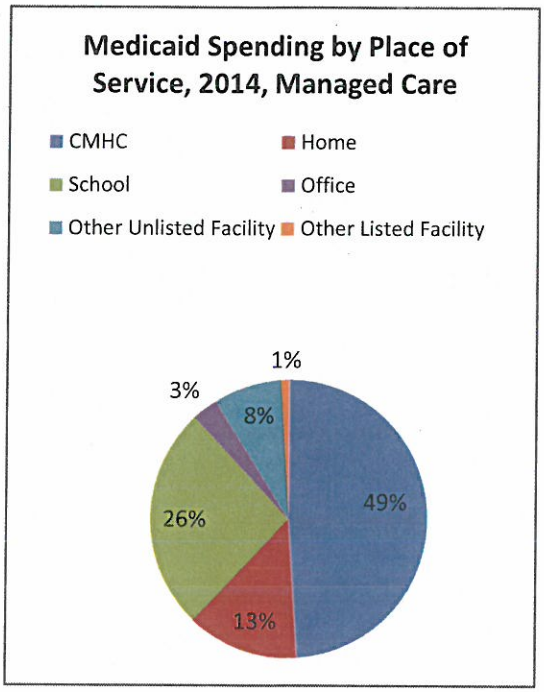


FIGURE 32: MEDICAID SPENDING BY PLACE OF SERVICE (FY10-FY14, FFS)

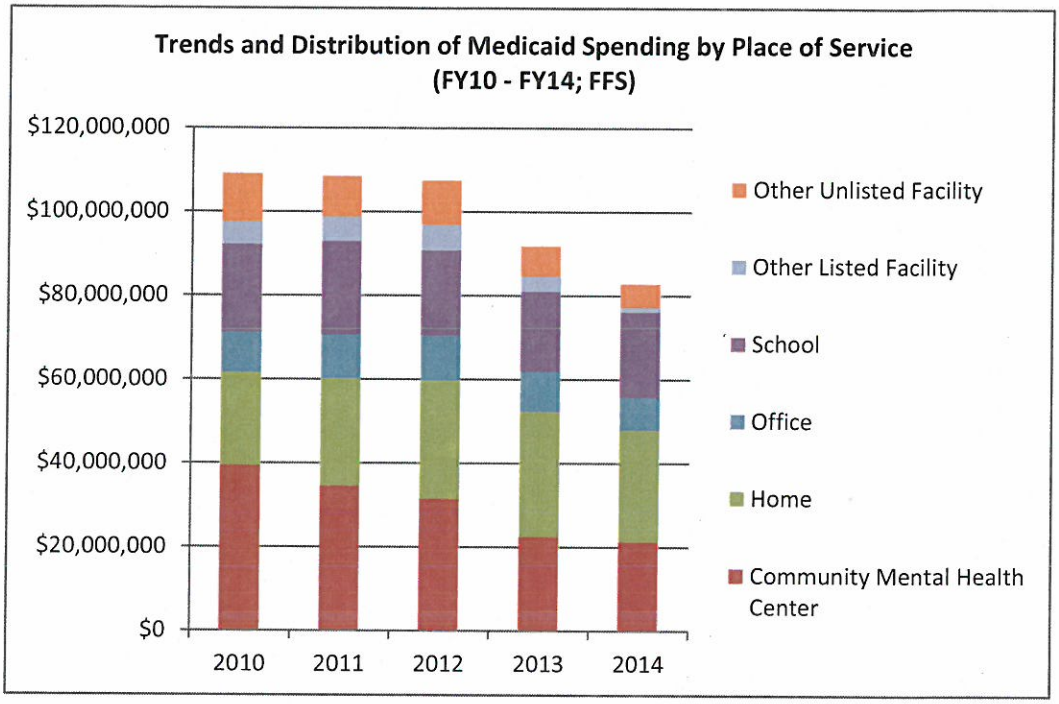


TABLE 11: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING BY PLACE OF SERVICE (FY10 - FY14; FFS)

	2010		2011		2012		2013		2014		
Place of Service	$	%	$	%	$	%	$	%	$	%	% Change
CMHC	$39,494,802	36%	$34,554,020	32%	$31,526,328	29%	$22,535,039	25%	$21,334,225	26%	-46%
Home	$22,123,785	20%	$25,705,136	24%	$28,251,918	26%	$29,876,149	32%	$26,692,396	32%	21%
School	$21,012,544	19%	$22,295,783	21%	$20,290,712	19%	$19,117,966	21%	$20,256,613	24%	-4%
Office	$9,630,947	9%	$10,393,878	10%	$10,734,836	10%	$9,577,245	10%	$7,862,400	9%	-18%
Other Unlisted Facility	$11,577,276	11%	$9,735,032	9%	$10,629,400	10%	$7,252,938	8%	$5,583,861	7%	-52%
Other Listed Facility	$5,368,009	5%	$5,910,814	5%	$6,099,791	6%	$3,586,275	4%	$1,168,003	1%	-78%

TABLE 12: TRENDS AND DISTRIBUTION OF YOUTH SERVED BY PLACE OF SERVICE (FY10 – FY14; FFS)

Place of Service	2010	2011	2012	2013	2014	% Change
CMHC	76,090	82,710	86,439	80,355	68,593	-10%
Office	44,715	46,471	47,622	42,203	26,903	-40%
School	30,621	34,289	32,968	31,760	36,234	18%
Home	24,281	25,042	30,531	25,187	25,329	4%
Other Unlisted Facility	15,982	21,691	25,780	18,364	13,916	-13%
Inpatient Hospital	5,705	6,185	5,935	3,822	1,275	-78%
Outpatient Hospital	4,232	4,696	4,133	2,885	3,177	-25%
Rural Health Clinic	2,630	3,718	4,120	2,995	358	-86%
Inpatient Psychiatric Facility	2,125	2,625	3,007	1,985	1,068	-50%
Federally Qualified Health Ctr	367	223	314	224	140	-62%
Psychiatric Resident TrmtCntr	255	262	291	286	135	-47%
Group Home**	13	29	30	84	114	777%
Skilled Nursing Facility	18	43	36	9	23	28%
Emergency Room Hospital	27	33	28	29	7	-74%
Nursing Facility	11	24	42	25	2	-82%
Urgent Care Facility	36	16	7	9	3	-92%
Res. Substance Abuse TxCtr	1	8	3	20	36	3500%
Mobile Unit	6	5	17	12	16	167%
State Local Public Hlth Clinic	12	12	14	10	2	-83%
Independent Laboratory	21	4	4	5	11	-48%
Independent Clinic	4	4	3	1	31	675%
Prison/Correctional Facility	0	2	5	19	15	650%
Tribal 638 Provider-based Fac	12	6	1	0	0	-100%
Assisted Living Facility	2	2	5	3	6	200%
Intermediate Care Facility-MR	0	1	0	4	12	1100%
Psych Facility Partial Hosp	0	0	5	1	6	20%
Pharmacy	2	1	0	2	0	-100%
Ambulance Land	0	0	0	1	4	300%
Ambulatory Surgical Center	2	2	0	0	0	-100%
Homeless Shelter	0	0	0	0	4	N/A
Custodial Care Facility	0	1	0	1	1	N/A
Tribal 638 Free-standing Fac	0	1	0	0	1	N/A
Comprehensive OP Rehab Faci	0	0	0	0	2	N/A

Walk-in Retail Health Clinic	0	2	0	0	0	N/A
Temporary Lodging	0	0	0	0	1	N/A
Ambulance Air or Water	0	0	0	0	1	N/A
IHS Provider-based Facility	0	1	0	0	0	N/A
IHS Free-standing Facility	0	0	0	0	1	N/A

**Services included from group home and below in this table comprise the "Other Listed Place of Service" category in the graph.

FIGURE 33: MEDICAID SPENDING BY PLACE OF SERVICE, FY13-FY14, MANAGED CARE

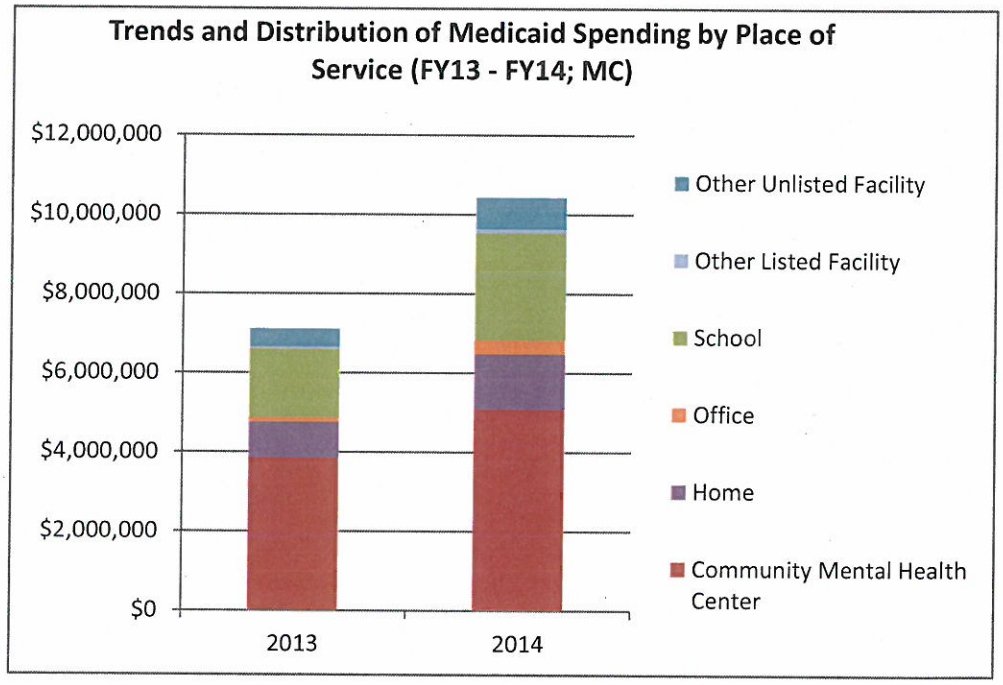


TABLE 13: TRENDS AND DISTRIBUTION OF MEDICAID SPENDING BY PLACE OF SERVICE (FY13 - FY14; MC)

	2013		2014	
Description	**Total Medicaid Payments**	**%**	**Total Medicaid Payments**	**%**
Community Mental Health Center	$3,850,050	54%	$5,080,401	49%
School	$1,738,958	24%	$2,707,561	26%
Home	$906,262	13%	$1,400,921	13%
Other Unlisted Facility	$457,952	6%	$798,201	8%
Office	$110,685	2%	$348,213	3%
Other Listed Facility	$47,490	1%	$96,148	1%

TABLE 14: TRENDS AND DISTRIBUTION OF YOUTH SERVED BY PLACE OF SERVICE (FY13 – FY14; MC)

Place of Service	**FY2013**	**FY2014**	**2-Year Average**
Community Mental Health Center	10,982	14,390	31%
School	3,754	5,499	46%
Home	3,321	4,666	40%
Other Unlisted Facility	1,504	2,095	39%
Office	809	1,838	127%
Inpatient Hospital	134	242	81%
Inpatient Psychiatric Facility	101	182	80%
Outpatient Hospital	29	152	424%
Rural Health Clinic	19	27	42%
Federally Qualified Health Ctr	6	27	350%
Group Home	1	25	2400%
ResdntlSbstnceAbseTrmtCntr	5	7	40%
Skilled Nursing Facility	3	5	67%
Emergency Room Hospital	2	1	-50%
Mobile Unit	0	2	N/A
Assisted Living Facility	0	1	N/A
Nursing Facility	1	0	-100%

Table 15: Number of Claims by Point of Service: Day Treatment

DAY TREATMENT	2010		2011		2012		2013		2014		% Change
	n	%	n	%	n	%	n	%	n	%	
CMHC	197,145	58%	153,530	57%	145,814	56%	108,763	52%	93,085	53%	-53%
Group Home		0%		0%		0%	2	0%	0	0%	N/A
Home	182	0%	886	0%	55	0%	34	0%	293	0%	61%
Independent Clinic		0%	1	0%		0%	0	0%	0	0%	N/A
Independent Laboratory		0%		0%		0%	0	0%	2	0%	N/A
Inpatient Psychiatric Facility		0%	3	0%		0%	0	0%	0	0%	N/A
Intermediate Care Facility-MR		0%		0%		0%	0	0%	4	0%	N/A
Office	673	0%	40	0%	41	0%	0	0%	1	0%	-100%
Other Unlisted Facility	53,695	16%	21,579	8%	21,133	8%	19,752	9%	13,937	8%	-74%
Outpatient Hospital		0%	2	0%		0%	0	0%	0	0%	N/A
Psych Facility Partial Hosp		0%		0%	1	0%	1	0%	1	0%	N/A
Psychiatric Resident Treatment Center	1	0%	1	0%		0%	0	0%	6	0%	500%
School	85,878	25%	92,194	34%	94,395	36%	81,464	39%	67,185	38%	-22%
Skilled Nursing Facility	9	0%	37	0%		0%	4	0%	0	0%	-100%
Total	**337,583**		**268,273**		**261,439**		**210,020**		**174,514**		

TABLE 16: NUMBER OF CLAIMS BY POINT OF SERVICE, MOBILE CRISIS

MOBILE CRISIS	2012		2013		2014		% Change
	n	%	n	%	n	%	
CMHC	222	72%	835	66%	987	44%	345%
Emergency Room Hospital		0%	12	1%	2	0%	N/A
Group Home		0%		0%	1	0%	N/A
Home	17	5%	93	7%	424	19%	2394%
Independent Laboratory		0%		0%	1	0%	N/A
Mobile Unit		0%		0%	2	0%	N/A
Office		0%	17	1%	36	2%	N/A
Other Unlisted Facility	47	15%	141	11%	358	16%	662%
School	24	8%	158	13%	447	20%	1763%
Total	**310**		**1,256**		**2,258**		

TABLE 17: NUMBER OF CLAIMS BY POINT OF SERVICE, COMMUNITY SUPPORT SERVICES

COMMUNITY SUPPORT SERVCIES	2012		2013		2014		% Change
	n	%	n	%	n	%	
CMHC	31,299	29%	42,091	21%	23,218	14%	-26%
Group Home		0%		0%	1	0%	N/A
Home	39,651	37%	86,519	44%	80,228	47%	102%
Nursing Facility		0%	1	0%		0%	N/A
Office		0%		0%	35	0%	N/A
Other Unlisted Facility	15,571	14%	25,715	13%	21,667	13%	39%
School	21,790	20%	42,414	22%	44,824	26%	106%
Skilled Nursing Facility		0%	4	0%		0%	N/A
Total	**108,311**		**196,744**		**169,973**		

TABLE 18: NUMBER OF CLAIMS BY POINT OF SERVICE, FAMILY THERAPY AND GROUP THERAPY

FAMILY THERAPY & GROUP THERAPY	2010		2011		2012		2013		2014		% Change
	n	%	n	%	n	%	n	%	n	%	
CMHC	21,347	23%	24,412	23%	23,946	19%	24,665	17%	27,796	17%	30%
Federally Qualified Health Ctr	19	0%	4	0%	6	0%	3	0%	2	0%	-89%
Group Home		0%		0%		0%		0%	6	0%	N/A
Home	23,340	25%	22,601	21%	24,784	20%	29,650	20%	32,544	20%	39%
Inpatient Hospital	23	0%	17	0%	24	0%	11	0%	2	0%	-91%
Nursing Facility		0%		0%	18	0%	4	0%		0%	N/A
Office	20,903	22%	25,646	24%	30,480	25%	44,983	31%	56,356	35%	170%
Other Unlisted Facility	6,902	7%	11,633	11%	19,915	16%	18,538	13%	14,851	9%	115%
Outpatient Hospital	494	1%	945	1%	619	1%	513	0%	912	1%	85%
PRTF	20	0%		0%		0%	3	0%	1	0%	-95%
Psychiatric Resident Trmt Cntr		0%		0%		0%		0%	1	0%	N/A
Rural Health Clinic	386	0%	393	0%	493	0%	319	0%	243	0%	-37%
School	20,681	22%	21,723	20%	22,536	18%	27,075	19%	30,022	18%	45%
Skilled Nursing Facility		0%	11	0%	3	0%	1	0%	1	0%	N/A
Total	93,729		107,385		122,824		145,765		162,737		

Child Welfare Performance Indicators Report Maryland Department of Human Resources Social Services Administration

December 2016

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK
RUTH YOUNG CENTER
FOR FAMILIES & CHILDREN

Acknowledgements

This report was prepared by staff at the Department of Human Resources, Social Services Administration (DHR/SSA) in partnership with faculty and staff at the University of Maryland, School of Social Work's Ruth H. Young Center for Families & Children (RYC). Terry V. Shaw and Nicholas Kolupanowich developed the performance indicators found in this report in partnership with David Ayer.

Legislative Charge: Senate Bill 567, 2015 Regular Session

Senate Bill 567 (cross filed with House Bill 643) was passed and signed into law in 2015. This bill requires the Department of Human Resources, Social Services Administration (DHR/SSA) to provide a report to the General Assembly by December 1st of each year. The following eleven questions are required to be provided and broken out by jurisdiction, race, gender and age.

(1) The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations;
(2) The number of children receiving in-home services;
(3) The number of new out-of-home placements by placement type;
(4) The number of exits from the child welfare system by exit type;
(5) The number of exits to reunification and reentries within 12 months after exit;
(6) The number of exits to reunification and reentries within 24 months after exit;
(7) The stability of out-of-home placements, including the number of placement changes;
(8) The stability of school placements;
(9) The number who graduate from high school;
(10) The number who qualify for a Maryland high school diploma by examination; and
(11) The number who receive tuition waivers

The first 7 questions listed above are all questions that can be measured using data and information available from the Maryland Department of Human Resources, Social Services Administration (DHR/SSA). The results from these questions are broken out into chapters based on jurisdictions and consist of the first section of this report.

Questions 8 through 11 require data sharing between agencies. Question 8 and 9 requires data from the Maryland State Department of Education (MSDE), question 10 requires data from the Maryland Department of Labor, Licensing and Regulation (DLLR), and question 11 requires data from the Maryland Higher Education Commission (MHEC). This information is presented in Section 2 of this report.

This report is the second annual report.

Table of Contents

Section 1: Maryland Department of Human Resources, Social Services Administration data.

Maryland Department of Human Resources, Social Services Administration (DHR/SSA) data and information pertaining to the following questions as requested by Senate Bill 567 (cross filed with House Bill 643).

(1) The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations;
(2) The number of children and foster youth receiving in-home services;
(3) The number of new out-of-home placements by placement type;
(4) The number of exits from the child welfare system by exit type;
(5) The number of exits to reunification and reentries within 12 months after exit;
(6) The number of exits to reunification and reentries within 24 months after exit; and
(7) The stability of out-of-home placements, including the number of placement changes.

Maryland State Summary

Maryland is a diverse state consisting of 24 jurisdictions. The table below provides a comparison across jurisdictions of the overall population. The population of youth between the ages of 0 and 20 are used throughout this report and are presented here alongside the total population. The population of children and youth between the ages of 0 to 20 broken out by jurisdiction is proportional to the total population. As can be seen in the table Montgomery County has the largest population and the largest number of youth ages 0 to 20 while Kent County has the smallest population in general and smallest number of youth ages 0 to 20. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[1].

	Population of Youth 0 to 20	County Percent 0 to 20	Total Population	County Percent Total
Maryland	1,580,584	100.00	6,006,401	100.00
Allegany	16,948	1.07	72,528	1.21
Anne Arundel	146,706	9.28	564,195	9.39
Baltimore City	156,563	9.91	621,849	10.35
Baltimore County	212,341	13.43	831,128	13.84
Calvert	24,868	1.57	90,595	1.51
Caroline	8,732	0.55	32,579	0.54
Carroll	43,537	2.75	167,627	2.79
Cecil	27,198	1.72	102,382	1.70
Charles	44,176	2.79	156,118	2.60
Dorchester	7,783	0.49	32,384	0.54
Frederick	67,785	4.29	245,322	4.08
Garrett	6,638	0.42	29,460	0.49
Harford	65,590	4.15	250,290	4.17
Howard	87,399	5.53	313,414	5.22
Kent	4,573	0.29	19,787	0.33
Montgomery	277,385	17.55	1,040,116	17.32
Prince Georges	245,176	15.51	909,535	15.14
Queen Anne's	12,280	0.78	48,904	0.81
Somerset	6,506	0.41	25,768	0.43
St. Mary's	32,106	2.03	111,413	1.85
Talbot	7,925	0.50	37,512	0.62
Washington	37,945	2.40	149,585	2.49
Wicomico	29,982	1.90	102,370	1.70
Worcester	10,442	0.66	51,540	0.86

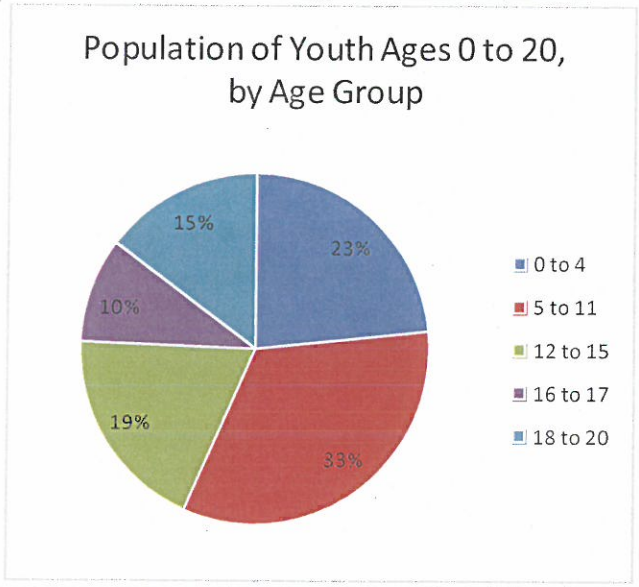
[1]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

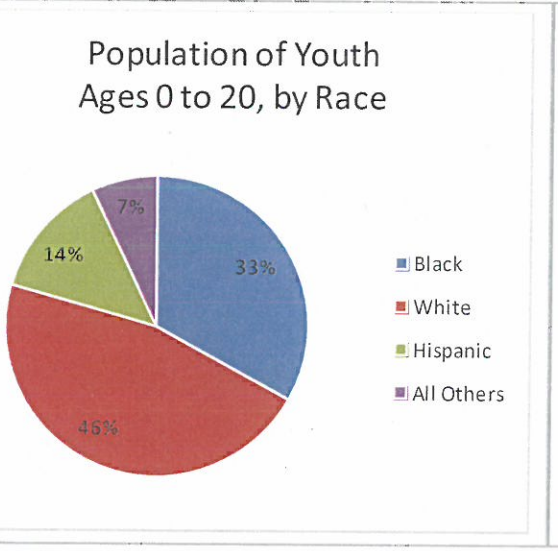
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Maryland

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[2].

Age Groups	Population of Youth Ages 0 to 20
Totals	1,580,584
0 to 4	369,035
5 to 11	524,177
12 to 15	302,203
16 to 17	152,811
18 to 20	232,358

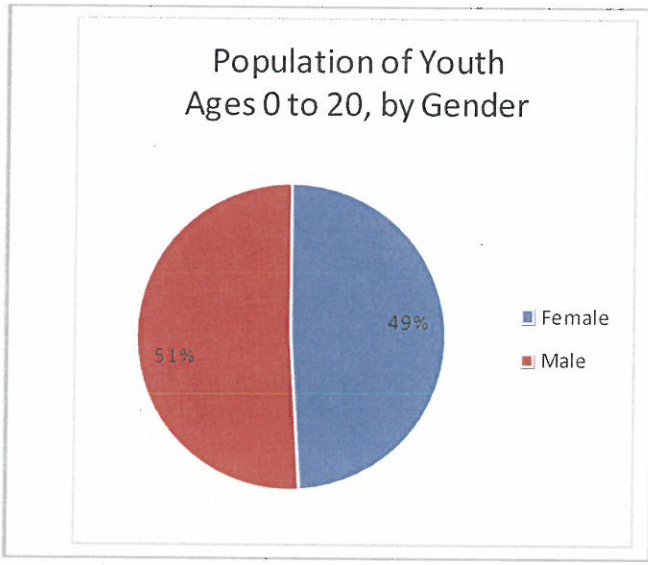




Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	1,348,226	1,580,584
Black	446,077	521,717
White	617,288	732,513
Hispanic	187,463	213,113
All Others	97,398	113,241

[2]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10



Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	1,348,226	1,580,584
Female	660,713	774,570
Male	687,513	806,014

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Maryland.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Maryland

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	30,881	11,870	38.43%	19,011	61.56%	5,576	29.33%	4,499	23.66%	8,936	47.00%
Ages 0 to 4	8,546	3,076	35.99%	5,470	64.00%	1,809	33.07%	1,314	24.02%	2,347	42.90%
Ages 5 to 11	13,487	5,552	41.16%	7,935	58.83%	2,201	27.73%	1,843	23.22%	3,891	49.03%
Ages 12 to 15	6,087	2,295	37.70%	3,792	62.29%	1,048	27.63%	947	24.97%	1,797	47.38%
Ages 16 to 18	2,667	938	35.17%	1,729	64.82%	491	28.39%	376	21.74%	862	49.85%
Age Invalid	93	***	9.67%	84	90.32%	27	32.14%	19	22.61%	38	45.23%
Age Missing	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	30,881	11,870	38.43%	19,011	61.56%	5,576	29.33%	4,499	23.66%	8,936	47.00%
Female	8,546	3,076	35.99%	5,470	64.00%	1,809	33.07%	1,314	24.02%	2,347	42.90%
Male	13,487	5,552	41.16%	7,935	58.83%	2,201	27.73%	1,843	23.22%	3,891	49.03%
Other/ Unknown	6,087	2,295	37.70%	3,792	62.29%	1,048	27.63%	947	24.97%	1,797	47.38%
Race/Ethnicity											
Totals	30,881	11,870	38.43%	19,011	61.56%	5,576	29.33%	4,499	23.66%	8,936	47.00%
Black	13,405	5,069	37.81%	8,336	62.18%	2,357	28.27%	2,040	24.47%	3,939	47.25%
White	10,586	3,878	36.63%	6,708	63.36%	2,020	30.11%	1,500	22.36%	3,188	47.52%
Hispanic	2,399	929	38.72%	1,470	61.27%	500	34.01%	357	24.28%	613	41.70%
All Others	376	164	43.61%	212	56.38%	72	33.96%	56	26.41%	84	39.62%
Unable to Determine	4,115	1,830	44.47%	2,285	55.52%	627	27.43%	546	23.89%	1,112	48.66%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Maryland.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	9,739	20,558
Ages 0 to 4	.	7,352
Ages 5 to 11	.	7,796
Ages 12 to 15	.	3,708
Ages 16 to 17	.	1,449
Age Unknown	.	253
Gender		
Totals	9,739	20,558
Female	.	10,164
Male	.	10,364
Unknown	.	30
Race/Ethnicity		
Totals	9,739	20,558
Black	.	11,603
White	.	5,305
Hispanic	.	875
All Others	.	144
Unable to Determine	.	2,631

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Maryland

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	1,912	109	5.70%	1,561	81.64%	191	9.98%	35	1.83%	15	0.78%
Ages 0 to 4	939	***	0.21%	785	83.59%	149	15.86%	***	0.00%	***	0.31%
Ages 5 to 11	499	10	2.00%	476	95.39%	***	1.80%	***	0.20%	***	0.60%
Ages 12 to 15	317	54	17.03%	215	67.82%	24	7.57%	18	5.67%	***	1.89%
Ages 16 to 18	157	43	27.38%	85	54.14%	***	5.73%	16	10.19%	***	1.91%
Gender											
Totals	1,912	109	5.70%	1,561	81.64%	191	9.98%	35	1.83%	15	0.78%
Female	949	62	6.53%	770	81.13%	87	9.16%	21	2.21%	***	0.94%
Male	963	47	4.88%	791	82.13%	104	10.79%	14	1.45%	***	0.62%
Race/Ethnicity											
Totals	1,912	109	5.70%	1,561	81.64%	191	9.98%	35	1.83%	15	0.78%
Hispanic	153	***	4.57%	125	81.69%	17	11.11%	***	2.61%	***	0.00%
Black	948	56	5.90%	795	83.86%	77	8.12%	***	0.94%	11	1.16%
White	625	39	6.24%	496	79.36%	68	10.88%	18	2.88%	***	0.48%
All other	16	***	31.25%	***	56.25%	***	0.00%	***	12.50%	***	0.00%
Unable to determine	170	***	1.17%	136	80.00%	29	17.05%	***	1.17%	***	0.58%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Maryland

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	2,557	1,126	44.03%	328	12.82%	401	15.68%	64	2.50%	468	18.30%	86	3.36%	84	3.28%
Ages 0 to 4	812	397	48.89%	200	24.63%	151	18.59%	***	1.10%	***	0.00%	44	5.41%	11	1.35%
Ages 5 to 11	682	352	51.61%	108	15.83%	152	22.28%	29	4.25%	***	0.00%	21	3.07%	20	2.93%
Ages 12 to 15	338	227	67.15%	14	4.14%	58	17.15%	16	4.73%	***	0.00%	13	3.84%	10	2.95%
Ages 16 to 18	271	142	52.39%	***	1.84%	39	14.39%	10	3.69%	43	15.86%	***	2.95%	24	8.85%
Over 18	454	***	1.76%	***	0.22%	***	0.22%	***	0.00%	425	93.61%	***	0.00%	19	4.18%
Gender															
Totals	2,557	1,126	44.03%	328	12.82%	401	15.68%	64	2.50%	468	18.30%	86	3.36%	84	3.28%
Female	1,273	567	44.54%	154	12.09%	195	15.31%	32	2.51%	242	19.01%	42	3.29%	41	3.22%
Male	1,283	559	43.56%	174	13.56%	206	16.05%	32	2.49%	225	17.53%	44	3.42%	43	3.35%
Other/Unknown	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	2,557	1,126	44.03%	328	12.82%	401	15.68%	64	2.50%	468	18.30%	86	3.36%	84	3.28%
Hispanic	126	70	55.55%	14	11.11%	***	3.96%	***	2.38%	21	16.66%	***	3.17%	***	7.14%
Black	1,469	624	42.47%	138	9.39%	224	15.24%	47	3.19%	339	23.07%	57	3.88%	40	2.72%
White	820	357	43.53%	148	18.04%	146	17.80%	14	1.70%	105	12.80%	18	2.19%	32	3.90%
All other	12	***	66.66%	***	8.33%	***	8.33%	***	0.00%	***	16.66%	***	0.00%	***	0.00%
Unable to determine	130	67	51.53%	27	20.76%	25	19.23%	***	0.00%	***	0.76%	***	5.38%	***	2.30%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Maryland

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	1,128	93	8.24%	134	11.87%	164	14.53%	199	17.64%
Ages 0 to 4	378	34	8.99%	46	12.16%	55	14.55%	69	18.25%
Ages 5 to 11	363	25	6.88%	37	10.19%	43	11.84%	52	14.32%
Ages 12 to 15	245	26	10.61%	36	14.69%	46	18.77%	55	22.44%
Ages 16 to 18	142	***	5.63%	15	10.56%	20	14.08%	23	16.19%
Gender									
Totals	1,128	93	8.24%	134	11.87%	164	14.53%	199	17.64%
Female	623	57	9.14%	78	12.52%	90	14.44%	114	18.29%
Male	505	36	7.12%	56	11.08%	74	14.65%	85	16.83%
Race/Ethnicity									
Totals	1,128	93	8.24%	134	11.87%	164	14.53%	199	17.64%
Hispanic	48	***	2.08%	***	6.25%	***	6.25%	***	16.66%
Black	687	68	9.89%	96	13.97%	117	17.03%	138	20.08%
White	336	24	7.14%	34	10.11%	43	12.79%	52	15.47%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	50	***	0.00%	***	2.00%	***	2.00%	***	2.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Maryland

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	1,332	84	6.30%	142	10.66%	182	13.66%	218	16.36%	245	18.39%	273	20.49%	308	23.12%	332	24.92%
Ages 0 to 4	472	32	6.77%	51	10.80%	64	13.55%	79	16.73%	91	19.27%	102	21.61%	114	24.15%	122	25.84%
Ages 5 to 11	394	17	4.31%	31	7.86%	46	11.67%	55	13.95%	62	15.73%	73	18.52%	87	22.08%	93	23.60%
Ages 12 to 15	275	22	8.00%	42	15.27%	52	18.90%	62	22.54%	68	24.72%	73	26.54%	81	29.45%	90	32.72%
Ages 16 to 18	191	13	6.80%	18	9.42%	20	10.47%	22	11.51%	24	12.56%	25	13.08%	26	13.61%	27	14.13%
Gender																	
Totals	1,332	84	6.30%	142	10.66%	182	13.66%	218	16.36%	245	18.39%	273	20.49%	308	23.12%	332	24.92%
Female	658	49	7.44%	79	12.00%	96	14.58%	108	16.41%	124	18.84%	141	21.42%	155	23.55%	170	25.83%
Male	673	35	5.20%	63	9.36%	86	12.77%	110	16.34%	121	17.97%	132	19.61%	153	22.73%	162	24.07%
Other/Unknown	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	1,332	84	6.30%	142	10.66%	182	13.66%	218	16.36%	245	18.39%	273	20.49%	308	23.12%	332	24.92%
Hispanic	70	***	1.42%	***	2.85%	***	5.71%	***	10.00%	***	12.85%	11	15.71%	12	17.14%	13	18.57%
Black	814	64	7.86%	100	12.28%	124	15.23%	144	17.69%	160	19.65%	176	21.62%	205	25.18%	224	27.51%
White	387	15	3.87%	35	9.04%	47	12.14%	60	15.50%	69	17.82%	78	20.15%	83	21.44%	87	22.48%
All other	14	***	21.42%	***	21.42%	***	21.42%	***	21.42%	***	21.42%	***	21.42%	***	21.42%	***	21.42%
Unable to determine	47	***	2.12%	***	4.25%	***	8.51%	***	8.51%	***	8.51%	***	10.63%	***	10.63%	***	10.63%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Maryland

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

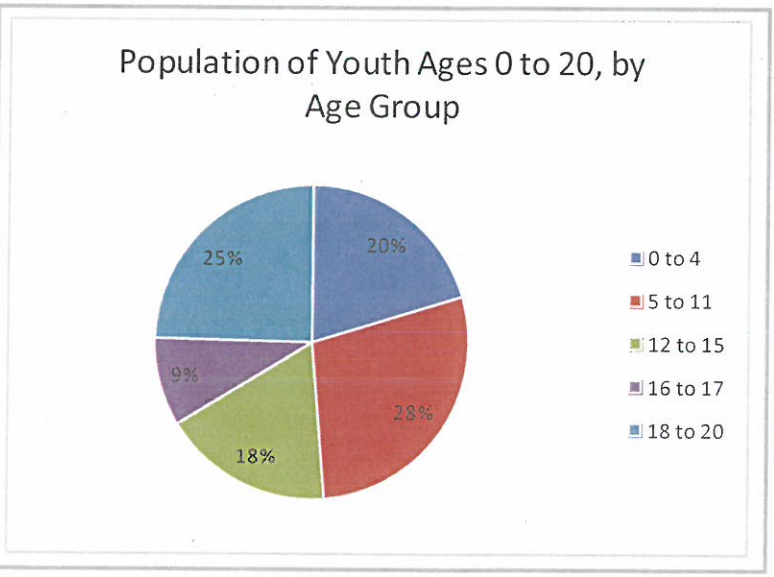
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	2,497	327,345	1,508	4.61
Ages 0 to 4	1,072	140,136	583	4.16
Ages 5 to 11	679	85,894	372	4.33
Ages 12 to 15	485	62,897	342	5.44
Ages 16 to 18	261	38,418	211	5.49
Gender				
Totals	2,497	327,345	1,508	4.61
Female	1,246	162,000	774	4.78
Male	1,250	165,184	732	4.43
Other/Unknown	***	161	2	12.42
Race/Ethnicity				
Totals	2,497	327,345	1,508	4.61
Hispanic	181	23,307	106	4.55
Black	1,333	169,176	865	5.11
White	782	110,985	427	3.85
All other	16	1,986	6	3.02
Unable to determine	185	21,891	104	4.75

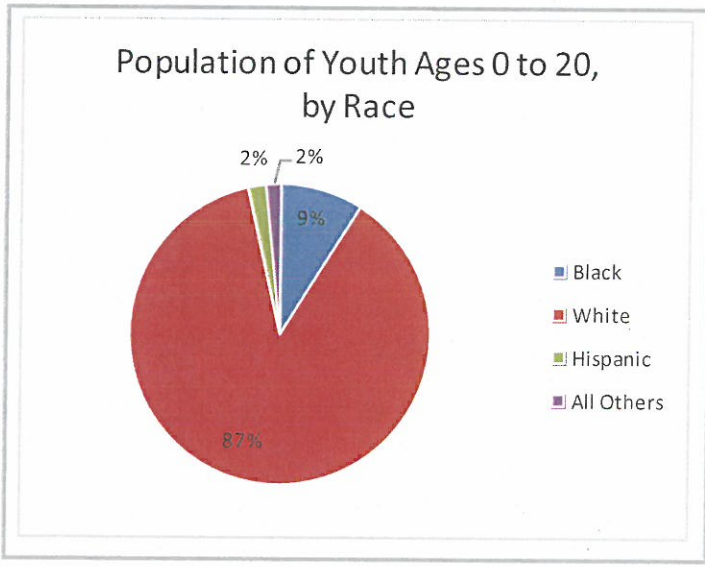
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Allegany

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[3].

Age Groups	Population of Youth Ages 0 to 20
Totals	16,948
0 to 4	3,435
5 to 11	4,810
12 to 15	2,981
16 to 17	1,542
18 to 20	4,180



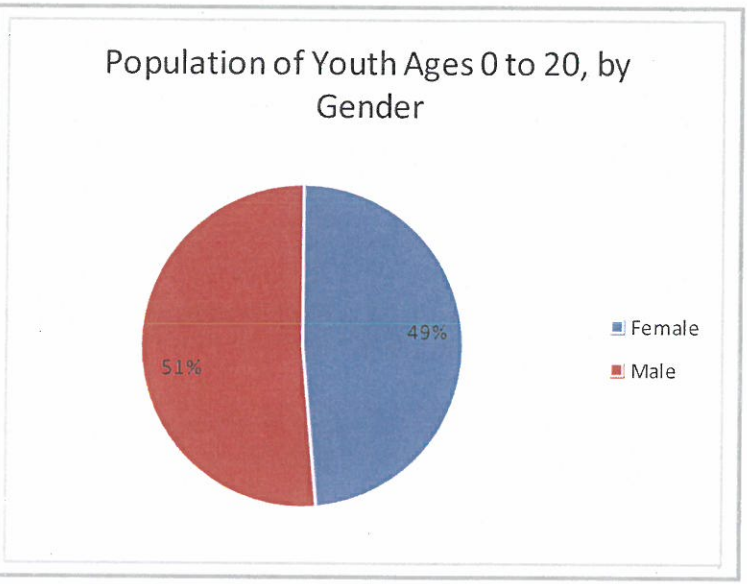


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	12,768	16,948
Black	707	1,506
White	11,656	14,843
Hispanic	240	326
All Others	165	273

[3]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	12,768	16,948
Female	6,074	8,225
Male	6,694	8,723



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Allegany.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Allegany

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	772	286	37.04%	486	62.95%	214	44.03%	101	20.78%	171	35.18%
Ages 0 to 4	275	95	34.54%	180	65.45%	103	57.22%	33	18.33%	44	24.44%
Ages 5 to 11	357	127	35.57%	230	64.42%	85	36.95%	48	20.86%	97	42.17%
Ages 12 to 15	104	47	45.19%	57	54.80%	20	35.08%	14	24.56%	23	40.35%
Ages 16 to 18	36	17	47.22%	19	52.77%	***	31.57%	***	31.57%	***	36.84%
Gender											
Totals	772	286	37.04%	486	62.95%	214	44.03%	101	20.78%	171	35.18%
Female	359	117	32.59%	242	67.40%	111	45.86%	52	21.48%	79	32.64%
Male	413	169	40.92%	244	59.07%	103	42.21%	49	20.08%	92	37.70%
Race/Ethnicity											
Totals	772	286	37.04%	486	62.95%	214	44.03%	101	20.78%	171	35.18%
Black	63	24	38.09%	39	61.90%	20	51.28%	10	25.64%	***	23.07%
White	675	251	37.18%	424	62.81%	180	42.45%	86	20.28%	158	37.26%
Hispanic	14	***	21.42%	11	78.57%	***	45.45%	***	27.27%	***	27.27%
All Others	***	***	0.00%	***	100.00%	***	66.66%	***	33.33%	***	0.00%
Unable to Determine	17	***	47.05%	***	52.94%	***	77.77%	***	11.11%	***	11.11%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Allegany.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	277	576
Ages 0 to 4	.	296
Ages 5 to 11	.	194
Ages 12 to 15	.	68
Ages 16 to 17	.	17
Age Unknown	.	***
Gender		
Totals	277	576
Female	.	255
Male	.	321
Race/Ethnicity		
Totals	277	576
Black	.	61
White	.	473
Hispanic	.	***
Unable to Determine	.	35

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Allegany

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	102	***	0.98%	93	91.17%	***	6.86%	***	0.00%	***	0.98%
Ages 0 to 4	64	***	0.00%	58	90.62%	***	9.37%	***	0.00%	***	0.00%
Ages 5 to 11	29	***	3.44%	27	93.10%	***	3.44%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	87.50%	***	0.00%	***	0.00%	***	12.50%
Ages 16 to 18	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	102	***	0.98%	93	91.17%	***	6.86%	***	0.00%	***	0.98%
Female	49	***	0.00%	43	87.75%	***	10.20%	***	0.00%	***	2.04%
Male	53	***	1.88%	50	94.33%	***	3.77%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	102	***	0.98%	93	91.17%	***	6.86%	***	0.00%	***	0.98%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	83.33%	***	16.66%	***	0.00%	***	0.00%
White	88	***	1.13%	81	92.04%	***	5.68%	***	0.00%	***	1.13%
Unable to determine	***	***	0.00%	***	85.71%	***	14.28%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Allegany

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type														
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	77	46	59.74%	***	7.79%	18	23.37%	***	3.89%	***	2.59%	***	1.29%	***	1.29%
	Ages 0 to 4	35	18	51.42%	***	11.42%	11	31.42%	***	2.85%	***	0.00%	***	2.85%	***	0.00%
	Ages 5 to 11	27	20	74.07%	***	7.40%	***	11.11%	***	7.40%	***	0.00%	***	0.00%	***	0.00%
	Ages 12 to 15	***	***	75.00%	***	0.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 16 to 18	***	***	40.00%	***	0.00%	***	40.00%	***	0.00%	***	0.00%	***	0.00%	***	20.00%
	Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender																
	Totals	77	46	59.74%	***	7.79%	18	23.37%	***	3.89%	***	2.59%	***	1.29%	***	1.29%
	Female	42	25	59.52%	***	4.76%	12	28.57%	***	4.76%	***	0.00%	***	0.00%	***	2.38%
	Male	35	21	60.00%	***	11.42%	***	17.14%	***	2.85%	***	5.71%	***	2.85%	***	0.00%
Race/Ethnicity																
	Totals	77	46	59.74%	***	7.79%	18	23.37%	***	3.89%	***	2.59%	***	1.29%	***	1.29%
	Hispanic	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Black	***	***	50.00%	***	0.00%	***	0.00%	***	33.33%	***	16.66%	***	0.00%	***	0.00%
	White	63	37	58.73%	***	9.52%	16	25.39%	***	1.58%	***	1.58%	***	1.58%	***	1.58%
	Unable to determine	***	***	33.33%	***	0.00%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Allegany

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	30	***	3.33%	***	3.33%	***	6.66%	***	6.66%
Ages 0 to 4	14	***	0.00%	***	0.00%	***	7.14%	***	7.14%
Ages 5 to 11	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	30	***	3.33%	***	3.33%	***	6.66%	***	6.66%
Female	26	***	3.84%	***	3.84%	***	7.69%	***	7.69%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	30	***	3.33%	***	3.33%	***	6.66%	***	6.66%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	24	***	4.16%	***	4.16%	***	8.33%	***	8.33%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Allegany

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	29	***	0.00%	***	3.44%	***	3.44%	***	6.89%	***	10.34%	***	17.24%	***	17.24%	***	17.24%
Ages 0 to 4	12	***	0.00%	***	8.33%	***	8.33%	***	16.66%	***	25.00%	***	41.66%	***	41.66%	***	41.66%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	29	***	0.00%	***	3.44%	***	3.44%	***	6.89%	***	10.34%	***	17.24%	***	17.24%	***	17.24%
Female	15	***	0.00%	***	6.66%	***	6.66%	***	13.33%	***	13.33%	***	26.66%	***	26.66%	***	26.66%
Male	14	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	7.14%	***	7.14%	***	7.14%	***	7.14%
Race/Ethnicity																	
Totals	29	***	0.00%	***	3.44%	***	3.44%	***	6.89%	***	10.34%	***	17.24%	***	17.24%	***	17.24%
White	29	***	0.00%	***	3.44%	***	3.44%	***	6.89%	***	10.34%	***	17.24%	***	17.24%	***	17.24%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Allegany

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

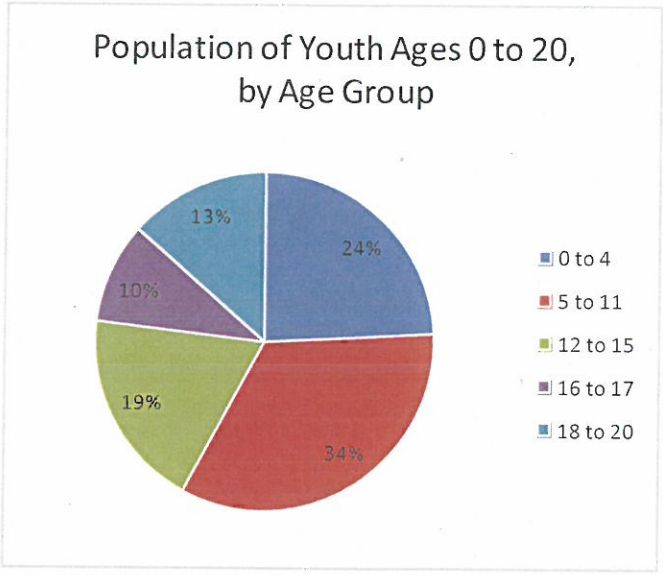
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	122	16,076	64	3.98
Ages 0 to 4	69	9,413	35	3.72
Ages 5 to 11	40	5,625	22	3.91
Ages 12 to 15	11	1,002	6	5.99
Ages 16 to 18	***	36	1	27.78
Gender				
Totals	122	16,076	64	3.98
Female	56	7,938	32	4.03
Male	66	8,138	32	3.93
Race/Ethnicity				
Totals	122	16,076	64	3.98
Hispanic	***	524	0	0.00
Black	***	1,493	3	2.01
White	103	13,451	61	4.53
Unable to determine	***	608	0	0.00

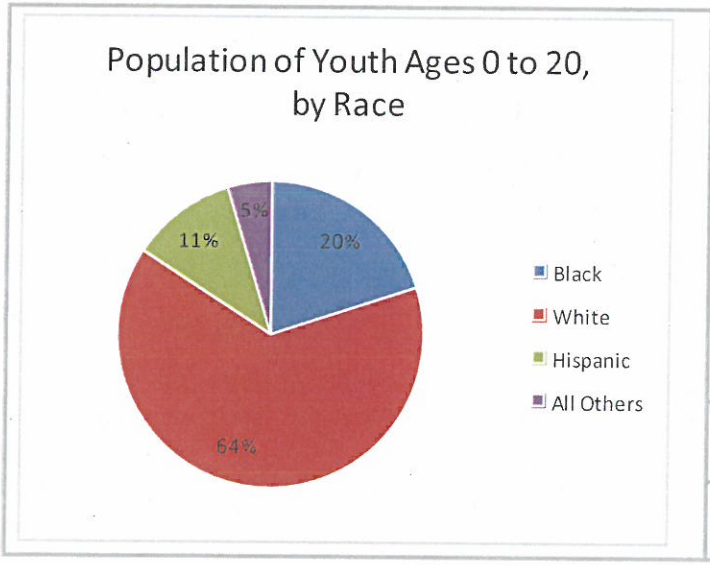
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Anne Arundel

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[4].

Age Groups	Population of Youth Ages 0 to 20
Totals	146,706
0 to 4	35,492
5 to 11	49,337
12 to 15	27,973
16 to 17	14,041
18 to 20	19,863



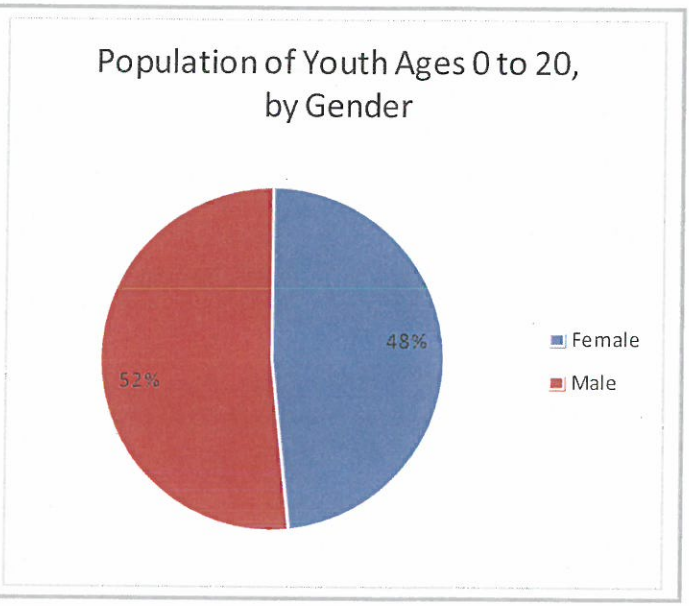


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	126,843	146,706
Black	25,483	29,281
White	80,950	94,133
Hispanic	14,473	16,400
All Others	5,937	6,892

[4]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	126,843	146,706
Female	62,126	70,865
Male	64,717	75,841



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Anne Arundel.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Anne Arundel

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	3,105	910	29.30%	2,195	70.69%	424	19.31%	475	21.64%	1,296	59.04%
Ages 0 to 4	809	199	24.59%	610	75.40%	134	21.96%	146	23.93%	330	54.09%
Ages 5 to 11	1,362	463	33.99%	899	66.00%	169	18.79%	175	19.46%	555	61.73%
Ages 12 to 15	603	174	28.85%	429	71.14%	71	16.55%	104	24.24%	254	59.20%
Ages 16 to 18	318	72	22.64%	246	77.35%	47	19.10%	47	19.10%	152	61.78%
Age Invalid	12	***	16.66%	10	83.33%	***	30.00%	***	30.00%	***	40.00%
Age Missing	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	3,105	910	29.30%	2,195	70.69%	424	19.31%	475	21.64%	1,296	59.04%
Female	1,532	400	26.10%	1,132	73.89%	237	20.93%	249	21.99%	646	57.06%
Male	1,571	509	32.39%	1,062	67.60%	187	17.60%	225	21.18%	650	61.20%
Other/ Unknown	***	***	50.00%	***	50.00%	***	0.00%	***	100.00%	***	0.00%
Race/Ethnicity											
Totals	3,105	910	29.30%	2,195	70.69%	424	19.31%	475	21.64%	1,296	59.04%
Black	1,066	292	27.39%	774	72.60%	147	18.99%	172	22.22%	455	58.78%
White	1,461	428	29.29%	1,033	70.70%	197	19.07%	210	20.32%	626	60.60%
Hispanic	183	61	33.33%	122	66.66%	35	28.68%	28	22.95%	59	48.36%
All Others	30	12	40.00%	18	60.00%	***	44.44%	***	22.22%	***	33.33%
Unable to Determine	365	117	32.05%	248	67.94%	37	14.91%	61	24.59%	150	60.48%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Anne Arundel.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	691	1,470
Ages 0 to 4	.	581
Ages 5 to 11	.	483
Ages 12 to 15	.	273
Ages 16 to 17	.	109
Age Unknown	.	24
Gender		
Totals	691	1,470
Female	.	752
Male	.	716
Unknown	.	***
Race/Ethnicity		
Totals	691	1,470
Black	.	531
White	.	584
Hispanic	.	91
All Others	.	17
Unable to Determine	.	247

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Anne Arundel

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	**Children (A)**	**N (B)**	**% (B/A)**	**n (C)**	**% (C/A)**	**n (D)**	**% (D/A)**	**n (E)**	**% (E/A)**	**n (F)**	**% (F/A)**
Totals	58	***	10.34%	44	75.86%	***	10.34%	***	3.44%	***	0.00%
Ages 0 to 4	32	***	0.00%	26	81.25%	***	18.75%	***	0.00%	***	0.00%
Ages 5 to 11	12	***	0.00%	12	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	10	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	25.00%	***	25.00%	***	0.00%	***	50.00%	***	0.00%
Gender											
Totals	58	***	10.34%	44	75.86%	***	10.34%	***	3.44%	***	0.00%
Female	31	***	9.67%	24	77.41%	***	9.67%	***	3.22%	***	0.00%
Male	27	***	11.11%	20	74.07%	***	11.11%	***	3.70%	***	0.00%
Race/Ethnicity											
Totals	58	***	10.34%	44	75.86%	***	10.34%	***	3.44%	***	0.00%
Hispanic	***	***	25.00%	***	75.00%	***	0.00%	***	0.00%	***	0.00%
Black	22	***	9.09%	18	81.81%	***	9.09%	***	0.00%	***	0.00%
White	25	***	12.00%	16	64.00%	***	16.00%	***	8.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Anne Arundel

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	85	30	35.29%	22	25.88%	***	8.23%	***	5.88%	17	20.00%	***	0.00%	***	4.70%
Ages 0 to 4	24	***	33.33%	10	41.66%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	26	10	38.46%	12	46.15%	***	3.84%	***	7.69%	***	0.00%	***	0.00%	***	3.84%
Ages 12 to 15	10	***	60.00%	***	0.00%	***	0.00%	***	30.00%	***	0.00%	***	0.00%	***	10.00%
Ages 16 to 18	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	22.22%	***	0.00%	***	11.11%
Over 18	16	***	0.00%	***	0.00%	***	0.00%	***	0.00%	15	93.75%	***	0.00%	***	6.25%
Gender															
Totals	85	30	35.29%	22	25.88%	***	8.23%	***	5.88%	17	20.00%	***	0.00%	***	4.70%
Female	47	16	34.04%	11	23.40%	***	2.12%	***	8.51%	12	25.53%	***	0.00%	***	6.38%
Male	38	14	36.84%	11	28.94%	***	15.78%	***	2.63%	***	13.15%	***	0.00%	***	2.63%
Race/Ethnicity															
Totals	85	30	35.29%	22	25.88%	***	8.23%	***	5.88%	17	20.00%	***	0.00%	***	4.70%
Hispanic	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%
Black	35	13	37.14%	***	20.00%	***	8.57%	***	5.71%	***	22.85%	***	0.00%	***	5.71%
White	38	13	34.21%	13	34.21%	***	0.00%	***	7.89%	***	21.05%	***	0.00%	***	2.63%
Unable to determine	***	***	22.22%	***	22.22%	***	44.44%	***	0.00%	***	0.00%	***	0.00%	***	11.11%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Anne Arundel

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	35	***	0.00%	***	0.00%	***	2.85%	***	2.85%
Ages 0 to 4	16	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	12	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	33.33%	***	33.33%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	35	***	0.00%	***	0.00%	***	2.85%	***	2.85%
Female	21	***	0.00%	***	0.00%	***	4.76%	***	4.76%
Male	14	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	35	***	0.00%	***	0.00%	***	2.85%	***	2.85%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	15	***	0.00%	***	0.00%	***	6.66%	***	6.66%
White	12	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Anne Arundel

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	32	***	3.12%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	12.50%
Ages 0 to 4	***	***	12.50%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	37.50%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	12.50%	***	12.50%	***	12.50%	***	12.50%	***	12.50%	***	12.50%	***	12.50%
Gender																	
Totals	32	***	3.12%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	12.50%
Female	21	***	4.76%	***	9.52%	***	9.52%	***	9.52%	***	9.52%	***	9.52%	***	9.52%	***	14.28%
Male	11	***	0.00%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%
Race/Ethnicity																	
Totals	32	***	3.12%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	12.50%
Black	11	***	0.00%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%
White	19	***	5.26%	***	10.52%	***	10.52%	***	10.52%	***	10.52%	***	10.52%	***	10.52%	***	15.78%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Anne Arundel

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

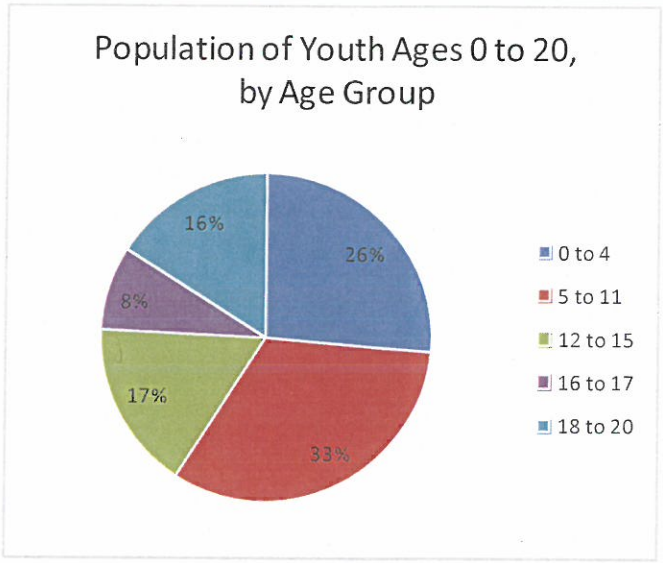
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	67	11,415	38	3.33
Ages 0 to 4	32	5,958	15	2.52
Ages 5 to 11	16	2,274	6	2.64
Ages 12 to 15	12	1,500	8	5.33
Ages 16 to 18	***	1,683	9	5.35
Gender				
Totals	67	11,415	38	3.33
Female	35	5,420	21	3.87
Male	32	5,995	17	2.84
Race/Ethnicity				
Totals	67	11,415	38	3.33
Hispanic	***	426	4	9.39
Black	26	4,836	23	4.76
White	28	4,972	11	2.21
Unable to determine	***	1,181	0	0.00

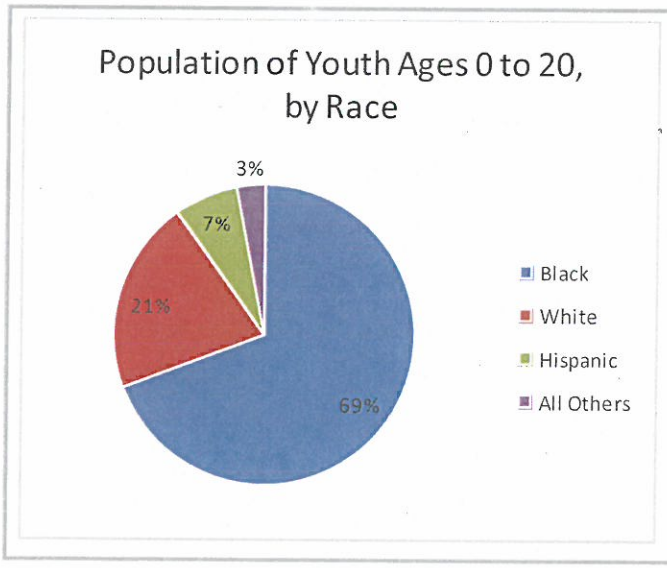
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Baltimore City

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[5].

Age Groups	Population of Youth Ages 0 to 20
Totals	156,563
0 to 4	41,301
5 to 11	51,220
12 to 15	26,028
16 to 17	12,804
18 to 20	25,210



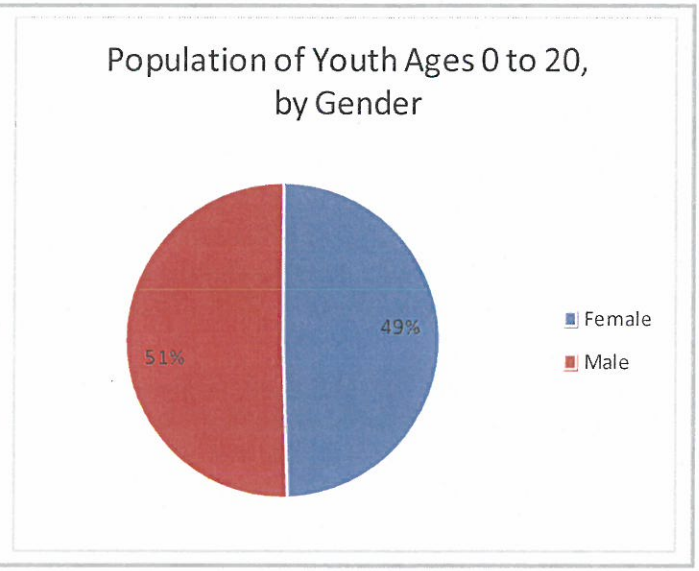


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	131,353	156,563
Black	92,480	108,459
White	26,033	32,528
Hispanic	9,440	10,747
All Others	3,400	4,829

[5]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	131,353	156,563
Female	64,503	77,462
Male	66,850	79,101



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Baltimore City.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Baltimore City

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	6,752	2,374	35.15%	4,378	64.84%	1,230	28.09%	822	18.77%	2,326	53.12%
Ages 0 to 4	1,993	648	32.51%	1,345	67.48%	439	32.63%	254	18.88%	652	48.47%
Ages 5 to 11	2,930	1,105	37.71%	1,825	62.28%	487	26.68%	341	18.68%	997	54.63%
Ages 12 to 15	1,251	426	34.05%	825	65.94%	217	26.30%	174	21.09%	434	52.60%
Ages 16 to 18	559	193	34.52%	366	65.47%	81	22.13%	53	14.48%	232	63.38%
Age Invalid	19	***	10.52%	17	89.47%	***	35.29%	***	0.00%	11	64.70%
Gender											
Totals	6,752	2,374	35.15%	4,378	64.84%	1,230	28.09%	822	18.77%	2,326	53.12%
Female	3,386	1,163	34.34%	2,223	65.65%	638	28.69%	401	18.03%	1,184	53.26%
Male	3,335	1,195	35.83%	2,140	64.16%	591	27.61%	415	19.39%	1,134	52.99%
Other/ Unknown	31	16	51.61%	15	48.38%	***	6.66%	***	40.00%	***	53.33%
Race/Ethnicity											
Totals	6,752	2,374	35.15%	4,378	64.84%	1,230	28.09%	822	18.77%	2,326	53.12%
Black	4,919	1,695	34.45%	3,224	65.54%	929	28.81%	600	18.61%	1,695	52.57%
White	869	275	31.64%	594	68.35%	173	29.12%	113	19.02%	308	51.85%
Hispanic	246	93	37.80%	153	62.19%	41	26.79%	27	17.64%	85	55.55%
All Others	22	***	27.27%	16	72.72%	***	25.00%	***	6.25%	11	68.75%
Unable to Determine	696	305	43.82%	391	56.17%	83	21.22%	81	20.71%	227	58.05%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Baltimore City.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	4,250	8,842
Ages 0 to 4	.	2,666
Ages 5 to 11	.	3,631
Ages 12 to 15	.	1,696
Ages 16 to 17	.	713
Age Unknown	.	136
Gender		
Totals	4,250	8,842
Female	.	4,466
Male	.	4,366
Unknown	.	10
Race/Ethnicity		
Totals	4,250	8,842
Black	.	7,415
White	.	561
Hispanic	.	164
All Others	.	39
Unable to Determine	.	663

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Baltimore City

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	772	16	2.07%	662	85.75%	88	11.39%	***	0.12%	***	0.64%
Ages 0 to 4	430	***	0.00%	350	81.39%	80	18.60%	***	0.00%	***	0.00%
Ages 5 to 11	211	***	0.00%	208	98.57%	***	1.42%	***	0.00%	***	0.00%
Ages 12 to 15	90	***	7.77%	75	83.33%	***	4.44%	***	1.11%	***	3.33%
Ages 16 to 18	41	***	21.95%	29	70.73%	***	2.43%	***	0.00%	***	4.87%
Gender											
Totals	772	16	2.07%	662	85.75%	88	11.39%	***	0.12%	***	0.64%
Female	376	***	2.39%	329	87.50%	34	9.04%	***	0.00%	***	1.06%
Male	396	***	1.76%	333	84.09%	54	13.63%	***	0.25%	***	0.25%
Race/Ethnicity											
Totals	772	16	2.07%	662	85.75%	88	11.39%	***	0.12%	***	0.64%
Hispanic	37	***	0.00%	33	89.18%	***	10.81%	***	0.00%	***	0.00%
Black	560	15	2.67%	492	87.85%	47	8.39%	***	0.17%	***	0.89%
White	104	***	0.96%	84	80.76%	19	18.26%	***	0.00%	***	0.00%
All other	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	70	***	0.00%	52	74.28%	18	25.71%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Baltimore City

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type														
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	1,161	575	49.52%	103	8.87%	168	14.47%	31	2.67%	209	18.00%	59	5.08%	16	1.37%
	Ages 0 to 4	390	231	59.23%	64	16.41%	54	13.84%	***	0.76%	***	0.00%	34	8.71%	***	1.02%
	Ages 5 to 11	314	180	57.32%	31	9.87%	72	22.92%	17	5.41%	***	0.00%	11	3.50%	***	0.95%
	Ages 12 to 15	149	102	68.45%	***	2.68%	26	17.44%	***	4.02%	***	0.00%	***	6.04%	***	1.34%
	Ages 16 to 18	95	59	62.10%	***	3.15%	16	16.84%	***	5.26%	***	2.10%	***	5.26%	***	5.26%
	Over 18	213	***	1.40%	***	0.46%	***	0.00%	***	0.00%	207	97.18%	***	0.00%	***	0.93%
Gender																
	Totals	1,161	575	49.52%	103	8.87%	168	14.47%	31	2.67%	209	18.00%	59	5.08%	16	1.37%
	Female	577	295	51.12%	50	8.66%	82	14.21%	14	2.42%	101	17.50%	27	4.67%	***	1.38%
	Male	584	280	47.94%	53	9.07%	86	14.72%	17	2.91%	108	18.49%	32	5.47%	***	1.36%
Race/Ethnicity																
	Totals	1,161	575	49.52%	103	8.87%	168	14.47%	31	2.67%	209	18.00%	59	5.08%	16	1.37%
	Hispanic	35	27	77.14%	***	0.00%	***	5.71%	***	2.85%	***	5.71%	***	8.57%	***	0.00%
	Black	928	428	46.12%	75	8.08%	142	15.30%	28	3.01%	197	21.22%	46	4.95%	12	1.29%
	White	150	91	60.66%	23	15.33%	16	10.66%	***	1.33%	***	6.00%	***	4.00%	***	2.00%
	Unable to determine	48	29	60.41%	***	10.41%	***	16.66%	***	0.00%	***	2.08%	***	8.33%	***	2.08%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Baltimore City

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	598	72	12.04%	105	17.55%	119	19.89%	148	24.74%
Ages 0 to 4	220	25	11.36%	35	15.90%	40	18.18%	51	23.18%
Ages 5 to 11	193	18	9.32%	28	14.50%	30	15.54%	38	19.68%
Ages 12 to 15	127	23	18.11%	31	24.40%	34	26.77%	41	32.28%
Ages 16 to 18	58	***	10.34%	11	18.96%	15	25.86%	18	31.03%
Gender									
Totals	598	72	12.04%	105	17.55%	119	19.89%	148	24.74%
Female	321	43	13.39%	59	18.38%	63	19.62%	82	25.54%
Male	277	29	10.46%	46	16.60%	56	20.21%	66	23.82%
Race/Ethnicity									
Totals	598	72	12.04%	105	17.55%	119	19.89%	148	24.74%
Hispanic	14	***	7.14%	***	14.28%	***	14.28%	***	42.85%
Black	498	63	12.65%	90	18.07%	102	20.48%	120	24.09%
White	68	***	11.76%	13	19.11%	15	22.05%	22	32.35%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	16	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Baltimore City

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	733	60	8.18%	96	13.09%	120	16.37%	143	19.50%	163	22.23%	179	24.42%	210	28.64%	227	30.96%
Ages 0 to 4	281	22	7.82%	35	12.45%	42	14.94%	54	19.21%	61	21.70%	65	23.13%	77	27.40%	83	29.53%
Ages 5 to 11	234	11	4.70%	18	7.69%	29	12.39%	35	14.95%	42	17.94%	50	21.36%	63	26.92%	67	28.63%
Ages 12 to 15	143	19	13.28%	34	23.77%	39	27.27%	43	30.06%	47	32.86%	50	34.96%	56	39.16%	63	44.05%
Ages 16 to 18	75	***	10.66%	***	12.00%	10	13.33%	11	14.66%	13	17.33%	14	18.66%	14	18.66%	14	18.66%
Gender																	
Totals	733	60	8.18%	96	13.09%	120	16.37%	143	19.50%	163	22.23%	179	24.42%	210	28.64%	227	30.96%
Female	367	39	10.62%	56	15.25%	67	18.25%	72	19.61%	83	22.61%	91	24.79%	104	28.33%	114	31.06%
Male	365	21	5.75%	40	10.95%	53	14.52%	71	19.45%	80	21.91%	88	24.10%	106	29.04%	113	30.95%
Other/Unknown	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	733	60	8.18%	96	13.09%	120	16.37%	143	19.50%	163	22.23%	179	24.42%	210	28.64%	227	30.96%
Hispanic	24	***	0.00%	***	0.00%	***	0.00%	***	8.33%	***	12.50%	***	16.66%	***	16.66%	***	16.66%
Black	592	53	8.95%	83	14.02%	103	17.39%	115	19.42%	131	22.12%	145	24.49%	172	29.05%	189	31.92%
White	92	***	7.60%	12	13.04%	15	16.30%	24	26.08%	27	29.34%	27	29.34%	31	33.69%	31	33.69%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	24	***	0.00%	***	4.16%	***	8.33%	***	8.33%	***	8.33%	***	12.50%	***	12.50%	***	12.50%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Baltimore City

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

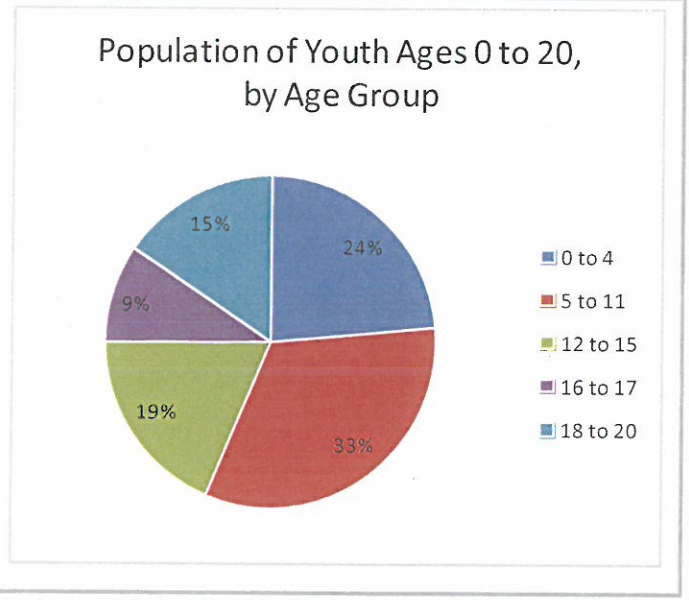
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	1,131	121,227	648	5.35
Ages 0 to 4	528	55,752	289	5.18
Ages 5 to 11	326	33,300	165	4.95
Ages 12 to 15	186	19,252	125	6.49
Ages 16 to 18	91	12,923	69	5.34
Gender				
Totals	1,131	121,227	648	5.35
Female	554	58,167	326	5.60
Male	577	63,060	322	5.11
Race/Ethnicity				
Totals	1,131	121,227	648	5.35
Hispanic	42	2,888	22	7.62
Black	850	93,620	503	5.37
White	158	17,229	80	4.64
All other	***	162	1	6.17
Unable to determine	80	7,328	42	5.73

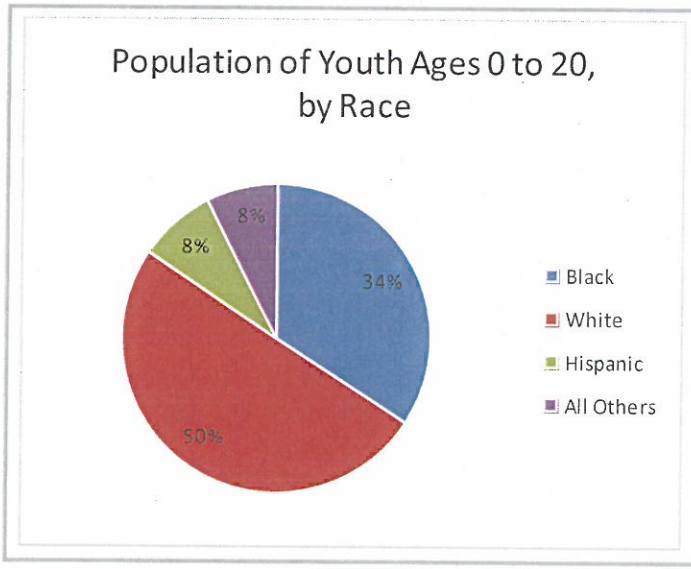
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Baltimore County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[6].

Age Groups	Population of Youth Ages 0 to 20
Totals	212,341
0 to 4	50,038
5 to 11	69,475
12 to 15	39,633
16 to 17	20,241
18 to 20	32,954



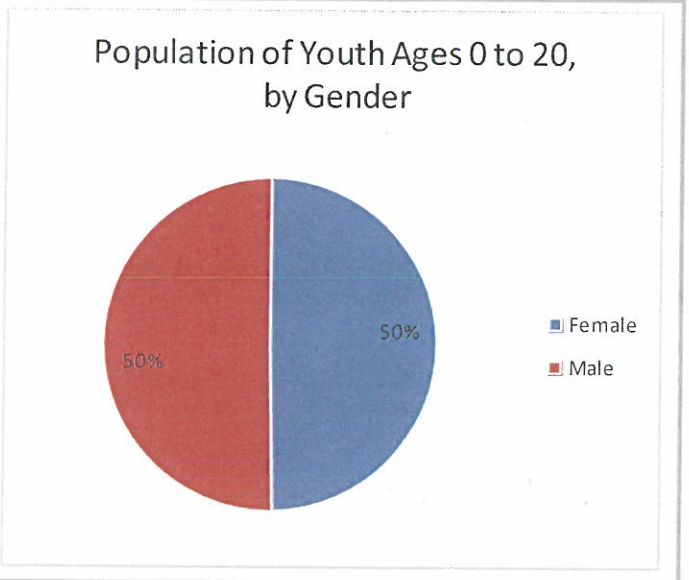


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	179,387	212,341
Black	62,232	72,502
White	88,291	106,661
Hispanic	15,246	17,303
All Others	13,618	15,875

[6]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	179,387	212,341
Female	88,564	105,439
Male	90,823	106,902



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Baltimore County.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Baltimore County

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	2,927	1,080	36.89%	1,847	63.10%	619	33.51%	526	28.47%	702	38.00%
Ages 0 to 4	776	237	30.54%	539	69.45%	179	33.20%	167	30.98%	193	35.80%
Ages 5 to 11	1,259	513	40.74%	746	59.25%	246	32.97%	213	28.55%	287	38.47%
Ages 12 to 15	574	212	36.93%	362	63.06%	117	32.32%	102	28.17%	143	39.50%
Ages 16 to 18	311	116	37.29%	195	62.70%	74	37.94%	43	22.05%	78	40.00%
Age Invalid	***	***	28.57%	***	71.42%	***	60.00%	***	20.00%	***	20.00%
Gender											
Totals	2,927	1,080	36.89%	1,847	63.10%	619	33.51%	526	28.47%	702	38.00%
Female	1,496	530	35.42%	966	64.57%	347	35.92%	272	28.15%	347	35.92%
Male	1,427	550	38.54%	877	61.45%	270	30.78%	253	28.84%	354	40.36%
Other/ Unknown	***	***	0.00%	***	100.00%	***	50.00%	***	25.00%	***	25.00%
Race/Ethnicity											
Totals	2,927	1,080	36.89%	1,847	63.10%	619	33.51%	526	28.47%	702	38.00%
Black	1,294	484	37.40%	810	62.59%	274	33.82%	226	27.90%	310	38.27%
White	1,040	371	35.67%	669	64.32%	224	33.48%	182	27.20%	263	39.31%
Hispanic	156	41	26.28%	115	73.71%	46	40.00%	32	27.82%	37	32.17%
All Others	52	24	46.15%	28	53.84%	***	28.57%	***	32.14%	11	39.28%
Unable to Determine	385	160	41.55%	225	58.44%	67	29.77%	77	34.22%	81	36.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Baltimore County.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	738	1,577
Ages 0 to 4	.	757
Ages 5 to 11	.	507
Ages 12 to 15	.	219
Ages 16 to 17	.	73
Age Unknown	.	21
Gender		
Totals	738	1,577
Female	.	742
Male	.	833
Unknown	.	***
Race/Ethnicity		
Totals	738	1,577
Black	.	537
White	.	626
Hispanic	.	100
All Others	.	13
Unable to Determine	.	301

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Baltimore County

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	**Children (A)**	**N (B)**	**% (B/A)**	**n (C)**	**% (C/A)**	**n (D)**	**% (D/A)**	**n (E)**	**% (E/A)**	**n (F)**	**% (F/A)**
Totals	188	36	19.14%	122	64.89%	13	6.91%	10	5.31%	***	3.72%
Ages 0 to 4	80	***	0.00%	69	86.25%	***	10.00%	***	0.00%	***	3.75%
Ages 5 to 11	37	***	16.21%	27	72.97%	***	0.00%	***	2.70%	***	8.10%
Ages 12 to 15	49	17	34.69%	22	44.89%	***	8.16%	***	10.20%	***	2.04%
Ages 16 to 18	22	13	59.09%	***	18.18%	***	4.54%	***	18.18%	***	0.00%
Gender											
Totals	188	36	19.14%	122	64.89%	13	6.91%	10	5.31%	***	3.72%
Female	93	15	16.12%	62	66.66%	***	6.45%	***	7.52%	***	3.22%
Male	95	21	22.10%	60	63.15%	***	7.36%	***	3.15%	***	4.21%
Race/Ethnicity											
Totals	188	36	19.14%	122	64.89%	13	6.91%	10	5.31%	***	3.72%
Hispanic	17	***	11.76%	13	76.47%	***	11.76%	***	0.00%	***	0.00%
Black	70	21	30.00%	37	52.85%	***	7.14%	***	4.28%	***	5.71%
White	87	10	11.49%	63	72.41%	***	6.89%	***	6.89%	***	2.29%
All other	***	***	42.85%	***	42.85%	***	0.00%	***	14.28%	***	0.00%
Unable to determine	***	***	0.00%	***	85.71%	***	0.00%	***	0.00%	***	14.28%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Baltimore County

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type															
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	219	82	37.44%	36	16.43%	33	15.06%	***	0.91%	43	19.63%	***	0.91%	21	9.58%
	Ages 0 to 4	70	30	42.85%	25	35.71%	12	17.14%	***	0.00%	***	0.00%	***	0.00%	***	4.28%
	Ages 5 to 11	50	23	46.00%	11	22.00%	10	20.00%	***	4.00%	***	0.00%	***	4.00%	***	4.00%
	Ages 12 to 15	27	19	70.37%	***	0.00%	***	22.22%	***	0.00%	***	0.00%	***	0.00%	***	7.40%
	Ages 16 to 18	27	10	37.03%	***	0.00%	***	18.51%	***	0.00%	***	25.92%	***	0.00%	***	18.51%
	Over 18	45	***	0.00%	***	0.00%	***	0.00%	***	0.00%	36	80.00%	***	0.00%	***	20.00%
Gender																
	Totals	219	82	37.44%	36	16.43%	33	15.06%	***	0.91%	43	19.63%	***	0.91%	21	9.58%
	Female	93	35	37.63%	14	15.05%	12	12.90%	***	0.00%	21	22.58%	***	2.15%	***	9.67%
	Male	125	47	37.60%	22	17.60%	21	16.80%	***	1.60%	21	16.80%	***	0.00%	12	9.60%
	Other/Unknown	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Race/Ethnicity																
	Totals	219	82	37.44%	36	16.43%	33	15.06%	***	0.91%	43	19.63%	***	0.91%	21	9.58%
	Hispanic	10	***	20.00%	***	20.00%	***	0.00%	***	0.00%	***	30.00%	***	0.00%	***	30.00%
	Black	77	29	37.66%	***	7.79%	11	14.28%	***	2.59%	19	24.67%	***	0.00%	10	12.98%
	White	119	43	36.13%	26	21.84%	20	16.80%	***	0.00%	21	17.64%	***	0.84%	***	6.72%
	All other	***	***	33.33%	***	33.33%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Unable to determine	10	***	70.00%	***	10.00%	***	10.00%	***	0.00%	***	0.00%	***	10.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Baltimore County

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (F/A)
Totals	81	***	4.93%	***	4.93%	***	11.11%	***	11.11%
Ages 0 to 4	20	***	0.00%	***	0.00%	***	10.00%	***	10.00%
Ages 5 to 11	24	***	12.50%	***	12.50%	***	16.66%	***	16.66%
Ages 12 to 15	17	***	0.00%	***	0.00%	***	5.88%	***	5.88%
Ages 16 to 18	20	***	5.00%	***	5.00%	***	10.00%	***	10.00%
Gender									
Totals	81	***	4.93%	***	4.93%	***	11.11%	***	11.11%
Female	38	***	5.26%	***	5.26%	***	10.52%	***	10.52%
Male	43	***	4.65%	***	4.65%	***	11.62%	***	11.62%
Race/Ethnicity									
Totals	81	***	4.93%	***	4.93%	***	11.11%	***	11.11%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	33	***	0.00%	***	0.00%	***	6.06%	***	6.06%
White	41	***	9.75%	***	9.75%	***	17.07%	***	17.07%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Baltimore County

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	102	***	1.96%	***	6.86%	10	9.80%	13	12.74%	14	13.72%	15	14.70%	15	14.70%	16	15.68%
Ages 0 to 4	29	***	0.00%	***	3.44%	***	10.34%	***	10.34%	***	10.34%	***	10.34%	***	10.34%	***	10.34%
Ages 5 to 11	21	***	0.00%	***	4.76%	***	4.76%	***	9.52%	***	9.52%	***	14.28%	***	14.28%	***	14.28%
Ages 12 to 15	26	***	3.84%	***	11.53%	***	15.38%	***	23.07%	***	26.92%	***	26.92%	***	26.92%	***	30.76%
Ages 16 to 18	26	***	3.84%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Gender																	
Totals	102	***	1.96%	***	6.86%	10	9.80%	13	12.74%	14	13.72%	15	14.70%	15	14.70%	16	15.68%
Female	47	***	2.12%	***	4.25%	***	10.63%	***	14.89%	***	14.89%	***	14.89%	***	14.89%	***	14.89%
Male	55	***	1.81%	***	9.09%	***	9.09%	***	10.90%	***	12.72%	***	14.54%	***	14.54%	***	16.36%
Race/Ethnicity																	
Totals	102	***	1.96%	***	6.86%	10	9.80%	13	12.74%	14	13.72%	15	14.70%	15	14.70%	16	15.68%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	46	***	2.17%	***	4.34%	***	6.52%	***	13.04%	***	13.04%	***	15.21%	***	15.21%	***	15.21%
White	47	***	2.12%	***	10.63%	***	14.89%	***	14.89%	***	17.02%	***	17.02%	***	17.02%	***	19.14%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Baltimore County

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

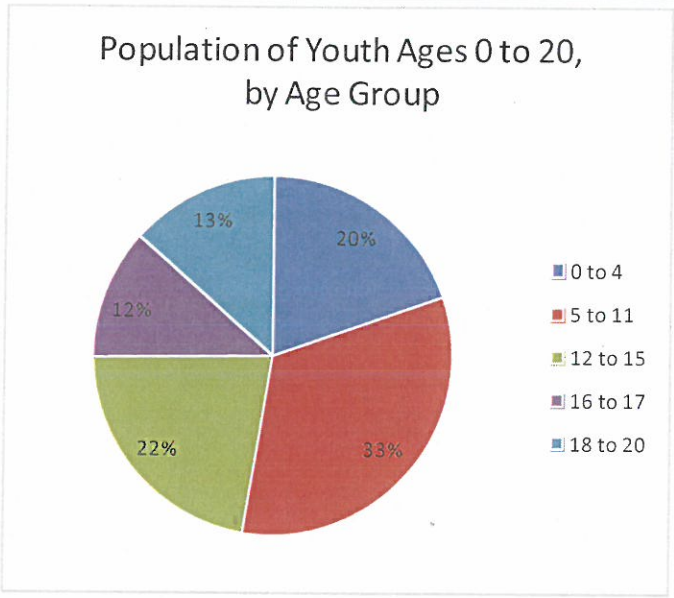
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	251	42,607	138	3.24
Ages 0 to 4	87	14,686	35	2.38
Ages 5 to 11	53	9,757	32	3.28
Ages 12 to 15	72	11,323	44	3.89
Ages 16 to 18	39	6,841	27	3.95
Gender				
Totals	251	42,607	138	3.24
Female	118	21,320	74	3.47
Male	132	21,126	62	2.93
Other/Unknown	***	161	2	12.42
Race/Ethnicity				
Totals	251	42,607	138	3.24
Hispanic	18	3,338	12	3.59
Black	106	18,597	77	4.14
White	112	18,988	42	2.21
All other	***	868	3	3.46
Unable to determine	***	816	4	4.90

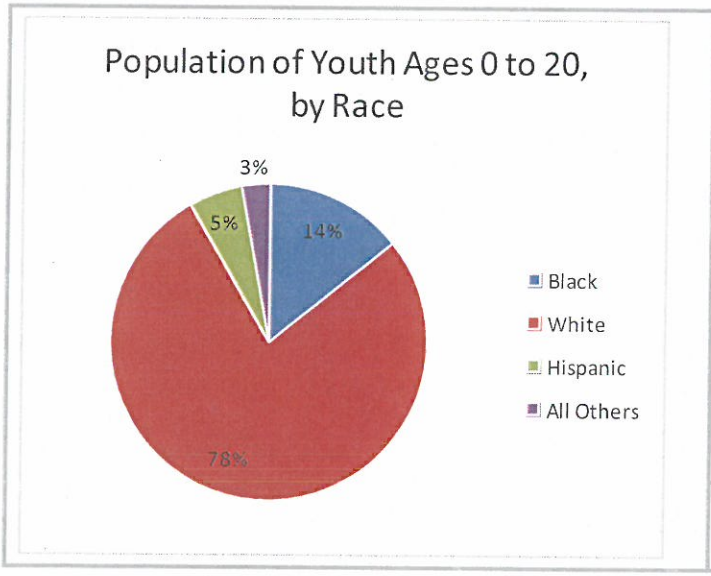
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Calvert County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[7].

Age Groups	Population of Youth Ages 0 to 20
Totals	24,868
0 to 4	4,888
5 to 11	8,183
12 to 15	5,536
16 to 17	2,909
18 to 20	3,352



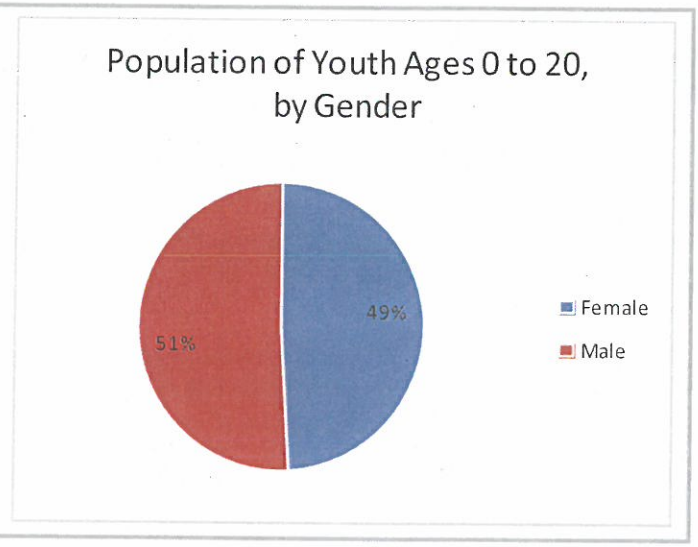


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	21,516	24,868
Black	2,998	3,528
White	16,714	19,262
Hispanic	1,161	1,357
All Others	643	721

[7]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	21,516	24,868
Female	10,606	12,190
Male	10,910	12,678



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Calvert.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Calvert

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	367	174	47.41%	193	52.58%	87	45.07%	30	15.54%	76	39.37%
Ages 0 to 4	103	43	41.74%	60	58.25%	37	61.66%	***	15.00%	14	23.33%
Ages 5 to 11	141	71	50.35%	70	49.64%	30	42.85%	***	12.85%	31	44.28%
Ages 12 to 15	94	45	47.87%	49	52.12%	16	32.65%	***	18.36%	24	48.97%
Ages 16 to 18	28	15	53.57%	13	46.42%	***	30.76%	***	15.38%	***	53.84%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	100.00%	***	0.00%
Gender											
Totals	367	174	47.41%	193	52.58%	87	45.07%	30	15.54%	76	39.37%
Female	183	81	44.26%	102	55.73%	46	45.09%	13	12.74%	43	42.15%
Male	184	93	50.54%	91	49.45%	41	45.05%	17	18.68%	33	36.26%
Race/Ethnicity											
Totals	367	174	47.41%	193	52.58%	87	45.07%	30	15.54%	76	39.37%
Black	84	40	47.61%	44	52.38%	21	47.72%	***	13.63%	17	38.63%
White	257	117	45.52%	140	54.47%	62	44.28%	22	15.71%	56	40.00%
Hispanic	14	***	57.14%	***	42.85%	***	33.33%	***	16.66%	***	50.00%
All Others	***	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to Determine	11	***	72.72%	***	27.27%	***	66.66%	***	33.33%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Calvert.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	125	266
Ages 0 to 4	.	115
Ages 5 to 11	.	95
Ages 12 to 15	.	44
Ages 16 to 17	.	10
Age Unknown	.	***
Gender		
Totals	125	266
Female	.	129
Male	.	137
Race/Ethnicity		
Totals	125	266
Black	.	86
White	.	149
Hispanic	.	***
All Others	.	***
Unable to Determine	.	21

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Calvert

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	15	***	6.66%	12	80.00%	***	13.33%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	77.77%	***	22.22%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	15	***	6.66%	12	80.00%	***	13.33%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Male	***	***	11.11%	***	88.88%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	15	***	6.66%	12	80.00%	***	13.33%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
White	13	***	7.69%	11	84.61%	***	7.69%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Calvert

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	35	11	31.42%	12	34.28%	***	14.28%	***	2.85%	***	14.28%	***	0.00%	***	2.85%
Ages 0 to 4	***	***	33.33%	***	55.55%	***	11.11%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	75.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	62.50%	***	12.50%	***	12.50%	***	12.50%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	75.00%	***	0.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	83.33%	***	0.00%	***	16.66%
Gender															
Totals	35	11	31.42%	12	34.28%	***	14.28%	***	2.85%	***	14.28%	***	0.00%	***	2.85%
Female	16	***	18.75%	***	37.50%	***	18.75%	***	0.00%	***	18.75%	***	0.00%	***	6.25%
Male	19	***	42.10%	***	31.57%	***	10.52%	***	5.26%	***	10.52%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	35	11	31.42%	12	34.28%	***	14.28%	***	2.85%	***	14.28%	***	0.00%	***	2.85%
Hispanic	***	***	25.00%	***	25.00%	***	0.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%
Black	***	***	22.22%	***	22.22%	***	0.00%	***	11.11%	***	33.33%	***	0.00%	***	11.11%
White	22	***	36.36%	***	40.90%	***	22.72%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Calvert

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	11	***	0.00%	***	0.00%	***	27.27%	***	27.27%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	40.00%	***	40.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	11	***	0.00%	***	0.00%	***	27.27%	***	27.27%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%
Race/Ethnicity									
Totals	11	***	0.00%	***	0.00%	***	27.27%	***	27.27%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	33.33%	***	33.33%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Calvert

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	15	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	15	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	15	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	13	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Calvert

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

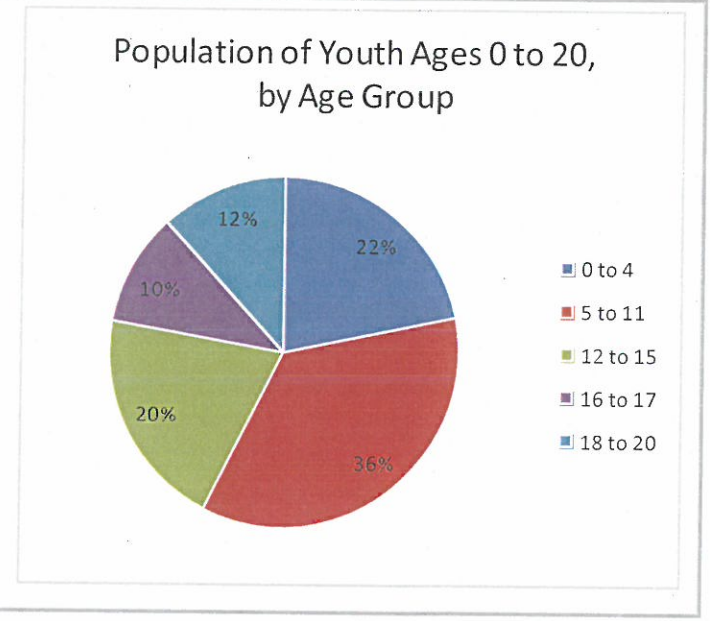
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	16	2,621	13	4.96
Ages 0 to 4	***	1,733	7	4.04
Ages 5 to 11	***	69	0	0.00
Ages 12 to 15	***	539	5	9.28
Ages 16 to 18	***	280	1	3.57
Gender				
Totals	16	2,621	13	4.96
Female	***	1,618	8	4.94
Male	10	1,003	5	4.99
Race/Ethnicity				
Totals	16	2,621	13	4.96
Black	***	750	5	6.67
White	13	1,871	8	4.28

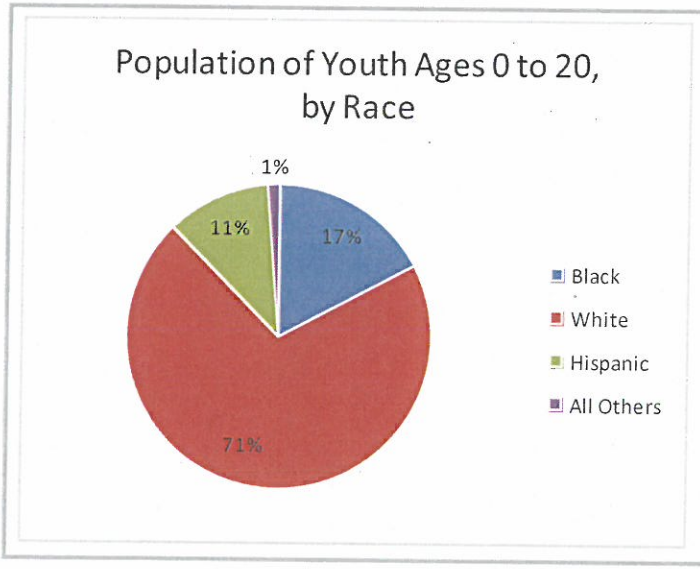
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Caroline County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[8].

Age Groups	Population of Youth Ages 0 to 20
Totals	8,732
0 to 4	1,898
5 to 11	3,113
12 to 15	1,783
16 to 17	907
18 to 20	1,031



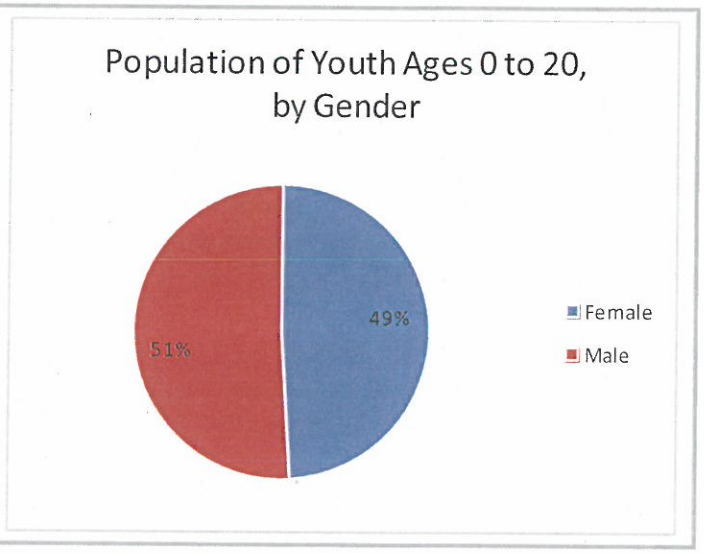


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	7,701	8,732
Black	1,327	1,500
White	5,393	6,152
Hispanic	881	966
All Others	100	114

[8]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	7,701	8,732
Female	3,792	4,280
Male	3,909	4,452



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Caroline.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Caroline

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	244	74	30.32%	170	69.67%	56	32.94%	54	31.76%	60	35.29%
Ages 0 to 4	74	28	37.83%	46	62.16%	14	30.43%	21	45.65%	11	23.91%
Ages 5 to 11	111	30	27.02%	81	72.97%	22	27.16%	28	34.56%	31	38.27%
Ages 12 to 15	44	11	25.00%	33	75.00%	14	42.42%	***	12.12%	15	45.45%
Ages 16 to 18	15	***	33.33%	10	66.66%	***	60.00%	***	10.00%	***	30.00%
Gender											
Totals	244	74	30.32%	170	69.67%	56	32.94%	54	31.76%	60	35.29%
Female	131	37	28.24%	94	71.75%	35	37.23%	26	27.65%	33	35.10%
Male	113	37	32.74%	76	67.25%	21	27.63%	28	36.84%	27	35.52%
Race/Ethnicity											
Totals	244	74	30.32%	170	69.67%	56	32.94%	54	31.76%	60	35.29%
Black	37	11	29.72%	26	70.27%	***	34.61%	***	30.76%	***	34.61%
White	179	58	32.40%	121	67.59%	39	32.23%	38	31.40%	44	36.36%
Hispanic	***	***	25.00%	***	75.00%	***	16.66%	***	66.66%	***	16.66%
All Others	***	***	0.00%	***	100.00%	***	66.66%	***	33.33%	***	0.00%
Unable to Determine	17	***	17.64%	14	82.35%	***	35.71%	***	21.42%	***	42.85%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Caroline.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	76	159
Ages 0 to 4	.	62
Ages 5 to 11	.	53
Ages 12 to 15	.	35
Ages 16 to 17	.	***
Age Unknown	.	***
Gender		
Totals	76	159
Female	.	80
Male	.	79
Race/Ethnicity		
Totals	76	159
Black	.	56
White	.	82
Hispanic	.	***
All Others	.	***
Unable to Determine	.	18

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Caroline

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	11	***	0.00%	10	90.90%	***	9.09%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	83.33%	***	16.66%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	11	***	0.00%	10	90.90%	***	9.09%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	75.00%	***	25.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	11	***	0.00%	10	90.90%	***	9.09%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	85.71%	***	14.28%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Caroline

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	13	***	38.46%	***	30.76%	***	7.69%	***	0.00%	***	23.07%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	66.66%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	33.33%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	13	***	38.46%	***	30.76%	***	7.69%	***	0.00%	***	23.07%	***	0.00%	***	0.00%
Female	***	***	37.50%	***	12.50%	***	12.50%	***	0.00%	***	37.50%	***	0.00%	***	0.00%
Male	***	***	40.00%	***	60.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	13	***	38.46%	***	30.76%	***	7.69%	***	0.00%	***	23.07%	***	0.00%	***	0.00%
Black	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	10	***	20.00%	***	40.00%	***	10.00%	***	0.00%	***	30.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Caroline

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Female	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	100.00%	***	100.00%	***	100.00%	***	100.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Caroline

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Caroline

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

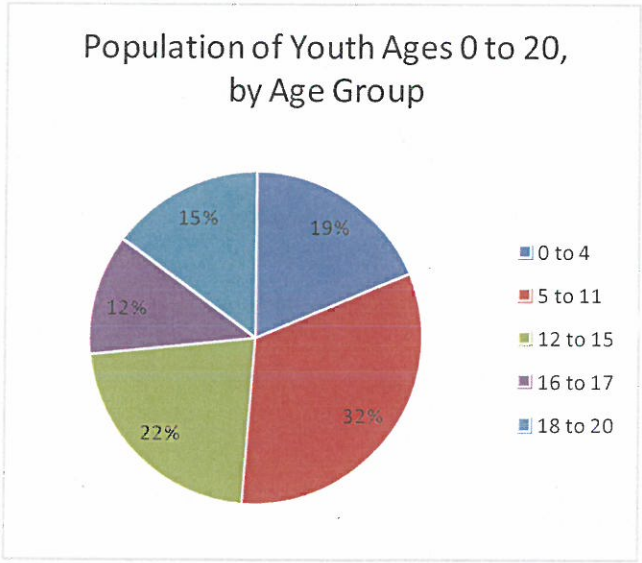
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	11	1,219	6	4.92
Ages 0 to 4	***	669	5	7.47
Ages 5 to 11	***	473	1	2.11
Ages 12 to 15	***	77	0	0.00
Ages 16 to 18	***	***	***	***
Gender				
Totals	11	1,219	6	4.92
Female	***	257	2	7.78
Male	***	962	4	4.16
Race/Ethnicity				
Totals	11	1,219	6	4.92
Black	***	150	0	0.00
White	***	877	4	4.56
Unable to determine	***	192	2	10.42

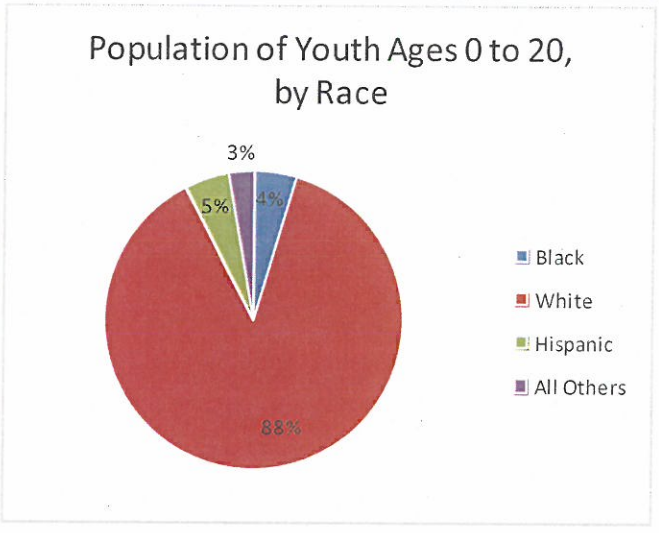
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Carroll County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[9].

Age Groups	Population of Youth Ages 0 to 20
Totals	43,537
0 to 4	8,138
5 to 11	14,146
12 to 15	9,664
16 to 17	5,099
18 to 20	6,490



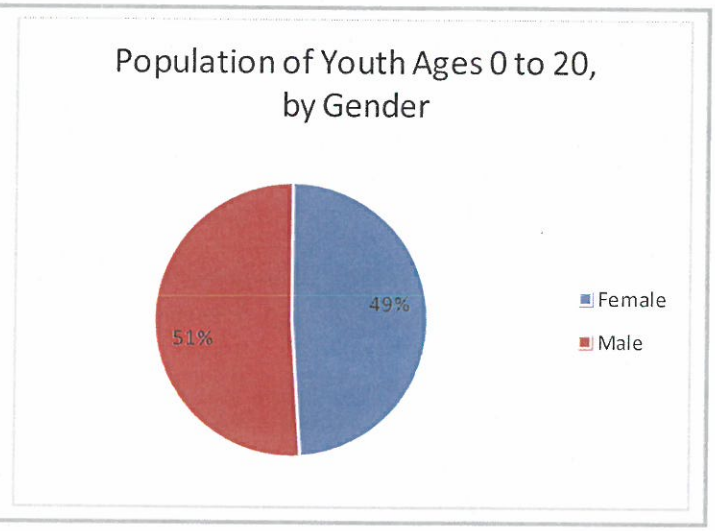


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	37,047	43,537
Black	1,698	1,985
White	32,489	38,239
Hispanic	1,815	2,104
All Others	1,045	1,209

[9]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	37,047	43,537
Female	18,148	21,286
Male	18,899	22,251



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Carroll.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Carroll

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	758	245	32.32%	513	67.67%	124	24.17%	41	7.99%	348	67.83%
Ages 0 to 4	210	69	32.85%	141	67.14%	46	32.62%	***	2.83%	91	64.53%
Ages 5 to 11	352	114	32.38%	238	67.61%	56	23.52%	19	7.98%	163	68.48%
Ages 12 to 15	136	44	32.35%	92	67.64%	14	15.21%	10	10.86%	68	73.91%
Ages 16 to 18	57	18	31.57%	39	68.42%	***	20.51%	***	12.82%	26	66.66%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	100.00%	***	0.00%
Gender											
Totals	758	245	32.32%	513	67.67%	124	24.17%	41	7.99%	348	67.83%
Female	390	113	28.97%	277	71.02%	67	24.18%	23	8.30%	187	67.50%
Male	368	132	35.86%	236	64.13%	57	24.15%	18	7.62%	161	68.22%
Race/Ethnicity											
Totals	758	245	32.32%	513	67.67%	124	24.17%	41	7.99%	348	67.83%
Black	75	23	30.66%	52	69.33%	14	26.92%	***	15.38%	30	57.69%
White	607	198	32.61%	409	67.38%	94	22.98%	29	7.09%	286	69.92%
Hispanic	29	***	10.34%	26	89.65%	***	30.76%	***	3.84%	17	65.38%
Unable to Determine	47	21	44.68%	26	55.31%	***	30.76%	***	11.53%	15	57.69%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Carroll.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	310	642
Ages 0 to 4	.	215
Ages 5 to 11	.	251
Ages 12 to 15	.	125
Ages 16 to 17	.	45
Age Unknown	.	***
Gender		
Totals	310	642
Female	.	336
Male	.	306
Race/Ethnicity		
Totals	310	642
Black	.	83
White	.	433
Hispanic	.	16
All Others	.	***
Unable to Determine	.	104

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Carroll

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	25	***	20.00%	17	68.00%	***	8.00%	***	0.00%	***	0.00%
Ages 0 to 4	12	***	0.00%	10	83.33%	***	16.66%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	14.28%	***	85.71%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	75.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	25	***	20.00%	17	68.00%	***	8.00%	***	0.00%	***	0.00%
Female	12	***	16.66%	***	75.00%	***	8.33%	***	0.00%	***	0.00%
Male	13	***	23.07%	***	61.53%	***	7.69%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	25	***	20.00%	17	68.00%	***	8.00%	***	0.00%	***	0.00%
Black	***	***	16.66%	***	83.33%	***	0.00%	***	0.00%	***	0.00%
White	19	***	21.05%	12	63.15%	***	10.52%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Carroll

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	24	11	45.83%	***	4.16%	***	4.16%	***	12.50%	***	20.83%	***	0.00%	***	12.50%
Ages 0 to 4	***	***	57.14%	***	14.28%	***	0.00%	***	14.28%	***	0.00%	***	0.00%	***	14.28%
Ages 5 to 11	***	***	66.66%	***	0.00%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	33.33%
Ages 16 to 18	***	***	50.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%	***	16.66%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	24	11	45.83%	***	4.16%	***	4.16%	***	12.50%	***	20.83%	***	0.00%	***	12.50%
Female	12	***	50.00%	***	8.33%	***	8.33%	***	8.33%	***	16.66%	***	0.00%	***	8.33%
Male	12	***	41.66%	***	0.00%	***	0.00%	***	16.66%	***	25.00%	***	0.00%	***	16.66%
Race/Ethnicity															
Totals	24	11	45.83%	***	4.16%	***	4.16%	***	12.50%	***	20.83%	***	0.00%	***	12.50%
Black	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	20	***	35.00%	***	5.00%	***	5.00%	***	15.00%	***	25.00%	***	0.00%	***	15.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Carroll

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	14	***	0.00%	***	7.14%	***	7.14%	***	7.14%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	33.33%	***	33.33%	***	33.33%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	14	***	0.00%	***	7.14%	***	7.14%	***	7.14%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	12.50%	***	12.50%	***	12.50%
Race/Ethnicity									
Totals	14	***	0.00%	***	7.14%	***	7.14%	***	7.14%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	12	***	0.00%	***	8.33%	***	8.33%	***	8.33%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Carroll

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	11.11%	***	11.11%	***	33.33%	***	44.44%	***	44.44%	***	44.44%	***	44.44%	***	44.44%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Ages 5 to 11	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	11.11%	***	11.11%	***	33.33%	***	44.44%	***	44.44%	***	44.44%	***	44.44%	***	44.44%
Female	***	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Male	***	***	0.00%	***	0.00%	***	33.33%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Race/Ethnicity																	
Totals	***	***	11.11%	***	11.11%	***	33.33%	***	44.44%	***	44.44%	***	44.44%	***	44.44%	***	44.44%
Hispanic	***	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.0%	***	100.0%	***	100.0%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	28.57%	***	42.85%	***	42.85%	***	42.85%	***	42.85%	***	42.85%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Carroll

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

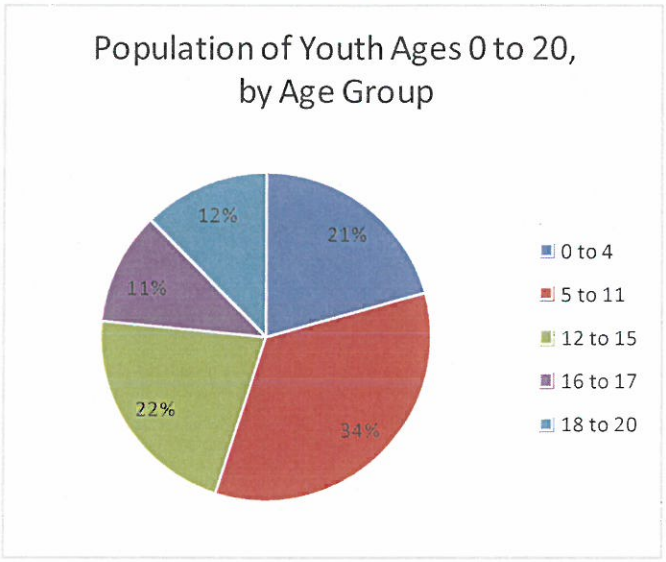
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	33	4,684	17	3.63
Ages 0 to 4	14	1,561	5	3.20
Ages 5 to 11	***	935	2	2.14
Ages 12 to 15	***	1,280	4	3.13
Ages 16 to 18	***	908	6	6.61
Gender				
Totals	33	4,684	17	3.63
Female	18	2,575	12	4.66
Male	15	2,109	5	2.37
Race/Ethnicity				
Totals	33	4,684	17	3.63
Black	***	944	1	1.06
White	24	3,740	16	4.28

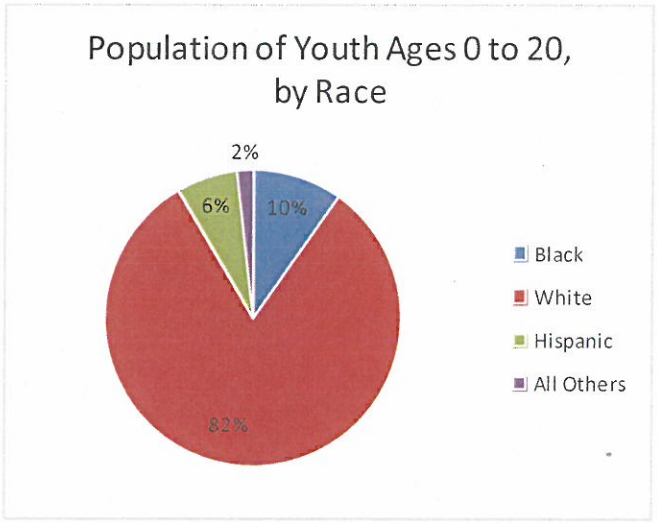
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Cecil County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[10].

Age Groups	Population of Youth Ages 0 to 20
Totals	27,198
0 to 4	5,627
5 to 11	9,306
12 to 15	5,877
16 to 17	2,998
18 to 20	3,390



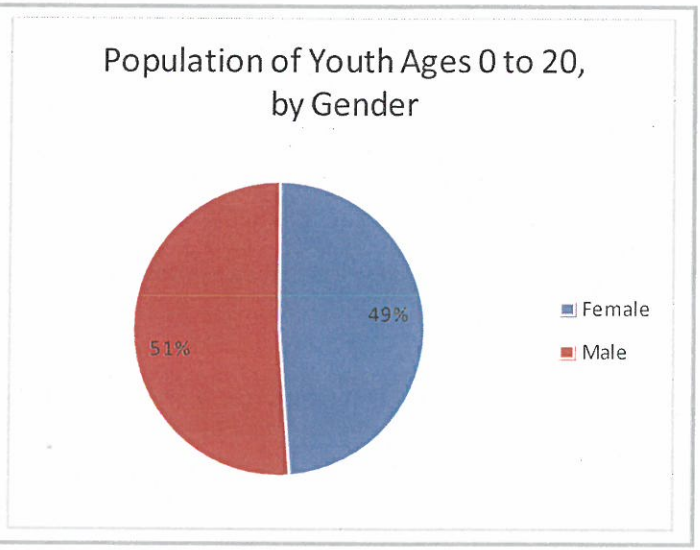


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	23,808	27,198
Black	2,302	2,639
White	19,516	22,239
Hispanic	1,570	1,821
All Others	420	499

[10]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	23,808	27,198
Female	11,652	13,250
Male	12,156	13,948



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Cecil.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Cecil

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	826	355	42.97%	471	57.02%	153	32.48%	121	25.69%	197	41.82%
Ages 0 to 4	279	120	43.01%	159	56.98%	53	33.33%	43	27.04%	63	39.62%
Ages 5 to 11	353	164	46.45%	189	53.54%	59	31.21%	52	27.51%	78	41.26%
Ages 12 to 15	135	50	37.03%	85	62.96%	29	34.11%	19	22.35%	37	43.52%
Ages 16 to 18	59	21	35.59%	38	64.40%	12	31.57%	***	18.42%	19	50.00%
Gender											
Totals	826	355	42.97%	471	57.02%	153	32.48%	121	25.69%	197	41.82%
Female	377	157	41.64%	220	58.35%	76	34.54%	59	26.81%	85	38.63%
Male	438	190	43.37%	248	56.62%	75	30.24%	61	24.59%	112	45.16%
Other/ Unknown	11	***	72.72%	***	27.27%	***	66.66%	***	33.33%	***	0.00%
Race/Ethnicity											
Totals	826	355	42.97%	471	57.02%	153	32.48%	121	25.69%	197	41.82%
Black	89	49	55.05%	40	44.94%	11	27.50%	10	25.00%	19	47.50%
White	569	230	40.42%	339	59.57%	109	32.15%	89	26.25%	141	41.59%
Hispanic	28	13	46.42%	15	53.57%	***	33.33%	***	13.33%	***	53.33%
All Others	***	***	0.00%	***	100.00%	***	100.00%	***	0.00%	***	0.00%
Unable to Determine	139	63	45.32%	76	54.67%	27	35.52%	20	26.31%	29	38.15%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Cecil.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	247	500
Ages 0 to 4	.	238
Ages 5 to 11	.	178
Ages 12 to 15	.	63
Ages 16 to 17	.	16
Age Unknown	.	***
Gender		
Totals	247	500
Female	.	229
Male	.	261
Unknown	.	10
Race/Ethnicity		
Totals	247	500
Black	.	45
White	.	286
Hispanic	.	12
Unable to Determine	.	157

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Cecil

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	38	***	7.89%	30	78.94%	***	13.15%	***	0.00%	***	0.00%
Ages 0 to 4	24	***	4.16%	20	83.33%	***	12.50%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	16.66%	***	83.33%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	14.28%	***	71.42%	***	14.28%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender											
Totals	38	***	7.89%	30	78.94%	***	13.15%	***	0.00%	***	0.00%
Female	14	***	7.14%	10	71.42%	***	21.42%	***	0.00%	***	0.00%
Male	24	***	8.33%	20	83.33%	***	8.33%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	38	***	7.89%	30	78.94%	***	13.15%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
White	24	***	8.33%	19	79.16%	***	12.50%	***	0.00%	***	0.00%
Unable to determine	10	***	10.00%	***	70.00%	***	20.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Cecil

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type														
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	76	27	35.52%	24	31.57%	16	21.05%	***	2.63%	***	7.89%	***	1.31%	***	0.00%
	Ages 0 to 4	24	***	29.16%	13	54.16%	***	16.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 5 to 11	27	***	25.92%	10	37.03%	***	25.92%	***	7.40%	***	0.00%	***	3.70%	***	0.00%
	Ages 12 to 15	14	10	71.42%	***	7.14%	***	21.42%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 16 to 18	***	***	50.00%	***	0.00%	***	33.33%	***	0.00%	***	16.66%	***	0.00%	***	0.00%
	Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender																
	Totals	76	27	35.52%	24	31.57%	16	21.05%	***	2.63%	***	7.89%	***	1.31%	***	0.00%
	Female	37	11	29.72%	11	29.72%	***	24.32%	***	5.40%	***	10.81%	***	0.00%	***	0.00%
	Male	39	16	41.02%	13	33.33%	***	17.94%	***	0.00%	***	5.12%	***	2.56%	***	0.00%
Race/Ethnicity																
	Totals	76	27	35.52%	24	31.57%	16	21.05%	***	2.63%	***	7.89%	***	1.31%	***	0.00%
	Hispanic	***	***	0.00%	***	50.00%	***	0.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%
	Black	10	***	20.00%	***	40.00%	***	40.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	White	55	21	38.18%	14	25.45%	12	21.81%	***	3.63%	***	9.09%	***	1.81%	***	0.00%
	Unable to determine	***	***	44.44%	***	55.55%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Cecil

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	26	***	3.84%	***	3.84%	***	7.69%	***	11.53%
Ages 0 to 4	***	***	12.50%	***	12.50%	***	12.50%	***	25.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	12.50%	***	12.50%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	26	***	3.84%	***	3.84%	***	7.69%	***	11.53%
Female	13	***	7.69%	***	7.69%	***	15.38%	***	15.38%
Male	13	***	0.00%	***	0.00%	***	0.00%	***	7.69%
Race/Ethnicity									
Totals	26	***	3.84%	***	3.84%	***	7.69%	***	11.53%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	33.33%	***	66.66%
White	19	***	5.26%	***	5.26%	***	5.26%	***	5.26%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Cecil

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	36	***	2.77%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	13.88%
Ages 0 to 4	15	***	0.00%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%
Ages 5 to 11	***	***	0.00%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Ages 12 to 15	***	***	0.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%
Ages 16 to 18	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	28.57%
Gender																	
Totals	36	***	2.77%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	13.88%
Female	22	***	4.54%	***	18.18%	***	18.18%	***	18.18%	***	18.18%	***	18.18%	***	18.18%	***	22.72%
Male	14	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	36	***	2.77%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	13.88%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	14	***	7.14%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	21.42%
White	20	***	0.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Cecil

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

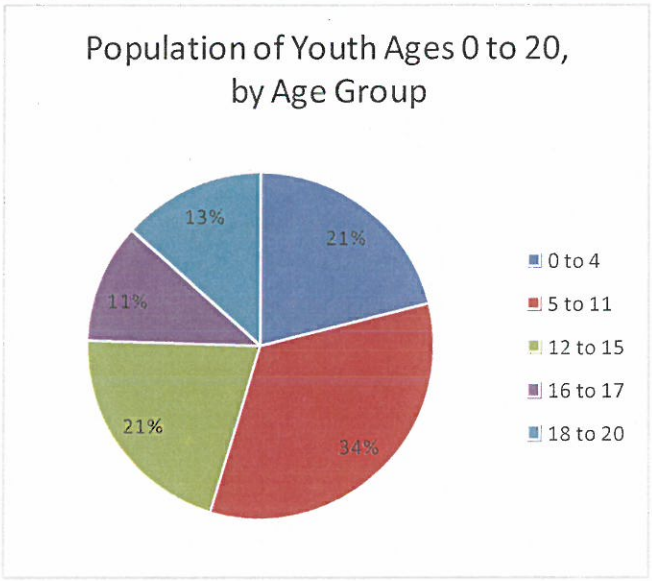
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	44	6,874	33	4.80
Ages 0 to 4	24	3,947	15	3.80
Ages 5 to 11	***	1,265	7	5.53
Ages 12 to 15	***	1,088	8	7.35
Ages 16 to 18	***	574	3	5.23
Gender				
Totals	44	6,874	33	4.80
Female	16	3,007	15	4.99
Male	28	3,867	18	4.65
Race/Ethnicity				
Totals	44	6,874	33	4.80
Black	***	741	8	10.80
White	30	4,917	18	3.66
Unable to determine	10	1,216	7	5.76

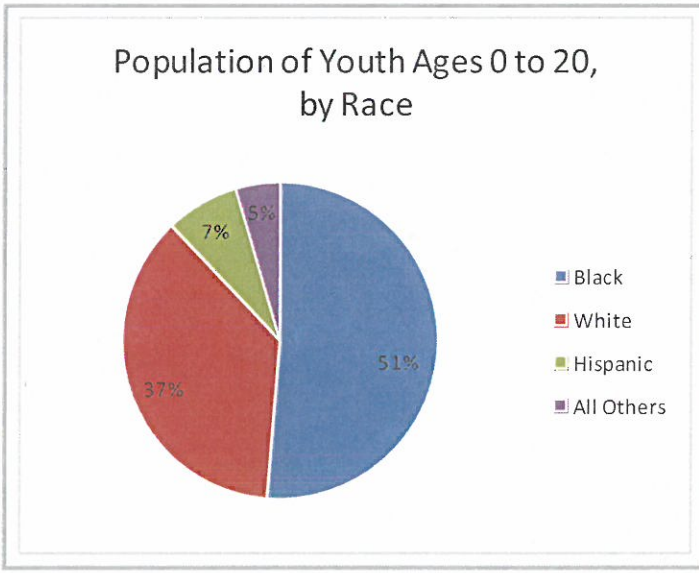
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Charles County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[11].

Age Groups	Population of Youth Ages 0 to 20
Totals	44,176
0 to 4	9,303
5 to 11	14,827
12 to 15	9,227
16 to 17	4,907
18 to 20	5,912



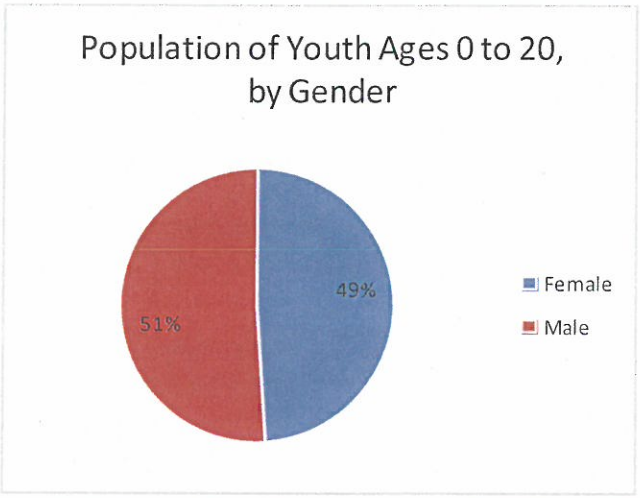


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	38,264	44,176
Black	19,454	22,641
White	14,097	16,219
Hispanic	2,933	3,310
All Others	1,780	2,006

[11]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	38,264	44,176
Female	18,761	21,593
Male	19,503	22,583



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Charles.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Charles

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	847	479	56.55%	368	43.44%	109	29.61%	95	25.81%	164	44.56%
Ages 0 to 4	220	112	50.90%	108	49.09%	32	29.62%	27	25.00%	49	45.37%
Ages 5 to 11	374	226	60.42%	148	39.57%	40	27.02%	32	21.62%	76	51.35%
Ages 12 to 15	153	95	62.09%	58	37.90%	18	31.03%	24	41.37%	16	27.58%
Ages 16 to 18	96	46	47.91%	50	52.08%	16	32.00%	12	24.00%	22	44.00%
Age Invalid	***	***	0.00%	***	100.00%	***	75.00%	***	0.00%	***	25.00%
Gender											
Totals	847	479	56.55%	368	43.44%	109	29.61%	95	25.81%	164	44.56%
Female	422	220	52.13%	202	47.86%	57	28.21%	48	23.76%	97	48.01%
Male	421	258	61.28%	163	38.71%	50	30.67%	47	28.83%	66	40.49%
Other/ Unknown	***	***	25.00%	***	75.00%	***	66.66%	***	0.00%	***	33.33%
Race/Ethnicity											
Totals	847	479	56.55%	368	43.44%	109	29.61%	95	25.81%	164	44.56%
Black	449	261	58.12%	188	41.87%	56	29.78%	38	20.21%	94	50.00%
White	265	134	50.56%	131	49.43%	42	32.06%	41	31.29%	48	36.64%
Hispanic	36	21	58.33%	15	41.66%	***	46.66%	***	53.33%	***	0.00%
All Others	***	***	71.42%	***	28.57%	***	0.00%	***	0.00%	***	100.00%
Unable to Determine	90	58	64.44%	32	35.55%	***	12.50%	***	25.00%	20	62.50%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Charles.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	222	496
Ages 0 to 4	.	122
Ages 5 to 11	.	201
Ages 12 to 15	.	117
Ages 16 to 17	.	52
Age Unknown	.	***
Gender		
Totals	222	496
Female	.	239
Male	.	257
Race/Ethnicity		
Totals	222	496
Black	.	238
White	.	136
Hispanic	.	34
All Others	.	***
Unable to Determine	.	87

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Charles

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	32	***	3.12%	27	84.37%	***	12.50%	***	0.00%	***	0.00%
Ages 0 to 4	16	***	6.25%	12	75.00%	***	18.75%	***	0.00%	***	0.00%
Ages 5 to 11	10	***	0.00%	10	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	75.00%	***	25.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	32	***	3.12%	27	84.37%	***	12.50%	***	0.00%	***	0.00%
Female	16	***	0.00%	15	93.75%	***	6.25%	***	0.00%	***	0.00%
Male	16	***	6.25%	12	75.00%	***	18.75%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	32	***	3.12%	27	84.37%	***	12.50%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Black	13	***	0.00%	11	84.61%	***	15.38%	***	0.00%	***	0.00%
White	14	***	0.00%	13	92.85%	***	7.14%	***	0.00%	***	0.00%
Unable to determine	***	***	33.33%	***	66.66%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Charles

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	52	10	19.23%	16	30.76%	15	28.84%	***	1.92%	10	19.23%	***	0.00%	***	0.00%
Ages 0 to 4	23	***	13.04%	13	56.52%	***	30.43%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	33.33%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	66.66%	***	0.00%	***	16.66%	***	16.66%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	60.00%	***	0.00%	***	20.00%	***	0.00%	***	20.00%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	52	10	19.23%	16	30.76%	15	28.84%	***	1.92%	10	19.23%	***	0.00%	***	0.00%
Female	23	***	21.73%	***	26.08%	***	30.43%	***	4.34%	***	17.39%	***	0.00%	***	0.00%
Male	29	***	17.24%	10	34.48%	***	27.58%	***	0.00%	***	20.68%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	52	10	19.23%	16	30.76%	15	28.84%	***	1.92%	10	19.23%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	33.33%	***	33.33%	***	33.33%	***	0.00%	***	0.00%	***	0.00%
Black	25	***	24.00%	***	28.00%	***	12.00%	***	0.00%	***	36.00%	***	0.00%	***	0.00%
White	21	***	14.28%	***	28.57%	11	52.38%	***	0.00%	***	4.76%	***	0.00%	***	0.00%
Unable to determine	***	***	33.33%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Charles

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Charles

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	13	***	0.00%	***	0.00%	***	0.00%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	13	***	0.00%	***	0.00%	***	0.00%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	11.11%	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Race/Ethnicity																	
Totals	13	***	0.00%	***	0.00%	***	0.00%	***	7.69%	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Charles

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

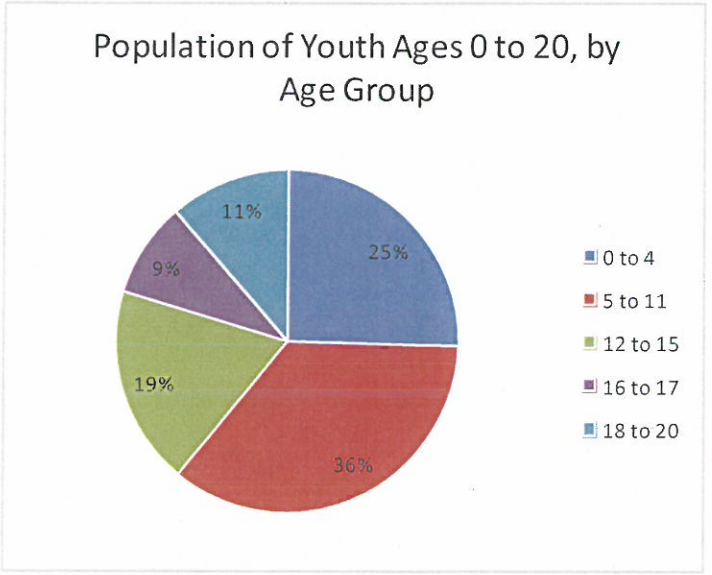
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	34	6,015	27	4.49
Ages 0 to 4	16	2,143	13	6.07
Ages 5 to 11	***	1,994	4	2.01
Ages 12 to 15	***	1,120	5	4.46
Ages 16 to 18	***	758	5	6.60
Gender				
Totals	34	6,015	27	4.49
Female	15	2,915	10	3.43
Male	19	3,100	17	5.48
Race/Ethnicity				
Totals	34	6,015	27	4.49
Hispanic	***	73	0	0.00
Black	15	3,003	12	4.00
White	15	2,925	15	5.13
Unable to determine	***	14	0	0.00

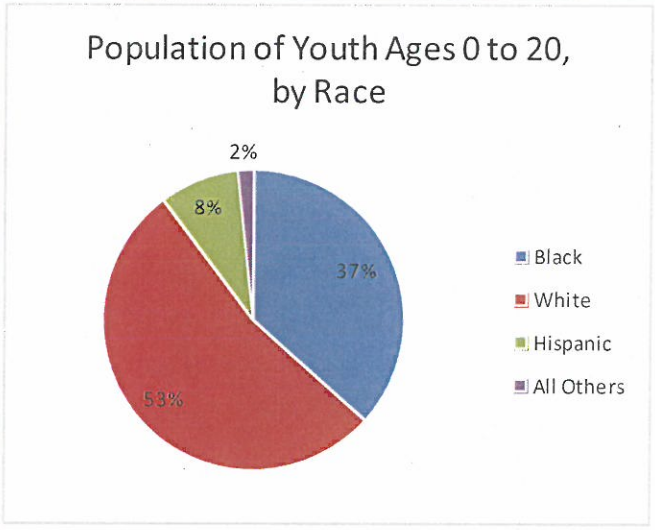
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Dorchester County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[12].

Age Groups	Population of Youth Ages 0 to 20
Totals	7,783
0 to 4	1,979
5 to 11	2,758
12 to 15	1,464
16 to 17	695
18 to 20	887



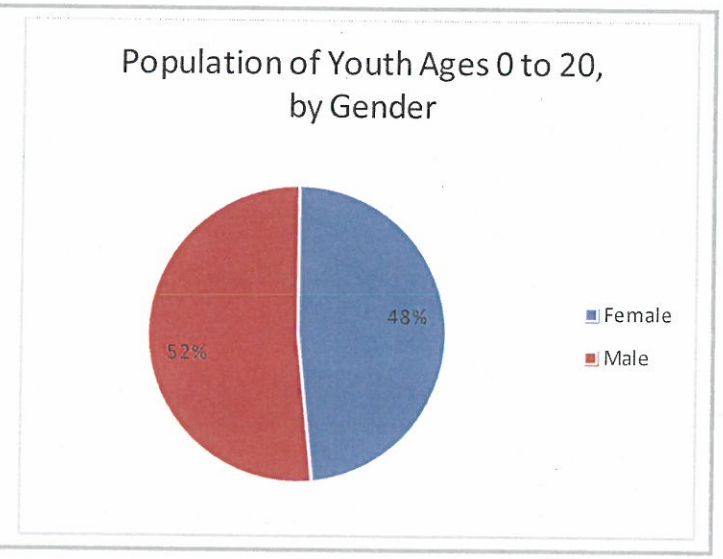


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	6,896	7,783
Black	2,540	2,851
White	3,619	4,129
Hispanic	623	669
All Others	114	134

[12]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	6,896	7,783
Female	3,340	3,760
Male	3,556	4,023



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Dorchester.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Dorchester

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	462	173	37.44%	289	62.55%	83	28.71%	49	16.95%	157	54.32%
Ages 0 to 4	132	50	37.87%	82	62.12%	25	30.48%	15	18.29%	42	51.21%
Ages 5 to 11	229	84	36.68%	145	63.31%	38	26.20%	19	13.10%	88	60.68%
Ages 12 to 15	68	27	39.70%	41	60.29%	13	31.70%	11	26.82%	17	41.46%
Ages 16 to 18	31	12	38.70%	19	61.29%	***	36.84%	***	21.05%	***	42.10%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	462	173	37.44%	289	62.55%	83	28.71%	49	16.95%	157	54.32%
Female	224	74	33.03%	150	66.96%	40	26.66%	27	18.00%	83	55.33%
Male	238	99	41.59%	139	58.40%	43	30.93%	22	15.82%	74	53.23%
Race/Ethnicity											
Totals	462	173	37.44%	289	62.55%	83	28.71%	49	16.95%	157	54.32%
Black	226	77	34.07%	149	65.92%	42	28.18%	24	16.10%	83	55.70%
White	182	73	40.10%	109	59.89%	29	26.60%	15	13.76%	65	59.63%
Hispanic	12	***	41.66%	***	58.33%	***	28.57%	***	14.28%	***	57.14%
Unable to Determine	42	18	42.85%	24	57.14%	10	41.66%	***	37.50%	***	20.83%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Dorchester.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	113	278
Ages 0 to 4	.	119
Ages 5 to 11	.	113
Ages 12 to 15	.	36
Ages 16 to 17	.	***
Age Unknown	.	***
Gender		
Totals	113	278
Female	.	135
Male	.	143
Race/Ethnicity		
Totals	113	278
Black	.	188
White	.	52
Hispanic	.	***
Unable to Determine	.	31

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Dorchester

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	16.66%	***	16.66%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	40.00%	***	40.00%	***	20.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	16.66%	***	16.66%
Female	***	***	0.00%	***	0.00%	***	66.66%	***	33.33%	***	0.00%
Male	***	***	0.00%	***	66.66%	***	0.00%	***	0.00%	***	33.33%
Race/Ethnicity											
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	16.66%	***	16.66%
Black	***	***	0.00%	***	33.33%	***	0.00%	***	33.33%	***	33.33%
White	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Dorchester

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	***	***	50.00%	***	12.50%	***	37.50%	***	***	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	50.00%	***	50.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	100.0%	***	0.00%	***	0.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	100.0%	***	0.00%	***	0.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	33.33%	***	0.00%	***	66.66%	***	***	***	0.00%	***	0.00%	***	0.00%
Gender															
Totals	***	***	50.00%	***	12.50%	***	37.50%	***	***	***	0.00%	***	0.00%	***	0.00%
Female	***	***	75.00%	***	0.00%	***	25.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Male	***	***	25.00%	***	25.00%	***	50.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	***	***	50.00%	***	12.50%	***	37.50%	***	***	***	0.00%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	0.00%	***	100.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	100.0%	***	0.00%	***	***	***	0.00%	***	0.00%	***	0.00%
White	***	***	60.00%	***	0.00%	***	40.00%	***	***	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	100.0%	***	0.00%	***	0.00%	***	***	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Dorchester

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	0.00%	***	33.33%	***	33.33%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	0.00%	***	0.00%	***	33.33%	***	33.33%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	0.00%	***	33.33%	***	33.33%
Black	***	***	0.00%	***	0.00%	***	50.00%	***	50.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Dorchester
No Data Available for this Table

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Dorchester

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

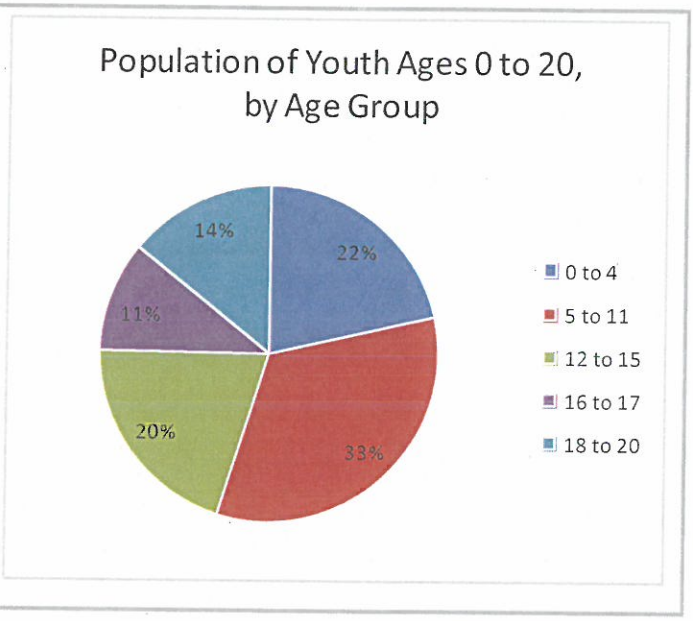
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	***	1,282	3	2.34
Ages 0 to 4	***	***	***	0.00
Ages 5 to 11	***	***	***	0.00
Ages 12 to 15	***	1,089	0	0.00
Ages 16 to 18	***	193	3	15.54
Gender				
Totals	***	1,282	3	2.34
Female	***	806	2	2.48
Male	***	476	1	2.10
Race/Ethnicity				
Totals	***	1,282	3	2.34
Black	***	893	3	3.36
White	***	302	0	0.00
Unable to determine	***	87	0	0.00

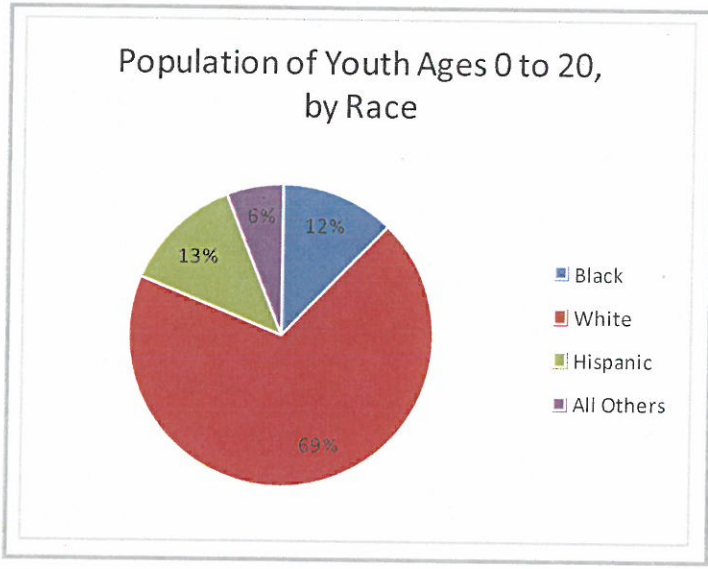
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Frederick County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[13].

Age Groups	Population of Youth Ages 0 to 20
Totals	67,785
0 to 4	14,519
5 to 11	22,638
12 to 15	13,818
16 to 17	7,129
18 to 20	9,681



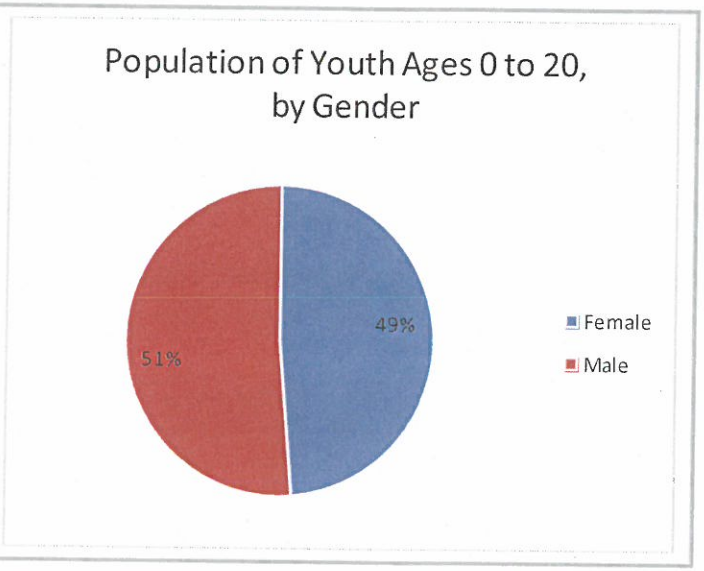


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	58,104	67,785
Black	7,107	8,277
White	39,856	46,781
Hispanic	7,505	8,603
All Others	3,636	4,124

[13]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	58,104	67,785
Female	28,305	32,956
Male	29,799	34,829



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Frederick.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Frederick

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	1,005	438	43.58%	567	56.41%	208	36.68%	129	22.75%	230	40.56%
Ages 0 to 4	253	105	41.50%	148	58.49%	67	45.27%	30	20.27%	51	34.45%
Ages 5 to 11	433	196	45.26%	237	54.73%	76	32.06%	58	24.47%	103	43.45%
Ages 12 to 15	225	100	44.44%	125	55.55%	42	33.60%	29	23.20%	54	43.20%
Ages 16 to 18	93	37	39.78%	56	60.21%	23	41.07%	12	21.42%	21	37.50%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	1,005	438	43.58%	567	56.41%	208	36.68%	129	22.75%	230	40.56%
Female	534	195	36.51%	339	63.48%	134	39.52%	67	19.76%	138	40.70%
Male	471	243	51.59%	228	48.40%	74	32.45%	62	27.19%	92	40.35%
Race/Ethnicity											
Totals	1,005	438	43.58%	567	56.41%	208	36.68%	129	22.75%	230	40.56%
Black	234	97	41.45%	137	58.54%	41	29.92%	31	22.62%	65	47.44%
White	479	196	40.91%	283	59.08%	117	41.34%	63	22.26%	103	36.39%
Hispanic	92	40	43.47%	52	56.52%	22	42.30%	15	28.84%	15	28.84%
All Others	24	10	41.66%	14	58.33%	***	28.57%	***	35.71%	***	35.71%
Unable to Determine	176	95	53.97%	81	46.02%	24	29.62%	15	18.51%	42	51.85%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Frederick.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	353	761
Ages 0 to 4	.	261
Ages 5 to 11	.	296
Ages 12 to 15	.	141
Ages 16 to 17	.	54
Age Unknown	.	***
Gender		
Totals	353	761
Female	.	367
Male	.	394
Race/Ethnicity		
Totals	353	761
Black	.	177
White	.	380
Hispanic	.	52
All Others	.	11
Unable to Determine	.	141

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Frederick

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	40	***	7.50%	30	75.00%	***	12.50%	***	5.00%	***	0.00%
Ages 0 to 4	19	***	0.00%	15	78.94%	***	21.05%	***	0.00%	***	0.00%
Ages 5 to 11	11	***	9.09%	10	90.90%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	16.66%	***	66.66%	***	16.66%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	25.00%	***	25.00%	***	0.00%	***	50.00%	***	0.00%
Gender											
Totals	40	***	7.50%	30	75.00%	***	12.50%	***	5.00%	***	0.00%
Female	19	***	10.52%	14	73.68%	***	10.52%	***	5.26%	***	0.00%
Male	21	***	4.76%	16	76.19%	***	14.28%	***	4.76%	***	0.00%
Race/Ethnicity											
Totals	40	***	7.50%	30	75.00%	***	12.50%	***	5.00%	***	0.00%
Hispanic	***	***	0.00%	***	71.42%	***	14.28%	***	14.28%	***	0.00%
Black	***	***	12.50%	***	87.50%	***	0.00%	***	0.00%	***	0.00%
White	19	***	10.52%	16	84.21%	***	5.26%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	33.33%	***	50.00%	***	16.66%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Frederick

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type													
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	59	19	32.20%	11	18.64%	14	23.72%	***	0.00%	13	22.03%	***	0.00%	***	3.38%
Ages 0 to 4	27	11	40.74%	***	33.33%	***	25.92%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	11	***	45.45%	***	9.09%	***	36.36%	***	0.00%	***	0.00%	***	0.00%	***	9.09%
Ages 12 to 15	***	***	66.66%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	16.66%	***	0.00%	***	33.33%	***	0.00%	***	33.33%	***	0.00%	***	16.66%
Over 18	12	***	0.00%	***	0.00%	***	8.33%	***	0.00%	11	91.66%	***	0.00%	***	0.00%
Gender															
Totals	59	19	32.20%	11	18.64%	14	23.72%	***	0.00%	13	22.03%	***	0.00%	***	3.38%
Female	29	10	34.48%	***	13.79%	***	17.24%	***	0.00%	***	31.03%	***	0.00%	***	3.44%
Male	30	***	30.00%	***	23.33%	***	30.00%	***	0.00%	***	13.33%	***	0.00%	***	3.33%
Race/Ethnicity															
Totals	59	19	32.20%	11	18.64%	14	23.72%	***	0.00%	13	22.03%	***	0.00%	***	3.38%
Hispanic	***	***	37.50%	***	25.00%	***	0.00%	***	0.00%	***	25.00%	***	0.00%	***	12.50%
Black	13	***	23.07%	***	23.07%	***	15.38%	***	0.00%	***	38.46%	***	0.00%	***	0.00%
White	30	***	26.66%	***	16.66%	10	33.33%	***	0.00%	***	20.00%	***	0.00%	***	3.33%
All other	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	25.00%	***	25.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Frederick

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	21	***	4.76%	***	4.76%	***	4.76%	***	9.52%
Ages 0 to 4	11	***	9.09%	***	9.09%	***	9.09%	***	18.18%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	21	***	4.76%	***	4.76%	***	4.76%	***	9.52%
Female	12	***	8.33%	***	8.33%	***	8.33%	***	16.66%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	21	***	4.76%	***	4.76%	***	4.76%	***	9.52%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	10	***	10.00%	***	10.00%	***	10.00%	***	20.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Frederick

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	41	***	7.31%	***	12.19%	***	12.19%	***	12.19%	***	14.63%	***	19.51%	***	19.51%	***	21.95%
Ages 0 to 4	13	***	15.38%	***	23.07%	***	23.07%	***	23.07%	***	30.76%	***	30.76%	***	30.76%	***	30.76%
Ages 5 to 11	15	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	20.00%	***	20.00%	***	26.66%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	10	***	0.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%
Gender																	
Totals	41	***	7.31%	***	12.19%	***	12.19%	***	12.19%	***	14.63%	***	19.51%	***	19.51%	***	21.95%
Female	21	***	4.76%	***	14.28%	***	14.28%	***	14.28%	***	19.04%	***	28.57%	***	28.57%	***	28.57%
Male	20	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	10.00%	***	15.00%
Race/Ethnicity																	
Totals	41	***	7.31%	***	12.19%	***	12.19%	***	12.19%	***	14.63%	***	19.51%	***	19.51%	***	21.95%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	11	***	0.00%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	9.09%
White	16	***	0.00%	***	6.25%	***	6.25%	***	6.25%	***	12.50%	***	25.00%	***	25.00%	***	31.25%
All other	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Frederick

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

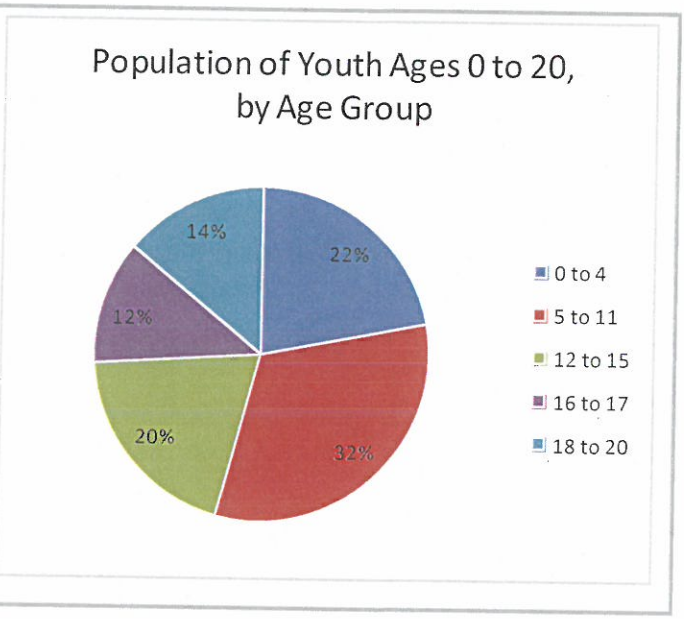
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	50	7,959	24	3.02
Ages 0 to 4	23	3,434	14	4.08
Ages 5 to 11	13	2,292	5	2.18
Ages 12 to 15	***	1,334	3	2.25
Ages 16 to 18	***	899	2	2.22
Gender				
Totals	50	7,959	24	3.02
Female	26	4,473	13	2.91
Male	24	3,486	11	3.16
Race/Ethnicity				
Totals	50	7,959	24	3.02
Hispanic	***	781	0	0.00
Black	***	1,284	5	3.89
White	26	5,171	13	2.51
Unable to determine	***	723	6	8.30

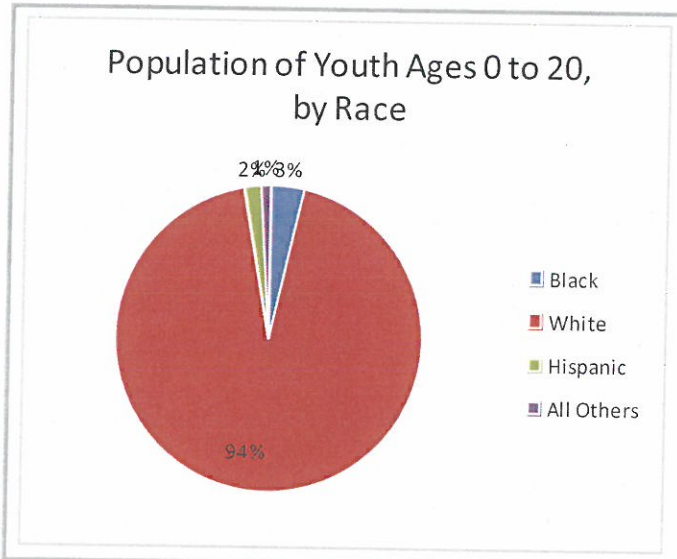
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Garrett County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[14].

Age Groups	Population of Youth Ages 0 to 20
Totals	6,638
0 to 4	1,458
5 to 11	2,136
12 to 15	1,319
16 to 17	791
18 to 20	934



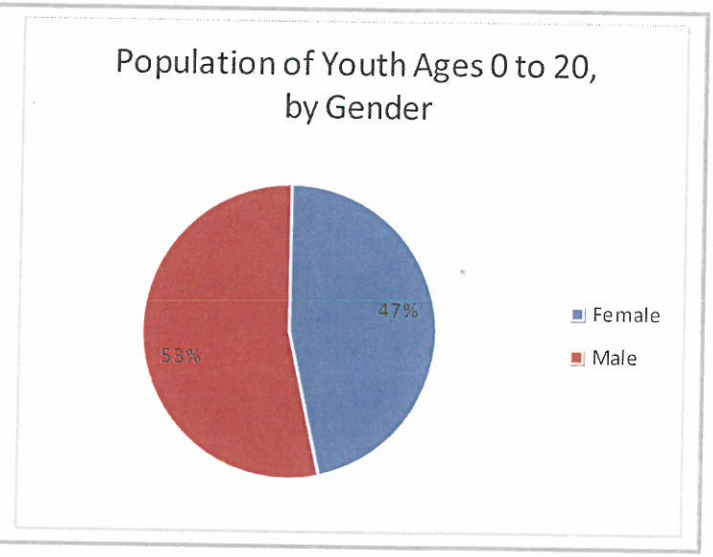


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	5,704	6,638
Black	185	232
White	5,350	6,220
Hispanic	109	117
All Others	60	69

[14]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	5,704	6,638
Female	2,664	3,089
Male	3,040	3,549



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Garrett.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Garrett

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	338	148	43.78%	190	56.21%	93	48.94%	26	13.68%	71	37.36%
Ages 0 to 4	137	61	44.52%	76	55.47%	39	51.31%	***	11.84%	28	36.84%
Ages 5 to 11	143	62	43.35%	81	56.64%	38	46.91%	11	13.58%	32	39.50%
Ages 12 to 15	46	21	45.65%	25	54.34%	14	56.00%	***	20.00%	***	24.00%
Ages 16 to 18	11	***	36.36%	***	63.63%	***	28.57%	***	14.28%	***	57.14%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	338	148	43.78%	190	56.21%	93	48.94%	26	13.68%	71	37.36%
Female	164	63	38.41%	101	61.58%	57	56.43%	12	11.88%	32	31.68%
Male	174	85	48.85%	89	51.14%	36	40.44%	14	15.73%	39	43.82%
Race/Ethnicity											
Totals	338	148	43.78%	190	56.21%	93	48.94%	26	13.68%	71	37.36%
Black	***	***	25.00%	***	75.00%	***	33.33%	***	0.00%	***	66.66%
White	310	138	44.51%	172	55.48%	80	46.51%	26	15.11%	66	38.37%
Hispanic	***	***	0.00%	***	100.00%	***	100.00%	***	0.00%	***	0.00%
All Others	***	***	100.00 %	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to Determine	19	***	42.10%	11	57.89%	***	72.72%	***	0.00%	***	27.27%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Garrett.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	62	124
Ages 0 to 4	.	64
Ages 5 to 11	.	47
Ages 12 to 15	.	***
Ages 16 to 17	.	***
Age Unknown	.	***
Gender		
Totals	62	124
Female	.	63
Male	.	61
Race/Ethnicity		
Totals	62	124
Black	.	***
White	.	116
Unable to Determine	.	***

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Garrett

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	41	***	2.43%	40	97.56%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	23	***	0.00%	23	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	13	***	0.00%	13	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	20.00%	***	80.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	41	***	2.43%	40	97.56%	***	0.00%	***	0.00%	***	0.00%
Female	24	***	4.16%	23	95.83%	***	0.00%	***	0.00%	***	0.00%
Male	17	***	0.00%	17	100.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	41	***	2.43%	40	97.56%	***	0.00%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
White	35	***	2.85%	34	97.14%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Garrett

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	34	16	47.05%	***	5.88%	11	32.35%	***	0.00%	***	11.76%	***	2.94%	***	0.00%
Ages 0 to 4	***	***	62.50%	***	12.50%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	15	***	60.00%	***	6.66%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	33.33%	***	0.00%	***	50.00%	***	0.00%	***	0.00%	***	16.66%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	66.66%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	34	16	47.05%	***	5.88%	11	32.35%	***	0.00%	***	11.76%	***	2.94%	***	0.00%
Female	16	***	50.00%	***	0.00%	***	31.25%	***	0.00%	***	12.50%	***	6.25%	***	0.00%
Male	18	***	44.44%	***	11.11%	***	33.33%	***	0.00%	***	11.11%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	34	16	47.05%	***	5.88%	11	32.35%	***	0.00%	***	11.76%	***	2.94%	***	0.00%
White	33	16	48.48%	***	6.06%	10	30.30%	***	0.00%	***	12.12%	***	3.03%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Garrett

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	27	***	18.51%	***	18.51%	***	18.51%	***	18.51%
Ages 0 to 4	***	***	44.44%	***	44.44%	***	44.44%	***	44.44%
Ages 5 to 11	13	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	27	***	18.51%	***	18.51%	***	18.51%	***	18.51%
Female	13	***	7.69%	***	7.69%	***	7.69%	***	7.69%
Male	14	***	28.57%	***	28.57%	***	28.57%	***	28.57%
Race/Ethnicity									
Totals	27	***	18.51%	***	18.51%	***	18.51%	***	18.51%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	23	***	21.73%	***	21.73%	***	21.73%	***	21.73%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Garrett

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	15	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	13.33%	***	13.33%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	100.00%	***	100.00%
Gender																	
Totals	15	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	13.33%	***	13.33%
Female	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	12.50%	***	12.50%
Race/Ethnicity																	
Totals	15	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	13.33%	***	13.33%
White	15	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	6.66%	***	13.33%	***	13.33%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Garrett

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

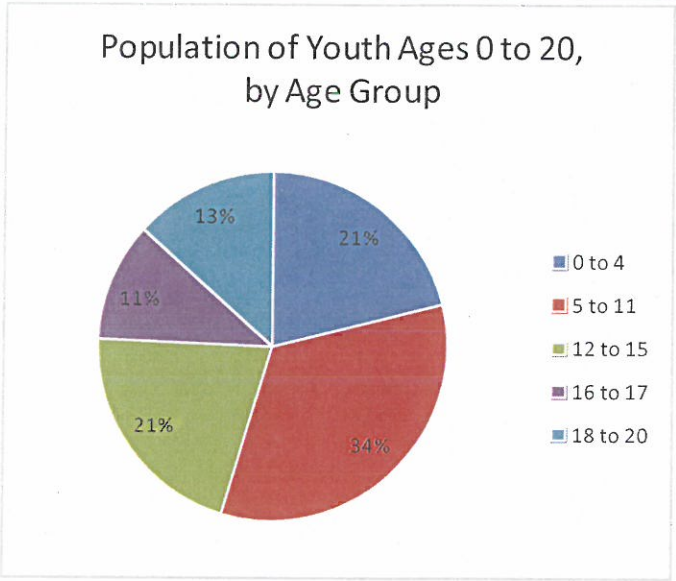
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	49	5,928	24	4.05
Ages 0 to 4	27	4,054	17	4.19
Ages 5 to 11	15	1,131	5	4.42
Ages 12 to 15	***	388	1	2.58
Ages 16 to 18	***	355	1	2.82
Gender				
Totals	49	5,928	24	4.05
Female	27	3,490	13	3.72
Male	22	2,438	11	4.51
Race/Ethnicity				
Totals	49	5,928	24	4.05
Hispanic	***	1,122	0	0.00
White	43	4,594	24	5.22
Unable to determine	***	212	0	0.00

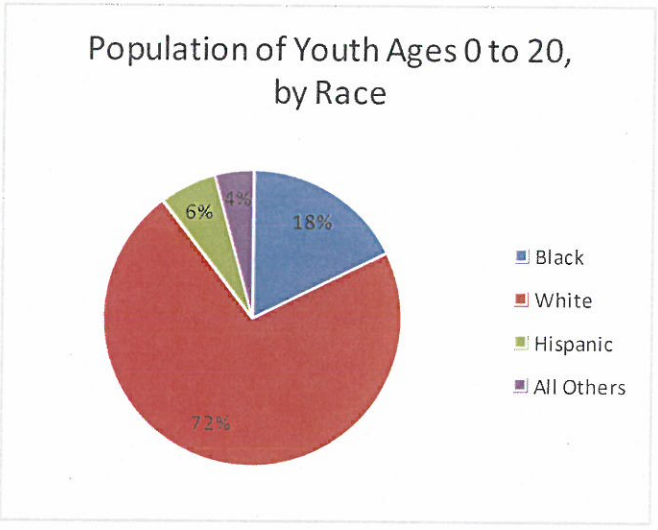
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Harford County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[15].

Age Groups	Population of Youth Ages 0 to 20
Totals	65,590
0 to 4	13,841
5 to 11	21,938
12 to 15	13,825
16 to 17	7,204
18 to 20	8,782



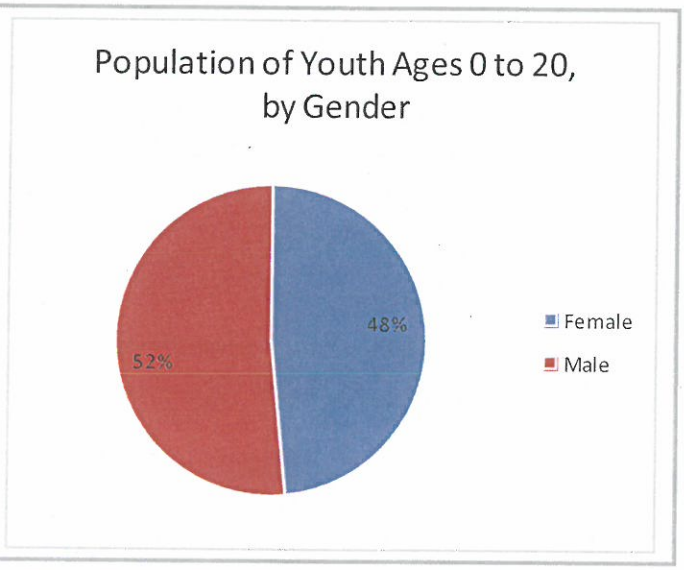


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	56,808	65,590
Black	10,097	11,631
White	40,685	47,042
Hispanic	3,530	4,105
All Others	2,496	2,812

[15]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	56,808	65,590
Female	27,551	31,734
Male	29,257	33,856



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Harford.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Harford

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	2,015	568	28.18%	1,447	71.81%	352	24.32%	504	34.83%	591	40.84%
Ages 0 to 4	624	167	26.76%	457	73.23%	129	28.22%	161	35.22%	167	36.54%
Ages 5 to 11	824	247	29.97%	577	70.02%	135	23.39%	194	33.62%	248	42.98%
Ages 12 to 15	408	109	26.71%	299	73.28%	63	21.07%	101	33.77%	135	45.15%
Ages 16 to 18	150	44	29.33%	106	70.66%	22	20.75%	45	42.45%	39	36.79%
Age Invalid	***	***	11.11%	***	88.88%	***	37.50%	***	37.50%	***	25.00%
Gender											
Totals	2,015	568	28.18%	1,447	71.81%	352	24.32%	504	34.83%	591	40.84%
Female	1,049	265	25.26%	784	74.73%	199	25.38%	261	33.29%	324	41.32%
Male	966	303	31.36%	663	68.63%	153	23.07%	243	36.65%	267	40.27%
Race/Ethnicity											
Totals	2,015	568	28.18%	1,447	71.81%	352	24.32%	504	34.83%	591	40.84%
Black	566	156	27.56%	410	72.43%	112	27.31%	149	36.34%	149	36.34%
White	1,157	321	27.74%	836	72.25%	189	22.60%	284	33.97%	363	43.42%
Hispanic	55	13	23.63%	42	76.36%	14	33.33%	19	45.23%	***	21.42%
All Others	22	11	50.00%	11	50.00%	***	18.18%	***	18.18%	***	63.63%
Unable to Determine	215	67	31.16%	148	68.83%	35	23.64%	50	33.78%	63	42.56%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Harford.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	239	500
Ages 0 to 4	.	186
Ages 5 to 11	.	184
Ages 12 to 15	.	88
Ages 16 to 17	.	37
Age Unknown	.	***
Gender		
Totals	239	500
Female	.	229
Male	.	270
Unknown	.	***
Race/Ethnicity		
Totals	239	500
Black	.	161
White	.	260
Hispanic	.	***
All Others	.	***
Unable to Determine	.	68

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Harford

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	92	***	5.43%	65	70.65%	20	21.73%	***	2.17%	***	0.00%
Ages 0 to 4	49	***	0.00%	35	71.42%	14	28.57%	***	0.00%	***	0.00%
Ages 5 to 11	21	***	0.00%	21	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	17	***	17.64%	***	47.05%	***	23.52%	***	11.76%	***	0.00%
Ages 16 to 18	***	***	40.00%	***	20.00%	***	40.00%	***	0.00%	***	0.00%
Gender											
Totals	92	***	5.43%	65	70.65%	20	21.73%	***	2.17%	***	0.00%
Female	42	***	9.52%	27	64.28%	***	21.42%	***	4.76%	***	0.00%
Male	50	***	2.00%	38	76.00%	11	22.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	92	***	5.43%	65	70.65%	20	21.73%	***	2.17%	***	0.00%
Hispanic	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Black	16	***	6.25%	12	75.00%	***	18.75%	***	0.00%	***	0.00%
White	57	***	5.26%	40	70.17%	12	21.05%	***	3.50%	***	0.00%
All other	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	88.88%	***	11.11%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Harford

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type														
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	129	47	36.43%	19	14.72%	26	20.15%	***	1.55%	19	14.72%	***	6.97%	***	5.42%
	Ages 0 to 4	43	17	39.53%	12	27.90%	11	25.58%	***	0.00%	***	0.00%	***	6.97%	***	0.00%
	Ages 5 to 11	47	21	44.68%	***	12.76%	10	21.27%	***	0.00%	***	0.00%	***	8.51%	***	12.76%
	Ages 12 to 15	***	***	33.33%	***	11.11%	***	22.22%	***	22.22%	***	0.00%	***	11.11%	***	0.00%
	Ages 16 to 18	11	***	45.45%	***	0.00%	***	27.27%	***	0.00%	***	18.18%	***	9.09%	***	0.00%
	Over 18	19	***	5.26%	***	0.00%	***	0.00%	***	0.00%	17	89.47%	***	0.00%	***	5.26%
Gender																
	Totals	129	47	36.43%	19	14.72%	26	20.15%	***	1.55%	19	14.72%	***	6.97%	***	5.42%
	Female	66	18	27.27%	10	15.15%	20	30.30%	***	3.03%	***	12.12%	***	9.09%	***	3.03%
	Male	63	29	46.03%	***	14.28%	***	9.52%	***	0.00%	11	17.46%	***	4.76%	***	7.93%
Race/Ethnicity																
	Totals	129	47	36.43%	19	14.72%	26	20.15%	***	1.55%	19	14.72%	***	6.97%	***	5.42%
	Hispanic	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Black	56	19	33.92%	***	8.92%	14	25.00%	***	3.57%	***	16.07%	***	8.92%	***	3.57%
	White	63	21	33.33%	11	17.46%	12	19.04%	***	0.00%	10	15.87%	***	6.34%	***	7.93%
	Unable to determine	***	***	62.50%	***	37.50%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Harford

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	86	***	1.16%	***	1.16%	***	2.32%	***	2.32%
Ages 0 to 4	23	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	33	***	0.00%	***	0.00%	***	3.03%	***	3.03%
Ages 12 to 15	17	***	5.88%	***	5.88%	***	5.88%	***	5.88%
Ages 16 to 18	13	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	86	***	1.16%	***	1.16%	***	2.32%	***	2.32%
Female	49	***	2.04%	***	2.04%	***	4.08%	***	4.08%
Male	37	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	86	***	1.16%	***	1.16%	***	2.32%	***	2.32%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	31	***	3.22%	***	3.22%	***	6.45%	***	6.45%
White	48	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Harford

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	64	***	1.56%	***	4.68%	***	6.25%	***	10.93%	10	15.62%	15	23.43%	15	23.43%	15	23.43%
Ages 0 to 4	23	***	0.00%	***	0.00%	***	0.00%	***	4.34%	***	17.39%	***	34.78%	***	34.78%	***	34.78%
Ages 5 to 11	21	***	4.76%	***	9.52%	***	9.52%	***	14.28%	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Ages 12 to 15	12	***	0.00%	***	8.33%	***	16.66%	***	25.00%	***	25.00%	***	33.33%	***	33.33%	***	33.33%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	64	***	1.56%	***	4.68%	***	6.25%	***	10.93%	10	15.62%	15	23.43%	15	23.43%	15	23.43%
Female	34	***	0.00%	***	2.94%	***	2.94%	***	8.82%	***	17.64%	11	32.35%	11	32.35%	11	32.35%
Male	30	***	3.33%	***	6.66%	***	10.00%	***	13.33%	***	13.33%	***	13.33%	***	13.33%	***	13.33%
Race/Ethnicity																	
Totals	64	***	1.56%	***	4.68%	***	6.25%	***	10.93%	10	15.62%	15	23.43%	15	23.43%	15	23.43%
Black	19	***	0.00%	***	0.00%	***	0.00%	***	10.52%	***	10.52%	***	15.78%	***	15.78%	***	15.78%
White	45	***	2.22%	***	6.66%	***	8.88%	***	11.11%	***	17.77%	12	26.66%	12	26.66%	12	26.66%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Harford

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

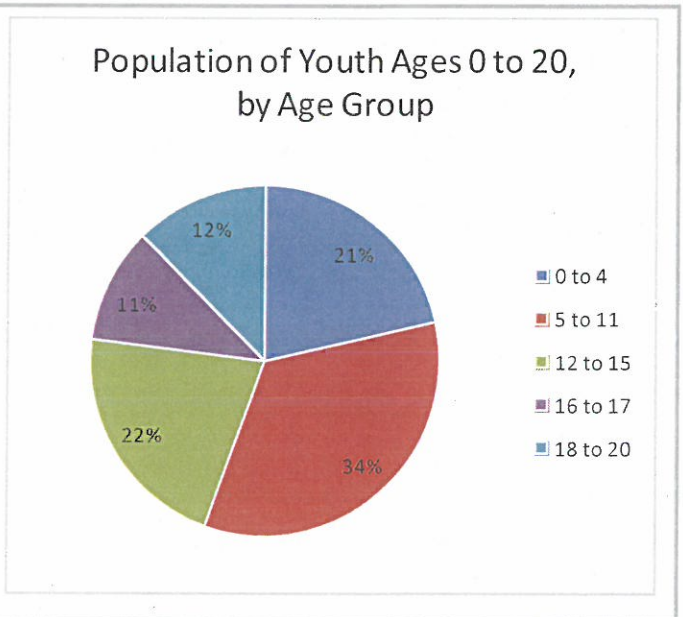
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	112	16,086	70	4.35
Ages 0 to 4	51	8,300	31	3.73
Ages 5 to 11	30	3,704	17	4.59
Ages 12 to 15	21	2,769	12	4.33
Ages 16 to 18	10	1,313	10	7.62
Gender				
Totals	112	16,086	70	4.35
Female	56	7,846	29	3.70
Male	56	8,240	41	4.98
Race/Ethnicity				
Totals	112	16,086	70	4.35
Hispanic	***	1,589	5	3.15
Black	26	1,923	11	5.72
White	67	10,721	46	4.29
All other	***	112	0	0.00
Unable to determine	***	1,741	8	4.60

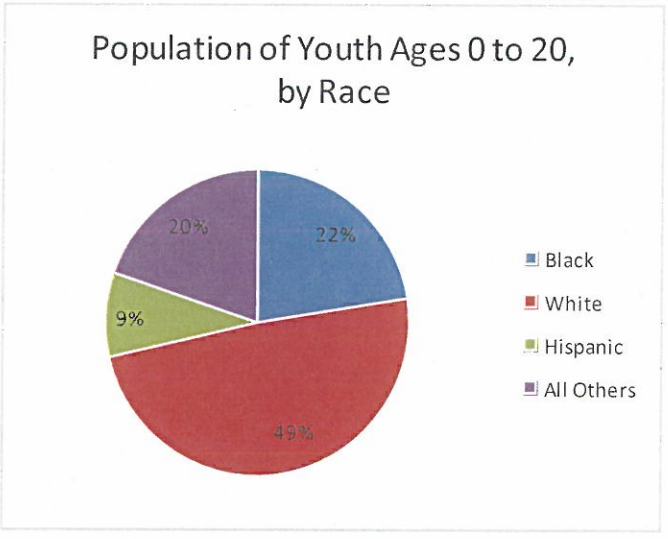
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Howard County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[16].

Age Groups	Population of Youth Ages 0 to 20
Totals	87,399
0 to 4	18,704
5 to 11	29,748
12 to 15	18,832
16 to 17	9,306
18 to 20	10,809



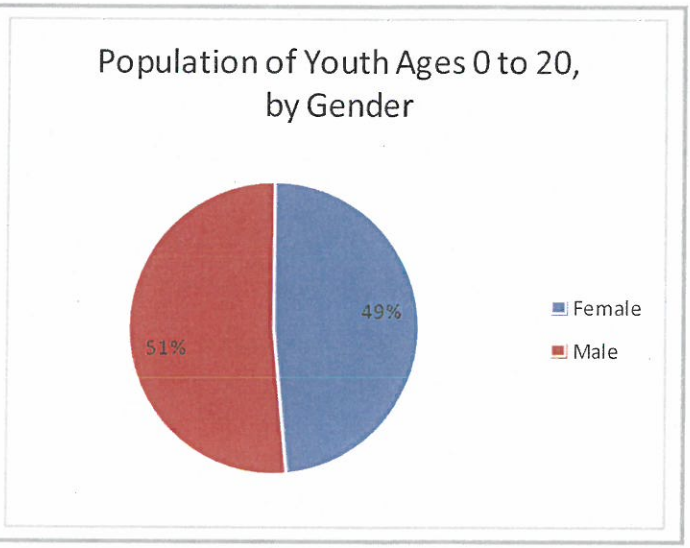


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	76,590	87,399
Black	17,153	19,590
White	36,832	42,715
Hispanic	6,930	7,834
All Others	15,675	17,260

[16]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	76,590	87,399
Female	37,235	42,394
Male	39,355	45,005



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Howard.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Howard

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	721	237	32.87%	484	67.12%	141	29.13%	119	24.58%	224	46.28%
Ages 0 to 4	140	50	35.71%	90	64.28%	27	30.00%	17	18.88%	46	51.11%
Ages 5 to 11	345	116	33.62%	229	66.37%	73	31.87%	61	26.63%	95	41.48%
Ages 12 to 15	165	55	33.33%	110	66.66%	28	25.45%	31	28.18%	51	46.36%
Ages 16 to 18	65	16	24.61%	49	75.38%	13	26.53%	***	14.28%	29	59.18%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	50.00%	***	50.00%
Gender											
Totals	721	237	32.87%	484	67.12%	141	29.13%	119	24.58%	224	46.28%
Female	386	134	34.71%	252	65.28%	75	29.76%	65	25.79%	112	44.44%
Male	334	102	30.53%	232	69.46%	66	28.44%	54	23.27%	112	48.27%
Other/ Unknown	***	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	721	237	32.87%	484	67.12%	141	29.13%	119	24.58%	224	46.28%
Black	281	105	37.36%	176	62.63%	44	25.00%	45	25.56%	87	49.43%
White	178	59	33.14%	119	66.85%	29	24.36%	31	26.05%	59	49.57%
Hispanic	89	28	31.46%	61	68.53%	29	47.54%	11	18.03%	21	34.42%
All Others	49	12	24.48%	37	75.51%	***	24.32%	***	24.32%	19	51.35%
Unable to Determine	124	33	26.61%	91	73.38%	30	32.96%	23	25.27%	38	41.75%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Howard.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	177	364
Ages 0 to 4	.	120
Ages 5 to 11	.	120
Ages 12 to 15	.	80
Ages 16 to 17	.	37
Age Unknown	.	***
Gender		
Totals	177	364
Female	.	173
Male	.	191
Race/Ethnicity		
Totals	177	364
Black	.	166
White	.	105
Hispanic	.	20
All Others	.	12
Unable to Determine	.	61

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Howard

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	23	***	13.04%	18	78.26%	***	0.00%	***	8.69%	***	0.00%
Ages 0 to 4	11	***	0.00%	11	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	33.33%	***	33.33%	***	0.00%	***	33.33%	***	0.00%
Ages 16 to 18	***	***	40.00%	***	40.00%	***	0.00%	***	20.00%	***	0.00%
Gender											
Totals	23	***	13.04%	18	78.26%	***	0.00%	***	8.69%	***	0.00%
Female	12	***	25.00%	***	75.00%	***	0.00%	***	0.00%	***	0.00%
Male	11	***	0.00%	***	81.81%	***	0.00%	***	18.18%	***	0.00%
Race/Ethnicity											
Totals	23	***	13.04%	18	78.26%	***	0.00%	***	8.69%	***	0.00%
Hispanic	***	***	25.00%	***	75.00%	***	0.00%	***	0.00%	***	0.00%
Black	10	***	20.00%	***	80.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	75.00%	***	0.00%	***	25.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Howard

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	29	14	48.27%	***	6.89%	***	6.89%	***	0.00%	***	31.03%	***	0.00%	***	6.89%
Ages 0 to 4	10	***	50.00%	***	20.00%	***	20.00%	***	0.00%	***	0.00%	***	0.00%	***	10.00%
Ages 5 to 11	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	55.55%	***	0.00%	***	0.00%	***	0.00%	***	44.44%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	83.33%	***	0.00%	***	16.66%
Gender															
Totals	29	14	48.27%	***	6.89%	***	6.89%	***	0.00%	***	31.03%	***	0.00%	***	6.89%
Female	18	10	55.55%	***	5.55%	***	0.00%	***	0.00%	***	27.77%	***	0.00%	***	11.11%
Male	11	***	36.36%	***	9.09%	***	18.18%	***	0.00%	***	36.36%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	29	14	48.27%	***	6.89%	***	6.89%	***	0.00%	***	31.03%	***	0.00%	***	6.89%
Black	15	***	53.33%	***	13.33%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%
White	11	***	27.27%	***	0.00%	***	18.18%	***	0.00%	***	36.36%	***	0.00%	***	18.18%
Unable to determine	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Howard

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	15	***	0.00%	***	0.00%	***	6.66%	***	13.33%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	14.28%	***	28.57%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	15	***	0.00%	***	0.00%	***	6.66%	***	13.33%
Female	11	***	0.00%	***	0.00%	***	0.00%	***	9.09%
Male	***	***	0.00%	***	0.00%	***	25.00%	***	25.00%
Race/Ethnicity									
Totals	15	***	0.00%	***	0.00%	***	6.66%	***	13.33%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	12.50%	***	25.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Howard

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	16.66%	***	16.66%	***	16.66%	***	16.66%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	50.00%	***	50.00%	***	50.00%	***	50.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Howard

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

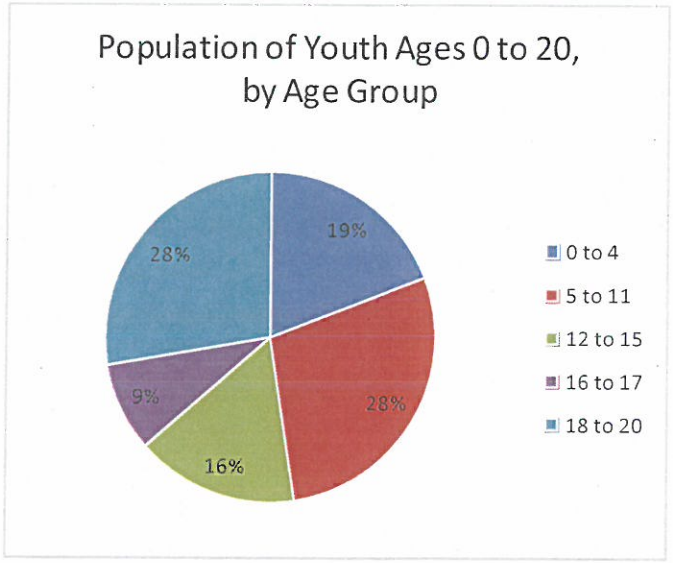
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	29	3,647	11	3.02
Ages 0 to 4	12	1,647	6	3.64
Ages 5 to 11	***	489	2	4.09
Ages 12 to 15	***	975	2	2.05
Ages 16 to 18	***	536	1	1.87
Gender				
Totals	29	3,647	11	3.02
Female	16	1,735	5	2.88
Male	13	1,912	6	3.14
Race/Ethnicity				
Totals	29	3,647	11	3.02
Hispanic	***	917	2	2.18
Black	14	2,109	6	2.84
White	***	607	2	3.29
Unable to determine	***	14	1	71.43

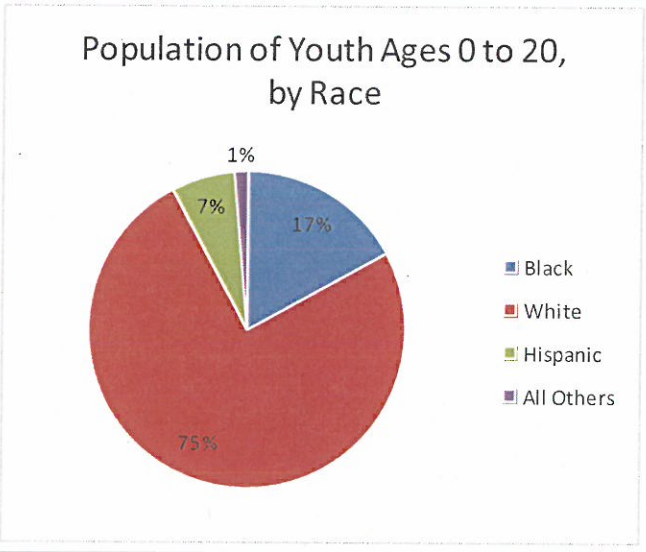
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Kent County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[17].

Age Groups	Population of Youth Ages 0 to 20
Totals	4,573
0 to 4	874
5 to 11	1,300
12 to 15	731
16 to 17	399
18 to 20	1,269



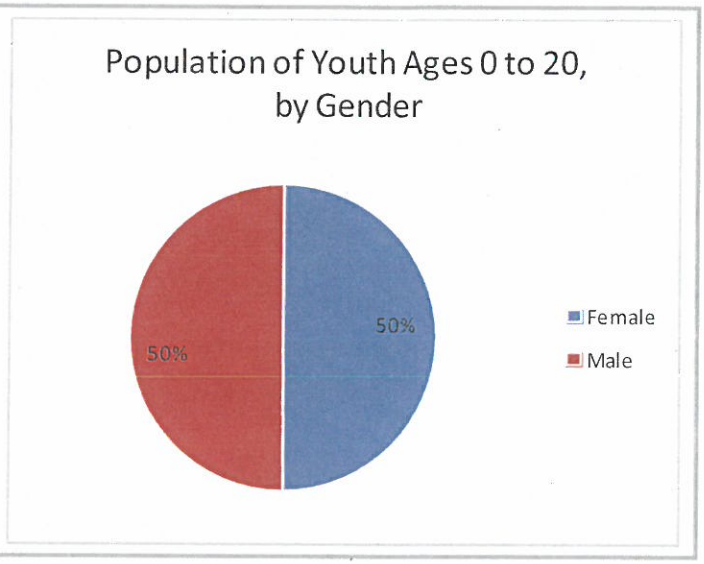


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	3,304	4,573
Black	656	775
White	2,370	3,439
Hispanic	243	295
All Others	35	64

[17]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	3,304	4,573
Female	1,571	2,283
Male	1,733	2,290



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Kent.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Kent

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	134	79	58.95%	55	41.04%	***	14.54%	19	34.54%	28	50.90%
Ages 0 to 4	36	22	61.11%	14	38.88%	***	0.00%	***	57.14%	***	42.85%
Ages 5 to 11	71	44	61.97%	27	38.02%	***	14.81%	***	22.22%	17	62.96%
Ages 12 to 15	21	10	47.61%	11	52.38%	***	27.27%	***	27.27%	***	45.45%
Ages 16 to 18	***	***	50.00%	***	50.00%	***	33.33%	***	66.66%	***	0.00%
Gender											
Totals	134	79	58.95%	55	41.04%	***	14.54%	19	34.54%	28	50.90%
Female	56	24	42.85%	32	57.14%	***	9.37%	14	43.75%	15	46.87%
Male	78	55	70.51%	23	29.48%	***	21.73%	***	21.73%	13	56.52%
Race/Ethnicity											
Totals	134	79	58.95%	55	41.04%	***	14.54%	19	34.54%	28	50.90%
Black	37	20	54.05%	17	45.94%	***	5.88%	***	41.17%	***	52.94%
White	78	48	61.53%	30	38.46%	***	16.66%	***	30.00%	16	53.33%
Hispanic	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	100.00%
Unable to Determine	15	***	60.00%	***	40.00%	***	33.33%	***	50.00%	***	16.66%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Kent.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	34	78
Ages 0 to 4	.	30
Ages 5 to 11	.	38
Ages 12 to 15	.	***
Ages 16 to 17	.	***
Gender		
Totals	34	78
Female	.	40
Male	.	38
Race/Ethnicity		
Totals	34	78
Black	.	26
White	.	40
Hispanic	.	***
Unable to Determine	.	11

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Kent

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Other/Unknown	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Kent

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	***	***	20.00%	***	60.00%	***	0.00%	***	0.00%	***	0.00%	***	20.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.0%	***	0.00%
Gender															
Totals	***	***	20.00%	***	60.00%	***	0.00%	***	0.00%	***	0.00%	***	20.00%	***	0.00%
Female	***	***	0.00%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%
Male	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	***	***	20.00%	***	60.00%	***	0.00%	***	0.00%	***	0.00%	***	20.00%	***	0.00%
Black	***	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	50.00%	***	0.00%
White	***	***	0.00%	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Kent

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Kent
No Data Available for this Table

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Kent

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	***	87	0	0.00
Ages 0 to 4	***	0	0	NA
Ages 5 to 11	***	87	0	0.00
Ages 12 to 15	***	0	0	NA
Ages 16 to 18	***	0	0	NA
Gender				
Totals	***	87	0	0.00
Female	***	0	0	NA
Male	***	87	0	0.00
Race/Ethnicity				
Totals	***	87	0	0.00
White	***	87	0	0.00

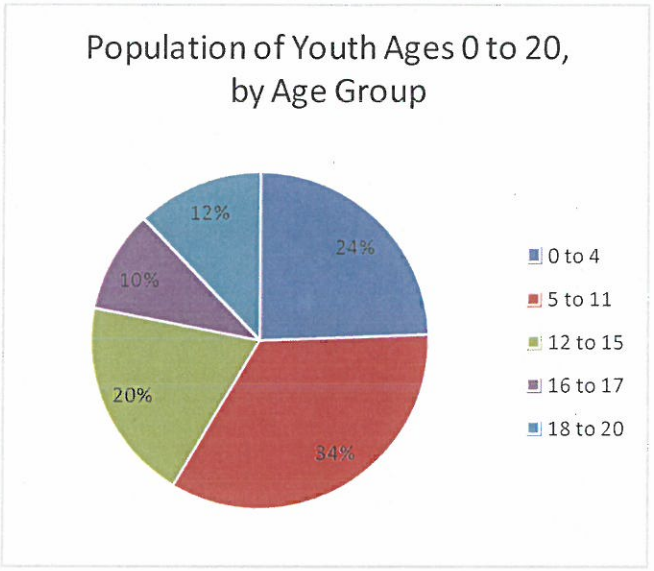
NA: Not Applicable

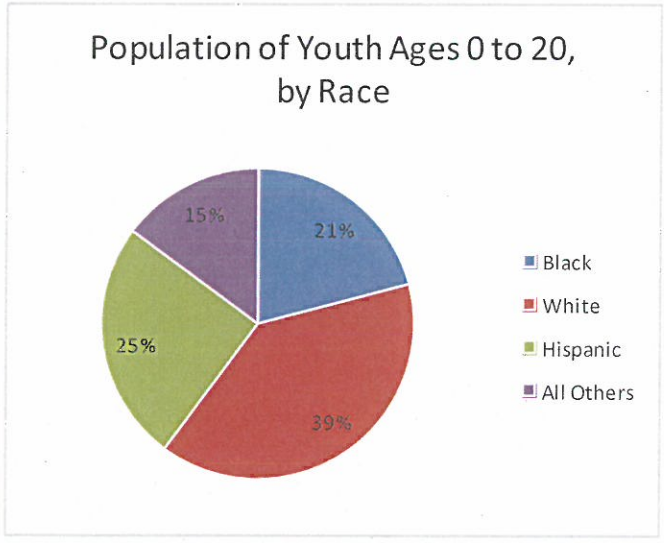
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Montgomery County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[18].

Age Groups	Population of Youth Ages 0 to 20
Totals	277,385
0 to 4	67,740
5 to 11	94,640
12 to 15	54,135
16 to 17	26,976
18 to 20	33,894



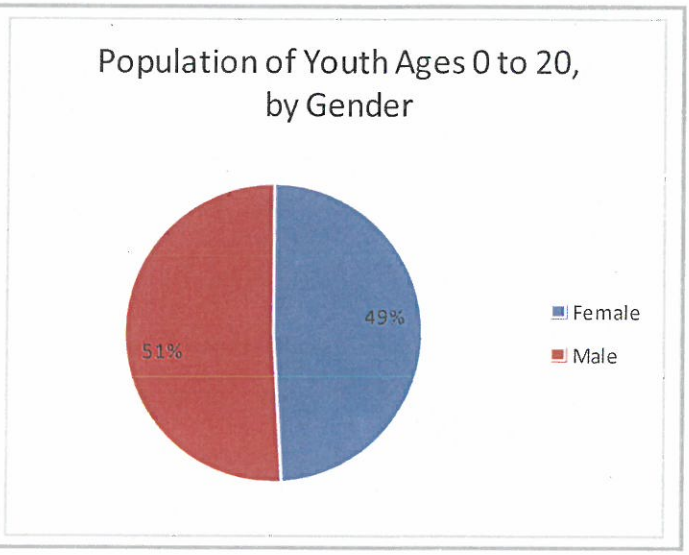


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	243,491	277,385
Black	50,792	57,976
White	95,191	108,854
Hispanic	60,825	69,229
All Others	36,683	41,326

[18]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	243,491	277,385
Female	119,574	135,978
Male	123,917	141,407



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Montgomery.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Montgomery

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	3,134	1,439	45.91%	1,695	54.08%	460	27.13%	393	23.18%	842	49.67%
Ages 0 to 4	671	293	43.66%	378	56.33%	112	29.62%	105	27.77%	161	42.59%
Ages 5 to 11	1,421	704	49.54%	717	50.45%	165	23.01%	169	23.57%	383	53.41%
Ages 12 to 15	734	316	43.05%	418	56.94%	124	29.66%	82	19.61%	212	50.71%
Ages 16 to 18	302	126	41.72%	176	58.27%	58	32.95%	36	20.45%	82	46.59%
Age Invalid	***	***	0.00%	***	100.00%	***	16.66%	***	16.66%	***	66.66%
Gender											
Totals	3,134	1,439	45.91%	1,695	54.08%	460	27.13%	393	23.18%	842	49.67%
Female	1,647	687	41.71%	960	58.28%	300	31.25%	218	22.70%	442	46.04%
Male	1,482	752	50.74%	730	49.25%	159	21.78%	175	23.97%	396	54.24%
Other/ Unknown	***	***	0.00%	***	100.00%	***	20.00%	***	0.00%	***	80.00%
Race/Ethnicity											
Totals	3,134	1,439	45.91%	1,695	54.08%	460	27.13%	393	23.18%	842	49.67%
Black	1,093	484	44.28%	609	55.71%	137	22.49%	164	26.92%	308	50.57%
White	436	167	38.30%	269	61.69%	71	26.39%	71	26.39%	127	47.21%
Hispanic	771	335	43.45%	436	56.54%	135	30.96%	85	19.49%	216	49.54%
All Others	107	59	55.14%	48	44.85%	21	43.75%	***	18.75%	18	37.50%
Unable to Determine	727	394	54.19%	333	45.80%	96	28.82%	64	19.21%	173	51.95%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Montgomery.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	260	557
Ages 0 to 4	.	206
Ages 5 to 11	.	198
Ages 12 to 15	.	114
Ages 16 to 17	.	34
Age Unknown	.	***
Gender		
Totals	260	557
Female	.	206
Male	.	198
Unknown	.	114
Race/Ethnicity		
Totals	260	557
Black	.	205
White	.	77
Hispanic	.	168
All Others	.	12
Unable to Determine	.	95

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Montgomery

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	158	12	7.59%	121	76.58%	15	9.49%	10	6.32%	***	0.00%
Ages 0 to 4	56	***	0.00%	50	89.28%	***	10.71%	***	0.00%	***	0.00%
Ages 5 to 11	53	***	0.00%	51	96.22%	***	3.77%	***	0.00%	***	0.00%
Ages 12 to 15	32	***	25.00%	16	50.00%	***	12.50%	***	12.50%	***	0.00%
Ages 16 to 18	17	***	23.52%	***	23.52%	***	17.64%	***	35.29%	***	0.00%
Gender											
Totals	158	12	7.59%	121	76.58%	15	9.49%	10	6.32%	***	0.00%
Female	87	***	9.19%	63	72.41%	***	10.34%	***	8.04%	***	0.00%
Male	71	***	5.63%	58	81.69%	***	8.45%	***	4.22%	***	0.00%
Race/Ethnicity											
Totals	158	12	7.59%	121	76.58%	15	9.49%	10	6.32%	***	0.00%
Hispanic	35	***	5.71%	25	71.42%	***	14.28%	***	8.57%	***	0.00%
Black	62	***	9.67%	50	80.64%	***	6.45%	***	3.22%	***	0.00%
White	36	***	8.33%	26	72.22%	***	11.11%	***	8.33%	***	0.00%
All other	***	***	50.00%	***	0.00%	***	0.00%	***	50.00%	***	0.00%
Unable to determine	23	***	0.00%	20	86.95%	***	8.69%	***	4.34%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Montgomery

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	174	72	41.37%	21	12.06%	30	17.24%	***	1.72%	40	22.98%	***	1.14%	***	3.44%
Ages 0 to 4	38	11	28.94%	12	31.57%	12	31.57%	***	2.63%	***	0.00%	***	2.63%	***	2.63%
Ages 5 to 11	41	17	41.46%	***	17.07%	15	36.58%	***	2.43%	***	0.00%	***	0.00%	***	2.43%
Ages 12 to 15	28	22	78.57%	***	3.57%	***	10.71%	***	0.00%	***	0.00%	***	0.00%	***	7.14%
Ages 16 to 18	26	20	76.92%	***	3.84%	***	0.00%	***	3.84%	***	7.69%	***	3.84%	***	3.84%
Over 18	41	***	4.87%	***	0.00%	***	0.00%	***	0.00%	38	92.68%	***	0.00%	***	2.43%
Gender															
Totals	174	72	41.37%	21	12.06%	30	17.24%	***	1.72%	40	22.98%	***	1.14%	***	3.44%
Female	96	44	45.83%	11	11.45%	14	14.58%	***	1.04%	22	22.91%	***	1.04%	***	3.12%
Male	78	28	35.89%	10	12.82%	16	20.51%	***	2.56%	18	23.07%	***	1.28%	***	3.84%
Race/Ethnicity															
Totals	174	72	41.37%	21	12.06%	30	17.24%	***	1.72%	40	22.98%	***	1.14%	***	3.44%
Hispanic	27	15	55.55%	***	25.92%	***	0.00%	***	0.00%	***	18.51%	***	0.00%	***	0.00%
Black	84	35	41.66%	***	8.33%	13	15.47%	***	3.57%	24	28.57%	***	0.00%	***	2.38%
White	48	17	35.41%	***	8.33%	13	27.08%	***	0.00%	***	18.75%	***	4.16%	***	6.25%
All other	***	***	60.00%	***	0.00%	***	0.00%	***	0.00%	***	40.00%	***	0.00%	***	0.00%
Unable to determine	10	***	20.00%	***	30.00%	***	40.00%	***	0.00%	***	0.00%	***	0.00%	***	10.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Montgomery

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	58	***	3.44%	***	10.34%	***	12.06%	***	13.79%
Ages 0 to 4	18	***	0.00%	***	11.11%	***	11.11%	***	11.11%
Ages 5 to 11	15	***	0.00%	***	6.66%	***	6.66%	***	13.33%
Ages 12 to 15	10	***	10.00%	***	10.00%	***	20.00%	***	20.00%
Ages 16 to 18	15	***	6.66%	***	13.33%	***	13.33%	***	13.33%
Gender									
Totals	58	***	3.44%	***	10.34%	***	12.06%	***	13.79%
Female	31	***	3.22%	***	12.90%	***	16.12%	***	19.35%
Male	27	***	3.70%	***	7.40%	***	7.40%	***	7.40%
Race/Ethnicity									
Totals	58	***	3.44%	***	10.34%	***	12.06%	***	13.79%
Hispanic	11	***	0.00%	***	9.09%	***	9.09%	***	18.18%
Black	28	***	7.14%	***	7.14%	***	10.71%	***	10.71%
White	11	***	0.00%	***	18.18%	***	18.18%	***	18.18%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	14.28%	***	14.28%	***	14.28%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Montgomery

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	81	***	11.11%	***	11.11%	12	14.81%	13	16.04%	13	16.04%	13	16.04%	14	17.28%	17	20.98%
Ages 0 to 4	26	***	19.23%	***	19.23%	***	23.07%	***	23.07%	***	23.07%	***	23.07%	***	23.07%	***	26.92%
Ages 5 to 11	24	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	12.50%	***	16.66%
Ages 12 to 15	20	***	10.00%	***	10.00%	***	20.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	30.00%
Ages 16 to 18	11	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	81	***	11.11%	***	11.11%	12	14.81%	13	16.04%	13	16.04%	13	16.04%	14	17.28%	17	20.98%
Female	32	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	9.37%	***	18.75%
Male	49	***	12.24%	***	12.24%	***	18.36%	10	20.40%	10	20.40%	10	20.40%	11	22.44%	11	22.44%
Race/Ethnicity																	
Totals	81	***	11.11%	***	11.11%	12	14.81%	13	16.04%	13	16.04%	13	16.04%	14	17.28%	17	20.98%
Hispanic	11	***	0.00%	***	0.00%	***	9.09%	***	9.09%	***	9.09%	***	9.09%	***	18.18%	***	27.27%
Black	40	***	15.00%	***	15.00%	***	17.50%	***	17.50%	***	17.50%	***	17.50%	***	17.50%	***	20.00%
White	21	***	14.28%	***	14.28%	***	19.04%	***	23.80%	***	23.80%	***	23.80%	***	23.80%	***	28.57%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Montgomery

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

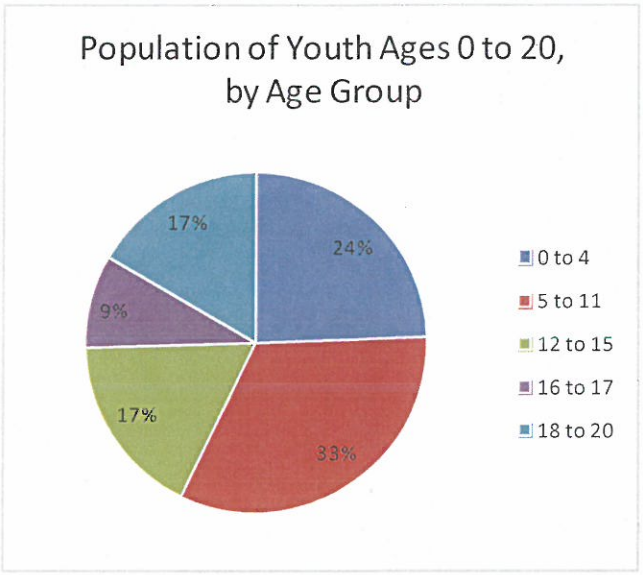
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	182	26,454	99	3.74
Ages 0 to 4	60	8,415	34	4.04
Ages 5 to 11	60	8,444	28	3.32
Ages 12 to 15	41	6,611	27	4.08
Ages 16 to 18	21	2,984	10	3.35
Gender				
Totals	182	26,454	99	3.74
Female	103	14,218	59	4.15
Male	79	12,236	40	3.27
Race/Ethnicity				
Totals	182	26,454	99	3.74
Hispanic	43	5,618	24	4.27
Black	74	11,732	43	3.67
White	40	4,629	16	3.46
All other	***	338	1	2.96
Unable to determine	23	4,137	15	3.63

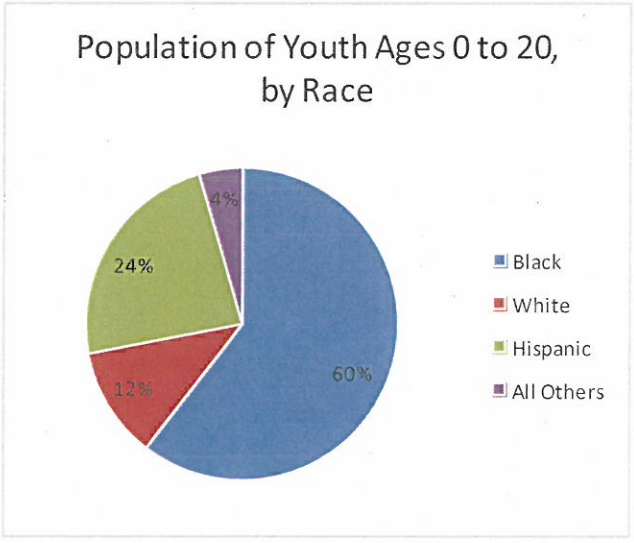
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Prince George's County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[19].

Age Groups	Population of Youth Ages 0 to 20
Totals	245,176
0 to 4	59,901
5 to 11	80,117
12 to 15	42,775
16 to 17	21,582
18 to 20	40,801



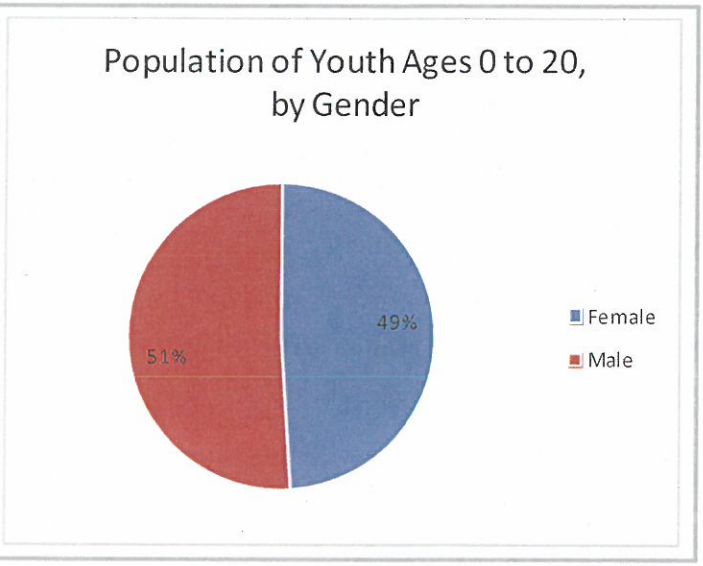


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	204,375	245,176
Black	125,933	148,180
White	19,225	28,229
Hispanic	50,990	57,744
All Others	8,227	11,023

[19]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	204,375	245,176
Female	100,037	120,003
Male	104,338	125,173



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Prince George's.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Prince George's

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	3,108	1,300	41.82%	1,808	58.17%	532	29.42%	684	37.83%	592	32.74%
Ages 0 to 4	741	280	37.78%	461	62.21%	140	30.36%	178	38.61%	143	31.01%
Ages 5 to 11	1,336	638	47.75%	698	52.24%	204	29.22%	267	38.25%	227	32.52%
Ages 12 to 15	718	287	39.97%	431	60.02%	123	28.53%	165	38.28%	143	33.17%
Ages 16 to 18	305	95	31.14%	210	68.85%	64	30.47%	71	33.80%	75	35.71%
Age Invalid	***	***	0.00%	***	100.00%	***	12.50%	***	37.50%	***	50.00%
Gender											
Totals	3,108	1,300	41.82%	1,808	58.17%	532	29.42%	684	37.83%	592	32.74%
Female	1,668	645	38.66%	1,023	61.33%	327	31.96%	380	37.14%	316	30.88%
Male	1,434	655	45.67%	779	54.32%	204	26.18%	304	39.02%	271	34.78%
Other/ Unknown	***	***	0.00%	***	100.00%	***	16.66%	***	0.00%	***	83.33%
Race/Ethnicity											
Totals	3,108	1,300	41.82%	1,808	58.17%	532	29.42%	684	37.83%	592	32.74%
Black	1,933	824	42.62%	1,109	57.37%	309	27.86%	448	40.39%	352	31.74%
White	161	62	38.50%	99	61.49%	27	27.27%	36	36.36%	36	36.36%
Hispanic	532	206	38.72%	326	61.27%	114	34.96%	98	30.06%	114	34.96%
All Others	29	14	48.27%	15	51.72%	***	13.33%	10	66.66%	***	20.00%
Unable to Determine	453	194	42.82%	259	57.17%	80	30.88%	92	35.52%	87	33.59%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Prince George's.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	560	1,168
Ages 0 to 4	.	413
Ages 5 to 11	.	377
Ages 12 to 15	.	249
Ages 16 to 17	.	115
Age Unknown	.	14
Gender		
Totals	560	1,168
Female	.	593
Male	.	571
Unknown	.	***
Race/Ethnicity		
Totals	560	1,168
Black	.	828
White	.	43
Hispanic	.	111
All Others	.	***
Unable to Determine	.	178

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Prince George's

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	159	***	3.14%	147	92.45%	***	3.14%	***	0.62%	***	0.62%
Ages 0 to 4	40	***	0.00%	37	92.50%	***	7.50%	***	0.00%	***	0.00%
Ages 5 to 11	37	***	0.00%	37	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	47	***	0.00%	44	93.61%	***	2.12%	***	2.12%	***	2.12%
Ages 16 to 18	35	***	14.28%	29	82.85%	***	2.85%	***	0.00%	***	0.00%
Gender											
Totals	159	***	3.14%	147	92.45%	***	3.14%	***	0.62%	***	0.62%
Female	89	***	4.49%	81	91.01%	***	3.37%	***	0.00%	***	1.12%
Male	70	***	1.42%	66	94.28%	***	2.85%	***	1.42%	***	0.00%
Race/Ethnicity											
Totals	159	***	3.14%	147	92.45%	***	3.14%	***	0.62%	***	0.62%
Hispanic	24	***	4.16%	23	95.83%	***	0.00%	***	0.00%	***	0.00%
Black	106	***	3.77%	96	90.56%	***	3.77%	***	0.94%	***	0.94%
White	19	***	0.00%	18	94.73%	***	5.26%	***	0.00%	***	0.00%
All other	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Prince George's

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	**Children (A)**	**n (B)**	**% (B/A)**	**n (C)**	**% (C/A)**	**n (D)**	**% (D/A)**	**n (E)**	**% (E/A)**	**n (F)**	**% (F/A)**	**n (G)**	**% (G/A)**	**n (H)**	**% (H/A)**
Totals	167	54	32.33%	14	8.38%	22	13.17%	***	2.99%	55	32.93%	***	1.79%	14	8.38%
Ages 0 to 4	29	12	41.37%	***	27.58%	***	20.68%	***	6.89%	***	0.00%	***	0.00%	***	3.44%
Ages 5 to 11	33	14	42.42%	***	15.15%	***	27.27%	***	3.03%	***	0.00%	***	0.00%	***	12.12%
Ages 12 to 15	26	15	57.69%	***	3.84%	***	19.23%	***	3.84%	***	0.00%	***	7.69%	***	7.69%
Ages 16 to 18	29	13	44.82%	***	0.00%	***	6.89%	***	3.44%	***	24.13%	***	3.44%	***	17.24%
Over 18	50	***	0.00%	***	0.00%	***	0.00%	***	0.00%	48	96.00%	***	0.00%	***	4.00%
Gender															
Totals	167	54	32.33%	14	8.38%	22	13.17%	***	2.99%	55	32.93%	***	1.79%	14	8.38%
Female	86	25	29.06%	***	9.30%	12	13.95%	***	3.48%	29	33.72%	***	2.32%	***	8.13%
Male	81	29	35.80%	***	7.40%	10	12.34%	***	2.46%	26	32.09%	***	1.23%	***	8.64%
Race/Ethnicity															
Totals	167	54	32.33%	14	8.38%	22	13.17%	***	2.99%	55	32.93%	***	1.79%	14	8.38%
Hispanic	19	***	31.57%	***	0.00%	***	5.26%	***	5.26%	***	26.31%	***	5.26%	***	26.31%
Black	136	41	30.14%	12	8.82%	21	15.44%	***	2.94%	48	35.29%	***	1.47%	***	5.88%
White	***	***	55.55%	***	11.11%	***	0.00%	***	0.00%	***	22.22%	***	0.00%	***	11.11%
Unable to determine	***	***	66.66%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Prince George's

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	41	***	4.87%	***	4.87%	***	7.31%	***	9.75%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	11.11%	***	11.11%	***	11.11%	***	11.11%
Ages 12 to 15	15	***	6.66%	***	6.66%	***	13.33%	***	20.00%
Ages 16 to 18	11	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	41	***	4.87%	***	4.87%	***	7.31%	***	9.75%
Female	28	***	7.14%	***	7.14%	***	10.71%	***	14.28%
Male	13	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	41	***	4.87%	***	4.87%	***	7.31%	***	9.75%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	29	***	6.89%	***	6.89%	***	10.34%	***	13.79%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Prince George's

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	61	***	3.27%	***	4.91%	***	8.19%	***	11.47%	***	11.47%	***	11.47%	***	14.75%	***	14.75%
Ages 0 to 4	15	***	6.66%	***	6.66%	***	6.66%	***	13.33%	***	13.33%	***	13.33%	***	13.33%	***	13.33%
Ages 5 to 11	12	***	0.00%	***	0.00%	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	8.33%
Ages 12 to 15	12	***	0.00%	***	0.00%	***	8.33%	***	8.33%	***	8.33%	***	8.33%	***	25.00%	***	25.00%
Ages 16 to 18	22	***	4.54%	***	9.09%	***	9.09%	***	13.63%	***	13.63%	***	13.63%	***	13.63%	***	13.63%
Gender																	
Totals	61	***	3.27%	***	4.91%	***	8.19%	***	11.47%	***	11.47%	***	11.47%	***	14.75%	***	14.75%
Female	30	***	0.00%	***	3.33%	***	10.00%	***	13.33%	***	13.33%	***	13.33%	***	16.66%	***	16.66%
Male	31	***	6.45%	***	6.45%	***	6.45%	***	9.67%	***	9.67%	***	9.67%	***	12.90%	***	12.90%
Race/Ethnicity																	
Totals	61	***	3.27%	***	4.91%	***	8.19%	***	11.47%	***	11.47%	***	11.47%	***	14.75%	***	14.75%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	49	***	2.04%	***	4.08%	***	8.16%	***	12.24%	***	12.24%	***	12.24%	***	16.32%	***	16.32%
All other	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%	***	25.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Prince George's

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

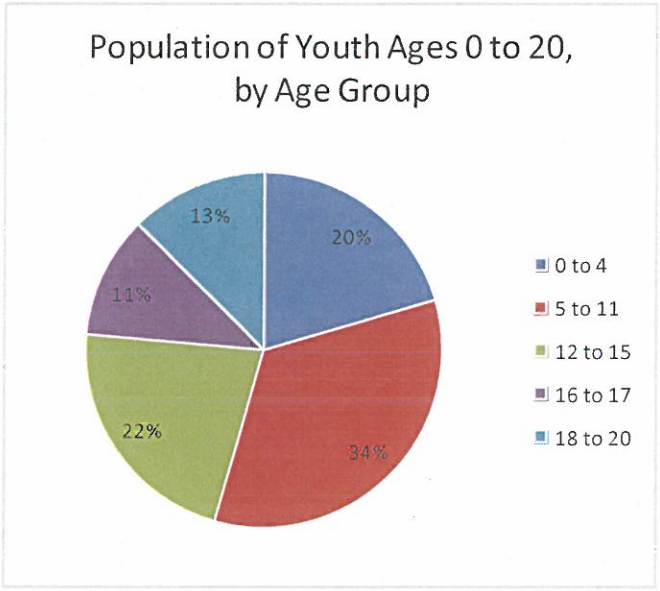
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	176	25,531	174	6.82
Ages 0 to 4	39	6,533	26	3.98
Ages 5 to 11	41	6,045	29	4.80
Ages 12 to 15	55	7,705	70	9.09
Ages 16 to 18	41	5,248	49	9.34
Gender				
Totals	176	25,531	174	6.82
Female	100	13,905	104	7.48
Male	76	11,626	70	6.02
Race/Ethnicity				
Totals	176	25,531	174	6.82
Hispanic	29	4,052	31	7.65
Black	118	16,987	124	7.30
White	19	3,014	14	4.64
All other	***	336	1	2.98
Unable to determine	***	1,142	4	3.50

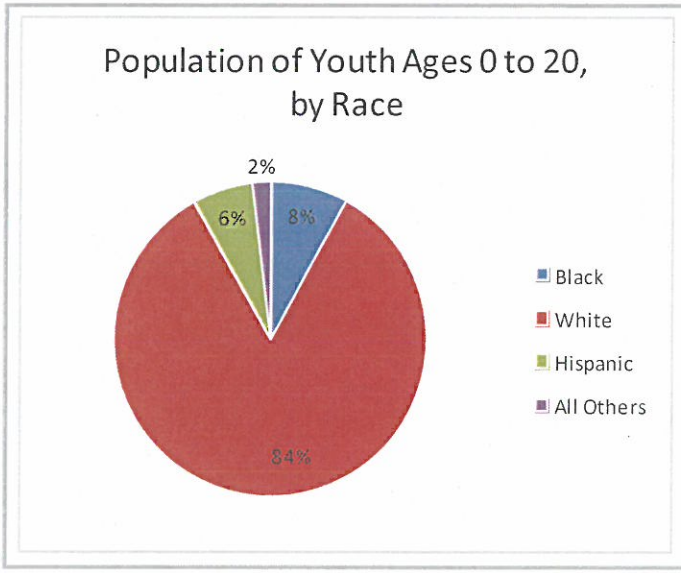
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Queen Anne's County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[20].

Age Groups	Population of Youth Ages 0 to 20
Totals	12,280
0 to 4	2,514
5 to 11	4,164
12 to 15	2,704
16 to 17	1,360
18 to 20	1,538



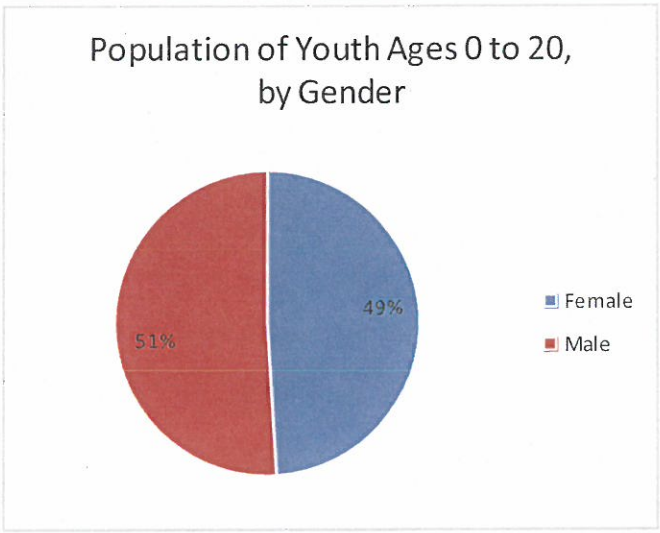


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	10,742	12,280
Black	852	966
White	8,988	10,311
Hispanic	684	763
All Others	218	240

[20]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	10,742	12,280
Female	5,326	6,020
Male	5,416	6,260



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Queen Anne's.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Queen Anne's

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	105	55	52.38%	50	47.61%	21	42.00%	12	24.00%	17	34.00%
Ages 0 to 4	30	18	60.00%	12	40.00%	***	58.33%	***	25.00%	***	16.66%
Ages 5 to 11	47	22	46.80%	25	53.19%	***	36.00%	***	28.00%	***	36.00%
Ages 12 to 15	16	10	62.50%	***	37.50%	***	50.00%	***	16.66%	***	33.33%
Ages 16 to 18	12	***	41.66%	***	58.33%	***	28.57%	***	14.28%	***	57.14%
Gender											
Totals	105	55	52.38%	50	47.61%	21	42.00%	12	24.00%	17	34.00%
Female	56	31	55.35%	25	44.64%	11	44.00%	***	16.00%	10	40.00%
Male	49	24	48.97%	25	51.02%	10	40.00%	***	32.00%	***	28.00%
Race/Ethnicity											
Totals	105	55	52.38%	50	47.61%	21	42.00%	12	24.00%	17	34.00%
Black	19	11	57.89%	***	42.10%	***	50.00%	***	12.50%	***	37.50%
White	69	30	43.47%	39	56.52%	16	41.02%	10	25.64%	13	33.33%
Hispanic	***	***	80.00%	***	20.00%	***	100.00%	***	0.00%	***	0.00%
Unable to Determine	12	10	83.33%	***	16.66%	***	0.00%	***	50.00%	***	50.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Queen Anne's.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	56	103
Ages 0 to 4	.	41
Ages 5 to 11	.	34
Ages 12 to 15	.	24
Ages 16 to 17	.	***
Gender		
Totals	56	103
Female	.	39
Male	.	64
Race/Ethnicity		
Totals	56	103
Black	.	12
White	.	62
All Others	.	***
Unable to Determine	.	28

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Queen Anne's

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	***	***	50.00%	***	25.00%	***	25.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	50.00%	***	25.00%	***	25.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	***	***	50.00%	***	25.00%	***	25.00%	***	0.00%	***	0.00%
Female	***	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	***	***	50.00%	***	25.00%	***	25.00%	***	0.00%	***	0.00%
Black	***	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	33.33%	***	33.33%	***	33.33%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Queen Anne's

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Over 18	***	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%
Gender															
Totals	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Male	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%
White	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Queen Anne's
No Data Available for this Table

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Queen Anne's

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Queen Anne's

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	***	716	5	6.98
Ages 0 to 4	***	0	0	NA
Ages 5 to 11	***	0	0	NA
Ages 12 to 15	***	716	5	6.98
Ages 16 to 18	***	0	0	NA
Gender				
Totals	***	716	5	6.98
Female	***	337	1	2.97
Male	***	379	4	10.55
Other/Unknown	***	0	0	NA
Race/Ethnicity				
Totals	***	716	5	6.98
Black	***	308	1	3.25
White	***	408	4	9.80

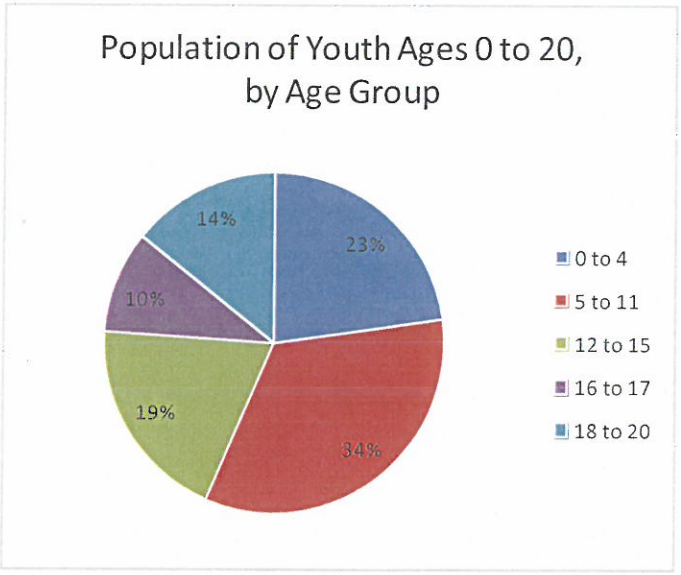
NA: Not Applicable

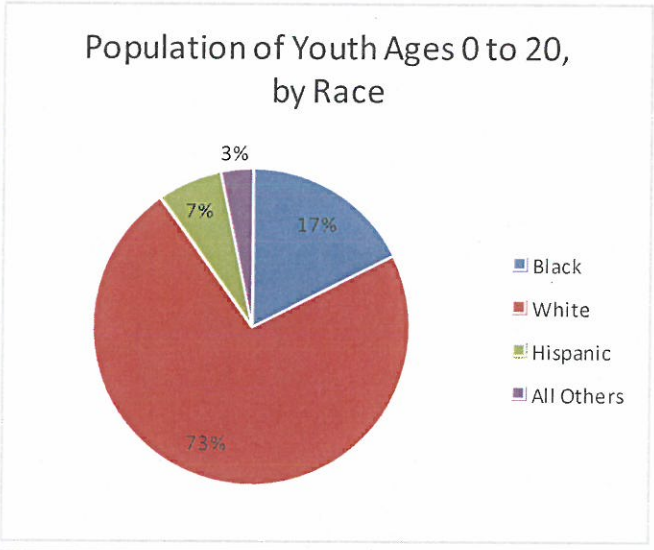
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

St. Mary's County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[21].

Age Groups	Population of Youth Ages 0 to 20
Totals	32,106
0 to 4	7,299
5 to 11	10,826
12 to 15	6,291
16 to 17	3,092
18 to 20	4,598



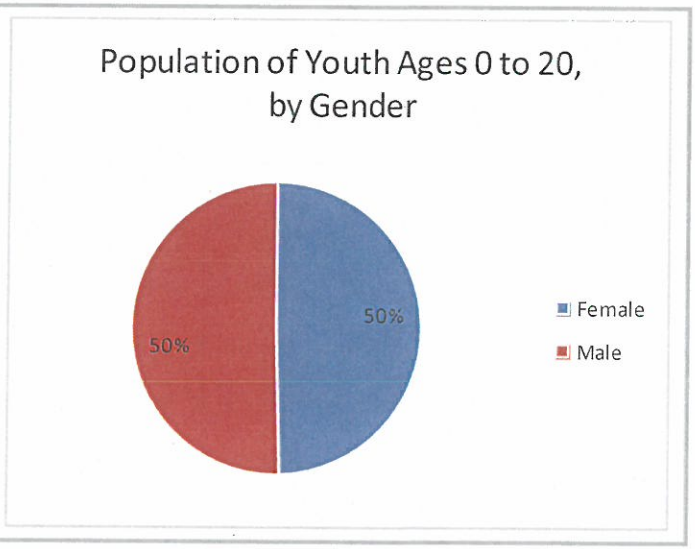


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	27,508	32,106
Black	4,899	5,625
White	19,878	23,312
Hispanic	1,836	2,108
All Others	895	1,061

[21]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	27,508	32,106
Female	13,607	15,911
Male	13,901	16,195



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in St. Mary's.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in St. Mary's

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	638	311	48.74%	327	51.25%	135	41.28%	29	8.86%	163	49.84%
Ages 0 to 4	202	97	48.01%	105	51.98%	40	38.09%	***	7.61%	57	54.28%
Ages 5 to 11	298	146	48.99%	152	51.00%	64	42.10%	15	9.86%	73	48.02%
Ages 12 to 15	99	51	51.51%	48	48.48%	22	45.83%	***	8.33%	22	45.83%
Ages 16 to 18	36	16	44.44%	20	55.55%	***	40.00%	***	10.00%	10	50.00%
Age Invalid	***	***	33.33%	***	66.66%	***	50.00%	***	0.00%	***	50.00%
Gender											
Totals	638	311	48.74%	327	51.25%	135	41.28%	29	8.86%	163	49.84%
Female	353	165	46.74%	188	53.25%	76	40.42%	16	8.51%	96	51.06%
Male	285	146	51.22%	139	48.77%	59	42.44%	13	9.35%	67	48.20%
Race/Ethnicity											
Totals	638	311	48.74%	327	51.25%	135	41.28%	29	8.86%	163	49.84%
Black	180	86	47.77%	94	52.22%	35	37.23%	***	8.51%	51	54.25%
White	342	172	50.29%	170	49.70%	75	44.11%	15	8.82%	80	47.05%
Hispanic	***	***	50.00%	***	50.00%	***	50.00%	***	25.00%	***	25.00%
All Others	14	***	21.42%	11	78.57%	***	72.72%	***	9.09%	***	18.18%
Unable to Determine	94	46	48.93%	48	51.06%	15	31.25%	***	8.33%	29	60.41%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in St. Mary's.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	245	529
Ages 0 to 4	.	244
Ages 5 to 11	.	194
Ages 12 to 15	.	63
Ages 16 to 17	.	24
Age Unknown	.	***
Gender		
Totals	245	529
Female	.	255
Male	.	274
Race/Ethnicity		
Totals	245	529
Black	.	176
White	.	217
Hispanic	.	12
All Others	.	10
Unable to Determine	.	114

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in St. Mary's

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	41	***	2.43%	34	82.92%	***	14.63%	***	0.00%	***	0.00%
Ages 0 to 4	22	***	0.00%	17	77.27%	***	22.72%	***	0.00%	***	0.00%
Ages 5 to 11	16	***	0.00%	16	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	41	***	2.43%	34	82.92%	***	14.63%	***	0.00%	***	0.00%
Female	19	***	5.26%	14	73.68%	***	21.05%	***	0.00%	***	0.00%
Male	22	***	0.00%	20	90.90%	***	9.09%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	41	***	2.43%	34	82.92%	***	14.63%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Black	27	***	0.00%	24	88.88%	***	11.11%	***	0.00%	***	0.00%
White	10	***	10.00%	***	60.00%	***	30.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in St. Mary's

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	45	29	64.44%	***	17.77%	***	6.66%	***	0.00%	***	8.88%	***	0.00%	***	2.22%
Ages 0 to 4	16	***	56.25%	***	25.00%	***	18.75%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	14	12	85.71%	***	14.28%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	75.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	33.33%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	45	29	64.44%	***	17.77%	***	6.66%	***	0.00%	***	8.88%	***	0.00%	***	2.22%
Female	23	14	60.86%	***	21.73%	***	8.69%	***	0.00%	***	8.69%	***	0.00%	***	0.00%
Male	22	15	68.18%	***	13.63%	***	4.54%	***	0.00%	***	9.09%	***	0.00%	***	4.54%
Race/Ethnicity															
Totals	45	29	64.44%	***	17.77%	***	6.66%	***	0.00%	***	8.88%	***	0.00%	***	2.22%
Hispanic	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	71.42%	***	0.00%	***	0.00%	***	0.00%	***	28.57%	***	0.00%	***	0.00%
White	35	21	60.00%	***	22.85%	***	8.57%	***	0.00%	***	5.71%	***	0.00%	***	2.85%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in St. Mary's

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	12	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	12	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	12	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	11	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in St. Mary's

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	19	***	5.26%	***	21.05%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	42.85%	***	42.85%	***	42.85%	***	42.85%	***	42.85%	***	42.85%	***	42.85%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	20.00%	***	20.00%	***	40.00%	***	40.00%	***	40.00%	***	40.00%	***	40.00%	***	40.00%
Gender																	
Totals	19	***	5.26%	***	21.05%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%
Female	***	***	11.11%	***	22.22%	***	22.22%	***	22.22%	***	22.22%	***	22.22%	***	22.22%	***	22.22%
Male	10	***	0.00%	***	20.00%	***	30.00%	***	30.00%	***	30.00%	***	30.00%	***	30.00%	***	30.00%
Race/Ethnicity																	
Totals	19	***	5.26%	***	21.05%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%	***	26.31%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%	***	16.66%
White	12	***	0.00%	***	25.00%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in St. Mary's

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

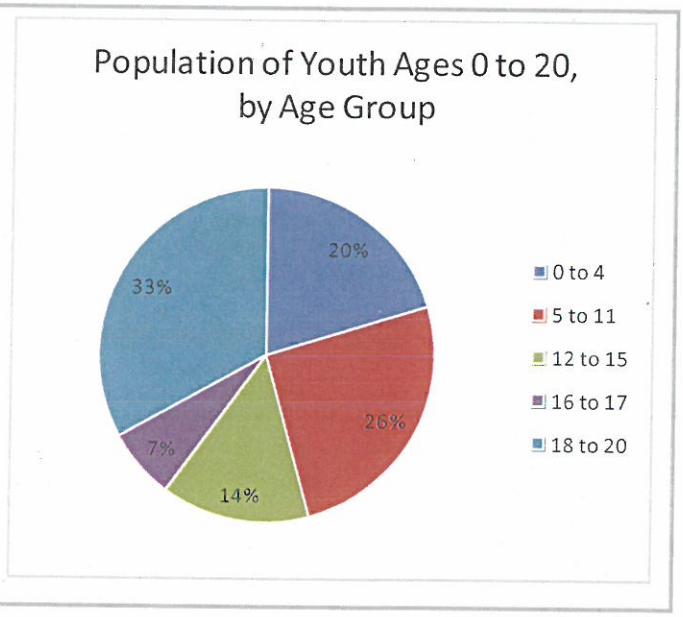
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	43	6,751	20	2.96
Ages 0 to 4	22	3,438	8	2.33
Ages 5 to 11	17	3,065	12	3.92
Ages 12 to 15	***	231	0	0.00
Ages 16 to 18	***	17	0	0.00
Gender				
Totals	43	6,751	20	2.96
Female	20	3,355	6	1.79
Male	23	3,396	14	4.12
Race/Ethnicity				
Totals	43	6,751	20	2.96
Hispanic	***	18	2	111.11
Black	27	5,216	15	2.88
White	12	1,417	3	2.12
Unable to determine	***	100	0	0.00

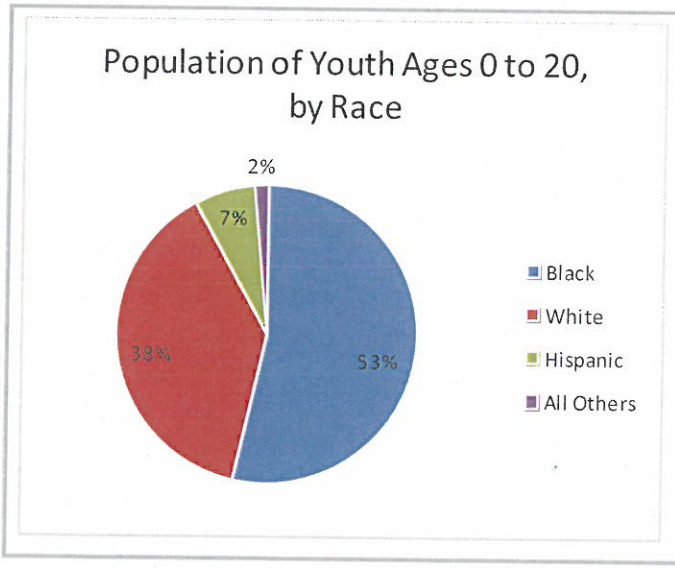
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Somerset County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[22].

Age Groups	Population of Youth Ages 0 to 20
Totals	6,506
0 to 4	1,316
5 to 11	1,653
12 to 15	936
16 to 17	445
18 to 20	2,156



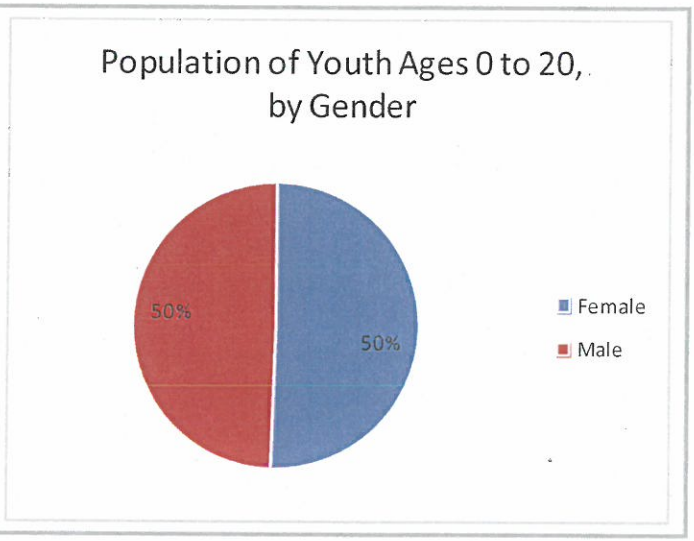


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	4,350	6,506
Black	1,869	3,482
White	2,070	2,498
Hispanic	338	427
All Others	73	99

[22]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	4,350	6,506
Female	2,157	3,282
Male	2,193	3,224



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Somerset.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Somerset

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	233	88	37.76%	145	62.23%	36	24.82%	43	29.65%	66	45.51%
Ages 0 to 4	78	26	33.33%	52	66.66%	15	28.84%	18	34.61%	19	36.53%
Ages 5 to 11	112	43	38.39%	69	61.60%	16	23.18%	17	24.63%	36	52.17%
Ages 12 to 15	32	15	46.87%	17	53.12%	***	11.76%	***	35.29%	***	52.94%
Ages 16 to 18	10	***	40.00%	***	60.00%	***	50.00%	***	33.33%	***	16.66%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	233	88	37.76%	145	62.23%	36	24.82%	43	29.65%	66	45.51%
Female	125	42	33.60%	83	66.40%	26	31.32%	23	27.71%	34	40.96%
Male	107	46	42.99%	61	57.00%	10	16.39%	20	32.78%	31	50.81%
Other/ Unknown	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Race/Ethnicity											
Totals	233	88	37.76%	145	62.23%	36	24.82%	43	29.65%	66	45.51%
Black	134	42	31.34%	92	68.65%	18	19.56%	31	33.69%	43	46.73%
White	79	36	45.56%	43	54.43%	18	41.86%	***	20.93%	16	37.20%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	40.00%	***	60.00%
All Others	***	***	100.00%	***	0.00%	NA	NA	NA	NA	NA	NA
Unable to Determine	14	***	64.28%	***	35.71%	***	0.00%	***	20.00%	***	80.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Somerset.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	76	178
Ages 0 to 4	.	79
Ages 5 to 11	.	71
Ages 12 to 15	.	21
Ages 16 to 17	.	***
Age Unknown	.	***
Gender		
Totals	76	178
Female	.	86
Male	.	92
Race/Ethnicity		
Totals	76	178
Black	.	85
White	.	67
Hispanic	.	***
Unable to Determine	.	21

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Somerset

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Somerset

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	***	***	11.11%	***	33.33%	***	33.33%	***	0.00%	***	22.22%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	33.33%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	25.00%	***	50.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	***	***	11.11%	***	33.33%	***	33.33%	***	0.00%	***	22.22%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	33.33%	***	0.00%	***	0.00%	***	66.66%	***	0.00%	***	0.00%
Male	***	***	16.66%	***	33.33%	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	***	***	11.11%	***	33.33%	***	33.33%	***	0.00%	***	22.22%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	50.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%
White	***	***	20.00%	***	60.00%	***	20.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Somerset

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Somerset

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%
Ages 12 to15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Female	***	***	0.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Hispanic	***	***	0.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%	***	100.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Somerset

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	***	577	4	6.93
Ages 0 to 4	***	389	3	7.71
Ages 5 to 11	***	87	1	11.49
Ages 12 to 15	***	101	0	0.00
Ages 16 to 18	***	0	0	NA
Gender				
Totals	***	577	4	6.93
Female	***	376	3	7.98
Male	***	201	1	4.98
Race/Ethnicity				
Totals	***	577	4	6.93
Black	***	476	4	8.40
White	***	101	0	0.00

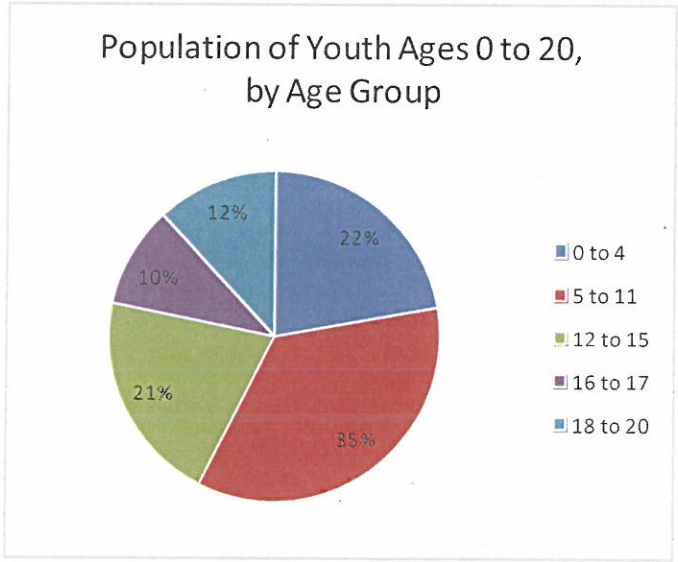
NA: Not Applicable

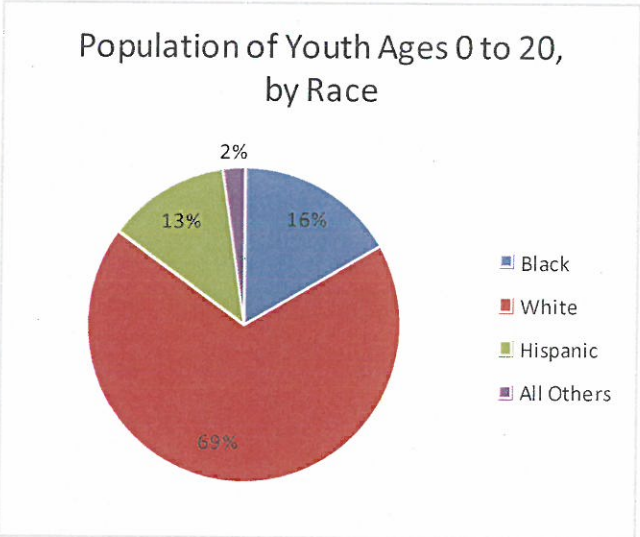
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Talbot County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[23].

Age Groups	Population of Youth Ages 0 to 20
Totals	7,925
0 to 4	1,755
5 to 11	2,793
12 to 15	1,650
16 to 17	780
18 to 20	947



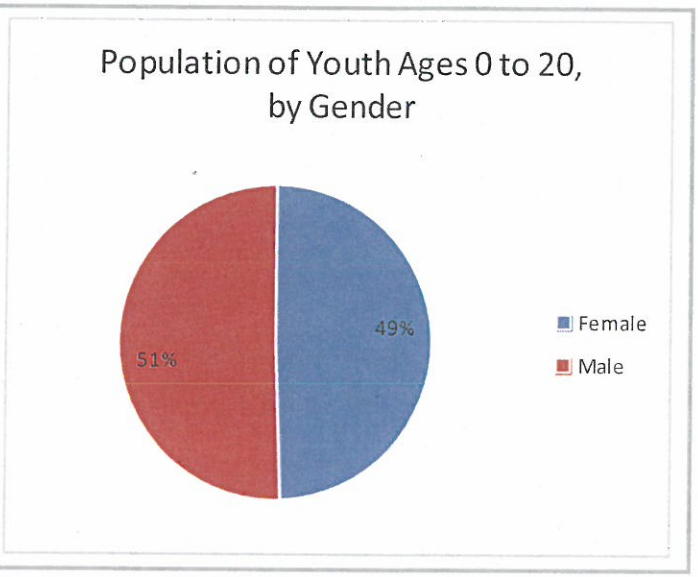


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	6,978	7,925
Black	1,141	1,311
White	4,748	5,432
Hispanic	926	999
All Others	163	183

[23]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	6,978	7,925
Female	3,448	3,916
Male	3,530	4,009



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Talbot.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Talbot

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	103	46	44.66%	57	55.33%	19	33.33%	11	19.29%	27	47.36%
Ages 0 to 4	28	15	53.57%	13	46.42%	***	46.15%	***	23.07%	***	30.76%
Ages 5 to 11	48	21	43.75%	27	56.25%	***	29.62%	***	11.11%	16	59.25%
Ages 12 to 15	20	***	30.00%	14	70.00%	***	28.57%	***	28.57%	***	42.85%
Ages 16 to 18	***	***	57.14%	***	42.85%	***	33.33%	***	33.33%	***	33.33%
Gender											
Totals	103	46	44.66%	57	55.33%	19	33.33%	11	19.29%	27	47.36%
Female	58	25	43.10%	33	56.89%	10	30.30%	***	24.24%	15	45.45%
Male	45	21	46.66%	24	53.33%	***	37.50%	***	12.50%	12	50.00%
Race/Ethnicity											
Totals	103	46	44.66%	57	55.33%	19	33.33%	11	19.29%	27	47.36%
Black	15	***	40.00%	***	60.00%	***	33.33%	***	22.22%	***	44.44%
White	58	29	50.00%	29	50.00%	***	24.13%	***	27.58%	14	48.27%
Hispanic	18	***	50.00%	***	50.00%	***	66.66%	***	11.11%	***	22.22%
Unable to Determine	12	***	16.66%	10	83.33%	***	30.00%	***	0.00%	***	70.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Talbot.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	49	103
Ages 0 to 4	.	30
Ages 5 to 11	.	45
Ages 12 to 15	.	26
Ages 16 to 17	.	***
Gender		
Totals	49	103
Female	.	50
Male	.	53
Race/Ethnicity		
Totals	49	103
Black	.	35
White	.	49
Hispanic	.	10
Unable to Determine	.	***

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Talbot

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	10	***	10.00%	***	70.00%	***	0.00%	***	20.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	25.00%	***	25.00%	***	0.00%	***	50.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	10	***	10.00%	***	70.00%	***	0.00%	***	20.00%	***	0.00%
Female	***	***	33.33%	***	33.33%	***	0.00%	***	33.33%	***	0.00%
Male	***	***	0.00%	***	85.71%	***	0.00%	***	14.28%	***	0.00%
Race/Ethnicity											
Totals	10	***	10.00%	***	70.00%	***	0.00%	***	20.00%	***	0.00%
Black	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	25.00%	***	25.00%	***	0.00%	***	50.00%	***	0.00%
Unable to determine	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Talbot

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	***	***	42.85%	***	14.28%	***	28.57%	***	0.00%	***	0.00%	***	0.00%	***	14.28%
Ages 0 to 4	***	***	33.33%	***	33.33%	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.0%
Ages 12 to 15	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender															
Totals	***	***	42.85%	***	14.28%	***	28.57%	***	0.00%	***	0.00%	***	0.00%	***	14.28%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	42.85%	***	14.28%	***	28.57%	***	0.00%	***	0.00%	***	0.00%	***	14.28%
Race/Ethnicity															
Totals	***	***	42.85%	***	14.28%	***	28.57%	***	0.00%	***	0.00%	***	0.00%	***	14.28%
Black	***	***	50.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	25.00%
White	***	***	33.33%	***	0.00%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Talbot

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Talbot

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Talbot

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

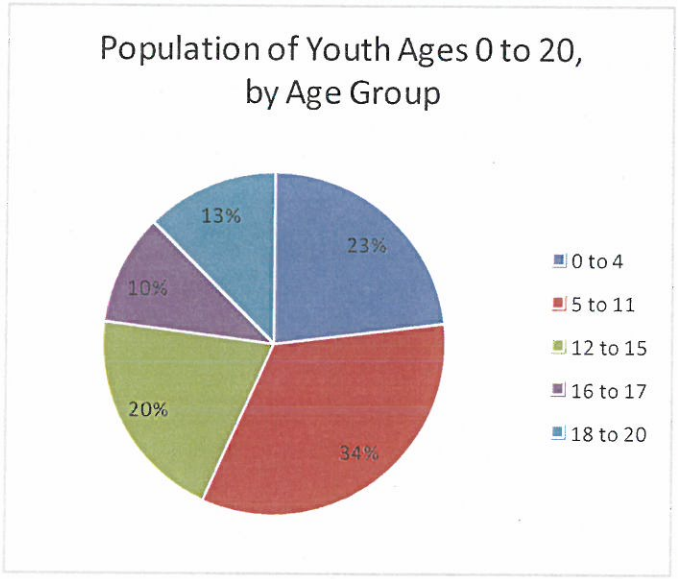
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	12	1,880	13	6.91
Ages 0 to 4	***	368	2	5.43
Ages 5 to 11	***	977	10	10.24
Ages 12 to 15	***	340	1	2.94
Ages 16 to 18	***	195	0	0.00
Gender				
Totals	12	1,880	13	6.91
Female	***	523	3	5.74
Male	***	1,357	10	7.37
Race/Ethnicity				
Totals	12	1,880	13	6.91
Black	***	745	3	4.03
White	***	445	2	4.49
Unable to determine	***	690	8	11.59

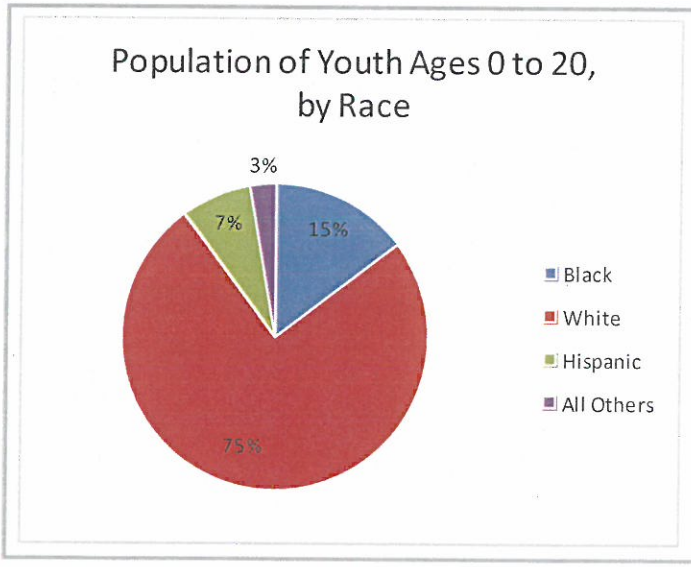
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Washington County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[24].

Age Groups	Population of Youth Ages 0 to 20
Totals	37,945
0 to 4	8,753
5 to 11	12,757
12 to 15	7,722
16 to 17	3,952
18 to 20	4,761



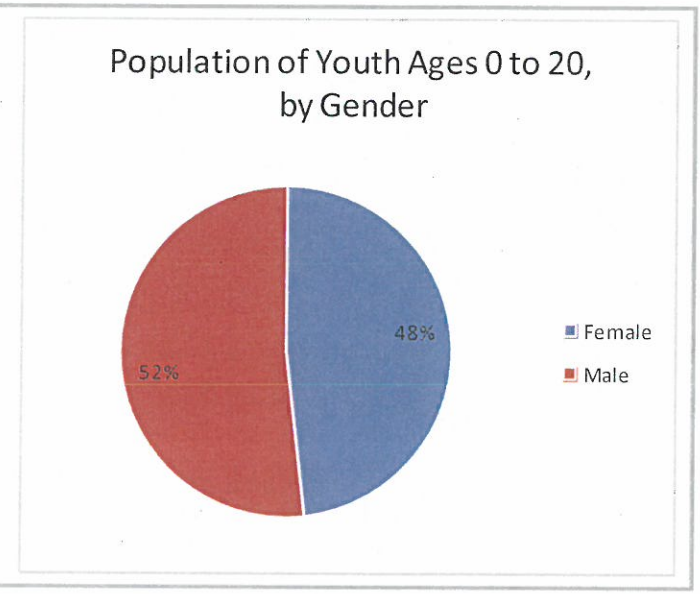


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	33,184	37,945
Black	4,679	5,546
White	25,034	28,517
Hispanic	2,521	2,821
All Others	950	1,061

[24]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	33,184	37,945
Female	16,129	18,258
Male	17,055	19,687



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Washington.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Washington

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	1,308	506	38.68%	802	61.31%	299	37.28%	106	13.21%	397	49.50%
Ages 0 to 4	451	191	42.35%	260	57.64%	115	44.23%	27	10.38%	118	45.38%
Ages 5 to 11	513	185	36.06%	328	63.93%	110	33.53%	51	15.54%	167	50.91%
Ages 12 to 15	256	97	37.89%	159	62.10%	55	34.59%	22	13.83%	82	51.57%
Ages 16 to 18	86	32	37.20%	54	62.79%	19	35.18%	***	11.11%	29	53.70%
Age Invalid	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	1,308	506	38.68%	802	61.31%	299	37.28%	106	13.21%	397	49.50%
Female	643	231	35.92%	412	64.07%	146	35.43%	56	13.59%	210	50.97%
Male	665	275	41.35%	390	58.64%	153	39.23%	50	12.82%	187	47.94%
Race/Ethnicity											
Totals	1,308	506	38.68%	802	61.31%	299	37.28%	106	13.21%	397	49.50%
Black	248	94	37.90%	154	62.09%	55	35.71%	22	14.28%	77	50.00%
White	697	255	36.58%	442	63.41%	168	38.00%	62	14.02%	212	47.96%
Hispanic	42	18	42.85%	24	57.14%	***	37.50%	***	33.33%	***	29.16%
All Others	***	***	100.00 %	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Unable to Determine	320	138	43.12%	182	56.87%	67	36.81%	14	7.69%	101	55.49%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Washington.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	237	502
Ages 0 to 4	.	218
Ages 5 to 11	.	183
Ages 12 to 15	.	77
Ages 16 to 17	.	22
Age Unknown	.	***
Gender		
Totals	237	502
Female	.	239
Male	.	263
Race/Ethnicity		
Totals	237	502
Black	.	100
White	.	225
Hispanic	.	17
All Others	.	***
Unable to Determine	.	159

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Washington

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	69	***	8.69%	60	86.95%	***	4.34%	***	0.00%	***	0.00%
Ages 0 to 4	32	***	0.00%	30	93.75%	***	6.25%	***	0.00%	***	0.00%
Ages 5 to 11	15	***	0.00%	14	93.33%	***	6.66%	***	0.00%	***	0.00%
Ages 12 to 15	16	***	31.25%	11	68.75%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	16.66%	***	83.33%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	69	***	8.69%	60	86.95%	***	4.34%	***	0.00%	***	0.00%
Female	37	***	13.51%	31	83.78%	***	2.70%	***	0.00%	***	0.00%
Male	32	***	3.12%	29	90.62%	***	6.25%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	69	***	8.69%	60	86.95%	***	4.34%	***	0.00%	***	0.00%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Black	15	***	13.33%	11	73.33%	***	13.33%	***	0.00%	***	0.00%
White	41	***	9.75%	36	87.80%	***	2.43%	***	0.00%	***	0.00%
Unable to determine	10	***	0.00%	10	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Washington

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type															
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	110	49	44.54%	15	13.63%	15	13.63%	***	3.63%	16	14.54%	***	6.36%	***	3.63%
	Ages 0 to 4	30	12	40.00%	***	30.00%	***	16.66%	***	0.00%	***	0.00%	***	13.33%	***	0.00%
	Ages 5 to 11	37	21	56.75%	***	16.21%	***	13.51%	***	2.70%	***	0.00%	***	8.10%	***	2.70%
	Ages 12 to 15	19	13	68.42%	***	0.00%	***	21.05%	***	10.52%	***	0.00%	***	0.00%	***	0.00%
	Ages 16 to 18	14	***	21.42%	***	0.00%	***	7.14%	***	7.14%	***	42.85%	***	0.00%	***	21.42%
	Over 18	10	***	0.00%	***	0.00%	***	0.00%	***	0.00%	10	100.00%	***	0.00%	***	0.00%
Gender																
	Totals	110	49	44.54%	15	13.63%	15	13.63%	***	3.63%	16	14.54%	***	6.36%	***	3.63%
	Female	56	28	50.00%	***	14.28%	***	8.92%	***	3.57%	***	16.07%	***	3.57%	***	3.57%
	Male	54	21	38.88%	***	12.96%	10	18.51%	***	3.70%	***	12.96%	***	9.25%	***	3.70%
Race/Ethnicity																
	Totals	110	49	44.54%	15	13.63%	15	13.63%	***	3.63%	16	14.54%	***	6.36%	***	3.63%
	Hispanic	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Black	38	15	39.47%	***	13.15%	***	21.05%	***	5.26%	***	7.89%	***	7.89%	***	5.26%
	White	54	25	46.29%	***	11.11%	***	7.40%	***	3.70%	13	24.07%	***	3.70%	***	3.70%
	Unable to determine	14	***	35.71%	***	28.57%	***	21.42%	***	0.00%	***	0.00%	***	14.28%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Washington

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	38	***	5.26%	***	10.52%	***	10.52%	***	13.15%
Ages 0 to 4	16	***	12.50%	***	12.50%	***	12.50%	***	18.75%
Ages 5 to 11	10	***	0.00%	***	10.00%	***	10.00%	***	10.00%
Ages 12 to 15	***	***	0.00%	***	11.11%	***	11.11%	***	11.11%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	38	***	5.26%	***	10.52%	***	10.52%	***	13.15%
Female	25	***	8.00%	***	12.00%	***	12.00%	***	16.00%
Male	13	***	0.00%	***	7.69%	***	7.69%	***	7.69%
Race/Ethnicity									
Totals	38	***	5.26%	***	10.52%	***	10.52%	***	13.15%
Hispanic	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	26	***	7.69%	***	15.38%	***	15.38%	***	19.23%
Unable to determine	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Washington

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	52	***	3.84%	***	7.69%	***	15.38%	***	17.30%	***	17.30%	11	21.15%	11	21.15%	11	21.15%
Ages 0 to 4	17	***	5.88%	***	11.76%	***	17.64%	***	17.64%	***	17.64%	***	23.52%	***	23.52%	***	23.52%
Ages 5 to 11	15	***	6.66%	***	6.66%	***	26.66%	***	33.33%	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Ages 12 to 15	14	***	0.00%	***	7.14%	***	7.14%	***	7.14%	***	7.14%	***	14.28%	***	14.28%	***	14.28%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	52	***	3.84%	***	7.69%	***	15.38%	***	17.30%	***	17.30%	11	21.15%	11	21.15%	11	21.15%
Female	20	***	0.00%	***	5.00%	***	10.00%	***	15.00%	***	15.00%	***	15.00%	***	15.00%	***	15.00%
Male	32	***	6.25%	***	9.37%	***	18.75%	***	18.75%	***	18.75%	***	25.00%	***	25.00%	***	25.00%
Race/Ethnicity																	
Totals	52	***	3.84%	***	7.69%	***	15.38%	***	17.30%	***	17.30%	11	21.15%	11	21.15%	11	21.15%
Hispanic	***	***	0.00%	***	0.00%	***	20.00%	***	40.00%	***	40.00%	***	60.00%	***	60.00%	***	60.00%
Black	13	***	7.69%	***	15.38%	***	15.38%	***	15.38%	***	15.38%	***	15.38%	***	15.38%	***	15.38%
White	29	***	3.44%	***	6.89%	***	13.79%	***	13.79%	***	13.79%	***	17.24%	***	17.24%	***	17.24%
Unable to determine	***	***	0.00%	***	0.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%	***	20.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Washington

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

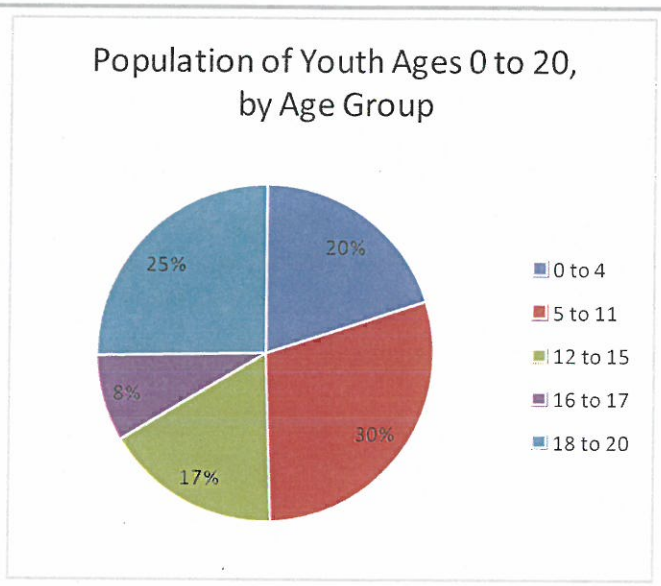
	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	88	11,697	52	4.45
Ages 0 to 4	37	5,103	12	2.35
Ages 5 to 11	20	2,214	16	7.23
Ages 12 to 15	20	3,277	16	4.88
Ages 16 to 18	11	1,103	8	7.25
Gender				
Totals	88	11,697	52	4.45
Female	48	5,117	25	4.89
Male	40	6,580	27	4.10
Race/Ethnicity				
Totals	88	11,697	52	4.45
Hispanic	***	711	0	0.00
Black	19	1,432	10	6.98
White	51	8,515	39	4.58
Unable to determine	11	1,039	3	2.89

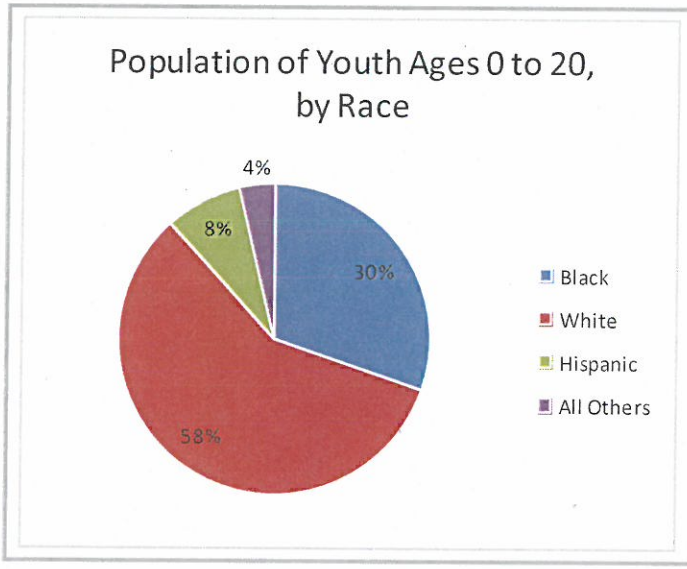
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Wicomico County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[25].

Age Groups	Population of Youth Ages 0 to 20
Totals	29,982
0 to 4	6,000
5 to 11	8,815
12 to 15	5,087
16 to 17	2,501
18 to 20	7,579



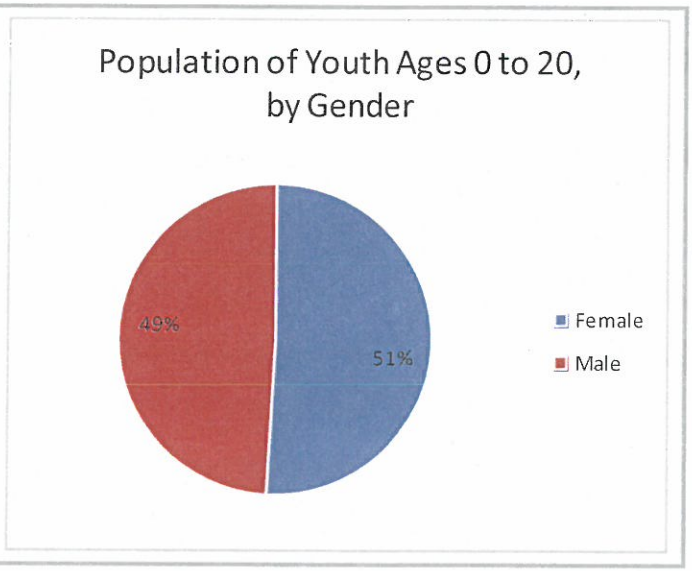


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	22,403	29,982
Black	7,596	9,073
White	11,928	17,396
Hispanic	2,036	2,392
All Others	843	1,121

[25]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	22,403	29,982
Female	11,048	15,253
Male	11,355	14,729



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Wicomico.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Wicomico

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	647	361	55.79%	286	44.20%	79	27.62%	71	24.82%	136	47.55%
Ages 0 to 4	191	110	57.59%	81	42.40%	20	24.69%	17	20.98%	44	54.32%
Ages 5 to 11	276	155	56.15%	121	43.84%	34	28.09%	32	26.44%	55	45.45%
Ages 12 to 15	125	70	56.00%	55	44.00%	15	27.27%	15	27.27%	25	45.45%
Ages 16 to 18	54	26	48.14%	28	51.85%	10	35.71%	***	25.00%	11	39.28%
Age Invalid	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	100.00%
Gender											
Totals	647	361	55.79%	286	44.20%	79	27.62%	71	24.82%	136	47.55%
Female	330	169	51.21%	161	48.78%	52	32.29%	41	25.46%	68	42.23%
Male	317	192	60.56%	125	39.43%	27	21.60%	30	24.00%	68	54.40%
Race/Ethnicity											
Totals	647	361	55.79%	286	44.20%	79	27.62%	71	24.82%	136	47.55%
Black	265	148	55.84%	117	44.15%	39	33.33%	22	18.80%	56	47.86%
White	252	142	56.34%	110	43.65%	28	25.45%	30	27.27%	52	47.27%
Hispanic	31	16	51.61%	15	48.38%	***	20.00%	***	53.33%	***	26.66%
All Others	***	***	50.00%	***	50.00%	***	50.00%	***	50.00%	***	0.00%
Unable to Determine	95	53	55.78%	42	44.21%	***	19.04%	10	23.80%	24	57.14%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Wicomico.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	163	366
Ages 0 to 4	.	137
Ages 5 to 11	.	147
Ages 12 to 15	.	57
Ages 16 to 17	.	24
Age Unknown	.	***
Gender		
Totals	163	366
Female	.	172
Male	.	194
Race/Ethnicity		
Totals	163	366
Black	.	216
White	.	87
Hispanic	.	23
All Others	.	***
Unable to Determine	.	38

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Wicomico

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	10	***	0.00%	***	70.00%	***	20.00%	***	10.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	75.00%	***	0.00%	***	25.00%	***	0.00%
Gender											
Totals	10	***	0.00%	***	70.00%	***	20.00%	***	10.00%	***	0.00%
Female	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	75.00%	***	12.50%	***	12.50%	***	0.00%
Race/Ethnicity											
Totals	10	***	0.00%	***	70.00%	***	20.00%	***	10.00%	***	0.00%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	57.14%	***	28.57%	***	14.28%	***	0.00%
White	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Wicomico

Exits by return reason code between July 1, 2015 and June 30, 2016

	Exits by return type														
		Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
Totals	11	***	18.18%	***	36.36%	***	0.00%	***	18.18%	***	18.18%	***	9.09%	***	0.00%
Ages 0 to 4	***	***	20.00%	***	40.00%	***	0.00%	***	20.00%	***	0.00%	***	20.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	50.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	50.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Over 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	100.00%	***	0.00%	***	0.00%
Gender															
Totals	11	***	18.18%	***	36.36%	***	0.00%	***	18.18%	***	18.18%	***	9.09%	***	0.00%
Female	***	***	0.00%	***	66.66%	***	0.00%	***	0.00%	***	0.00%	***	33.33%	***	0.00%
Male	***	***	25.00%	***	25.00%	***	0.00%	***	25.00%	***	25.00%	***	0.00%	***	0.00%
Race/Ethnicity															
Totals	11	***	18.18%	***	36.36%	***	0.00%	***	18.18%	***	18.18%	***	9.09%	***	0.00%
Black	***	***	16.66%	***	16.66%	***	0.00%	***	16.66%	***	33.33%	***	16.66%	***	0.00%
White	***	***	20.00%	***	60.00%	***	0.00%	***	20.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Wicomico

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	0.00%	***	50.00%	***	50.00%	***	50.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	100.00%	***	100.00%	***	100.00%
Gender									
Totals	***	***	0.00%	***	50.00%	***	50.00%	***	50.00%
Female	***	***	0.00%	***	100.00%	***	100.00%	***	100.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	0.00%	***	50.00%	***	50.00%	***	50.00%
Black	***	***	0.00%	***	50.00%	***	50.00%	***	50.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Wicomico
No Data Available for this Table

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Wicomico

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	11	2,628	10	3.81
Ages 0 to 4	***	925	3	3.24
Ages 5 to 11	***	573	2	3.49
Ages 12 to 15	***	0	0	NA
Ages 16 to 18	***	1,130	5	4.42
Gender				
Totals	11	2,628	10	3.81
Female	***	564	1	1.77
Male	***	2,064	9	4.36
Race/Ethnicity				
Totals	11	2,628	10	3.81
Hispanic	***	538	2	3.72
Black	***	1,909	8	4.19
White	***	181	0	0.00

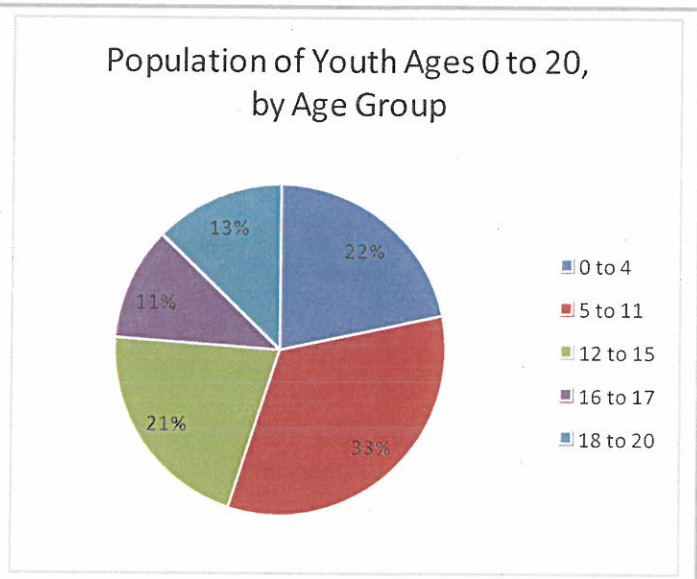
NA: Not Applicable

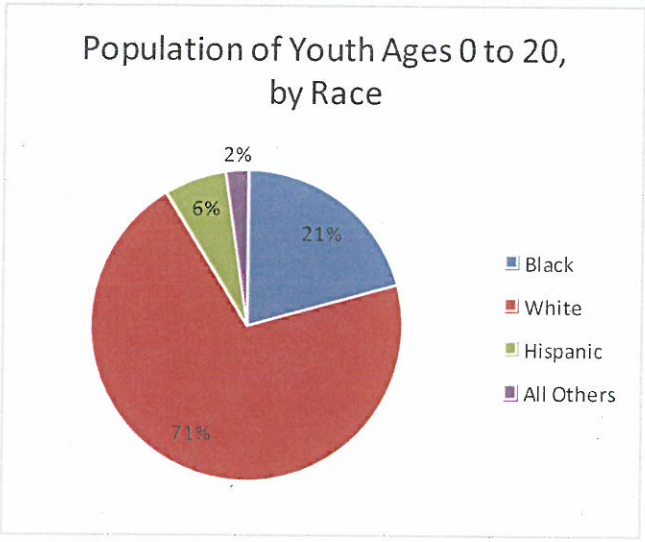
NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Worcester County

In order to briefly set the context for each jurisdiction census information is provided broken out by age, race and gender. The Bridged-Race Population Estimates Data Files provided free of charge by the Centers for Disease Control (CDC) were used throughout the report[26].

Age Groups	Population of Youth Ages 0 to 20
Totals	10,442
0 to 4	2,262
5 to 11	3,477
12 to 15	2,212
16 to 17	1,151
18 to 20	7,579



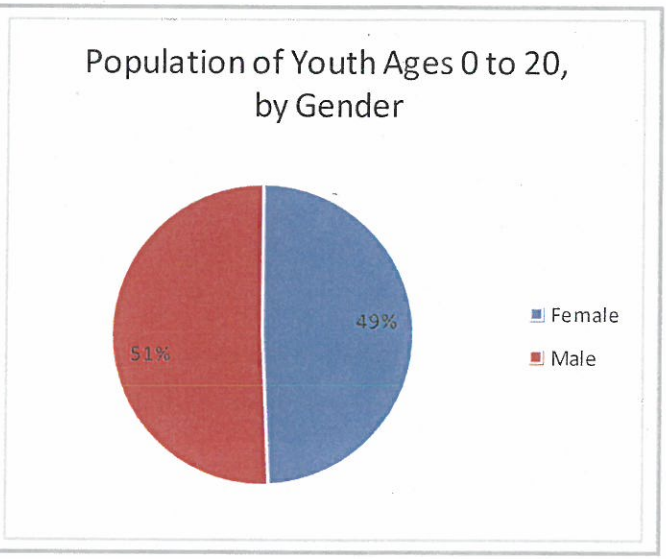


Race	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 20
Totals	9,102	10,442
Black	1,897	2,161
White	6,375	7,362
Hispanic	608	673
All Others	222	246

[26]Documentation of The Bridged-Race Population Estimates Data Files is available online at: http://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Gender	Population of Youth Ages 0 to 17	Population of Youth Ages 0 to 21
Totals	9,102	10,442
Female	4,495	5,143
Male	4,607	5,299



NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 1: The number of child abuse and neglect reports, alternative responses, investigative responses, and findings for completed investigations in Worcester.

Examination of Investigative Response/Alternative Response for State Fiscal Year 2016 in Worcester

				Investigative Response							
	Children	Alternative Response		Investigative Response		Indicated		Unsubstantiated		Ruled Out	
Age Groups	(A)	(B) n	(B/A) %	(C) n	(C/A) %	(D) n	(D/C) %	(I) n	(I/C) %	(O) n	(O/C) %
Totals	320	144	45.00%	176	55.00%	84	47.72%	37	21.02%	55	31.25%
Ages 0 to 4	93	40	43.01%	53	56.98%	30	56.60%	11	20.75%	12	22.64%
Ages 5 to 11	149	76	51.00%	73	48.99%	31	42.46%	15	20.54%	27	36.98%
Ages 12 to 15	57	17	29.82%	40	70.17%	18	45.00%	***	20.00%	14	35.00%
Ages 16 to 18	20	11	55.00%	***	45.00%	***	44.44%	***	33.33%	***	22.22%
Age Invalid	***	***	0.00%	***	100.00%	***	100.00%	***	0.00%	***	0.00%
Gender											
Totals	320	144	45.00%	176	55.00%	84	47.72%	37	21.02%	55	31.25%
Female	162	70	43.20%	92	56.79%	41	44.56%	21	22.82%	30	32.60%
Male	157	74	47.13%	83	52.86%	42	50.60%	16	19.27%	25	30.12%
Other/ Unknown	***	***	0.00%	***	100.00%	***	100.00%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	320	144	45.00%	176	55.00%	84	47.72%	37	21.02%	55	31.25%
Black	84	39	46.42%	45	53.57%	27	60.00%	***	13.33%	12	26.66%
White	186	88	47.31%	98	52.68%	41	41.83%	21	21.42%	36	36.73%
Hispanic	17	***	23.52%	13	76.47%	***	69.23%	***	15.38%	***	15.38%
All Others	***	***	40.00%	***	60.00%	***	0.00%	***	100.00%	***	0.00%
Unable to Determine	28	11	39.28%	17	60.71%	***	41.17%	***	29.41%	***	29.41%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 2: The number of children and foster youth receiving In-Home services in Worcester.

This table contains the number of In-Home cases served during the fiscal year, and children included in the cases served.

All In-Home Services - State Fiscal Year 2016

	All In-Home Services State Fiscal Year 2016	
Age Group	**Cases**	**Children**
All Ages	146	346
Ages 0 to 4	.	128
Ages 5 to 11	.	126
Ages 12 to 15	.	62
Ages 16 to 17	.	28
Age Unknown	.	***
Gender		
Totals	146	346
Female	.	167
Male	.	179
Race/Ethnicity		
Totals	146	346
Black	.	125
White	.	179
Hispanic	.	***
All Others	.	***
Unable to Determine	.	33

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 3: The number of new out-of-home placements by placement type in Worcester

New out-of-home placements by placement type between July 1, 2015 and June 30, 2016

	Removals by placement type										
		Community-Based Residential Placement		Family Home Settings		Hospitalization		Non-Community Based Residential Placement		Unknown	
Age Group	Children (A)	N (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)
Totals	14	***	7.14%	10	71.42%	***	14.28%	***	7.14%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	33.33%	***	33.33%	***	0.00%	***	33.33%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Gender											
Totals	14	***	7.14%	10	71.42%	***	14.28%	***	7.14%	***	0.00%
Female	***	***	12.50%	***	75.00%	***	0.00%	***	12.50%	***	0.00%
Male	***	***	0.00%	***	66.66%	***	33.33%	***	0.00%	***	0.00%
Race/Ethnicity											
Totals	14	***	7.14%	10	71.42%	***	14.28%	***	7.14%	***	0.00%
Hispanic	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Black	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	12.50%	***	62.50%	***	12.50%	***	12.50%	***	0.00%
All other	***	***	0.00%	***	100.00%	***	0.00%	***	0.00%	***	0.00%
Unable to determine	***	***	0.00%	***	50.00%	***	50.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 4: The number of exits from the child welfare system by exit type in Worcester

Exits by return reason code between July 1, 2015 and June 30, 2016

		Exits by return type															
			Reunification		Adoption		Custody/ Guardianship Relative		Custody/ Guardianship Non-Relative		Emancipation		Court ordered return home against DSS recommendation		Other	
Age Group		Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)
	Totals	25	16	64.00%	***	0.00%	***	24.00%	***	0.00%	***	8.00%	***	0.00%	***	4.00%
	Ages 0 to 4	12	***	75.00%	***	0.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 5 to 11	***	***	75.00%	***	0.00%	***	25.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 12 to 15	***	***	50.00%	***	0.00%	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
	Ages 16 to 18	***	***	33.33%	***	0.00%	***	0.00%	***	0.00%	***	66.66%	***	0.00%	***	0.00%
	Over 18	***	***	50.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	50.00%
Gender																
	Totals	25	16	64.00%	***	0.00%	***	24.00%	***	0.00%	***	8.00%	***	0.00%	***	4.00%
	Female	14	***	57.14%	***	0.00%	***	21.42%	***	0.00%	***	14.28%	***	0.00%	***	7.14%
	Male	11	***	72.72%	***	0.00%	***	27.27%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																
	Totals	25	16	64.00%	***	0.00%	***	24.00%	***	0.00%	***	8.00%	***	0.00%	***	4.00%
	Black	***	***	66.66%	***	0.00%	***	16.66%	***	0.00%	***	16.66%	***	0.00%	***	0.00%
	White	15	***	53.33%	***	0.00%	***	33.33%	***	0.00%	***	6.66%	***	0.00%	***	6.66%
	Unable to determine	***	***	100.0%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 5: The number of exits to reunification and reentries within 12 months after exit in Worcester

Exits to reunification between July 1, 2014 and June 30, 2015 and the number of reentries within 12 months after exit

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)
Totals	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Ages 0 to 4	***	***	33.33%	***	33.33%	***	33.33%	***	33.33%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender									
Totals	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Female	***	***	25.00%	***	25.00%	***	25.00%	***	25.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity									
Totals	***	***	14.28%	***	14.28%	***	14.28%	***	14.28%
Black	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	33.33%	***	33.33%	***	33.33%	***	33.33%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 6: The number of exits to reunification and reentries within 24 months after exit in Worcester

Exits to reunification between July 1, 2013 and June 30, 2014
And the number of reentries up to 24 months after exit
By jurisdiction, age, gender and race

	Exits to reunification	Reentries within 3 months		Reentries within 6 months		Reentries within 9 months		Reentries within 12 months		Reentries within 15 months		Reentries within 18 months		Reentries within 21 months		Reentries within 24 months	
Age Group	Children (A)	n (B)	% (B/A)	n (C)	% (C/A)	n (D)	% (D/A)	n (E)	% (E/A)	n (F)	% (F/A)	n (G)	% (G/A)	n (H)	% (H/A)	n (I)	% (I/A)
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 0 to 4	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 5 to 11	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 12 to 15	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Ages 16 to 18	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Gender																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Female	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Male	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
Race/Ethnicity																	
Totals	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%
White	***	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%	***	0.00%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 7: The stability of out-of-home placements, including the number of placement changes in Worcester

Stability of out-of-home placements for children entering care between July 1, 2015 and June 30, 2016
Included are the total number of days in out-of-home care, the number of placements moves
And the number of placement moves per 1,000 days

	Number of Entries	Total number of days in care	Number of placement moves	Moves per 1,000 days
Age Group	**Children**	**B**	**C**	**C/B x 1000**
Totals	19	3,384	15	4.43
Ages 0 to 4	***	1,668	8	4.80
Ages 5 to 11	***	1,094	6	5.48
Ages 12 to 15	***	180	0	0.00
Ages 16 to 18	***	442	1	2.26
Gender				
Totals	19	3,384	15	4.43
Female	13	2,038	10	4.91
Male	***	1,346	5	3.71
Race/Ethnicity				
Totals	19	3,384	15	4.43
Hispanic	***	712	2	2.81
Black	***	28	0	0.00
White	11	1,823	9	4.94
All other	***	170	0	0.00
Unable to determine	***	651	4	6.14

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Section 2: Questions requiring data sharing between agencies.

Questions requiring data sharing between State agencies are the following:
(8) The stability of school placements;
(9) The number who graduate from high school;
(10) The number who qualify for a Maryland high school diploma by examination; and
(11) The number who receive tuition waivers.

Questions 8 and 9 require data from the Maryland State Department of Education (MSDE), question 10 requires data from the Maryland Department of Labor, Licensing and Regulation (DLLR), and question 11 requires data from the Maryland Higher Education Commission (MHEC).

For this second annual report, information pertaining to the stability of school placements and the number of high school graduates (Questions 8 and 9) has been provided by MSDE, and information pertaining to the number of youth who received educational waivers (Question 11) was provided by MHEC.

The data required for Question 10 (the number qualifying for a Maryland high school diploma by examination) are not yet available. Due to agency transition and resource constraints, the efforts being made to form a data sharing agreement to obtain this data between DHR and DLLR have been delayed. The data sharing agreement, and obtaining the high school diploma by examination data needed, will be accomplished for next year's report.

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 8: The stability of school placements

Information about the stability of school placements has been made available through an agreement between DHR and MSDE. For the first time this year, DHR and MSDE have matched children in foster care with student education records, in order to gain accurate data about the education experiences for these children. The overall match rate is high, with 89% of foster children matching student records, based on a good matching process using first name, last name, middle name, date of birth, and gender (with a minimum standard of matching at least last name, first name, and date of birth). In the tables below, there is information about 2,780 children who experienced foster care during the Academic Year 2016. Broken out by elementary, middle, and high school levels, the first table contains statewide information about the number of schools attended by foster children during the academic year. The second table contains jurisdiction level information about the foster children who experienced only one school setting during the academic year.

Number of Schools Attended during Academic Year 2016

Number of Schools Attended	Elementary School	Middle School	High School	Total
1 School	843	367	941	2,151
	76.5%	75.8%	78.8%	77.4%
2 Schools	212	86	209	507
	19.2%	17.8%	17.5%	18.2%
3 or more Schools	47	31	44	122
	4.3%	6.4%	3.7%	4.4%
Total	1,102	484	1,194	2,780

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Jurisdiction Breakdown for Foster Children Attending One School: AY2016

Jurisdiction	Elementary School	%	Middle School	%	High School	%	Grand Total
Allegany	33	64.7%	10	19.6%	***	15.7%	**51**
Anne Arundel	25	41.0%	10	16.4%	26	42.6%	**61**
Baltimore City	339	39.1%	137	15.8%	392	45.2%	**868**
Baltimore County	81	33.8%	40	16.7%	119	49.6%	**240**
Calvert	16	36.4%	***	18.2%	20	45.5%	**44**
Caroline	***	37.5%	***	25.0%	***	37.5%	**16**
Carroll	11	42.3%	***	11.5%	12	46.2%	**26**
Cecil	41	55.4%	11	14.9%	22	29.7%	**74**
Charles	19	46.3%	10	24.4%	12	29.3%	**41**
Dorchester	***	25.0%	***	25.0%	10	50.0%	**20**
Frederick	22	50.0%	***	9.1%	18	40.9%	**44**
Garrett	17	54.8%	***	9.7%	11	35.5%	**31**
Harford	38	45.8%	16	19.3%	29	34.9%	**83**
Howard	***	16.7%	***	11.1%	13	72.2%	**18**
Kent	***	0.0%	***	40.0%	***	60.0%	***
Montgomery	63	38.2%	24	14.6%	78	47.3%	**165**
Prince George's	49	26.9%	34	18.7%	99	54.4%	**182**
Queen Anne's	***	0.0%	***	33.3%	***	66.7%	***
Somerset	***	50.0%	***	25.0%	***	25.0%	***
St. Mary's	20	55.6%	10	27.8%	***	16.7%	**36**
Talbot	***	58.3%	***	8.3%	***	33.3%	**12**
Washington	35	39.3%	24	27.0%	30	33.7%	**89**
Wicomico	***	18.8%	***	25.0%	***	56.3%	**16**
Worcester	***	33.3%	***	11.1%	10	55.6%	**18**
Attending 1 School	**843**	**39.2%**	**367**	**17.1%**	**941**	**43.8%**	**2,151**

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 9: The number who graduate from high school

Information about high school graduation has been made available through an agreement between DHR and MSDE. For the first time this year, DHR and MSDE have matched children in foster care with student education records, in order to gain accurate data about the education experiences for these children. The Overall match rate is high, with 89% of foster children matching student records, based on a good matching process using first name, last name, middle name, date of birth, and gender (with a minimum standard of matching at least last name, first name, and date of birth). In the table below, there is information about 286 foster care children who were in 12th grade during Academic Year 2016.

High School Graduation among Foster Children in 12th Grade: AY 2016

Jurisdiction	Graduated	Percent Graduating	Did not Graduate	Transfer or Termination	Percent Not Graduating	Total
Allegany	***	100.0%	***	***	0.0%	***
Anne Arundel	***	75.0%	***	***	25.0%	***
Baltimore City	61	55.0%	37	13	45.1%	**111**
Baltimore County	25	69.4%	***	***	30.6%	**36**
Calvert	***	50.0%	***	***	50.0%	***
Caroline	***	0.0%	***	***	100.0%	***
Carroll	***	100.0%	***	***	0.0%	***
Cecil	***	66.7%	***	***	33.3%	***
Charles	***	100.0%	***	***	0.0%	***
Dorchester	***	0.0%	***	***	100.0%	***
Frederick	***	50.0%	***	***	50.0%	***
Garrett	***	75.0%	***	***	25.0%	***
Harford	***	71.4%	***	***	28.6%	***
Howard	***	50.0%	***	***	50.0%	***
Kent	***	100.0%	***	***	0.0%	***
Montgomery	24	82.8%	***	***	17.2%	**29**
Prince George's	19	59.4%	***	***	40.6%	**32**
Queen Anne's	***	0.0%	***	***	100.0%	***
St. Mary's	***	50.0%	***	***	50.0%	***
Talbot	***	100.0%	***	***	0.0%	***
Washington	10	76.9%	***	***	23.1%	**13**
Wicomico	***	66.7%	***	***	33.3%	***
Worcester	***	0.0%	***	***	100.0%	***
Total	180	62.9%	59	47	37.1%	**286**

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Question 11: The number who receive tuition waivers

According to the Maryland Higher Education Committee (MHEC) there were 106 individuals who received the foster care tuition waiver in the 2014-2015 academic year (the latest information that is available). These individuals have been broken out by jurisdiction, gender, race/ethnicity and age groupings in the tables below.

Geographic areas of recipients

Jurisdiction	Count	%
Maryland	217	100.0%
Allegany County	***	0.9%
Anne Arundel County	***	0.5%
Baltimore City	71	32.7%
Baltimore County	58	26.7%
Calvert County	***	0.5%
Caroline County	***	0.0%
Carroll County	***	0.5%
Cecil County	***	0.0%
Charles County	***	1.4%
Dorchester	***	0.0%
Frederick County	***	0.9%
Harford County	17	7.8%
Garrett County	***	0.0%
Howard County	***	1.8%
Kent County	***	0.0%
Montgomery County	35	16.1%
Prince George's County	14	6.5%
Queen Anne's	***	0.5%
Saint Mary's County	***	0.0%
Somerset County	***	0.0%
Talbot County	***	0.0%
Washington County	***	0.0%
Wicomico County	***	0.0%
Worcester County	***	0.0%
Florida	***	0.5%
Virginia	***	0.5%
Washington, D.C.	***	1.4%
No Geographic Information	***	0.9%

Gender of recipients

Jurisdiction	Count	%
Maryland	217	100.0%
Male	77	35.5%
Female	140	64.5%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

Race and ethnicity of recipients Foster Care Waiver Recipient

Jurisdiction	Count	%
Maryland	217	100.0%
Hispanic (of any race)	***	0.0%
Black or African-American	140	64.5%
White	55	25.3%
American Indian/Alaska Native	***	2.3%
Asian	***	1.8%
Native Hawaiian/Pacific Islander	***	0.5%
Multiracial	***	3.2%
International	***	0.0%
Unknown	***	2.3%

Ages by age band

To better understand the age distribution, the recipients were grouped into bands.

Jurisdiction	Count	%
Maryland	217	100.0%
Ages 17 to 19	113	52.1%
Ages 20 to 22	90	41.5%
Ages 23 to 24	12	5.5%
Ages 25 to 26	***	0.9%
Ages 27 to 28	***	0.0%
Missing data	***	0.0%

NOTE: Cells containing triple asterisk (***) indicate counts less than 10

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Stephen Peterson, Assistant Director

(Name, Title)

(Printed Name and Title)
620 West Lexington St. 4th Fl, Baltimore, Maryland, 21201

(Address)
410-706-3615 / 410-706-6630

(Phone Number) / (Fax Number)
speterson@umaryland.edu

(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

University of Maryland, Baltimore

(Company)

(Authorized Signature) (Representative Name, Title)

Stephen Peterson, Assistant Director

(Printed Name and Title of Authorized Representative)

9/6/2019

(Date)

410-706-3615 / 410-706-6630

(Phone Number) (Fax Number)

REQUEST FOR PROPOSAL
CRFP 0506 HHR2000000001
Department of Health and Human Resources
DOJ Subject Matter Expert Services

6.8. Availability of Information: Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

University of Maryland, Baltimore

(Company)

Stephen Peterson, Assistant Director

(Representative Name, Title)

410-706-3615

(Contact Phone/Fax Number)

9/6/2019

(Date)

REQUEST FOR PROPOSAL
CRFP 0506 HHR2000000001
Department of Health and Human Resources
DOJ Subject Matter Expert Services

Vendor Name:	University of Maryland, Baltimore
Physical Address:	620 West Lexington St. 4th Fl Baltimore, Maryland 21201
Remit to Address:	University of Maryland, Baltimore P.O. Box 41428 Baltimore, MD 21203-6428
Telephone:	410-706-3615
Fax:	410-706-6630
Email:	speterson@umaryland.edu
Vendor Representative (print name):	Stephen Peterson
Signature:	
Date:	9/6/2019

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

Pursuant to *W. Va. Code* § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of $1 million or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation, but does not include publicly traded companies listed on a national or international stock exchange.

"Interested party" or *"Interested parties"* means:

(1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
(2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
(3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of W. Va. Code § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

Revised June 8, 2018

West Virginia Ethics Commission

Disclosure of Interested Parties to Contracts

(Required by *W. Va. Code* § 6D-1-2)

Name of Contracting Business Entity: University of Maryland, Baltimore **Address:** 620 West Lexington St. 4th Floor Baltimore, Maryland, 21201

Name of Authorized Agent: Stephen Peterson **Address:** 620 West Lexington St. 4th Floor

Contract Number: CRFP 0506 HHR2000000001 **Contract Description:** _____

Governmental agency awarding contract: _____

☐ **Check here if this is a Supplemental Disclosure**

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below *(attach additional pages if necessary)*:

1. **Subcontractors or other entities performing work or service under the Contract**
   ☑ Check here if none, otherwise list entity/individual names below.

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**
   ☑ Check here if none, otherwise list entity/individual names below.

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**
   ☑ Check here if none, otherwise list entity/individual names below.

Signature: _____ Date Signed: 9/6/2019

Notary Verification

State of Maryland, County of Baltimore:

I, Stephen Peterson, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 6th day of September, 2019.

_____
Notary Public's Signature

YELENA KOVALETS
Notary Public - State of Maryland
Harford County
My Commission Expires Jul 27, 2022

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____

Revised June 8, 2018