
**Coordinated Funding for Children with Serious Emotional Disturbance:
Current Funding, Services and Recommendations**

**Texas Mental Health Transformation
Transformation Working Group: Children and Adolescent Workgroup
Children's Coordinated Funding Committee
Final Report**

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**Report coordinated and prepared for the
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1. INTRODUCTION

The following is an excerpt of a true story from a South Central Texas family¹. Names have been changed to protect the family's privacy.

Norma has an 11 year old son, Roger, with an above average IQ and impressive verbal skills, gaining the attention of everyone as soon as he speaks. Roger also has a diagnosis of Bipolar, Attention Deficit Hyperactivity Disorder and Depression, along with health concerns of allergies and low body weight. Prior to Roger's birth, Norma was employed and on track to career advancements. As Roger grew older and his challenging and disturbing behaviors increased, she decided to take a job with less responsibility and salary to meet Roger's intensifying needs. Over a five year time period, Roger was hospitalized 11 times. His aggressive behavior resulted in permanent damage to his teacher's fingers and hands, and as a result, Roger was placed in a segregated school campus with a one-to-two student teacher ratio. At the age of 10, Roger was charged with assault to a public servant and was ordered by a judge to provide community service. He was on probation for 6 months, resulting in additional costs not only to himself and his family, but also to his community and the state. Throughout the years, his Mom lost an average of 10 work hours per week attending to her son's needs in school meetings, court hearings, therapy sessions, hospital required activities, crisis center visits and emergency room visits – leaving no opportunity for typical family activities. Roger's Dad does not take an active role in his son's treatment and interventions. Due to pressures from the constant need for interventions, Roger's parents remain friends, but recently divorced. Visitation continues with his Dad on weekends and other days, but otherwise his Dad does not participate in therapy. At this point, Roger had been seeing a psychiatrist once a month, a counselor once a week, and taking medication for six years. Norma's monthly costs were about \$650 as her insurance did not cover behavioral health at the same rate as physical health. She drove over 200 miles a month to access services for her son. The medications, doctors, counseling, appointments and gas fill ups essentially cost her a full week's salary each month. Roger's treatments and services maxed out his insurance in 2008 and a crisis that could have been avoided resulted in a county hospital emergency room visit, resulting in Norma losing two days of work and a hospital bill for over \$2,500. In addition to paying on this monthly, she is still paying for three previous hospital stays. Roger has been involved in multiple systems including schools, public and private mental health services and juvenile probation. Although some families in similar situations have chosen to relinquish custody, Mom has never considered this option as means to obtain services. Up to this point, she felt that only her dedication to her son prevented the involvement of child protective services.

Norma paid 100% out of pocket for two years of her son's services until she learned that community mental health using Medicaid was an option. Roger was then served by community mental health outpatient services and referred to a small Wraparound demonstration program. Wraparound provides an interdisciplinary team of natural supports including parent, youth, school, mental health, juvenile probation, private counseling, friend, behavior consultant, advocate and mental health providers who together develop a coordinated plan of care for Roger. Since January of 2010, mom and son have participated with a team that coordinates services and supports. Roger had one brief hospital stay in March but since has not been hospitalized in 12 months. There was some success through the outpatient and wraparound planning but there were still more intensive needs, so in the fall of 2010, the family was referred to a 1915(c) YES Waiver pilot (currently in two Texas communities) for intensive in-home services, medication coverage, and wraparound support. Since then, Roger has moved from a special intensive school campus with one-on-one instruction and numerous educational supports to his regular campus. He currently is in regular education classes with the support of the district's intervention team, which has resulted in considerable instructional costs savings, from \$31,000 for six months at the special intensive campus to \$800 at his regular campus. Due to significant improvements and decreasing need for monthly wraparound team meetings, the family is considering a transition plan to phase out some of the home-based intensive services. Outpatient services will likely be a long term need for her son but because these services are available in the area, Norma now has the skills to recreate an individualized wraparound team whenever she and her son see the need.

¹ Roger's story was provided by San Antonio Bexar Cares.

To date, Roger is active with Boy Scouts, is a spokesperson with a local youth advocacy organization, was a presenter at a national organization's summer board meeting, was very active in the youth legislative training class and personally advocated for children's mental health legislation. Mom is able to work a full 40 hours and is considering a promotion. She is active with a Texas consumer advocacy organization and received a scholarship to attend a national children's mental health training at Georgetown University. Norma and Roger want to continue increasing positive social interaction individually and as a family, have a positive and successful school experience, and most of all keep their family intact. They are thankful to be achieving their family goals and are strong advocates of coordinated care.

Features of Roger's experience are common among children and youth with serious emotional disturbance and their families although many more children, youth and families are not as fortunate as Norma and Roger due to the lack of resources in their communities and / or the natural skills and tenacity that this youth and his family have. The costs to these youth, their families, community, county, and state are high. This report examines the issues experienced by these children and their families and proposes recommendations on the coordination of financing and services to improve the outcomes for other children with serious emotional disturbance and families in Texas.

1.1 Background

The 2003 [New Freedom Commission on Mental Health](#) report states that a basic principle for a recovery-oriented system of care includes examining financing: “The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a resiliency and recovery-oriented system of care.” The report provides evidence of fragmented funding across programs and restrictive financing sources. A need to evaluate and streamline the financing of mental health services is reflected in the report recommendations.

After the report was issued, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a competitive call for proposals to transform state mental health infrastructure. Following submission of a proposal, the Texas Governor’s Office was awarded a Mental Health Transformation State Incentive Grant (MHT-SIG). The Department of State Health Services is the grant’s administrative home and is advised by the Transformation Working Group (TWG) comprised of state agencies, consumers and family members, and governor and legislative office representatives. The [Texas Needs Assessment and Resource Inventory](#) identified a lack of effective service coordination for youth and children as an issue in the state. A significant percentage of youth receive services from multiple agencies, resulting in increased costs but no clear improvement in long term outcomes (described in this report ; NFC, 2005; Texas Legislative Budget Board, 2007). Additionally, service system gaps allow youth to “fall through the cracks” and leave families and communities with no alternative but expensive, restrictive services or relinquishment to juvenile probation or child welfare systems (Texans Care for Children, 2011). A variety of intensive community-based services and supports have been shown to reduce out-of-home placements and juvenile justice involvement (Skowrya, & Coccozza, 2006; National Mental Health Association, 2004) but there may be little access to these services in Texas, in part due to the expense to implement them and the difficulty coordinating various funding streams to support the services. If agencies coordinated funding streams and services for youth with serious emotional disturbance (SED) this could result in more efficient use of existing resources and substantially improved outcomes, for example, improvements in school outcomes and a decrease in costly out of home placements (Huang, et al, 2005; Kamradt, 2001).

1.2 Charge of the Children’s Coordinated Funding Committee

The Children’s Coordinated Funding Committee (Appendix A) is comprised of program and finance representatives from child-serving state agencies. It was charged by the TWG to examine the issue of fragmented funding and service coordination for children with SED. This specific population was selected due to the high costs shared among agencies and programs, and because of the potential to coordinate funds across agencies to improve outcomes and reduce costs that could then be redirected to intervention and prevention efforts. The Committee was charged to (see full charge, Appendix B):

- Examine how services for children and adolescents with serious emotional disorder (SED) are currently funded by gathering funding and program data from committee agencies.
- Understand how specific programs and budgets for children with SED in TWG child/youth serving state agencies operate and what requirements (state or federal) are associated with these programs and funding streams.
- Determine if fiscal opportunities exist to more efficiently coordinate across agencies to improve outcomes of these children through committee consultation with national experts².

² National experts consulted: Jim Wotring, Director of the National Technical Assistance Center for Children’s Mental Health at Georgetown University; Sheila Pires, Human Service Collaborative; and Bruce Kamradt, Director of Wraparound Milwaukee.

This report presents the committee’s findings and recommendations to transform existing structures to support a more integrated service delivery approach at the state and community level for children with SED. The recommendations are based on consideration of feasible strategies from the perspective of state decision makers, state and community agencies, family members, and community stakeholders, national best practices research, and promotion of evidence-based and promising practices.

1.3 Committee Identified Opportunities

The committee identified opportunities to improve services to and outcomes of children with SED through the development of coordinated financing structures based on review of past reports, existing models and feedback from communities implementing coordinated funding in systems of care^{3 4} and program and funding data provided by agency representatives. Given the economic environment, the committee agreed that the identified opportunities and recommendations would not require a request of new funds but could be implemented with existing agency funds if these funds were coordinated. The following opportunities for improvement at the state level were identified by the committee:

- Provide access to a coordinated, flexible service array
- Increase data sharing and agency coordination
- Improve child transition from one system to another and out of the system
- Increase the flexibility of current funding
- Enhance local service provider capacity to provide and support an array of services
- Increase cultural and linguistic competence of providers and systems

2. WHAT DO WE KNOW?

2.1 Prevalence of SED and Service Utilization

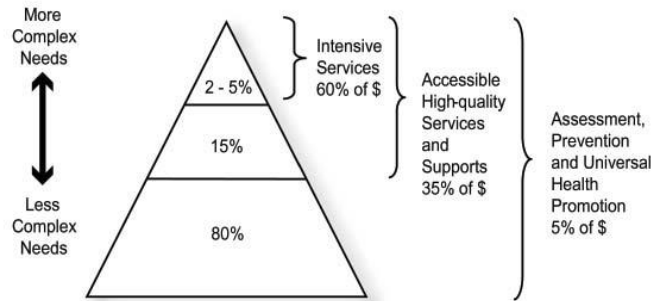
According to Section 1911(c) of the Public Health Service Act, children with a serious emotional disorder (SED) are from birth up to age 18 and currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities (Federal Register, 1993).

³ Communities implementing systems of care refers to communities receiving Child Mental Health Initiative grants through SAMHSA. Four Texas System of Care communities (Harris County System of Hope, Tarrant County Hand-in-Hand, Rural Children’s Initiative, and El Paso Border Children’s Mental Health Collaborative) provided feedback to the committee regarding issues involved with coordinated funding and sustainability of efforts in their respective communities. Their issues were similar to those identified by the committee and included: The need for flexible funding opportunities to meet the needs of children with SED and their families; use of Wraparound services per national standards; ongoing cross-agency training and technical assistance for the workforce to provide coordinated care and evidence-based practices; providing assistance to transitioning youth (transition from youth to adult and transitioning into the community from out of home placements); integrating and coordinating services; and data sharing.

⁴ Information on Wraparound can be found on <http://www.nwi.pdx.edu/>. Examples of services and supports provided through a Wraparound approach include family support and sustenance, therapeutic services, school-related services, medical services, crisis plans and services, independent living services, interpersonal and recreational skills development, vocational services, and other additional reinforcers.

National data indicate that children with SED comprise two to five percent of the total children’s population but utilize the largest percentage of funding for services (approximately 60 percent of all funds). Figure 1 visually represents the prevalence of behavioral health needs (high to less complex needs) and the utilization of funds among children with varying needs. At the top of the triangle is the relatively small percentage of children and families with serious and complex problems who use the largest percentage of funds. The middle of the triangle represents the various at risk populations of children and families who need services and supports, but where there may be few resources available (because a large percentage of the dollars are going to the top of the triangle). At the bottom of the triangle are the majority of children and families, *the universal population*, who do not need specialized services and supports but where primary prevention is imperative (Pires, 2006).

Figure 1. Level of Need and Utilization: Youth Population with Behavioral Health Needs

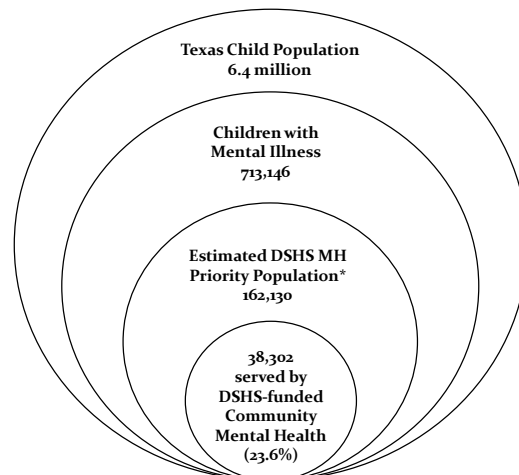


In Texas, as in most states, fewer resources are available for the middle and bottom of the triangle because the majority of funds are spent on services that fall in the top of the triangle (see Figures 4 and 5). Developing a coordinated financing system could rebalance funds from the top to the middle and bottom of the triangle, reducing the need for higher end services through prevention and intervention efforts as well as providing more appropriate, less restrictive care for those who need intensive services. Importantly, this could also reduce the number of children with SED who move into the criminal justice or child welfare system.

2.2 Who Funds Services for Children with SED?

Data provided for this report shows that 643,349 Texas children (not an unduplicated number) received a mental health service in fiscal year 2008 with funding provided by the nine agencies serving on the committee⁵. One might think of the state and local mental health authority as the primary provider of children’s mental health services, but as Figure 2 and other data in this report illustrate, the provision of mental health services to children with SED is a responsibility shared by a number of Texas agencies. Figure 2 presents the estimated prevalence of children with mental illness in Texas (713,146) along with the legislatively defined priority population

Figure 2: Prevalence of Mental Health Disorders and Number Served by the MH Authority



Retrieved from the 2008 Community Mental Health Services Block Grant Plan
 * The DSHS priority population is children with SED

⁵ All committee agencies serve children with mental health disorders but do not share a common assessment. Use of assessment varies by agency and not all use an assessment that will determine if the child has a SED by definition.

(children with SED) for the Department of State Health Services (DSHS) mental health authority (162,130) and the number actually served by DSHS funded mental health community providers in FY2008 (38,302). Other committee agencies (Health and Human Service Commission (HHSC), Department of Family and Protective Services (DFPS), Department of Aging and Disability Services (DADS), Department of Assistive and Rehabilitative Services (DARS), Texas Youth Commission (TYC), Texas Juvenile Probation Commission (TJPC), Texas Education Agency (TEA), and Texas Council on Offenders with Mental or Medical Impairments (TCOOMMI) have their own priority populations that do not specifically include children with SED, but it is clear from the number of children receiving services from these other agencies that the state and local mental health authority is not the only, or even the primary provider, of mental health services for children with SED in Texas.

2.3 Children with SED Receive Uncoordinated Services from Multiple Agencies

One of the concerns of the Children’s Coordinated Funding Committee was that a significant percentage of services for children were shared across the agencies and that these shared children might be those with higher behavioral health needs or SED. In 2006, Texas participated in a Children’s Co-Occurring Disorders Policy Academy sponsored by SAMHSA. The intent of the academy was to bring together state agencies to determine the extent to which these agencies provided services to the same youth, which was anecdotally, but not empirically known at the time.

Among other activities occurring under the policy academy, an agency data match was conducted (Table 1) utilizing children served by participating agencies in fiscal year 2005 (HHSC, DSHS-Mental Health, TJPC, or TYC). The committee found that HHSC (Medicaid) has the most children in common with other agencies, with 7% of the HHSC sample also served by TJPC, 9% served by DSHS, and a small percentage (>.2%) served by TYC. Similarly, the committee found significant overlap between mental health and juvenile justice, with 32.4% of youth served by DSHS also served by TJPC and the converse – 4.6% of youth in TJPC also served by DSHS. Youth in TYC were also commonly served by TJPC in the same year, with 33.7% of TYC youth also receiving TJPC services.

Table 1.	
Children with SED receiving services from HHSC (2008)	
	7% also received services from TJPC
	9% also received services from DSHS
	>.2% also received services from TYC
Children with SED receiving services from DSHS (2008)	
	32% also received services from TJPC

The percentage of children served across multiple service systems represent an opportunity for the state to better coordinate funding streams, services, and data sharing to improve the outcomes of these children and prevent their out-of-home placement or progressing into deeper involvement in the system. If a coordinated approach (funds, services, data) was applied to the service system for these children, similar to approaches other states and cities have effectively utilized (e.g., Wraparound Milwaukee, Indianapolis DAWN Project, New Jersey, Maryland), it could be reasonably expected that costs of services would decrease while positive outcomes would increase (Kamradt, 2001). Cost savings from these efforts could be redirected to other intervention and prevention efforts to reduce the number of children needing restrictive, expensive services.

2.4 Funding and Programs in Texas for Children with SED

To examine the status of funding and programs for children with SED in Texas, the committee members reviewed past work in children’s mental health (state policy and programs), current state agency funding of and

services for children with SED, and existing models for effective children’s mental health financing and service structures (state and national).

2.4.1 The 2007 Texas Legislative Budget Board Effectiveness and Efficiency Report

In January 2007, the Legislative Budget Board produced a report: [Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations](#) that included the selected issue to “Create a Coordinated State Infrastructure to Support Children’s Behavioral Health Services.” The recommendations within this issue included designing an integrated cross-agency funding structure for children’s behavioral health services using existing federal, state, and local funds and maximizing Medicaid financing for home and community-based services for children with behavioral health needs by requesting federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver.

Since this report was issued, the HHSC and DSHS received approval by the federal government to implement a 1915(c) Medicaid Waiver, named Youth Empowerment Services (YES), in two Texas communities (Bexar and Travis Counties). This waiver focuses on allowing more flexibility in the funding of intensive community-based services and supports (e.g., respite services, family supports, transportation) for children meeting criteria for psychiatric hospitalization and their families. If shown to be cost neutral, the YES waiver could be expanded to additional communities within the state, however, it remains restricted to a small percentage of youth with SED and the service array is limited in its flexibility due to requirements of the Center for Medicare and Medicaid Services. In addition to implementation of the YES waiver, the Texas Council on Children and Families was established by the legislature in 2008 and has produced its first required report that includes recommendations for behavioral health congruent with the recommendations of this committee’s report.

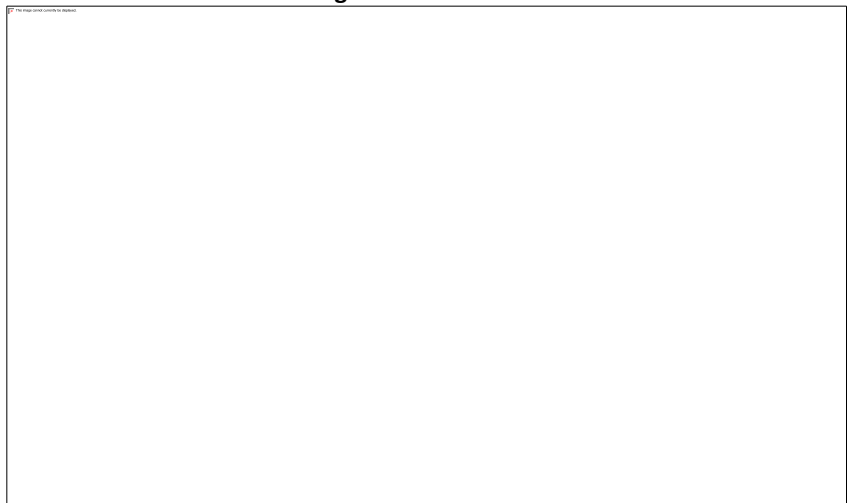
2.4.2 Texas Funding Sources

To examine the status of funding and programs for children with SED in Texas, the committee members established guidelines to provide agency specific information including:

- The funding sources for services funded for children with SED and their limitations
- Types of programs and services available for children with SED
- Information provided would include funds and services for children under 18 years of age
- Information provided would be based on fiscal year 2008 (which would provide the most up to date Medicaid data available)

To ensure the most complete data on Medicaid was included, funding data was provided for fiscal year 2008. Nine committee agencies reported total spending in the amount of \$686,746,271 on services for children with SED in 2008 (Table 2). Figure 3 shows that three agencies comprise the majority of state and federal funds for children with SED (97.91 percent) – HHSC and two of its umbrella departments, DSHS and DFPS. DFPS funds represent costs for room and board, with treatment dollars reported

Figure 3.



under Medicaid (HHSC). The remaining six agencies provide 2.09 percent of funds for children with SED. The amount of funds contributed at the local level is significant but unknown. This is particularly true for funds within the education and juvenile probation systems. Given this mix of state and local funding, effective financing strategies will need to focus on each of these sources, depending on the agency involved.

Examining funding sources in Table 2 reveals that the majority of funds are Federal Medicaid (about 46 percent), State Medicaid General Revenue (about 29 percent) and State General Revenue (about 15 percent). Table 1 does not include the significant amount of local level funds contributed to services provided by the county juvenile probation departments (from TJPC) and local school districts (through the education system – TEA). This number is difficult to establish due to the differences from community to community but it is known that local funds often pay for higher cost services, such as residential treatment or out-of-home or out-of-community placement.

Table 2.

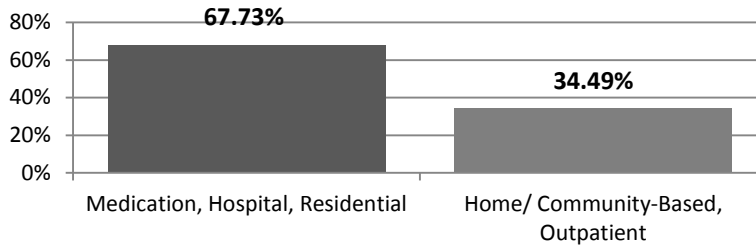
Agency Funding Sources and Amounts*						
	<i>Medicaid Federal</i>	<i>Medicaid GR</i>	<i>State GR</i>	<i>Formula Grant</i>	<i>Federal Block Grant</i>	<i>Other Federal</i>
HHSC	\$298,366,949	\$191,739,519				
DADS	\$56,111	\$36,512	\$288,166			
DARS			\$115,001	\$424,911		
DFPS			\$35,670,907		\$21,324,403	\$31,620,959
DSHS-MH	\$10,619,357	\$6,910,119	\$53,535,656		\$6,142,793	\$3,374,580
DSHS-NS	\$4,382,306	\$2,851,609	\$5,607,068		\$2,057,110	\$522,264
TEA**					\$1,277,707	
TJPC			\$1,368,872			
TYC			\$2,284,236			
TCOOMMI	\$1,033,893		\$5,135,263			
Category Total	\$314,458,616	\$201,537,759	\$104,005,169	\$424,911	\$30,802,013	\$35,517,803
	45.79%	29.35%	15.14%	0.06%	4.49%	5.17%
All Funds Total	\$686,746,271					

* Some funds may be duplicated within or across agencies; ** TEA does not collect this data from local education agencies

2.4.3 Services Funded in Texas (and do these services align with the evidence?)

As Figure 4 presents, the largest percentage of funds for Children with SED were used for medication or high intensity services (67.73 percent of all funds). Medication represented almost 35 percent of all funds, with a large percentage of funds used to provide hospital (almost 18 percent) and residential services (15 percent). Home and/or community-based services comprise 14.26 percent of service funding and outpatient services (e.g. medication management, assessment, office-based therapy) comprise 20 percent. Research indicates that community-based services are the most appropriate, effective treatment for children with SED, with little evidence supporting the long-term effectiveness of hospitals and residential services (Burns & Hoagwood, 2002; Huang, Stroul, Friedman, et al., 2005) and a study completed by Mental Health America Texas (2005) showed that in Texas, on average, it costs six times more to treat an individual in an inpatient setting than in the community.

Figure 4. Types of Services Funded as a Percentage of All Funds (State Level Funds FY2008)



Because there is no uniform reporting across agencies, the information on funding provided by state agencies is limited in its ability to fully reflect the costs associated with restrictive placements for children with SED. However, a picture can be reflected by understanding the costs for each child served in one of these placements⁶. As illustrated in Figure 5, monthly costs for placements in a prison or high security post-adjudication placement range from \$3,000 to \$8,142 per individual per month. Placement in a residential treatment setting in the child welfare system ranges from \$4,147 to \$7,285 per individual per month. Psychiatric hospitalization has the largest cost, ranging from \$11,348 to \$13,522, but frequently has the shortest duration of stay. In contrast, communities operating effective, intensive systems of care have provided these community-based services at a significantly reduced rate. As one example in which all behavioral health services are included in the case rate, Wraparound Milwaukee provides services based on case rates ranging from \$2,000 to \$4,300 per child per month.

For each child effectively deflected from incarceration, an estimated \$4,142 per month could be saved and reinvested. For each child who is able to remain in a community foster care placement, an estimated \$1,790 per month in savings could be realized. When examining current state spending and national best practices, it is clear that there are opportunities to redirect funds and services away from restrictive placements and into community-based settings. This would likely lead to reduced costs for Texas and better outcomes for children with SED.

Figure 5. Costs per Child per Month by Placement

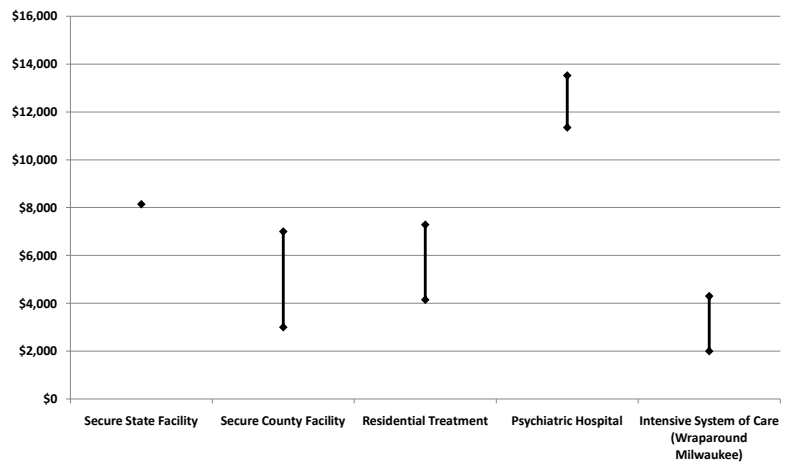


Figure presents range of cost by placement in Texas. Wraparound Milwaukee is included as an alternative community-based cost comparison.

⁶ Secure State Facility includes variation of costs per child per month across state-operated Texas Youth Commission facilities; Secure County facilities refers to secure post-adjudication; Hospital cost data found in the DSHS Statewide Performance Indicators, 4th Qtr FY 2010: <http://www.dshs.state.tx.us/mhreports/mhbook/MhBook10q4.pdf> (Performance Measure 1A: Average Cost per Patient); Residential Treatment is estimated based on DFPS specialized and intense rates: http://www.dfps.state.tx.us/PCS/rates_childcare_reimbursement.asp; and Cost of Intensive System of Care: per member per month case rates for Wraparound Milwaukee, reported in Financing Strategies that Support Effective Systems of Care, presented by Mary I. Armstrong, Sheila A. Pires, and Beth A. Stroul (March, 2010).

2.4.4 Existing models for effective children’s mental health financing and service structures

In addition to the LBB report and agency data, the committee also reviewed local level projects (System of Care communities), the [Texas Integrated Funding Initiative Financing Field Guide](#), the System of Care Primer (Pires, 2002 & 2008), and the University of South Florida’s *Effective Financing Strategies for Systems of Care: Examples from the Field* (2009) to launch strategic discussions about financing recommendations for children and youth with serious emotional disturbances.

It is well understood by the committee that Texas is a diverse state in population and geography and that needs at the community level vary and are best understood by the community. Because of this, the committee feels that a coordinated funding approach that utilizes system of care values and principles are the best to apply within the state. The system of care philosophy (Table 3) is based on a community level approach that is supported, but not dictated, at the state level. Systems of care are not static and continue to change over time based on the changing need, opportunities, environmental circumstances, and populations. The intent of the system of care concept is to provide a framework and philosophy to guide service systems and service delivery to improve the lives of children with mental health challenges and their families but not to propose a “model” for “replication” (Stroul, Blau & Friedman, 2010).

The system of care concept emphasizes the importance of local control and ownership of the system. The more “local” a system is, the more likely it will reflect community strengths, needs, values, and day-to-day realities. However, system building at local levels cannot sustain itself without state-level commitment; indeed, systems of care at local levels may not even be able to get off the ground without state-level involvement. For better or worse, state-level policies and practices have an impact on local systems of care. Effective system building requires a partnership between state and local stakeholders to clarify and address the ways state policies and practices (e.g., regulations, funding, reporting requirements) can be strengthened or altered to support local systems of care, including financing structures (Pires, 2002). The strength of the system of care values and principles is that they are not prescriptive and allow for adaptation to fit the community need.

Table 3.

System of Care Definition:
A system of care is a comprehensive spectrum of mental health and other necessary services organized into a coordinated network to meet the multiple and changing needs of children and their families.
System of Care Core Values:
1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations served.
System of Care Guiding Principles:
Services should be:
• Comprehensive, incorporating a broad array of services and supports
• Individualized
• Provided in the least restrictive, appropriate setting
• Coordinated both at the system and service delivery levels
• Involve families and youth as full partners
• Emphasize early identification and intervention.
<small>Source: Georgetown University</small>

A national study of system of care, which included Texas sites, showed a reduction in mental health problems and costly out-of-state residential placements and an increase in behavioral and emotional strengths. Residential stability, school attendance, and school performance improved, and contacts with law enforcement and substance use decreased (Huang, et al, 2005). Several communities in Texas that have adopted the values and follow at least some of the principles of System of Care (via System of Care grants from the federal Substance Abuse and Mental Health Services Administration or grants from Texas HHSC). These communities provide coordinated care for children with SED and to the greatest extent possible, use flexible funding to meet service needs. In most instances, the communities are limited in their ability to use funds flexibly due to state

agency level limitations or requirements on funds received. Results of these systems of care initiatives have been positive. Children and family outcomes from a selection of these communities⁷ in Texas include:

- A longitudinal evaluation of 47 families demonstrated the effectiveness of wraparound for youth and their families with improvements seen in severity of problem behaviors, school and home functioning, and caregiver strain (Mental Health Connection of Tarrant County).
- An update of ongoing evaluation revealed caregiver strain has decreased over time, the majority of services meet the needs of clients in a culturally competent manner, and an increasing trend in positive statements toward family life by participants (Harris County Systems of Hope).
- Evaluation of the Wraparound delivery approach revealed an overall reduction in problem behaviors with consistent improvement at every follow-up period, a 25 percent decrease in arrests, adjudications, and probation from intake to 24 month follow-up, significant improvements in reducing out of home placements, and improvement in school attendance, school performance, and out of school suspensions and expulsions (The Children’s Partnership in Travis County).

The success of these communities is due in part to their ability to coordinate service provision and use funding in a flexible manner to meet the needs of their children and families. The Children’s Partnership in Travis County has experienced some success implementing a small integrated funding pool to provide a wraparound service delivery approach. In most local communities flexible funds that allow for nontraditional wraparound services typically come from a limited number of local level funds and have not included state-level funding.

3. Now What? Recommendations

After a review of information and consultation with national children’s mental health system financing consultants, the committee identified key issues and developed recommendations that are in line with the values and principles of a system of care for children with SED. The committee also considered the work of other committees and legislatively established councils (e.g. the previously mentioned Council on Children and Families) and the recommendations are compatible with those of these related groups.

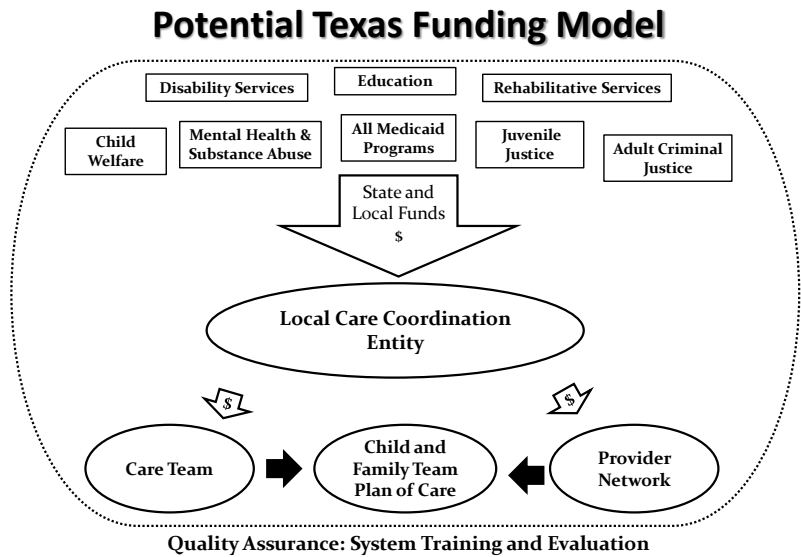
The recommendation of the Children’s Coordinated Funding Committee is to establish several voluntary demonstration sites in diverse areas of the state where state and local funding can be coordinated to provide comprehensive, flexible services for children with SED and their families that prevents out of home placement and improves both short and long term outcomes for these children.

⁷ Some communities in Texas have adopted the values and principles of a system of care in varying degrees. These include federally funded **System of Care Communities**: Harris County System of Hope, Tarrant County Hand-in-Hand, Rural Children’s Initiative (Hale plus 10 surrounding counties), the Travis County Children’s Partnership, and the El Paso Border Children’s Mental Health Collaborative; as well as **Texas Integrated Funding Initiative (TIFI)** communities: the Alliance for Children and Families of Denton County and Bexar Cares. **Community Resource Coordinating Groups** do not coordinate funds but are local interagency groups available to all counties and are comprised of public and private providers who together develop individual services plans for children, youth, and adults whose needs can be met only through interagency coordination and cooperation.

3.1 Potential Texas Funding Model

Figure 6 presents a broad overview of a potential funding model. Children with SED at risk of institutional or out-of-home placement would be targeted for services. Child serving agencies would work together to coordinate funding through a local Care Coordination Entity, responsible for fiscal management, network development, and coordination of services. Although models can vary, the care coordination entity is different from current Texas models in that the Care Coordination Entity accepts the financial risk for enrolled youth, providing all services that the youth needs to prevent or reduce the length of more restrictive placement. In return for accepting this risk, the Care Coordination Entity has significant financial flexibility to purchase necessary services, supports, or goods.

Figure 6.



Communities would select the target population(s) to address and the number of children and families to enroll in the initial test of the model’s effectiveness. Youth could be referred into services from any system contributing funding, i.e., mental health, child welfare, juvenile justice, schools. Care coordinators would facilitate child and family teams, consisting of the youth and caregiver, friends, family or other community supports, and system representatives associated with the child (i.e. child welfare, probation, education, mental health, etc. workers would join child and family team). The team would develop an individualized, strength-based plan of care with the child and family utilizing the traditional (e.g., medication, therapy) and/or non-traditional services and supports (e.g., mentoring, transportation assistance) available in the community. The care coordinator would be responsible for authorizing and monitoring provider services, measuring youth and family outcomes, and representing the team at key meetings (e.g., attend court hearings or educational meetings). They would coordinate plan provision across child serving systems, one care plan and one care coordinator. To determine the quality of outcomes and consistently improve the workforce, an outside entity would provide evaluation and training for quality assurance.

3.2 Suggested Approach for Implementation – Voluntary Community Demonstration Sites

The committee recommends developing local level voluntary demonstration sites in Texas that utilize coordinated funding approaches to implement system of care principles in a manner that resonates with the community’s need. Voluntary demonstration sites are recommended rather than suggesting particular communities or a statewide approach because of the commitment of local leadership and infrastructure necessary for success. This recommendation is based on research showing that infrastructure, community leadership and a broad service array are related to successful implementation and outcomes (Fixsen, Naoom, Biase, Friedman, & Wallace, 2005).

Texas has the opportunity to make locally-driven interagency initiatives more successful. Since there will be a need for close state and local coordination, the committee suggests that the recruitment of demonstration sites be based on the following criteria:

- 1) Local infrastructure exists (fiscal and data capacity for coordinating funding and services);
- 2) Local community leadership is interested and willing to partner on the endeavor; and,
- 3) Local availability or potential to provide a broad service array (including nontraditional services).

A Request for Information (RFI) could be used to examine the potential interest and capacity to implement a coordinated funding approach at the community level by identifying interested communities and their capacity to implement the approach. To ensure time to develop an approach that would be successful in diverse communities, the committee recommends the following timeline:

- | | |
|----------------------|--|
| 1 st Year | State and local agencies address issues and barriers to coordinated funding; develop state and local infrastructure for implementation; establish evaluation to determine effectiveness. |
| 2 nd Year | Serve a limited number of children and families; continue to address barriers and build capacity; evaluate initial demonstration. |
| 3 rd Year | Continued implementation with additional children and families; assess and tweak model via evaluation; add service providers to address identified needs. |
| 4 th Year | Recruit additional communities. |

3.2.1 Considerations for Implementation

To implement this type of funding model (Figure 6), there are issues that must be examined at both the state and local level to ensure success. The multiple agencies that provide services to children with serious emotional disturbances need to further develop their cross system vision for delivering services to children with SED and their families. Operationalizing a cross system vision will help align financing policies and guidelines to better coordinate funding for local child serving agencies. This will maximize the impact of limited funding on the local service array or continuum of care and may increase the amount of federal revenue. Currently, individual agency-based contract restrictions and legislative requirements on funding streams result in local agencies providing services in silos based on the funding available and not the individual need of the youth. To address barriers, it would be necessary for participating agencies to jointly examine and address funding, contracting and monitoring, data coordination and cross agency outcomes so that accountability for children’s positive outcomes are in place but that communities are not overburdened by separate agency requirements and processes. Some of these important considerations and resources available to address these issues are documented below. There are national examples and resources available for consultation in these areas.

Resources to Implement the Proposed Approach:

- The proposed project could be implemented with little to no additional resources, and may eventually lead to reduced costs or maintained costs of services to this population.
- A state-level advisory committee currently in existence could provide oversight to the initiative and address state-level barriers.
- The initial implementation of the model could utilize communities with the greatest resources and infrastructure in place to maximize its success.
- Subsequent efforts to expand the model to additional communities, if shown to be effective, could utilize a percentage of any cost savings to enhance the state infrastructure for supports (e.g., workforce training, provider certification), allowing for economies-of-scale over time.

State Infrastructure for Implementation and Accountability

- A collaboration between local and state partners should be tasked with identifying and addressing barriers to implementing the model found within agency policies and/or contracts. The collaborative workgroup should clearly document policies that support the coordinated funding effort, to ensure all stakeholders are aware of acceptable practices and dispel any misunderstandings. This workgroup could also identify any legislative barriers to implementation and provide recommendations to the designated oversight committee.
- Infrastructure should be developed to ensure adequate and consistent training of the workforce in evidence-based treatments for the targeted population.
- State agencies should identify staff members with expertise in network development, billing systems, or other key implementation tasks and offer technical assistance to local communities when requested
- Infrastructure should be developed to allow for monitoring of quality and outcomes, including cost effectiveness.

Data Sharing and Coordination:

- Consider strategies used by other states to successfully address data sharing and privacy issues (e.g. those associated with HIPAA and FERPA), such as cross-agency memorandums of understanding.
- Create processes for regular data sharing and coordination at the state and local level to improve care coordination, monitor family outcomes, and evaluate the child-serving system.
- Use a common assessment or share assessment data across agencies serving children with SED.

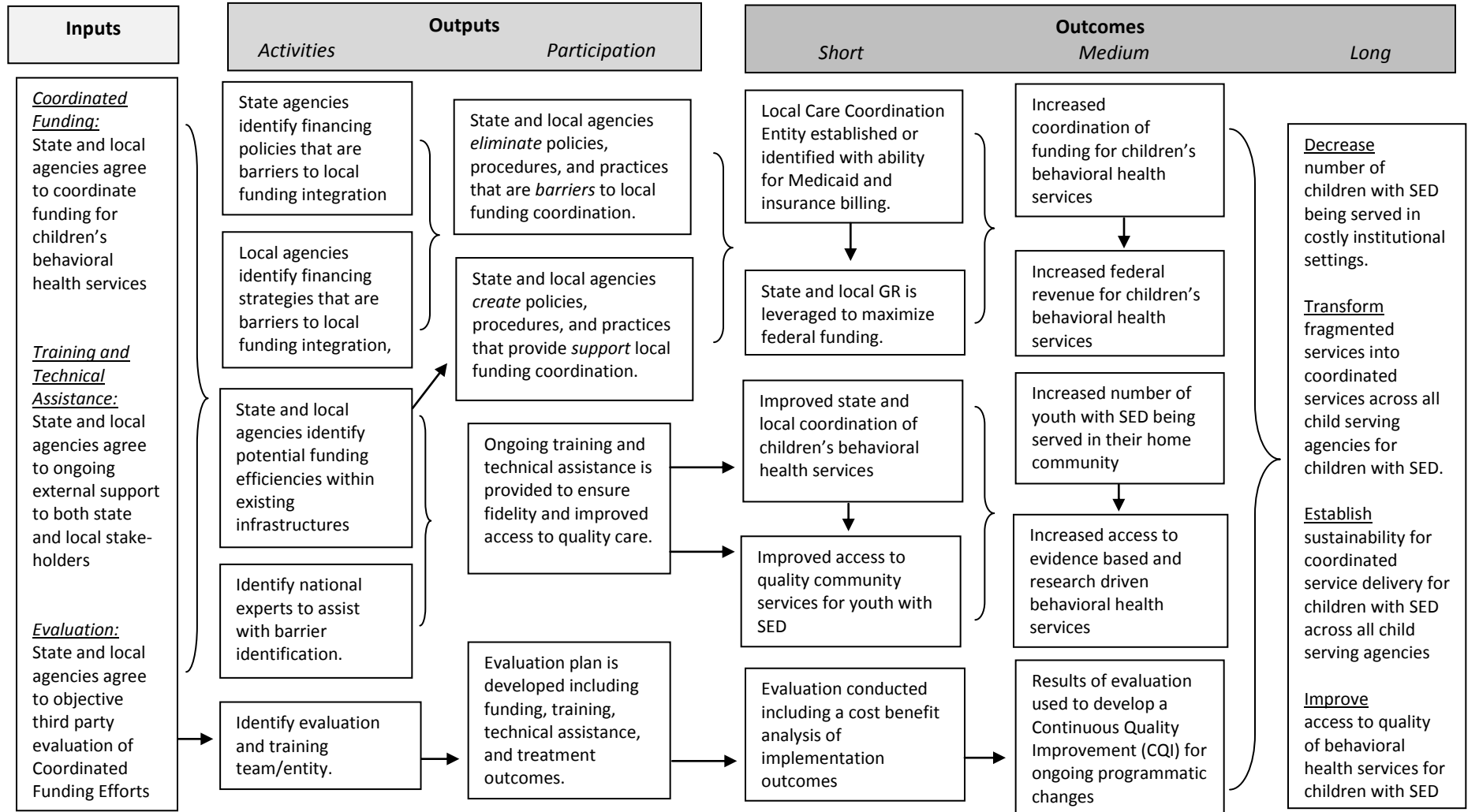
Potential Areas to Examine for Cost Savings or Funding Opportunities:

- Examine benefits to school systems for participation in coordinated funding at the local level (re: reduced RTC placements, reduced costs to alternative education placements, etc).
- Explore the potential availability of disproportionate minority contact funds to reduce the percentage of minority youth in secure confinement.
- Share costs across agencies for workforce development initiatives.
- Examine psychotropic prescribing outliers among Medicaid providers to identify potential cost savings and redirect savings into community based services.
- Examine existing Medicaid data to identify inefficiencies and support the aim of improving outcomes without increasing costs.
- Identify the potential for flexible funds within existing state funding sources and maximize their availability at the local level to reduce out of home placement.
- Explore the potential match of juvenile justice general revenue to maximize Medicaid funding by examining whether or not probation is considered as secure corrections or incarceration and thus ineligible for Medicaid draw down.
- Examine and plan for the impact of Health Care Reform on payment systems and opportunities to enhance funding for intensive, community-based services.
- Explore additional opportunities for flexibility within the Medicaid system (i.e., waivers, service definitions, etc.) to support the model.

The logic model that follows provides an outline to demonstrate the potential model inputs, outputs, and outcomes. Within the logic model, the committee recommends the examining the previously described issues for implementation as potential areas for increases or efficiencies in funding, coordination, and outcomes.

Children's Coordinated Funding Logic Model

Situation: Demonstration of potential Texas funding model for coordinated behavioral health services



Assumptions

- Children with SED comprise 2 to 5% of the total children's population but utilize approximately 60% of all funds
- Children with SED often receive services in costly institutional or residential settings
- Multiple state and local child serving agencies fund behavioral health services for children with SED but in general do not coordinate funding or services

External Factors

- State-wide budget deficits impact the amount of GR for behavioral health services for children with SED
- Existing state and local agency policies, procedures, and practices result in limited cross agency communication and coordination of behavioral health services

4. Summary and Recommendations

The work conducted by the Texas Mental Health Transformation Children's Coordinated Funding Committee identified the following issues affecting children with SED:

- Children with SED comprise 2 to 5 percent of the youth population with behavioral health needs but utilize 60 percent of all children's behavioral health funding and services.
- They receive services funded by multiple agencies but these services are not coordinated and agencies only know anecdotally that they serve some of the same children.
- The majority of funds spent are for medication and more expensive, restrictive placements when the evidence shows community placement is more effective and less costly over time.
- Coordinated financing structures and service systems can provide more appropriate, less restrictive care for children who need intensive services and redirect savings to prevention and intervention that can reduce the need for higher end care.
- The state and local mental health authority is often perceived as the primary provider of children's mental health services but state agency data reveals this is a shared agency responsibility.
- Texas communities following some of the principles and values of systems of care (coordinated funds and services) have positive outcomes. A community's ability to coordinate funds is typically focused on local dollars due to requirements attached to state and federal funds that do not include services such as respite and transportation (e.g. DSHS is legislatively mandated to provide Resiliency and Disease Management ; federal Medicaid dollars are directed to specific services).
- Systems of Care values and principles emphasize local ownership to reflect community strengths, needs, and day to day realities, but recognize that sustainability requires state level commitment and examination of policies and practices that impact local implementation.

Given the conclusions highlighted above and the current state fiscal environment, the committee makes the following recommendations with the goal of providing more efficient, effective, community-based services that improve the long term outcomes of children with SED in Texas:

- Establish several voluntary demonstration sites in diverse areas of the state where state and local funding can be coordinated to provide comprehensive, flexible services for children with SED and their families to prevent out of home placement and improves both short and long term outcomes for these children.
- Develop infrastructure for the coordination of state and local funds to a local care coordination entity which utilizes system of care principles and is responsible for services and outcomes.
- Use an RFI to determine community interest, capacity, and concerns to become a demonstration site and use a timeline for implementation. Recruit voluntary demonstration sites based on local infrastructure (including fiscal and data capacity), leadership interest and willingness to partner, and potential to provide a broad service array that includes nontraditional services.
- Address state level barriers and burdens to coordinating funds and services at the local level by examining agency funding restrictions and requirements, contracting and monitoring, data coordination, and developing shared outcomes for children with SED and their families.
- Use a logic model to examine existing resources, potential areas for cost savings, data sharing and coordination at the state level to further chances of successful implementation in communities.
- To carry out these recommendations, utilize an existing interagency state level structure that has interest in children and youth and behavioral health issues. The Texas Council on Children and Families could guide the implementation and sustainability of the recommendations in this report.

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APPENDICES

Appendix A

Committee Members – Agency Representatives

Each agency was represented by one program and one budget staff and the list below presents all agency staff who participated during the course of the committee’s work. Members may have changed during the course of the committee’s work depending on staff availability and the task at hand.

Health and Human Services Commission

Sherrri Hammack (Committee Chair)

Tania Colon

Judy Temple

Laurie Vanhoose

Monica Smoot

Barbara Duty

Stephanie Stephens

Sheila Latting

Department of Family and Protective Services

Liz Kromrei

Ada Gomez

Norton Teutsch

Texas Youth Commission

Tracy Levins

Pamela Darden

Janie Duarte

Department of Assistive and Rehabilitative Services

Becky Ashton

Bill Bittick

Texas Juvenile Probation Commission

Vonzo Tolbert

Bill Monroe

Erin Espinosa

Linda Brooke

Department of Aging and Disability Services

Corliss Powell

Steve Buoy

Texas Education Agency

Michelle Rosales

Phyllis Gandy

Department of State Health Services

Angela Hobbs-Lopez

Dena Stoner

Ardas Khalsa

Gary Hamilton

Randolph Lovejoy

Texas Department of Criminal Justice

Dana Collins

April Zamora

Family Representative

Monica Thyssen

Serving as Resources to the Committee:

The Governor's Office

Senator Jane Nelson's Office

Speaker of the House Joe Straus

Legislative Budget Board

Jessica Olson

Tara Swayzee

Jennifer Deegan

Donna Morstad

University of Texas at Austin, Center for Social Work Research:

Stacey Stevens Manser, PhD

Molly Lopez, PhD

Appendix B
Coordinated Funding Committee Charge
February 11, 2010

Charge

To make recommendations to the Mental Health Transformation (MHT) Texas Workgroup (TWG) regarding transforming the existing state level mental health financing system to a more coordinated approach that produces improved outcomes for children and youth with serious emotional disturbances whose service needs and costs are shared among multiple agencies.

Background

National: The [President's New Freedom Commission on Mental Health](#) report states that a basic principle for a transformed recovery-oriented system of care includes examining financing: "The transformed mental health system will rely on multiple sources of financing with the flexibility to pay for effective mental health treatments and services. This is a basic principle for a recovery-oriented system of care."

The report acknowledges throughout that funding is fragmented across programs and that financing sources can be restrictive. The need to evaluate and streamline the financing of mental health services is reflected within several of the recommendations of the report, including:

- 1.2 Address mental health with the same urgency as physical health;
- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a comprehensive state mental health plan.
- 4.1 Promote the mental health of young children.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

State: Upon receipt of the Mental Health Transformation State Incentive Grant, a Needs Assessment and Resource Inventory (NARI) was conducted to inform development of a Comprehensive Mental Health Plan (CMHP) for Texas. The NARI and CMHP identified that services for youth and children are often not coordinated even though a significant percentage of youth receive services from multiple agencies, increasing costs without improved outcomes. Additionally, there are gaps in the service system that allow youth to "fall through the cracks" when better coordination of funded services could assist these youth from moving deeper into the public mental health system. Focusing on coordinated funding of services for youth with SED could substantially improve outcomes.

In January 2007, the Legislative Budget Board produced a report: [Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations](#) that included the selected issue to "Create a Coordinated State Infrastructure to Support Children's Behavioral Health Services."

Two of the five recommendations within this issue involved:

- designing an integrated cross-agency funding structure for children’s behavioral health services using existing categorical and/or non-categorical Federal Funds, General Revenue Funds and/or General Revenue-Dedicated Funds, and Local Funds in a coordinated manner to support systems of care, focusing on blended or braided funding arrangements.
- maximizing Medicaid financing for home and community-based services for children with behavioral health needs by requesting federal approval to implement a Medicaid 1915(c) Home and Community-Based Services Waiver and/or to amend the Medicaid State Plan no later than fiscal year 2009 if these options are found cost-effective and can be implemented within existing resources.

This report and information it contains, (i.e., calculations on public spending on children’s behavioral health services reported by state agencies: FY 2005) may be a good starting point to launch strategic discussions about financing recommendations for children and youth with serious emotional disturbances. Additionally, the [Texas Integrated Funding Initiative Financing Field Guide](#) may be a worthwhile reference to begin this work.

Assumptions:

Children’s behavioral health needs, interests, and responsibility cut across a variety of disciplines and domains. Along with the interests of parents, family members, and community members, there are several state and federal child-serving agencies that are direct stakeholders in providing an integrated service delivery approach. Those agencies and local components include:

- Public mental health service providers (DSHS and local mental health authorities, EPSDT),
- Publicly-funded substance abuse providers (DSHS and contracted providers),
- DARS and youth in transition programs,
- DADS programs that address children and youth with disabilities with behavioral health concerns,
- Education (TEA and local independent school districts),
- Child welfare (DFPS and local child protective services),
- Health and human services for low income families (HHSC-Medicaid, CHIP, and local health and human services departments), and
- Juvenile justice (TJPC/TYC/TCOOMMI and local juvenile probation and TCOOMMI departments, TYC facilities and contract providers).

Target Population:

Children and youth with serious emotional disturbances as defined in the President’s New Freedom Commission on Mental Health report:

A serious emotional disturbance (SED) is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems (Individuals with Disabilities Education Act (IDEA) Pub. L. No. 105-17. 1997).

Methodology:

Convene a multi-agency committee comprised of:

- at least one program agency staff member with working knowledge of the agency's programs and services for children and youth with serious emotional disturbance (recommended by the TWG member),
- at least one fiscal agency staff member with working knowledge of the agency's programs and services for children and youth with serious emotional disturbance (recommended by the agency Chief Fiscal Officer).
- TWG legislative liaisons,
- TWG Governor's Office liaison, and
- Family Representative(s) with knowledge of programs and services for children and youth with serious emotional disturbances.

Agency staff of the Child and Adolescent Workgroup Action Team (Evidence Based and Promising Practices) will support the committee by assisting with:

- developing the scope of work,
- assisting with identifying national consultants, and
- developing a work plan.

Utilize a professional facilitator and UT Center for Social Work Research staff to support the committee's work, including:

- facilitating and documenting committee meetings,
- documenting state financing of programs and services for children and youth with SED,
- reviewing other states' experiences with coordinated funding,
- arranging for consultation between committee members and the selected national consultants,
- capturing and documenting the dialogue of the financial consultation, and
- preparing documents, reports, and recommendations that reflect the work of the committee.

Debriefing meetings and/or focus meetings with community level providers will be planned at appropriate intervals during the committee's work process to gather input and feedback to determine local impressions of the findings of the committee and the feasibility of recommendations that are developed.

Work Product:

A set of recommendations for transforming the existing state level mental health financing system to support a more integrated service delivery approach will be made to the Mental Health Transformation Texas Workgroup. These recommendations will be grounded in:

- consideration of feasible strategies from the perspective of state agencies, legislative, family member, and local level expertise,
- national best practices research, and
- promotion of evidence-based and promising practices.

The goal is recommendations that:

- are acceptable to committee members and local partners,
- are considered for implementation by state agency decision-makers and legislators, and
- improve behavioral health outcomes for children and youth with SED and their families in Texas.

Appendix C
Agency Funding Amounts by Source of Funds and Service Types

Agency Funding Amounts by Source by Service Types									
Source of Funds	Other/ General	Drugs	Home, &/or Community- Based	Residential	Hospital	Crisis	Professional (typically outpatient)	Total Funds	Number Served*
CHIP Federal			1,225,631		2,931,333		4,788,608	8,945,572	27,041
CHIP GR			467,230		1,117,469		1,825,492	3,410,191	
FFS and PCCM Medicaid Federal			9,790,651		40,412,025		50,865,602	101,068,278	167,766
FFS and PCCM Medicaid GR			6,370,873		26,296,501		33,098,746	65,766,120	
HMO Medicaid Federal			\$2,169,681		\$13,938,208		\$20,388,892	\$36,496,780	84,633
HMO Medicaid GR			\$1,411,833		\$9,069,728		\$13,267,252	\$23,748,813	
Vendor Drug Medicaid Federal		\$134,432,994						\$134,432,994	266,782
Vendor Drug Medicaid GR		\$87,476,868						\$87,476,868	
SHARS Medicaid Federal							\$78,219	\$78,219	226
SHARS Medicaid GR							\$50,898	\$50,898	
STARHealth Medicaid Federal			\$330,513		\$7,890,716		\$9,123,876	\$17,345,105	18,485
STARHealth Medicaid GR			\$215,068		\$5,134,566		\$5,936,996	\$11,286,630	
State GR			\$288,166					\$288,166	312
Medicaid Federal			\$56,111					\$56,111	
Medicaid GR			\$36,512					\$36,512	
State GR	\$115,001							\$115,001	607
Voc Rehab Fed Formula Grant	\$424,911							\$424,911	
State GR				\$35,670,907				\$35,670,907	3,927
Federal Block Grant	\$123,519			\$21,200,884				\$21,324,403	
Other Federal (IV-E and IV-B)			\$45,174	\$31,575,785				\$31,620,959	
State GR			\$32,877,103	\$9,106,026	\$10,540,748	\$1,011,779		\$53,535,656	36,823
Medicaid Federal			\$9,630,319	\$431,362	\$528,848	\$28,828		\$10,619,357	
Medicaid GR			\$6,266,543	\$280,691	\$344,126	\$18,759		\$6,910,119	
Federal Block Grant			\$6,057,027			\$85,766		\$6,142,793	
Other Federal (grants)			\$3,197,775	\$75,100	\$21,743	\$79,962		\$3,374,580	
State GR	\$7,967		\$1,825,927		\$3,561,895	\$211,279		\$5,607,068	30,343
Medicaid Federal			\$4,382,306					\$4,382,306	
Medicaid GR			\$2,851,609					\$2,851,609	
Federal Block Grant			\$2,057,110					\$2,057,110	
Other Federal (grants)			\$522,264					\$522,264	
Federal Block Grant				\$1,277,707				\$1,277,707	34
Local Funds				\$2,366,029				\$2,366,029	
State GR	\$1,368,872							\$1,368,872	unknown
State GR			\$10,885	\$2,273,351				\$2,284,236	4,182
State GR			\$5,135,263					\$5,135,263	2,188
Medicaid Federal			\$1,033,893					\$1,033,893	
Total Funds by Service Type	\$2,040,270	\$221,909,862	\$98,255,467	\$104,257,842	\$121,787,906	\$1,436,373	\$139,424,581	\$689,112,300	643,349
% of total funds	0.30%	34.93%	14.26%	15.13%	17.67%	0.21%	20.23%		
<i>* number served is not an unduplicated count</i>									
<i>Local funds and services funded are unknown</i>									

Appendix D
Individual Agency Funding and Program Information

Separate Attachment