

AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

Research, Advocacy, and Policy for Health Care Transition and a System of Care for Youth with Emotional Disorders

March 6-10, 2010

SHARON CORAL: Welcome to the session. I'm Sharon Coral, I'm the moderator for the session, I'm also an AMCHIP staff person. I've been at AMCHIP almost 7 years, and I have oversight for adolescent health programs and I have say you transition issues are something that we need to focus on a little bit more, so I'm happy to see everyone in the crowd.

This presentation is entitled Research Advocacy and Policy for Healthcare Transition and a System of Care for Youth with Emotional Disorders. It is session ID H2, which is a workshop session and it's eligible for continuing education. And you'll notice in your handouts, the top sheet is goldenrod yellow and if you just go to the Tuesday sessions, make sure you identify the session with a title when you're filling out the evaluation. And if you are getting continuing education credits, the link is now live. And so I reference the evaluations, just please, as you're going through the session, just jot down your comments and feedback, it's really important for AMCHIP and the workshop facilitators that we know, you know, how well we're going to meet your needs as our conference attendees.

And then just a final reminder, because it's written in here, I have to say it, please turn cell phones on to silent mode.

Now, it's my pleasure to introduce our speakers. What I'm going to do is just say their names and they are going to tell you a little bit about themselves and kind of their background and, you know, why they're doing this session themselves.

So we have Janet Hess, who's the Assistant Program Director in the Department of Pediatrics, Adolescent Medicine, at the University of South Florida College of Medicine; we have Dr. Debra Waldron, who is a pediatrician at the University of Iowa Children's Hospital; and we have Vicky Miene, who currently works at the University of Iowa Center for Disabilities and Development and the Iowa Child Health Specialty Clinics. So with that, I'm going to turn it over to our presenters.

JANET HESS: I'm Janet Hess and we've got two separate presentations, so I'm first going to talk about some work that we're doing in Florida. I am in the Department of Pediatrics at USF in Tampa, my primary job is as Project Director for a new program in Florida called Florida HATS, which is Florida Health and Transition Services. And my contact information is here if you have any follow up questions later, please don't hesitate to get in touch with me.

Well, it's been an exciting couple of years around our efforts in Florida, with healthcare transition. We've taken a little bit different approach than other states have, so what I'd like to do today is talk a little bit about that process and let you know what we've been doing. First I'll talk about research and just some background issues with healthcare transition, then I'll talk a little about the advocacy that led to a state mandate to develop a statewide strategic plan for healthcare transition, and then I'll finally talk about how that plan is being implemented and how it's driving policy.

You probably have a good understanding and knowledge of the research, so I won't spend a lot of time on this. This is the definition that was introduced in 1993 by Dr. Robert Bloom and his colleagues, healthcare transition is the purposeful planned movement of adolescents and young adults with chronic physical and medical conditions from child centered care to an adult-oriented care system.

Why is it necessary? Well, primary reason is the epidemiological changes that have been occurring over the years, from what had historically been childhood diseases, the life expectancy rates have increased dramatically. As you can see, for sickle cell disease and cystic fibrosis, adults now comprise 40% of the CF population. Even in congenital heart disease, we've got about 800,000 adults with congenital heart disease, and that's more adults than children now. And same with cerebral palsy, again, about 800,000, 400,000 are adults, so about half the population.

Some statistics, some current statistics, approximately 16 to 18% of youth have a special healthcare need, and among those, about 4-5% have a disabling condition that could possibly be a complex physical health condition or a developmental disability, and then 4-5% have serious mental illness.

And as we all know, the outcomes for this population are not very encouraging. Youth with special healthcare needs are less likely to finish high school, pursue post secondary education, find a job, or live independently. They're also three times more likely to live in poverty and an income less than 15,000, and really importantly, they are at risk for developing secondary disabling conditions, and that's at a great cost to everyone, themselves, their families, the communities.

The good news is that a lot of work has been done in the last ten years to address these issues and they're driving change. At the national level, the MCHB identified healthcare transition as one of its six core outcomes, you can see youth with special healthcare needs will receive the services necessary to make transitions to all aspects of adult life, including healthcare, work, and independence.

And in addition to that, a variety of medical associations have developed policy statements around healthcare transition. In 1992, a consensus statement was jointly developed by societies for pediatricians, internists, and family practitioners. And what it did is identify critical steps that the medical community needs to take to ensure successful healthcare transition. So these are some of the things that they've identified

in their consensus statement. The youth needs to have a primary care provider, the professional needs to have the core knowledge and skills to help that youth, that's including a knowledge of the condition. The provider needs to provide an updated medical summary that's affordable and accessible, needs to apply preventive screening guidelines and help that youth access affordable, continuous health insurance coverage.

So what are some of the issues and barriers to healthcare transition? The research identifies and talks a lot about some of these things, the culture shift between pediatric, healthcare systems, and adult healthcare systems, the difficulty that pediatric providers have in preparing you for transition, health insurance, and then issues within the adult healthcare system.

This quote is from a parent of a child with cerebral palsy, "When we left pediatric care, it was as if someone flipped the switch and turned the lights off." And I'm sure that if you work with families, this is something that you hear, or something like this, fairly frequently.

Looking at the culture switch, pediatricians, as we know, are very nurturing and family oriented. They have a very developmental focus, they're child friendly, and in the adult physician world, there is an expectation that the patient is going to be knowledgeable and understand his or her own condition, it's very much a one-on-one relationship between doctor and patient. There's an expectation that that patient's going to be

collaborative, and there's a real focus on disease. And even operationally, in pediatric practices, you're much more likely to find kind of that medical home environment, where you've got of support staff that can provide care coordination, you've got social workers, and nurse staff that help the pediatrician, and in the adult world, oftentimes it's the physician by himself. If there's any kind of care coordination, it's the physician's responsibility to take care of that. So it's a real change.

This shows from the adult perspective how they are feeling in terms of comfort level with different types of conditions among youth. And so you can see that, you know, the healthier and less complex conditions, the adult physicians are very comfortable with, but as they get down to some of the more complex conditions, and particularly technology dependant, there's a lot of discomfort among adult providers. And certainly this is probably a reflection of the culture, but it's also a reflection of the training.

And the insurance barriers, young adults have the lowest insurance rate of any group. Approximately 34% of adults 18 to 24 are uninsured, and that number's even greater if that person is poor, or a minority, or has low educational attainment. Some of the reasons for the loss of insurance is ineligibility for parent's insurance, coverage for public insurance ends at 18, 19, or 22, and then the SSI rules change at 18. The re-determination process essentially decreases about a third of childhood SSI recipients, so about a third don't re-qualify as they become 18.

This is just, it shows another graph on the insurance coverage. You can see how coverage dips in the early 20's. You can see that the younger teens do have more insurance but again, there's a question about the adequacy of that insurance, but they do dip at 21 and don't ever quite come back up to the level of the younger teens.

So all of this points to a suggested framework for healthcare transition and this is very similar to the elements you saw on that consensus statement. We should provide ongoing access to age and disease-appropriate primary and specialty care providers, we need to have access to insurance. The youth needs to have disease self-management skills and there needs to be access to appropriate educational and vocational opportunities to allow for economic self-sufficiency.

So how are we doing? If you're not familiar with the national survey for children with special healthcare needs, it is a terrific measurement tool. It has been administered twice, the first one was in 2001, the second one was in 2005, and it will be administered again this year. It is a telephone-based survey among parents of children with special healthcare needs through age 17. So it captures up to age 17, we don't have data on those youngsters or young adults that are 18 or older, but there is a whole section on transition that asks specific questions among parents. They ask questions about whether the family or the youth have had a conversation with their doctor about health insurance. They ask about whether they have had a discussion about healthcare providers in the adult system, they ask about whether the adult healthcare needs have

been discussed, and whether the youth is encouraged to take responsibilities for their healthcare.

And so the way that the core transition outcome is measured, it's really a composite of all of these other variables and what the data from the 2005, 2006 survey shows is that 41% of those youth ages 12 to 17 met all of those criteria. If you look at the component measures, not so good for talking about changes in insurance, only about 34% had talked changing insurance and 42% had discussed shipping to an adult care provider. So that was the low end of the component measures, did a little bit better with talking about adult health needs, and actually did a pretty good job in encouraging youth to take responsibility for health. So among those, it was calculated to about 41%. The survey also found that there's a greater likelihood of transition if the youth was cared for in a medical home and had insurance and less likely if the youth was lower income, didn't speak English, or was black or Hispanic. And this national survey provides both the national figures, as well as state figures, so you can see this performance map, might want to pick out your own state. The green are the significantly higher, down to the very pale green, which is significantly lower than the average.

So how did we do in Florida? Well, if the nation didn't do all that great, we did more all not that great. You can see that 41.2%, compared to 33.8% in Florida met all of those criteria from the survey. And actually that number drops to 16% in rural areas in Florida.

Well, despite our challenges in Florida, we are fortunate to have some really outstanding leaders and advocates that are very committed to healthcare transition and are very knowledgeable, including Phyllis Sawyer, who is the Director of our Title V program in Florida, some of you may know John Rice and David Wood, all really national experts, so real fortunate to have them provide some leadership in this issue.

The first thing we did is we identified a legislative champion. Senator Stephen Weiss in Jacksonville proposed a bill, the 2008 legislative session, and with a lot of work, that bill passed. What the bill talked about was mandating that we assemble a multi-agency task force and include youth and young adults on the task force. The task force would be chaired by the Title V Directory, and it required participation among key agency leaders. So we've got representatives from the Department of Education, the Department of Children and Families, from Medicaid, for persons with disabilities, Voc Rehab, and then a variety of other legislatively required participants. And actually this bill language is posted on the website, if anybody is interested in seeing how the language actually reads.

What the bill called for was we were to develop a statewide plan for healthcare transition and it was to assess and document need, identify strategies and best practices, present a range of different models that take into account geographic and cultural diversity, that could be adapted locally, and that were integrated with these other agencies. And it's really important to note that this is not just for Title V youth, this was a mandate for all youth and young adults with disabilities and special healthcare

needs. So while it was to be headed and led by Title V, it really was a much broader definition and in fact, we adopted the definition that's commonly used to be really inclusive. And then finally we were to identify existing and potential funding sources.

So this, the bill was passed and effective in July of 2008 and we had about six months from that time that it was formally adopted to present a report to the Governor and legislature. And actually this, I have a few copies, if anybody wants to see it. Also on our website it can be downloaded.

Well, not surprisingly, there was no budget allocation with this mandate. But again, we were really fortunate that our developmental disabilities council in Florida had allocated some financial support and that was really important because it allowed a manager or project director to be hired to manage this whole process. And when you're talking about trying to do this in a real short period of time, you really need to have a dedicated person overseeing that. So an RFP was developed and it went out for competitive bid, project facilitator was hired, then the task force was assembled. Again, it included those legislative appointees, and then 21 additional stakeholders throughout the state. So the total was a 35-member workgroup.

And we held our first meeting in August of '08. We tried to have as many people physically attend the meeting as possible, but we did have a few teleconference. And really, the first order of business was to identify different focus areas and then identify subcommittee members, really the work happened in those subcommittees. So the

three focus areas that we identified were financing, services and models of care, and education and training.

We then developed a website so that we could post all of the documents, including all the subcommittee meeting notes. Again, this was for, this was on public record, so we had to have everything posted and available and open. We developed an email distribution list to facilitate communication.

And then over the course of about two months, the project director facilitated about 13 subcommittee teleconferences. So all of the subcommittee work was done via teleconference, and so that was about four to five calls per subcommittee. And then concurrently we started compiling stories from stakeholders in Florida, from youth, families, providers. We asked for experiences, good and bad, you know, what worked and what didn't. And then we had a draft from all of the subcommittee meetings and the task force met again face to face in November and again we had some via teleconference and the final report was completed. Really, realistically, it was completed in about three months. A lot of work. So it's entitled Ensuring Successful Transition from Pediatric to Adult Healthcare, and again, it's available in print and online.

So I'm just going to go through very quickly some of the strategies that are in the report. Services and models of care, remember, that's one of our focus areas. One of the primary recommendations that came out of this project, is that we recommended the establishment of a state office of healthcare transition, that was to be located within

CMS, our Title V agency, and it would provide oversight in TA. But one of its primary functions would be to support local coalitions in building regional service systems. And this is really important, because I think this is kind of what distinguishes some of our efforts from others, in that we're really looking to the local communities to develop coalitions and systems with help from the state. It's a big task.

Healthcare financing, where we wanted to create an insurance guide that provided insurance options for young adults 18 to 30. We recommended that we work with insurers to develop policies that supported medical homes, care coordination, co-management, advocate for a Medicaid buy-in program, which we don't have in Florida, and then advocate for reasonable insurance payments.

In education and training, we're fortunate to have a lot of very high quality education and training materials, so one of the recommendations was to really get it disseminated, you know, get it available and out there to youth and families and providers. We want to provide training for professional and create an online tool kit and clearinghouse of information.

And then finally, the infrastructure recommendations just had to do with, you know, having the money and the funding and the legislation available to do all this.

And obviously you can't really read this, but we wanted to have at least, you know, one page visual that kind of showed the gist of the plan. This again is located on the website

and it just, you know, goes through some of the mission, the foundation, foundational goals, strengths, and then those strategies. And it just highlights each of those recommendations.

Some of the challenges with that process, in that short timeframe was very difficult. Like I said, it was so important to have somebody that was kind of dedicated to the process moving it along. We also found it very difficult to engage youth and young adults in the process. Again, some with the time issue, I mean, it's hard enough finding a time to bring together, you know, a group of professionals, much less to try to make that a time also that youth can meet. So you know, we would've like to have had more youth participation. Again, just coordinating large groups of people is very challenging. And then, I mean, in an ideal situation, we would've had a little bit more time and maybe more face-to-face interactions, because this whole recommendation is predicated on building relationships between agencies and it would've been nice to have had a little bit more face time, but we did what we were able to do.

This is a work in progress, the policy. We are very excited that in this legislative session in Florida, which just started last week, that we again have a proposed bill that basically formalizes the things that I just outlined. So we're very hopeful that that will get passed.

The activities that have been going on for this last year since we did this legislative report, have been jointly funded by the DD Council and Children's Medical Services, and it's administered through USF. We've been enhancing the website and we're in the

process of trying to continue to develop tool kits and resources. We have developed a cross-disciplinary training for professionals, it's actually going to be available in about a month and it's targeted to physicians, nurses, social workers, therapists, dentists, and it's going to be free to them, free CME's and CE's. It's a six-hour course, or I'm sorry, it's a four-hour course, two modules, a four-hour course. We are in the process of finalizing the insurance guide, really challenging, we've been working with Meg **** in the Catalyst Center and Patti Hackett, using their expertise, and that is just about ready to go. But as you can imagine, it's really complex information.

And then with the local coalition development, one of the things that we developed is this guide right here. This is a strategic planning guide for regional coalitions that uses the MAP strategic planning model that many county health departments used. MAP stands for mobilizing for action and partnerships, policy and partnerships, something like that. At any rate, it's a model that is very cross-disciplinary, it involves a diverse group coming together and doing some assessments around a common problem. So many communities use this process in identifying and starting work in health issues. We're a little bit further along the way because we've already identified healthcare transition as our issue, but what we did is we went through and adapted the model to healthcare transition, and then we also, about half of this book, is data. We provided county-level data on everything we could find about youth with special healthcare needs in Florida. So we've got data from Medicaid, from the school system, from CMS, census data, rehab data, and wherever it was possible, we broke it down to county level data, as well as by CMS region.

SPEAKER: So that data is comprehensive to all youth, not just targeted to youth with special healthcare needs?

JANET: Right. The age range we used was 16 to 24 and the definition of special healthcare needs is chronic health conditions or disabilities. So the school system uses, you know, the data they provided us is a little bit different from the rehab data from the Medicaid data, but we were as broad as possible in that definition.

And so what we're doing is piloting this process, currently in three sites in Florida, in Jacksonville, in Tampa, and then in Panama City. And the intent was to pilot it in at least one rural and one urban area and believe me, the rural area, the panhandle area is very challenging, very challenging. But we're about, we're in the middle of the process for all three markets and we'll end that in May. What this is consisting of is a series of five strategic planning meetings in each of those areas, that bring together all of the key agency representatives and the result, the outcome from the meetings is going to be that community's strategic plan.

And then in the meantime, we've also adopted a program name. Again, Florida HATS, Health and Transition Services.

Looking forward, definitely, you know, have to keep our eye on what's going on with healthcare reform, and then in our own state legislature, legislative activity. Again, we

hope that the proposed bill formalizes the task force and this new office located within our Title V program, will continue the local coalition development. Our Title V area offices all have a leadership role in this. So as we go into these pilot areas, the CMS area offices are very much involved. So what we'll be doing over this next year is evaluating the pilot sites that we've already started and then hopefully start introducing some new pilot sites.

And then finally, we really need to look at developing indicators and benchmarks to assess progress. And the local coalitions will be doing this somewhat on their own, but we need to have, you know, multiple-level assessments done.

That's it.

Okay. Well, any questions? Yes?

SPEAKER: I'm interested in how are you going about, you know, **** insurers **** you know, insurance payments, ****

JANET HESS: Right, right. Yeah, those are long-term strategies. We have the local Medicaid reps at the table for our local coalitions, but in terms of, you know, really making policy changes, the intent is that going forward, we'll have some strategic meetings. And you know, hopefully some of this is going to be addressed by healthcare reform. Don't know, it's changing daily.

SPEAKER: So I understand you have a project facilitator?

JANET HESS: Uh-huh.

SPEAKER: That moved in, was there, what other funding or staffing did you draw upon within your **** healthcare needs program to help **** this?

JANET HESS: For the planning part, really there wasn't, it was basically the project facilitator that drove that process. Now certainly, you know, Phyllis, as a Title V Director, and then each of the committees, each of those subcommittees, had chairs, they identified chairs. So there was a lot of communication between the chairs and the project facilitator in terms of kind of organizing the content and identifying, you know, the issues that needed to be addressed in each of those focus areas. Yeah, but the funding from the DD Council paid for the project facilitator and also for the meetings. I mean, it was not an insignificant expense to have to bring everybody throughout the state to have to attend the meetings.

DEBRA WALDRON: Good afternoon and actually this is a tag team presentation, as you can tell by there being two of us here. I don't think two of us can make a circle, but that's okay, we can try.

Anyway, I'm Debra Waldron, I am actually the Title V Director for the Children with Special Healthcare Needs in Iowa. My other responsibility or role is actually the Medical Director, Chief Medical Officer, for Child Health Specialty Clinics in Iowa, which you all heard about somewhat on Sunday evening, in terms of Dr. John McQueen, he actually was the founder of Child Health Specialty Clinics in Iowa, which actually has been in existence for over 50 years, they are regional centers which are located in 13 sites across the state of Iowa and basically the role of Dr. McQueen, was to make sure that children with special healthcare needs would have access to medical care, at that time, it was really just about medical care without having to travel more than two hours. So we don't have a picture of where we're located across the state, but we're actually located in the periphery of the state, or around the circumference of the state. We actually are not really located in the central area of the state, which is where Des Moines and Iowa City are located, because there is a plethora of pediatricians and medical providers there.

Over the years, Child Health Specialty Clinics has actually, I like to say evolved and not devolved into including care coordination, as well as family support, as some of the hallmarks of our system of care for all children with special healthcare needs.

Community Circle of Care is just one project that Child Health Specialty Clinics actually manages or runs in coordination with the Department of Human Services and Vicky Miene, I will let introduce herself, who is actually our Project Director for Community Circle of Care.

VICKY MIENE: All right. Well, like Debra said, I'm Vicky Miene, Project Director. My training is that I'm a mental health therapist, I did administrative and kind of therapy work for 22 years prior to coming into this position. I'm also a parent of four adopted children, all of whom have serious emotional and behavioral problem or some type of a special healthcare need.

DEBRA WALDREN: Okay, our objectives today are really to, actually before I start with our objectives, raise of a hand, how many have actually know what a system of care is? Or think you know what a system of care is? Okay. Good, well, I'm not going to tell you our definition of a system of care until the end, so I'd like to see at the end whether or not your system meets the principals and needs of actually what Iowa has developed as its system of care. Because each of system of care, even though **** does have a definition and some other people have definitions, are actually unique to the state or to the project that you're running. Our goals and objectives may be the same, but each of system of care, again, is unique to the individuals that it serves.

So our objectives today are really to describe the progression of how Iowa went about developing their system of care, discuss what our vision was, and then actually provide you with some information about our specific system of care in terms of service array, community partners, and how we actually involved family and youth in what we're doing.

VICKY MIENE: So part of our, the progression that we took, we need to kind of review a little bit of the history, because we all know that building a system of care and changing

the system takes time. So there were actually kind of simultaneous things happening. One was the State of Iowa in general. The other was projects and things that were happening at Child Health Specialty Clinics during the same timeframe. And then also, a smaller cohort, but in northeast Iowa, there were specific things that were happening in that area, which kind of led us to the ability to begin a system of care.

So initially back in 1992, Iowa established a funding that was called de-categorization and I'm not sure if any of you are familiar with that term, but essentially it was funding that came into the Department of Human Services, but because all of that was dedicated toward safety of children, there was funding that was allowed to be used for community specific needs. And so each little de-cat area, some of them are one county, some of them are up to four counties, depending on the population of the counties, really kind of got to pick about what they wanted to do within their community to help keep children safe and actually to divert them from the Department of Human Services system.

In 2003 through 2007, the State of Iowa was operating without a mental health division and I think, you know, that's happened in some other states, too. We, Iowa, we tend to activate a division and now more recently with the budget cuts, we've changed our division again. So it's fewer people that are trying to do the same amount of work. But in 2003, we were able to, or I'm sorry, in 2006, we were able to begin the division again and at that time, a new director was hired and then in 2007, a children's bureau person

was hired. That was the first time in Iowa that we had a dedicated staff person or staff team dedicated for children's issues.

In 2007, the other thing that happened was that mental health services were de-linked from the Department of Human Services. In Iowa, our DHS system was kind of the default mental health system, that's where people went if they needed help. But of course, we all know that as parents, the last place you want to go to get help is the Department of Human Services, so there was a lot of stigma attached to that and a lot of kids just went untreated because of where they had to go to get the help.

In 2010, we are restructuring again, and that's where I said, we have fewer staff that are trying to do the same amount of work.

DEBRA WALDRON: And I want to say, I was impressed with Florida, you were able to do all that work in a year.

VICKY MIENE: Yeah.

DEBRA WALDRON: As you can tell by our timeline, it's taken us more than 15 years to get where we are. And again, I know you're all familiar with, at least if you're in Title V:, with needs assessment, so back in 1997, I think it was when Dick Nelson, who I'm sure some of you are familiar with, was part of Child Health Specialty Clinics, and they started to undertake a needs assessment on what were the needs for mental health or

children's mental health within the State of Iowa. And because of that, by 2001, they were able to actually write a paper, so again, you have a very short timeline, Iowa took a little longer about getting things done, and in that white paper they really went over all the difficulties, the challenges, and some solutions that may, could be put into place that would actually help solve the mental health crises that was facing the state of Iowa.

So in 2002, Child Health Specialty Clinics, trying to be proactive or responsive to the needs of the community, developed a project in Creston, Iowa and for those of you that aren't familiar with Iowa, Creston is in the southwest part of the state, it's a pretty rural area, and I don't think there are any pediatricians in the area, mostly care is provided by family practice physicians and there really is a dearth of community mental health centers or community mental health providers in that area as well.

So CHSC, of Child Health Specialty Clinics, partnered and received a grant and they developed the project, which is a really mini, mini, mini, mini system of care. Basically we included the ability to have a nurse practitioner as part of the team, some family support, as well as some telehealth with a psychiatric backup.

Magellan, which is the managed care organization in Iowa that deals with Medicaid in terms of mental health, partnered with CHSC in 2003 and actually provided us with some seed money, as well as some funding for care coordination around children with mental health disorders. And since that, in 2004, CHSC was able to go statewide, based on those findings, in 2005, Vicki alluded to the oversight committee, which was

from the MH, Mental Health Brain Injury Developmental Disability Council, and they actually came out with a pretty nice description of what they thought that the system of care could look like for the State of Iowa, and we'll get into that a little later. And then in 2007, as Vicki said, DHS was successful with the **** grant around the system of care and DHS again is the recipient of the award, CHSC, or Child Health Specialty Clinics, is the subcontractor, we provide the direct clinical care, the care coordination, as well as the family support that's necessary to make the system work.

VICKY MIENE: So again, at the same time then in northeast Iowa, and that little map up there just kind of shows you the little counties, if you think about Iowa and where it's at, I talked about the de-cat dollars and how that was working across the state. Within the northeast Iowa corner, there are four de-cat attachment areas and they're kind of divided out by the map there. The one purple county kind of fits all three of the ones that surround it, so it's kind of split up.

But essentially what was happening is with those de-cat dollars, we were able to start a number of different community programs that were beneficial to the families and the kids who live there. Each of those programs had local advisory boards and those decisions were made as to what was needed by getting them all together and kind of doing some planning and figuring out what it was that we wanted to provide. The good thing was that we were able to definitely keep kids diverted from the DHS or other service system, we developed crises intervention programs, we decreased shelter placements, we were placing kids less in foster care. But the thing that we weren't

doing, even within individual counties, is we weren't coordinating those programs, so there were a number of different programs that were kind of popping up, but there was no way to link them together and even if you were in the same county, agencies didn't know what the other agency was doing, or what the eligibility criteria were for those different programs, so hooking families up was difficult.

In 2006, while the oversight committee was meeting at the statewide level, we were actually meeting to write an RFP for some local state money that had come out through a mental health block grant and we were successful in being awarded about \$100,000 for a project for three years to see if we could serve kids with emotional and mental health challenges by providing them a broader array of services, like support services, skill building, and care coordination.

So this is really Iowa's current system. It's very fragmented, it looks like a puzzle, but there's no picture, there's no guide, there's no where to start and families look at this and like, what do we do? And that just how it is. Now, in our northeast Iowa corner, we're tending to fix that a little bit, but the rest of the State of Iowa, this is what it looks like.

DEBRA WALDRON: And I was going to say, we probably should have a puzzle for northeast Iowa that looks like it's actually has a roadmap or something.

VICKY MIENE: We should, we should.

DEBRA WALDREN: As I alluded to before, there was a children's oversight commission model and we actually, as you can tell, there are about six components there on the left hand side and we really modeled community circle of care over the oversight committees recommendations. What the oversight committee, I think one of the key things that they recommended was a lighthouse concept, or No Wrong Door, meaning, you know, whatever the project would be would be a beacon in the dark and as long as you knew where that beacon was, you would be able to access services. We call it the No Wrong Door, but again, it really is about that beacon light. They called for navigators, ours are care coordinators, but again, I think the most important thing is the concept of, there was no wrong door and also that our treatment plans are individualized and coordinated with our wraparound services and supports that we're able to offer.

And this is really just what a quote from the oversight committee and their vision and really, I'd like to read it to you because I think it's pretty powerful. "All Iowa children with serious emotional disturbances, mental retardation, developmental disabilities and brain injury, and their families," and again, I accentuate their families, "will have access to a statewide system of care that's child focused, family driven, flexible, and coordinated with effective, quality services supported by sufficient funding and a structure to assure families are supported and children reach their greatest potential." And again, we need to remember, it's really about the children meeting their greatest potential. It's not about

us, it's not about how we built the system of care, it's about what that ultimate outcome is and that ultimate outcome is about the child.

VICKY WALDRON: So this is a map of all of the systems of care that SAMSA has funded. SAMSA is the Substance Abuse Mental health Service Administration, and it's hard to see, but they are color coded according to the year they were funded. Congress started implementing these grants back in 1993. And for those of you, if you're from the Midwest, you might have heard of programs like Wrap Around Milwaukee, or the Dawn Project, or in Michigan, the Impact Project, those were some of the earlier funded sites. Each one of these sites are a little bit different in nature.

Some of them are a single city, some of them are multiple counties, some of them focus on like juveniles as their target population, others focus on the whole population, which is what Community Circle of Care focuses on, which is birth through 21. The thing that ties them all together is that they are systems of care that follow the system of care principals that are set out by SAMSA. And we're going to get into those a little bit more.

DEBRA WALDRON: And again, in terms of system of care, I asked all of you if you had a definition and knew what it meant, again, we're not going to go to that yet, but I think again, these are the values that need to be part of the system of care, and really the family voice and the youth voice needs to be heard, it needs to be strength-based, I mean, we're really, you know, sometimes I hear the term instead of at-risk children, it's

at-promised children. Again, we really want to focus on what's working well within the family and for the child and build on that.

Yesterday morning, I guess, we heard one of the speakers talk about change and gave reference, or an example, of a child that was successful because someone intervened and capitalized on the success that was going on in that child's life. So again, we, in our system of care, really try to build upon that.

The natural supports are, we want children to stay within their community, within their families if at all possible, and again, how do we build those supports, make it individualized, and again, community based.

VICKY MIENE: We use what is called a wraparound philosophy and sometimes people know what that means and sometimes they don't. A lot of times we think of wraparound as a funding mechanism or a way to get services or to get things. Maybe some people think of it as a flexible funding pot, but really wraparound is a planning process and it's a deliberate process that includes the family basically leading that meeting and that process. It's a philosophy that helps kids realize their hopes and their dreams, along with their families.

Wraparound is not the entire system of care, it's not a new funding source, although it's easy to follow into that and think about it like that. It's not a service, it's not a way to get stuff or services that are typically reimbursable. It's not just for a small group of kids, it's

not case management, it's not a specific intervention or a program, it's really much broader than that.

So these are the principals, again, that are part of our system of care. And I like this diagram because it really shows the family voice and the family choice and the youth voice and choice are right there in the middle and the services are wrapping around them, and we're looking at their strengths as a family and how we can use them, we're looking at their natural supports and trying to figure out how we can bring those folks in to help support that family.

DEBRA WALDRON: This is my least favorite slide in the presentation today because I can never read the entire thing, and it was actually developed before I came to the State of Iowa, not that I think it's a bad slide, but it is a complicated one.

The two things that I really want to point out are what the two goals were of our project and really, it was to make sure that there was a mental health care component for children with mental health illness in northeast Iowa, and again, that's the direct clinical service piece, that's the piece about making sure these children's needs were served. I think the more important goal is really to develop that infrastructure using a bottom-up approach. And again, we really had a lot, we still have a lot of community partners, a lot of family partners, and really, it was how we were able to use their talents, their resources, and obviously some funding, to build upon all of those areas of expertise. And we're still working to build that infrastructure. We are in year four of at least of the

SAMSA funded project, but we have no plans for the project to go away and actually for the system care to continue and to continue very strongly, not only in northeast Iowa, but across the state. And we, again, always rely on the commission, the oversight commission's report because as of right now, that's a lasting document within Iowa and we do like to say that that is kind of our lighthouse.

VICKY MIENE: So Community Circle of Care then is actually a partnership between the Iowa Department of Human Services, Child Health Specialty Clinics, and the Center for Disabilities and Development. CHSC and CDD, which is the Center for Disabilities and Development, help to support different functions of our system of care. Some of it is, you know, support, family support, assessment, diagnosis, care coordination, and some of it is infrastructure supports, we have staff that are really trying to build the system as we go. It really is a system transformation initiative and it's the first of its kind in Iowa.

DEBRA WALDRON: Actually before you, that slide goes away, I do want to point out who the significant partners are. As you can see on the right-hand side of the slide, CHSC, which is really Title V:, the University of Iowa, Children's Hospital, which is where the Center for Disabilities and Development resides, but really, we do have the power and the support of University of Iowa behind us, and then we have the Department of Human Services. So again, we have three very powerful partners in the State of Iowa all working for this project to be a success.

And again, as Vicky alluded to, it's where we were and what we moved to, and again, away from fragmentation, toward coordination, away from categorical, toward blending, we want a more comprehensive service array. As we all know, we want to focus really more on prevention and early intervention, so identify the needs of these families early on and again, youth and family driven, as well as community based.

VICKY MIENE: That's you.

DEBRA WALDRON: Sorry. And again, as a pediatrician and as a practitioner, and I know there are a few practitioners in the room here, again, it's really, we as primary care providers, need to remember what our role is within the system of care and how our practices need to shift a little bit, it's not the same old paradigm of, you know, within those four walls of your clinic, it's what you do when the patient leaves the office, hopefully you fix them. Well, we know that that doesn't work and we know that especially doesn't work for children with serious emotional disorders, as well as kids with special healthcare needs.

So we as professionals needs to give up some of that control and remember that we're in partnership with families. Again, I know I'm preaching to the choir here, we all are aware of that, but again, we need to get that message out to the professional societies and to our clinicians that are practicing in the office that they need to be more inclusive of families. And I have to say, the Academy of Pediatrics and lots of pediatricians do embrace those principals. As we go forward with medical home and healthcare reform,

we need to make sure that everyone has the right focus and mindset in involving and engaging families in what's best for their children.

Again, we talked about the partnership, one thing that we do have, instead of having multiple case managers, as may be evidenced in some of your states with some of the care that your children receive, within Community Circle of Care, we only have one service coordinator that's assigned to a family. We still work in a team approach, but there is one, as we said, lighthouse or beacon, that helps guide that family. And in terms of how we achieve that, we do have individualized family plan and we want to make sure, as we said, that we're strength based and cultural competence is something that we view as very important. As you may be aware, Iowa is not a very diverse state in terms of race and ethnicity, but we are a diverse state in terms of levels of poverty, in terms of rural verses urban communities, so there are a lot of cultural issues that we can work on within our state.

VICKY MIENE: This is just a slide of the roles and expectations of family members and youth as they shift into a system of care and probably the best way that I can give to kind of explain how this all works is just giving a good example. Iowa was the last state in the nation to receive a system of care grant from SAMSA, so we're behind, okay? We're not as progressive as what we'd like to think we are. I think that there are pediatricians and things that are progressive and they embrace families and we're definitely working on that, but that has been one of the issues that we've had.

We actually have family members that sit on all of our advisory boards and committees, they make up 51% of our system of care, all of the committee meetings that we have, and the reason for that is because we don't want to build a system that isn't going to work and the families and youth are the ones who can tell us how that works and what's useful and what's not.

And the other thing that's happened and that we've been able to use as a way to show how it happens is that family members who've received services from us initially, when we were just getting started, now four years into it are actively participating in delivering services or helping to support parents in their area by leading a support group. I mean, they're really valuable pieces of our capacity as a whole.

We have a family that we're very proud of, this mom and her husband have two children that are middle school and they have a set of triplets that are now, I think they're nine, and all of the kids have a lot of emotional and behavioral challenges and this mom was not, I don't want to say well liked, but she wasn't well received at the school where the kids were, you know, attending, and part of that was because she was trying to advocate for her kids. She knew, really, what they needed, but they weren't in a spot where they wanted to hear what she had to say.

So she received services from our project, but she also worked closely with our key family contact and we were able to take her to a rights education law seminar where she picked up a book and we kind of helped her go through it and taught her how to use

the book and how she could maybe improve her communication style with the school.

Our family contact went with her to a meeting and kind of showed her, you know, how to lead the meeting, and at the next meeting, she led the meeting and she brought out her book and she said, "My kids have these rights," and the school is now working very, very well with her, so it's been a real amazing transformation.

This is a slide that I found particularly helpful because the process of going through change is so ambiguous. We know there's steps, they're hard to define, when you get off track, you kind of maybe don't pick that up until you're a little bit further off target than what you want. But because I'm a visual learner and a visual person, this was very helpful to me.

So along the top line, the vision, skills, incentives, resources, and action plan. The whole idea behind the slide is that if you have those things in place and they are useful and they're at the right level and they give the message that is intended to give, then you can create change in a positive way.

But if you get those other behaviors and emotions, like confusion or anxiety or resistance, frustration or feeling like you're on a treadmill, then the missing box that's not there in that row, that's where the work needs to be focused. And this is actually a slide that I've used with groups, you know, our big planning community meetings, our advisory groups, but also with families and family team meetings. Our care coordinators would talk initially a lot about families just kind of spinning their wheels and when we got

to looking at it, we thought, okay, the action plan isn't well defined or maybe they don't have the resources to act on the action plan, or maybe they just don't understand what exactly they're supposed to be doing. So this has just been very helpful to me and that's why I decided to share it.

We all know there's lots of required services in a system of care and particularly when you're dealing with mental health and emotional disorders, you don't want kids to spend a lot of time in a higher, you know, more restrictive placement, like a hospital or a psychiatric medical institution, you really want to keep kids at home. But sometimes you need those services to be able to make sure that a kid gets restabilized quickly or is able to, you know, get through some of their own transitions, for example, when kids go through adolescence, that's a very tough time, so it's important that all of those services are available, both the community-based wraparound services so we can keep the kids at home, and also, if needed, the other higher-end services.

I don't know where he came from, but that's interesting. He looks like he's crying.

This is an example of our service array, and you can't really see it very well, because the slides are on end, but essentially what we're trying to illustrate is that Community Circle of Care is the umbrella and under that umbrella, we can access things like respite and outpatient therapy and inpatient stuff if we need to. We can access crises services and we can respond within an hour to our families that are having some kind of a crises. It doesn't matter how big or small the crises is, we have the ability to utilize a youth

shelter for up to 48 hours in case a family or a youth needs a cooling off period. But they don't stay longer than 48 hours, the whole point of that is just to cool off, get things fixed, reconvene, you know, and make tweaks to that plan so we can make sure that we're getting things on the right track.

We have the ability to have physicians involved, we have our nurse practitioners who refer out to local providers, including the mental health centers. And we also have youth events that happen in each of our little areas, things like Express Yourself art events or suicide awareness or anti-stigma campaign events.

DEBRA WALDRON: And again, while we've said that system of care is not only about direct clinical services, our system of care would not be successful without direct clinical services. What our Community Circle of Care project does is actually marry the medical model with the social model. We do have a very strong basis of nurse practitioners, as well as child psychiatrists, who are a significant part of the project in terms of providing a very comprehensive medical assessment, as well as a psychiatric assessment. And the other thing that we are able to provide, if needed, is medication for the child. And again, that's not the only thing that's important in the child's life, but that is something that really is necessary for some families and children and again, we are able to provide that. We are also able to work within certain evidence-based guidelines that have been developed by the child and adolescent psychiatry society and again, what we strongly emphasize is yes, we can provide medical care for these children, but we want them to return to the medical home. So one of the things that we do and work with very strongly,

is when a family enters our system, we already start discharge planning. One of the first things that's done in the family team meeting is to make sure that you're going to have a usual source of care and if you don't have that, we will help you get that established. Because you know that mental health is only one part of a child's health and well being, the physical, emotional, as well as the social or other needs that need to be met and that's why the social support is down there as well.

Vicky's going to talk about some of the other components, but the medical component again, is the strength of our program.

VICKY MIENE: So one of the services that we provide is care coordination and we've been talking about care coordination and how important that is for the last few days, so I know that everybody realizes that. The thing that might be a little different with what our care coordinators do, is that they actually lead the family team meeting. And that's, sometimes family team meetings are used in states for various reasons, the family team model that we embrace is definitely the strength-based model, we are making sure that families are at the table and they're setting the agenda and our care coordinators are the ones who are really kind of facilitating that and they're helping them initially by saying, okay, who's a support to you? Who's a natural support? And maybe it's somebody like the lunch lady at school, because maybe that's the person that little 10-year-old Johnny connects with at school every day. Maybe she's the only person that has a positive relationship with him every day, so you can use that.

So we try to gather information and ask questions about those types of things so we can build them into the care plan. They also assist with all of the making referrals and linking families to community resources. If there's a service that is not available, but that is felt like it's needed, our care coordinators can request to use wraparound funding to provide that services, so they also have that ability and there are times when we decided to actually build a service so that we can help those families keep their kids at home.

With the family team meeting, are you all familiar with family team meetings or is that something different? Okay, so it looks like most people are familiar. I think that the important piece about this is that families really enjoy it, they don't feel like they're being told what to do, they feel like they're actually a part of it and they're empowered. They don't feel like they can't speak up and say what it is that they want or need.

DEBRA WALDRON: Actually this is probably my favorite slide in the whole presentation, because to me, social determinants to health and life course health development are concepts that you can't ignore in a child's life or in a family's life. And again, part of what we do in Community Circle of Care in our medical assessment, is actually to assess all these domains along the life course and as you can tell, some of these are social determinants of health, building on some of them as strengths, trying to work on some of those that may be weaknesses. And again, it's not only for the child, it's for the entire family and as that child progresses through his or her life. So again, as you know, you cannot, if there's economic barriers, if there's some legal concerns that the family's involved with, all of those things need to be assessed.

And I know in my background as training as a pediatrician, when I trained more than one year ago, but those are not part of the things that we assessed in our social history, and they're very important. And I do see that our physician pediatric consultants in the back of the room there for CHSC and she's very involved with the pediatric residency program at the University of Iowa and is involved in teaching these skills to medical students and residents.

VICKY WALDRON: We talked a lot about social supports through the various slides that we've had. These things are so important. What we're trying to do is really teach families and youth how to advocate, how to educate others about what's happening with them, and actually, they've had quite the opportunity to put those skills to use in the last couple weeks here, given our Iowa legislator and how we're trying to, they're trying to cut money, in the particular, from our program. So they've been able to actually gear up and make some presentations and talk about advocacy and how important it is for them. And those were skills that many of them really did not have before we started this project.

We've been able to establish parenting classes, and we've established them according to what the folks in that community wanted. We also have regular support groups that occur, if people want them, they're open to anybody who has a child or a sibling or somebody who has a, you know, a kid with an emotional or behavioral challenge.

We also have a number of youth activities that happen in our ten-county area and one of the new fun ones that our youth coordinator is working on is digital storytelling. And essentially it's what we saw in the morning with the family voices folks who are telling their story and their struggle and that's what we're teaching youth to do so that they can really kind of speak to what's happening in their life.

We also have a unique project called Elevate, it's a support group for foster youth. If they've been placed in a congregate care or in a foster home, they can be a member of this group and they really kind of focus on teaching advocacy and skills regarding being placed, being removed from your family, and then how to transition out of foster care successfully.

This is a slide, it's kind of an organized mess, is what I call it, but it really is a work in progress. It's our CQA process and it kind of shows, we have four different individual sites and each of those clinic sites, at the bottom of the screen you have your individual family team meetings that are led by care coordinators. And those care coordinator staff and those families are working very closely with each other to make sure that the needs are being met, but then also to identify what needs are being met, what services aren't available that maybe need to be looked at.

Those things kind of circle around and we have two teams that make a group, each one of them, each one of them is led by an **** and they're having meetings and they're talking about what it is that needs to be developed in the community or what types of

barriers they're coming against. And then all of that stuff eventually flows up to local advisory boards and then into our ten-county planning committee, which is a committee of about 40 people, we meet usually quarterly for about a day and they really kind of steer what happens within the Community Circle of Care project. Nothing really happens, we don't go down a path unless they're the ones who are directing that path, and on each of those groups, we have, like I said before, 51% family members of those groups.

DEBRA WALDRON: So right now, I will give you my definition of what a system of care is. It's actually not a thing, it's a philosophy, it's how you actually wrap all these things together and make sure that your process is something that's achieving, helping a child achieve success. So again, it's the medical piece, the social piece, but it's also the quality improvement piece, the community partners, the meetings, the communication, all of those things together, so it's not something, it's actually abstract, it's not something that you actually can say that you, when you achieve it you know it, but you can't absolutely put your finger on all the different parts that it takes. And again, each state and each system of care project is unique. But as we've learned, Rome was not built in a day, and I'm actually not how sure it took the Coliseum to be destructed was, but anyway, it's a time consuming process, it's not the year, it's not the 15 years. As I heard somebody say in the forestry world they talk about the 100-year plan. This really is a 100-year plan. We're not going to solve the problems of the world in a day and we are just going to continually build on it.

So again, it is time consuming, it's meetings, it's talking, it's communicating, it's recognizing what your barriers are, its celebrating your successes and again, it's an ongoing process. As I said, when the SAMSA funding goes away, our system of care won't go away because it's actually a philosophy that's now being embedded into what we do in Iowa.

VICKY MIENE: Another lesson that we learned is the importance of community resources and how it's so important to pull them together and draw them together and connect them then with a common thread. And the system of care model allows us to do that because we are constantly pulling people together and we want all kinds of different folks to be on our committees, it's not just the typical child welfare or therapy providers or pediatricians, it's also folks like faith-based folks, lunch ladies at school, if they want to participate, business people, because one thing that we know is that when parents get called away from their job because their child is acting up or having a, you know, an emotional breakdown at school, then there's less productivity. And so businesses are interested in this as well.

But the thing that our system of care does is it pulls them together, everybody on a common thread because we are embedding all of those principals, the family voice, the youth guided data competent, culturally competent system of care.

DEBRA WALDRON: One large lesson that we learned and actually I'm not sure we had to learn it, we knew it going into it, there are only about 100 child psychiatrists within the

State of Iowa, and we're not even sure that all of those are actively practicing at a full-time effort. So that actually leaves us with about 1 child psychiatrist for every 8,000 children in Iowa. As you can imagine, that is not a successful way of reaching out to all the children.

What we're trying to do in Iowa looking forward, is how we're going to build the capacity and competency of those areas where there are no child psychiatrists. One of the ways we're doing it innovatively is through telepsych, but that again, really is a one-on-one process that again, if you only have 1 child psychiatrist for 8,000 children, that's not going to work that well. So we realize we have to get into those primary care practices and start to build their competency and capacity. And one of the models we're looking at is the Massachusetts Child and Adolescent Psychiatry Project, which has been quite successful in the model that they've developed, which is actually real time consultation for primary care providers when they have a child in their office that is having either a serious emotional disorder or a mental health problem. And really what that helps to do is spread the knowledge, spread the skills, and actually provide reinforcement to pediatricians and family practitioners that they can do it, that there is a role for us to play and we need to step up to the plate to play that role.

VICKY MIENE: Another lesson learned and actually it's kind of combined. Evidence-based practices, we know that evidence-based practices are important, we know that that's how we can get the best results for kids is if we use evidence-based practices.

The issue, and I think, I'm not sure that it's just Iowa, it's probably all over, but we don't have a way to find out and to know which of our providers are providing evidence-based practices or not. There's no database, there's no running kind of roster of who's had particular training. Another example is parent-child interaction therapy, we know that that model of therapy works for certain kids, but we only have a few people trained in the state and there's no central place to know where those folks are.

And the other problem is that even though they work for mental health centers, there's no database that they have to put information in, and so we don't really have the data.

Evidence-based practices are, like I said, important, but there's other things that are important, too, and one of those is respite. It's difficult to find respite homes. Initially folks thought if we just had a way to fund respite that we'd be able to, you know, provide it, but the issue isn't the funding. With our wraparound project, we have the funding, it's finding those homes.

What we've learned with our emotionally and behaviorally challenged youth is that foster parents in the State of Iowa tend to be the ones who are best equipped to deal with their behaviors, they've had certain trainings, they have to take a, I think it's a 24-hour course regarding some of the behaviors and stuff, and interventions that could be successfully used with those kids. But our foster parents are completely over capacity because of the children in the Child Welfare System, so us being able to access those folks is difficult, at best.

The other thing that we learned is regarding our system and partnerships across the system. And that's not only on a local level, but it's on a statewide level as well. Getting the big departments of education and public health and Department of Human Services to talk and to kind of work on issues is something that we continue to work on. It's something that's very difficult, but we're making progress.

Also, locally, being able to pull, again, those agencies together, when you do that, you find out some of the issues, and for example, in our ten-county area, providers were hesitant to sign on at first because, you know, the rates are low and we don't know what this is all about, and how are we going to get paid because when they work for the state, it takes a long time for them to get reimbursed. But we've been able to help them with those issues and that has actually increased their investment into Community Circle of Care. We do pay them a decent rate, we pay them a little bit over the Medicaid rate for the services that they provide for us. We've been able to help support them when there's been a difficult administrative kind of issue, particularly with a certain child. We've been able to kind of help support them so they don't feel like they're going in and doing this alone. They also have access to any of the training and staff development that we provide.

DEBRA WALEDRON: And while I talked about the statewide partners before, the University of Iowa, Child Health Specialty Clinics,

Title V, and DHS, we are very proud of our local system partnerships and as you can see on there, there may be some players that you're a little surprised to see. We do partner with local restaurants, Wal-Mart, libraries, we'll take the help that we can get to help build the community and to give us the system building for these, for children.

VICKY MIENE: So we've talked about the challenges, one of the biggest lessons, I think, and the biggest challenge is that we continue to have more need than what resources can provide. In our ten-county area, we've served over 900 kids with our clinical services within the first 18 months of being up and running, and that's a lot, and we still have new referrals that are coming in all the time, so the need hasn't slowed down.

Teaching providers and policymakers and others in leadership roles that families really are key to the success of this is sometimes difficult but that process is getting a little better. It's taken a while for some of our providers to realize that family members can contribute to a group, they can articulate what it is that they need in a meaningful way.

DEBRA MIENE: I think we talked enough about the evidence-based practice, but the data collection is actually a challenge, it is an onerous task at times, there is a **** evaluation associated with the SAMSA project and, you know, I'm not going to say it's not without struggles, I mean, there are a lot of data challenges and we are working to try to make those better. I don't have any answer to the data collection piece of what we, barriers we're facing. We should have a system of care around data collection.

And the next slide, I mean, again, we don't want you to think the system of care isn't doing anything. We actually do have some outcomes that we're proud of. We actually have been able to show on a small scale that, well, actually on a large scale that there's better accessibility of services, but there have been fewer hospitalizations, out of home placements, less use of utilization of **** and actually a decrease in foster care placements due to the mental health and behavioral challenges that the child is experiencing.

VICKY MIENE: And these are actually some of the actual numbers that were recorded for state fiscal year 2009. The hard part is we don't have anything to compare those to so we can't say, well, prior to system of care we had 25 commitments and now we have 7. But one of the statistics that we can talk about is the out of state placements in Iowa. In our ten-county area, the kids that we serve, we had 1 out of state placement in the last 18 months. On any given day in Iowa, there's 130 kids who are placed out of state from mental health and behavioral challenges. So that to me is a really good data point that we can illustrate the success of our program with.

DEBRA WALDRON: And we're very proud of our website, it's actually a nice, interactive website and we're constantly building it, developing new links, and adding new materials. So please feel free to visit it and offer us any comments or concerns that you have.

Any questions? Okay. And that's just our contact information in case you want to call us, visit us. Our phone number's not on there, email us.

VICKY MIENE: Email.

DEBRA WALDRON: Or stop by, we'll bring you to the state fair.