

## **State Funding, Structure, and Management Strategies in Workforce Development for Children’s Behavioral Health**

This document is prepared to inform the Children’s Behavioral Health (CBH) Workforce Development (WD) Infrastructure Feasibility Study, conducted under a contract between the New Hampshire Endowment for Health and Cliff Davis, Partner, Human Service Collaborative. The purpose of this document is to describe infrastructure models, processes, and funding strategies currently utilized in various states for CBH WD and to extract from the experiences of those states lessons that might guide New Hampshire in establishing and sustaining such an infrastructure. The experiences described here demonstrate approaches against which feasibility can be measured for implementation in New Hampshire.

The information presented in this document was obtained through three primary methods: 1) consultation with experts in the field; 2) researching information about relevant topics and organizations readily available via the internet; and 3) interviews conducted with key informants in each state to clarify information, obtain further details, and sharpen understanding about establishing and sustaining WD infrastructures.

Information about SOC WD infrastructure and activities in eight states was explored in this research, including: Arizona (AZ), Connecticut (CT), Georgia (GA), Maryland (MD), Michigan (MI), New Jersey (NJ), Ohio (OH), and Vermont (VT)<sup>1</sup>. Those states were selected on the basis of known success in the development of SOC WD activities focused on children’s behavioral health, similarity to New Hampshire in state structures, and/or proximal relevance to New Hampshire.

It should be noted that this document, and the research preceding this document, explored beyond the confines of CBH systems, seeking information about WD activities that support effective systems of care (SOC), inclusive of the multiple partner systems involved in SOCs. The competencies necessary to effectively address behavioral health concerns among children, youth, young adults, and their families are central to the SOC approach; staff working in all of the partner systems need access to those competencies AND effective care requires that those competencies be supported across the full set of SOC partner systems.

This document is organized in four sections. First, operational definitions are offered so that the reader understands the meaning of key terms used throughout. Second, information describing two SOC WD infrastructure models is presented, with references to state examples of specific infrastructure model elements. This is the raw data for this report. Third, key characteristics, functions, and elements of infrastructures relevant to New Hampshire are extracted and discussed. This section contains the analysis most useful to the Feasibility Study. The fourth and final section provides operational guidance for utilizing federal fund streams (Medicaid and Title IV-E) for WD activities and is provided for information purposes only.

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<sup>1</sup> The State of Maine was initially included at the request of the Children’s Behavioral Collaborative Workforce Development Leadership Team, but limited information was available to describe WD efforts in behavioral health focused on children and families. The primary thrust of WD activities in Maine has been around serving adults.

It should be noted that this document does not make explicit recommendations to NH decision-makers. The primary purpose of this document is to inform stakeholders. The Feasibility Study report provided later in this Study will offer recommendations based on this and other information.

## I. Definitions of Concepts Explored in this Document

In order to discuss models or examples of WD infrastructure, it is useful to first offer definitions for key terms and concepts: *system of care*; *workforce development*; and *WD infrastructure*.

*Building Systems of Care: A Primer* (Pires, S.A., 2<sup>nd</sup> Edition, 2010) defines a System of Care as follows:

*a broad flexible array of effective services and supports for a defined multisystem involved population, which is organized into a coordinated network, integrates care planning and care management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and with youth at service delivery, management and policy levels, has supportive management and policy infrastructure, and is data-driven.*

For the purposes of this study, a System of Care is further defined to describe “a collaborative system comprised of all public service components (including private entities contracted with public dollars) that touch children, youth, young adults, and their families to promote their well-being and to address/resolve needs that may detract from their well-being.” This additional language emphasizes: 1) the shared responsibilities held by all publicly funded service and support systems to actively participate in the coordinated network; and 2) the ultimate, uniting goal of all system of care activities to achieve positive, meaningful outcomes among the children, youth, young adults, and families served by those systems.

Workforce development, as used here, refers to all activities aimed at ensuring and/or building the necessary competencies in the totality of the workforce fulfilling an entity’s mission. It includes pre-service training to ensure that new staff enter with basic competencies, in-service training to ensure that the workforce continues to develop competencies, and developmental supports, such as supervision, coaching, and supportive policies, which lead to maintaining system competencies and increased staff longevity.

WD Infrastructure refers to the policies, structures, mechanisms, and processes that support, surround, and sustain the activities of workforce development within a functioning system of care. An explicit assumption of such policies, structures, mechanisms, and processes within a functioning system of care is that they are deliberately coordinated and aligned across separate service systems, operating synergistically to create a whole that is more than the sum of its parts.

Generally, most activities devoted to workforce development are unconnected, focused on discrete aspects of WD (such as preparation for licensure or use of a specific evidence-based practice - EBP), offered by different entities operating without coordination in planning or implementation, funded by various and distinct fund streams, each with its own requirements, and provided to different populations of staff without regard to the overlap or gaps between their abilities, interests, or job responsibilities. These disparate pieces and approaches are often driven by the categorical service

systems supported by public funds at the federal, state, and local levels, each with its own mission, fund streams, policies, requirements, and workforce development strategies. The system of care infrastructure for WD is intended to bring cohesion and coordination to these disparate elements, achieving greater practice alignment across disciplines and systems, and ensuring that children, youth, young adults, and families served by the system of care benefit from the most efficient and effective application of system competencies. This cohesion and coordination across systems also leads to a more efficient use of public funds.

## II. System of Care Workforce Development Infrastructure

Research into the strategies utilized by the Study states to maintain and operate WD infrastructure that affects systems of care demonstrates that there exist two general models for such an infrastructure. For the purposes of this Study, the two models will be labeled *Center of Excellence Model* and *System Coordination Model*.

### Center of Excellence Model

The most common SOC WD infrastructure model utilized across the study states is a Center of Excellence (COE)<sup>2</sup> Model. Five of the eight states support a COE with a stated purpose of promoting and/or managing competency development in the workforce serving children and families. Such centers may directly provide training and technical assistance to develop system competencies, such as family and youth engagement or strategies for collaborative decision-making (CT, GA, MD, NJ). They may also focus on the implementation of behavioral health EBPs, such as wraparound care planning and monitoring, Trauma-Informed Cognitive Behavioral Therapy (TI-CBT), or Mult-Systemic Therapy (MST) (CT, GA, MD, NJ, OH). They may offer in-house training packages, utilizing curricula developed within the COE or curricula procured from outside sources. They may simply provide training and rely on existing support structures to sustain the competencies, or offer ongoing support through coaching, refresher courses, and ladder skill development, eventually enabling those trained in certain methods to become trainers (i.e. training of trainers). Additionally, the COEs may play key roles in orienting stakeholders to larger reform goals, such as Medicaid reforms that impact child behavioral healthcare, and in facilitating the implementation of such reforms. It is worth noting that the fundamental mission for each of these COE's is aimed at improving the health and/or well-being of the state's children, and workforce development is a strategy or tool by which that well-being is achieved. There is an explicit belief that improving the competencies of the system workforce will lead to improved health and well-being of the state's children.

Location – The COEs are commonly, but not always, sited within a university department (e.g., GA State University's Andrew Young School of Policy Studies; University of Maryland's School of Social Work; Rutgers University's Behavioral Research & Training Institute within Biomedical and Health Sciences;

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<sup>2</sup> The term COE has been used in multiple contexts in recent years. "Building Centers of Excellence: Impacting Systems for and with Children, Youth and Families," currently in publication by the Institute for Innovation & Implementation at the University of Maryland, offers this definition: COE refers to an entity or group of entities, grounded in implementation science, which supports States & localities with the design, implementation, evaluation, and sustainability of evidence-based and promising practices, interventions, service delivery models, and supports on behalf of children, youth, young adults, and families, or other identified populations.

Case Western Reserve University's Jack, Joseph and Morton Mandel School of Applied Social Sciences). In general, those university departments demonstrate a long-term relationship with the state's efforts to develop a SOC and the COE was a natural development within those relationships. In two instances (NJ, OH) the COE was recently inherited or taken over by a different university following significant personnel changes in the original university. This is worth noting because in each case the public system work of the COE continued relatively uninterrupted in spite of the transfer. In one state (CT) the COE is a free-standing entity, directly supported by a philanthropic, endowed foundation (Children's Fund of Connecticut), although it maintains very close, functional relationships with Yale University and the University of Connecticut.<sup>3</sup>

Relationships with SOC Agencies – In each of these states the COE maintains a close relationship with the state agencies most directly involved with establishing and sustaining the system of care, although those relationships vary across the states. In two states (GA, MD), the center is viewed unofficially as working for the state level interagency cabinet group that provides governance and/or direction to the state's system of care. The cabinet agencies also provide sustaining funding support to those COEs through contracts with one or more state departments. In two states (NJ, OH), the center contracts primarily with a specific department in state government responsible for children's mental health (and perhaps other) services and the contract deliverables include activities designed to give support to interagency, collaborative service activities. In one state (CT), the center contracts with a single agency – the Department of Children and Families (DCF) – with responsibilities across multiple child- and family-serving systems (CT-DCF is responsible for child welfare, juvenile justice, and children's behavioral health), and that center also has substantial contracts for other activities less related to SOC development.

WD Strategies – These centers use diverse strategies for maintaining ongoing involvement in SOC development. In two states (GA, MD), the centers directly advise the interagency cabinet councils that oversee the systems of care, utilizing evaluation data and other lessons learned from WD activities to provide guidance about practice, policy, and funding decisions, particularly as those decisions relate to front-line practices across system of care agencies. In one state (NJ), the COE contract includes the placement of two COE staff in the state agency administrative office to directly provide technical assistance regarding policy development and implementation relative to the system of care. This unique arrangement ensures that the best current knowledge is easily accessible as decisions are made. In other states, the COE may have less direct influence over policy and decision-making but nonetheless seeks opportunities to utilize learning from WD activities to inform state policy makers. All of the centers provide various types of training, whether (as noted above) the training is focused on collaborative competencies (such as MD's focus on wraparound care planning for children and families) or the dissemination of EBPs (such as Ohio's focus on MST and Integrated Dual Disorder Treatment (IDDT)). All of the centers provide technical assistance related to workforce development strategies and other system of care functions. All of the centers also conduct numerous grant-writing activities, usually on behalf of state agency partners and aimed at bringing additional resources to the tasks of system development, an advantage of COEs located within universities with expertise in grant development.

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<sup>3</sup> For comparison, it is noted that the California Institute for Behavioral Health Solutions (CIBHS) is an independent, free-standing, non-profit entity that supports workforce development within California's behavioral health system (adults and children). CIBHS was created by the state association of community mental health centers and now is operated as a partnership between community behavioral health providers and the state behavioral health system, with financial support from providers, state general funds, and federal and private grants.

Funding – Funding support for each COE is somewhat different, utilizing different sources and in different amounts, as described in the following paragraphs.

In NJ, the entire COE budget is funded through a contract with a state agency (NJ Department of Children and Families). That contract primarily utilizes state general funds through behavioral health and child welfare, Federal grant funds (through the Substance Abuse and Mental Health Services Administration - SAMHSA and the Administration for Children and Families - ACF), and Federal Block Grant funds (MH), totaling \$1.8M annually.

In GA, the COE was begun using Federal dollars from the Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration Program and the Child Health Insurance Program Reauthorization Act (CHIPRA) grant funds, both time-limited and competitive sources. State general funds have replaced those dollars as the federal grants ended, and now partial support comes through a Federal system of care grant and a set of other smaller grants, totaling approximately \$1M annually.

In two states (MD, OH), the funding related to SOC WD activities which comes through contracts with state agencies is viewed as “core funding” but comprises only a fraction of the total funds supporting the center’s operations. In MD, funding support (state general revenue funds with some federal dollars) comes from the state agencies responsible for child welfare, juvenile justice, behavioral health, education, Maternal and Child Health, homelessness, and public housing. In the past year, funding was added through a contract with the state’s behavioral health Administrative Service Organization (ASO), Value Options, to address certain aspects of WD among the ASO’s provider network. The MD COE has a total operating budget of approximately \$1.4M (exclusive of its national contract with SAMHSA to provide technical assistance to implementing sites under the System of Care Initiative as the Technical Assistance Network). In contrast, the OH COE receives core funding from that state’s federal Mental Health Block Grant funds (approximately 25% of its operating budget), along with system of care grant funding and direct contracts with entities purchasing its capabilities to train and support implementation of EBPs, for a total operating budget of approximately \$750,000 annually.

In CT, the contract with DCF covers most of the costs of the WD activities specific to that contract, in the amount of \$875,000 annually, but much of the center’s other work (less related to system of care development) is directly supported by the endowment of its host foundation.

All of these centers have expertise in grant-writing and frequently submit grants to federal and philanthropic funding sources on behalf of state partners; such grant applications commonly include services to be purchased from the centers, should the grants be awarded, but the centers are rarely the primary applicant for such grant funds.

### System Coordination Model

The second infrastructure model identified in the states explored in this study is what can be called a System Coordination Model. This model is simpler than the COE Model and also less defined. In the System Coordination Model there is no central entity that is readily identified as the source or coordinator of WD activities, although there is commonly an individual or a small collaborative group of individuals at the center of WD activities. There are training and technical assistance activities taking

place in different components of the system of care, most commonly around the implementation of EBPs, and those activities might best be described as project-based.

In Michigan (MI), for example, as an EBP is introduced to the system, a training and technical assistance mechanism for that specific EBP is established and a state-level coordinator is chosen. In this state, the initial expertise to train the EBP is obtained via contract with an outside entity, with a goal of establishing in-state training capacity over time through a train-the-trainer approach. As in-state capacity is developed, individuals demonstrating the practice competencies are used to train others and to provide technical assistance to agencies or communities implementing the EBP. The coordination is provided by EBP-specific coordinators who work in the Division of Mental Health Services to Children and Families (DMHSCF) within the Michigan Department of Community Health. It is the Director of the DMHSCF who serves functionally as the coordinator of WD activities related to SOC development.

As a different example, Arizona (AZ) utilizes a group named the Arizona Children's Executive Committee, an interagency group of managers operating one or two management levels below the public agency cabinet directors in partnership with two parent representatives, which is recognized within state systems as the group managing the development of the state's SOC. As part of its ongoing work, this group regularly discusses WD projects that are being considered, planned, or implemented by any of the SOC partner systems; these discussions may lead to cross-system training in specific practices for front-line staff across the partner systems and/or to sharing the implementation costs for such training programs. WD is only one of many areas of SOC responsibility held by the Executive Committee.

Location – As noted above, there is no obvious entity or site identified as leading WD efforts in this model, but what AZ, MI, and Vermont (VT) demonstrate in common is the central involvement of the state office most responsible for children's mental health: in AZ, the children's mental health staff person from the Division of Behavioral Health Services within the AZ Department of Health Services chairs the Children's Executive Committee; in MI, the Director of the DMHSCF within the Department of Community Health oversees the activities of the various EBP state coordinators; in VT, the Director of the Children, Adolescent, and Family Unit in the Department of Mental Health in the integrated Agency of Human Services provides the guiding vision for the SOC and works to coordinate WD activities related to the SOC. In each instance, WD is just one of many SOC activities managed within the respective offices and, to the extent that children's behavioral health has administrative functions beyond the SOC functioning (such as program licensure and certification), those offices are also responsible for those additional aspects. Within this small set of states, only VT has a developed relationship with a university to provide SOC WD activities. VT has relied heavily on Southern New Hampshire University (SNHU), which has sites in VT, NH, and several other states, and which operates training programs in community mental health and mental health counseling, to prepare staff for licensure to fill professional positions within VT's community mental health treatment structure. SNHU operates entirely on a fee-for-credits structure; the state agency provides no public funds to support its training programs.

Relationships with SOC Agencies – Within the System Coordination Model, the relationships with SOC partner systems are managed primarily by the lead entity or individual, as discussed just above. The AZ Children's Executive Committee includes representatives from all of the major child and family serving systems, as well as two parent representatives, providing a collaborative table at which SOC activities and issues are regularly discussed. However, this collaborative group has only as much authority as is given to it by the member system executives, and it was noted that in recent years the group has been

given very minimal authority to direct meaningful SOC changes. At the time of this writing, the group was described as “re-establishing its core goals” after a period of significant inactivity. In MI and VT, the respective children’s mental health directors manage relationships with partner system peers on a primarily informal basis, built upon years of forming those relationships. There are a variety of formal arrangements on a project-by-project basis that define funding and implementation strategies for implementing SOC best practices. Again, it is the respective directors who coordinate those arrangements.

WD Strategies – In the System Coordination Model there are few comprehensive WD strategies in action. With respect to individual EBP implementation, specific training programs are in place and the state agencies offer limited technical assistance to implementing communities, to the extent that resources exist within the departmental budgets to support such TA. Whenever possible, the state agencies encourage informal, peer-to-peer information sharing and supportive relationships between longer-term implementers and newly trained implementers, but these relationships vary in quality and intensity, with limited statewide consistency. In AZ, the common WD strategies are built around the utilization of child and family teams (CFT), even though each partner system follows a slightly different model for team-based care planning, monitoring, and implementation. The AZ Children’s Executive Committee attempts to ensure that the respective CFT models are aligned, to the extent possible, so that front-line system representatives are able to work together when called into CFT teams for individual children and their families. In VT, the primary strategy is to ensure that the content of training programs leading to provider certifications is built upon the foundational SOC values and operating principles.

Funding – The most visible difference found when comparing the System Coordination Model to the COE Model, as implemented in the states explored in this Study, is the minimal amount or absence of any funding dedicated to SOC WD activities in the System Coordination Model states. In AZ and VT, there are currently no resources dedicated to WD activities, although as grant applications are prepared WD strategies are normally included so that, if grants are awarded, there will be identified grant funds to support specific WD activities related to the purpose of each grant. In MI, the “children’s share” (assigned by the state) of the federal Mental Health Block Grant dollars is almost entirely utilized for the implementation of EBPs (BG funds pay for the state-level coordinators of each EBP and for some of the related training events). This is not a substantial amount of funding but reflects a commitment by the State of Michigan to use its Block Grant funding to improve the quality of services provided to children and their families. All other WD activities in these states are grant-supported or managed through small budgets within the respective children’s mental health offices.

### III. Key Infrastructure Elements Relevant to New Hampshire

There are several elements of the WD infrastructures across the studied states that may be relevant to future NH efforts. In this section individual elements are explored with respect to each of the infrastructure models identified in this document, followed by a brief discussion of their possible relevance to the development of a sustainable CBH WD infrastructure in New Hampshire.

## Type of Infrastructure

There is a range of structures and foci in WD infrastructures functioning in different states. The creation and function of a COE provides a more recognizable focus for WD activities, but those activities can also take place without the focus provided by such a center. With a COE responsible for managing WD, there is an established driver and an ability to bring attention discretely to bear on competency development and the injection of new practices, and all the system stakeholders know who and where that driver exists. As the COE achieves success in one area, other programs or funders take notice and explore how that COE might bring success in other areas, so the potential to grow over time is great. In the absence of a COE to provide the clear focus, it appears necessary that an individual, office, or leadership group be empowered to maintain a clear and steady focus on guiding and managing WD activities. The WD infrastructure is then built around that leadership. Based on the experiences of the Study states, when the leadership comes from the state children's mental health office WD is more likely to focus on the implementation of behavioral health EBPs than on broader SOC practices. When that leadership comes from an interagency leadership group its effectiveness depends significantly on the degree of empowerment given to that group by system executives to promote and develop SOC practices. That empowerment is considerably enhanced if that group has access to dedicated funding for workforce development.

In New Hampshire there exist a number of COE-type entities, each focused on specific WD activities, populations, or categorical systems. As documented in the *Comparative Inventory Matrix*, developed previously under this Study, each of those entities has expertise in certain areas and the total collection of such entities offers a fairly wide range of WD expertise to New Hampshire service systems. However, there is little to no coordination and communication among those entities. NH stakeholders might consider supporting one of those existing centers to expand its responsibilities to play more of a coordinating role on behalf of the full system of care, thus retaining the expertise already at work but providing the missing element of cohesion. They might also consider the creation of a new COE with the express purpose of coordinating and integrating the work of all the existing centers, while also adding responsibilities to develop system of care competencies and practices not currently promoted by any center.

With respect to the System Coordination Model, it appears that the New Hampshire Children's Behavioral Health Collaborative would be the strongest leadership group available to play a central role in managing WD activities if it is empowered by state agencies and/or political leaders to play such a role. Its current empowerment primarily comes through the financial support provided by the Endowment for Health and the individual system representation, and yet that support does not give the Collaborative authority to implement changes in system policies or practices. At the current time it does not appear that the Children's program within the Bureau of Behavioral Health in the Division of Community Based Care Services in the NH DHHS has a strong enough influence within that Division, or with partner divisions or other state departments, to play a lead, coordinating role in system of care WD, such as is documented in VT and MI within this document.

## Funding Support for WD Infrastructure

A direct correlation can be seen between funding dedicated to WD and the ability of a state to maintain a COE. When funding is available and used to support COEs, most of the centers explored in this Study have purposefully developed multiple funding sources, often described as "diversified" funding support.

In this way those centers have tried to ensure that their continued existence is not dependent upon a single contract from a single public agency. Most also have what they term “core funding,” which may represent the initial funding used to begin the center and which generally reflects a relationship with at least one governmental entity (e.g., University of Maryland’s core relationship with the Governor’s Office on Children). Most centers work explicitly to write grant applications to the Federal government, private funders (e.g., Annie E Casey Foundation), or other funders on behalf of their government partners. Most commonly the center is NOT proposed as the lead entity if such a grant is won, but it is common for certain proposed grant strategies to be assigned to the center, especially WD, evaluation, and/or coordination activities. In other words, the centers use their in-house expertise to create competitive grant applications wherein the awarded funds will eventually flow through the government agency contracting with them to prepare the applications.

The amount of annual funding supporting the COEs explored in this Study varies in a range from \$750,000 to \$1.8 million and, generally, higher funding equates to the implementation of a greater number of WD strategies for a larger number of systems. The CT COE reported only the funding support that comes from the state agency (CT DCYF), whereas the other COEs reported total budget amounts. The informant in MD noted that the initial investment made by the MD Children’s Cabinet to establish the COE in 2005 was \$220,000 and at that time the vision for the role of the COE was limited to the statewide implementation of the EBP of high fidelity wraparound. As noted above, that center’s budget has grown to well over \$1m and the COE now plays an important role in supporting implementation of statewide reforms related to children’s behavioral health. State informants consistently reported that the COEs had more than repaid the investment of funds to establish and maintain them through successful grant submissions and returns on investment from the increased utilization of best practices across the system of care.

COEs rely to varying degrees on state-controlled sources, including general fund appropriations and allocations from the federal Block Grant, from NJ (nearly 100%) to OH (25%) (with GA at more than 50%, MD at less than 50%, and CT proportion unknown). Each of these COEs, except in NJ, currently receives substantial support under federal system of care Cooperative Agreements for roles each plays in implementing aspects of those initiatives including, but not limited to, WD strategies. It is interesting to note that none in this sample of state COEs receives Medicaid administrative funds or Title IV-E training funds for their activities, although the center’s work in both NJ and CT is directly coordinated with the state’s training efforts in Child Welfare that are funded with Title IV-E funds<sup>4</sup>. (Also see final section of this report.) Several of the COEs utilize grants from and contracts with other sources, including philanthropies, individual communities, or other states, to deliver very specific WD products to those sources. In fact, two of the COEs (MD and OH) market specific training and technical assistance products related to EBPs, thus generating additional income through fees or contracts with other states or localities and spreading awareness of their products and capabilities.

For states utilizing the System Coordination Model, funding dedicated to WD activities is much more limited or non-existent. MI utilizes the “children’s share” of the federal Mental Health Block Grant dollars to support the implementation of EBPs, slightly supplemented by contracts using federal system of care grant funds when awarded to specific MI communities; VT previously utilized general revenue funds to support some WD but now uses only a small amount of federal system of care grant dollars; AZ

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<sup>4</sup> Illinois has just started funding a COE that will be based at University of Illinois-Champaign Urbana and is using Medicaid administrative dollars to help finance it.

does not dedicate funding to WD but uses portions of various grant awards when appropriate to the purposes of WD.

New Hampshire stakeholders would need to consider the availability of general revenue funds and the likelihood of a commitment of those funds to establish and/or sustain a system of care COE. It is possible that some dollars from the state's system of care grant award (Fast Forward) or the Safe Schools/Healthy Students award (or other relevant federal grants) could supplement such funds but it is not likely those grant awards alone would be enough to establish or maintain a COE. The MD experience indicates that it is possible to create a COE with a relatively small initial investment and that investment has grown over 10 years to support a COE that is now one of the largest and better-known COEs within this field. Many NH informants have raised the possibility of supporting a COE utilizing Medicaid administrative matching funds and/or Title IV-E training funds, but the experiences in the states reviewed in this Study suggest that those are not widely used WD sources. These funding sources should not be ruled out, however. Illinois is just launching a COE that will use Medicaid administrative dollars, and other states, such as North Carolina, have in the past used Title IV-E (child welfare) training dollars to support reforms in children's behavioral health. These funding streams have particular constraints and accountability requirements, which the state and COE must understand and have the ability to track. (See final report section below.) While not as "easy" to use as discretionary grant or state general revenue dollars, IV-E and Medicaid can possibly serve as more enduring sources of support over time.

#### University Involvement in WD Infrastructure

All but one of the states studied that utilize COEs have located those entities within a major university, although a different arrangement exists in CT. Many of the university-based COEs represent unusual or idiosyncratic relationships with the host university, sometimes operating under unique business rules that enable the COE to function on an almost entrepreneurial basis, with more flexible relationships with funder agencies. Others operate within the university host's indirect cost rate agreement, which adds to the overall cost of operating the COE. In return for those higher costs, informants described the expertise present in universities as essential to WD, as are the universities' collective capabilities to write competitive grant applications. It was noted that it is extremely helpful to have specific "champions" within the university – one or more faculty members who understand the SOC approach and comprehend the vital role WD plays in an effective SOC. These champions were especially important when the COEs moved from one university to another (NJ and OH).

In states utilizing the System Coordination Model (without COEs) there is limited connection to university partners. The dominant training paradigm in these states is a train-the-trainers approach in which an initial cadre of interested staff are trained in a specific best practice and they, in turn, train others over time. VT relies on SNHU to provide pre-service preparation (meeting professional licensure and certification requirements) for many staff hired into the state's children's mental health system, and that university offers a competitive per-credit hour rate that is paid for by the individual students. All three states in this group (AZ, MI, & VT) have limited relationships with university partners through other system of care programs (e.g., child welfare, education, or public health) and there is an awareness of what takes place within those WD functions, but only limited coordination or influence is in place between those programs and the central behavioral health agency.

New Hampshire has numerous university-based WD programs in place offering programming that is built around and/or supportive of system of care practices within the state's workforce (pre-service and in-service) and, as noted elsewhere, the relationships among and between those programs are very limited – there is no overall coordination or a shared vision among them. Nonetheless, this core of existing WD programs already situated within university structures is a clear asset in the state; the creation of a structure and process to improve their linkages and coordination would greatly increase their collective benefit to New Hampshire's system of care. Such a structure would need to be capable of building linkages between colleges within individual universities, between multiple universities, and between those universities and the state's community college network.

#### Strategies Employed by a WD Infrastructure

*Building Centers of Excellence: Impacting Systems for and with Children, Youth and Families*<sup>5</sup>, currently in final production by the Institute for Innovation & Implementation at the University of Maryland (also a subject in this Study), identifies five primary functions in current COEs across the country, and those functions usefully describe the types of WD strategies explored in this Study and described in this document: 1) policy and finance; 2) intervention selection and implementation support; 3) research, evaluation and data linking; 4) partnership engagement and collaboration; and 5) workforce development. This use of the term “*workforce development*” specifically references training, coaching, and local capacity-building for EBPs and service delivery models and is thus a somewhat narrower use of the term than the definition provided and used in this document.

The core strategies commonly associated with a WD infrastructure fall under this fifth category of training, coaching, and capacity-building for specific EBPs and service delivery models, but the states supporting COEs demonstrate extensive work in the other four function categories named in that recent paper. As noted above, two COEs (NJ and GA) provide direct input about policy and finance to high-level state policy-makers; all to some extent play a role in identifying and disseminating EBPs throughout their states (including certification programs for specific practices); most provide valuable research, evaluation, and data support (CT, GA, NJ, & OH); and all are described by informants as playing a vital role in partnership engagement and collaboration within the system of care in support of reforms within one system or across multiple systems. Most of the centers provide multiple types of technical assistance that may align with or go beyond the competency areas covered by training activities. One especially noteworthy arrangement in New Jersey includes a COE, under a contract with the lead government agency, placing COE staff back in the agency's central administration to provide technical assistance to department decision-makers regarding SOC policy and strategic practices.

In states utilizing the System Coordination Model the WD strategies are more generally limited to the narrower definition of workforce development discussed above – training, coaching and local capacity-building in specific EBPs. MI and VT are focused on those types of activities, whereas AZ's Children's Executive Committee tries to coordinate the training activities implemented by specific partner agencies by bringing them to a collaborative table for discussion.

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<sup>5</sup> Mettrick, J., Canary, P.J., Harburger, D.S., & Zabel, M. (2015 – in production). *Building Centers of Excellence: Impacting Systems for and with Children, Youth and Families*. Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland.

The existing COEs in New Hampshire collectively provide more than training and dissemination of EBPs or best practices; indeed some are noted for providing outcomes-based research and evaluation support to their contracting agencies (e.g., CPE in Child Welfare) and several play key roles in linking together collaborative partners (e.g., IOD's role in the Children's Behavioral Health Collaborative). Any infrastructure put in place to support system of care WD in New Hampshire would need to support and coordinate all of those successful strategies currently in place and enhance their value by increasing the positive interactions among and between them, while also embedding the higher lens of system of care collaboration in all related activities to ensure alignment with the values and principles that drive the SOC approach. With reference to the strategies discussed here, New Hampshire would benefit the most from a WD infrastructure focused especially on system-level policy and finance, evaluation and data-linking, and partnership engagement and collaboration, in addition to training and coaching around systemic best practices.

### Long-Term Sustainability of WD Infrastructure

The ability of the system of care to maintain a functional WD infrastructure over time is directly linked to the commitment of resources and the diversity of revenue sources. The states with the most robust infrastructures commit WD funds to establish and maintain a COE and the COE seeks out multiple additional funding sources. These entities can be described as entrepreneurial and give their public funders added value by generating additional, sustaining income. Currently strong, but more vulnerable to year-to-year political changes, are centers in which the sole or major source of supporting funds is the state budget. The weakest infrastructures are those with no dedicated funding and in which the importance of WD varies as leadership commitment to collaborative systems of care within the public systems varies. The use of the COE Model among the states reviewed for this Study represents a higher level of commitment than those states using the System Coordination Model and, predictably, the states supporting COEs get a more tangible return on the investment they make in WD. The growth of support over time, such as reported by informants in CT, GA, MD, NJ, and OH, indicates a stronger likelihood of success and sustainability through the commitment of resources to a system of care COE. Informants in states using the System Coordination Model (AZ, MI, and VT) all expressed the wish that they had more support and could do more to influence front-line practice, while recognizing realistically the limitations on the resources available for WD.

New Hampshire system of care stakeholders need to explore the degree to which financial and political support is available or can be built to establish a system of care WD infrastructure. If the simpler infrastructure model is chosen – especially using the CBH Collaborative as the integrating body – stakeholders need to maintain the current support being provided to the Collaborative, and those stakeholders currently involved in the Collaborative need to continue making their individual and agency contributions of time and effort, or increase those contributions, to the development of WD resources. Under this approach, WD would be enhanced if the Collaborative were given more formal recognition and responsibilities from state authorities, which might include some amount of state funding support.

If New Hampshire system of care stakeholders choose to pursue the development of a COE as the primary WD infrastructure component, the most difficult challenge is likely to be finding the initial investment of resources necessary to allow such a structure to become operational. Considering the experiences of the states in this Study, the NH child- and family-serving systems might each be asked to make a relatively small contribution to a start-up fund, with the expectation that the COE would provide some tangible return to each system. Based upon the good work already being done by individual

entities in NH and the experiences of other state COEs reviewed for this Study, it appears that sustaining and growing the work of the COE would occur somewhat naturally as it proves its worth to the many system of care partners.

#### IV. Using Federal Fund Streams to Support Workforce Development

Although the states explored for this Study do not make any or significant use of Federal fund streams (as opposed to grants) to support SOC WD activities, a few states do use, or have used, such sources for WD purposes. The information in this section is included to ensure that NH stakeholders know what options are available if a decision is made to pursue the establishment of a WD infrastructure.

##### Title IV-E<sup>6</sup>

Under Section 474(a)(3)(A) of the Social Security Act (the Act), the cost of training of personnel employed or preparing for employment by the IV-E agency, including long-term training (leading to a baccalaureate or graduate degree) and short-term training (acquisition of new, necessary skills), can be a matchable training expenditure at 75% federal financial participation (FFP, and only public funds consisting of cash outlays may be used as State's share). Those costs may include: 1) salaries, fringe benefits, travel, per diem, tuition, books and registration fees for the time period the employee is actually participating in training; 2) salaries, fringe benefits, travel and per diem for staff development personnel assigned to training functions to the extent time is spent performing such functions; 3) salaries, fringe benefits, travel and per diem for experts outside the agency engaged to develop or conduct training programs; 4) travel, per diem, tuition, books and registration fees for foster parents and other persons identified under section 474(a)(3)(B) of the Act in short-term training; and 5) costs of space, postage, training supplies, and purchase of development of training material. All such training costs must be included in the state agency training plan for Title IV-B, which must be approved by the federal agency.

These costs are not limited to staff employed by the state's child protection system, although that is the primary workforce towards which these funds are normally directed. Beyond staff working directly for the child protection agency, staff in child caring facilities serving children in foster care or subsidized adoptions, court personnel, agency attorneys, guardians ad litem, CASA staff, and staff at juvenile justice facilities serving children in foster care or subsidized adoptions can all be trained under the agency training plan. The State agency may contract with other organizations, such as a community college, to conduct trainings on its behalf. It is within the discretion and flexibility of the State agency to determine the most efficacious and cost effective means of meeting short- and long-term training needs.

Relevant training topics for which the State may claim FFP include (selected from larger list): eligibility determinations; referral to services; development of the case plan; case reviews; case management and supervision; social work practice (such as family centered practice and social work methods); cultural competency related to children and families; the impact of child abuse and neglect on a child; general substance abuse, domestic violence, and mental health issues related to children and families in the

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<sup>6</sup> Information taken from the Child Welfare Policy Manual at the Administration for Children & Families (ACF), frequently asked questions regarding 8.1H Title IV-E, Administrative functions/costs, training, which may be found at [http://www.acf.hhs.gov/cwpm/programs/cb/laws\\_policies/laws/cwpm/policy\\_dsp.jsp?citID=116](http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=116) .

child welfare system (not about providing treatment); effects of separation, grief and loss, child development, and visitation; communication skills required to work with children and families; activities designed to preserve, strengthen, and reunify the family (not about providing treatment); the importance of using evidence-based practices and modifying agency culture to support and sustain EBPs (not how to deliver EBPs); the concept of risk and protective factors; strategies for minimizing the traumatic experience of placement, including facilitating attachment and promoting stable relationships; principles of child growth and social, emotional, physical and intellectual development; and overview of trauma, the ways that trauma may impact children's functioning and well-being at various stages of development, and general descriptions of effective treatments for addressing traumatic reactions (not to provide the treatments themselves).

### Medicaid<sup>7</sup>

Medicaid is a means-tested benefit program that provides health care coverage and medical services to low income children, pregnant women, families, persons with disabilities, and elderly citizens. Medicaid is financed jointly by the states and federal government and administered directly by states. Each state establishes a Medicaid plan that outlines eligibility standards, provider requirements, payment methods, and benefit packages tailored to the needs of its citizens. The costs associated with meeting requirements to be a qualified Medicaid service provider are not reimbursable, but costs associated with maintaining status as a qualified provider may be included in determining the rate paid for services. These latter costs may be included as part of the rate paid for the service and not claimed separately as an administrative expense. Also, if a state wishes to increase the availability of providers qualified to offer specialized services or meet more complicated needs, costs associated with that advanced training can be included in the development of rates paid for services requiring more complex levels of care. The state could set provider qualification requirements at a separate and distinct level for those advanced level providers and pay rates commensurate with those higher skill levels, thus reimbursing agencies for the cost of the necessary advanced training as services are provided and billed.

In recent years, the Centers for Medicare and Medicaid Services (CMS) have placed increasing emphasis on strategies to utilize federal matching dollars most effectively and efficiently, including the articulation of strategies to support WD. In a document titled "Coverage of Direct Service Workforce Continuing Education and Training within Medicaid Policy and Rate Setting: A Toolkit for State Medicaid Agencies,"<sup>8</sup> four specific strategies to deploy Medicaid funding in support of WD activities are detailed, including Acuity-based Rate Setting, Mentorship Rate Setting, State Training and Career Pathway Rate Setting, and Incentive Based Rate Setting Models. It is important for states wishing to utilize any of these approaches to consult with this resource and with CMS as strategies are explored.

In addition to reimbursing states for the cost of covered services provided to eligible recipients, federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan (referred to informally as "administrative claiming"). Such activities might include: outreach; facilitating eligibility determination; program planning and coordination; training; and referral, coordination, and monitoring of services.

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<sup>7</sup> Information from CMCS Informational Bulletin, dated July 13, 2011, from Cindy Mann, Director, Center for Medicaid, CHIP and Survey and Certification, subject: Updates on Medicaid/CHIP.

<sup>8</sup> Prepared by the National Direct Service Workforce Resource Center and published by CMH August, 2013.

Such administrative costs captured in an appropriate and approved documentation methodology may be reimbursed at a 50% federal financial participation (FFP) rate. Medicaid regulations also allow an enhanced administrative claiming at a rate of 75% FFP for activities performed by Skilled Professional Medical Personnel (SPMP) when that administrative activity requires the use of their professional training and expertise.

#### Discussion of Use of these Funds in New Hampshire

Both Title IV-E and Medicaid provide avenues for recouping some training costs (a major portion of workforce development) and may be desirable to pursue to support a WD infrastructure. In order to utilize these sources state agencies must be able and willing to conduct at least two specific strategies – detailed accounting of relevant practices to be able to separate eligible and ineligible costs for reimbursement, and close coordination and cooperation between state agencies/divisions and, possibly, providers in the community.

Regarding the first strategy, Title IV-E training dollars are aimed at staff providing child welfare functions to children and families eligible for child welfare services. While this is somewhat a limiting factor, experience shows that a significant portion of children served within the system of care and manifesting behavioral health needs are involved with children’s protective services. Many of the training topics allowable under Title IV-E requirements (e.g., cultural competency, or the effects of separation, grief and loss, child development, and visitation) cover topics valuable across all system of care partner workforces, raising the possibility that such training content might be provided in a cross-system training environment. In order to claim Title IV-E funds using such an approach, the state would need to provide a careful accounting of the participants in training events (i.e., tracking child welfare and related staff as a portion of all participants) and the portion of the content aligned with acceptable topics. Likewise, Medicaid administrative claiming can only occur when the training (or other administrative activities) is directly related to the support functions described above, not to the direct provision of services. Therefore, careful accounting of participants according to the system functions they perform and the competencies being promoted in the training would be required to make such reimbursement claims. The detailed accounting required in either case is possible but it is also complex and may incur a significant cost itself that offsets any benefit derived from the accounting and resulting reimbursement claimed from these sources.

The second strategy is ultimately the most important – the State Medicaid Authority, the state’s designated child welfare agency, and other system partners, including some community service providers, must be willing to work closely together within a legally binding framework (e.g., a contract or Memorandum of Agreement) in order to work out the details of providing training programming and maintaining the detailed accounting referenced above, thus enabling the use of funds from these two significant federal fund streams in support of a system of care workforce development infrastructure.