Report on the Transfer of the Care Management Entity

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Statement of Charge

The 2016 Joint Chairmen's Report stated that the Governor's Office for Children should work with the Department of Health and Mental Hygiene to submit a report detailing the services offered under the Care Management Entity (CME) and the structure of the CME program before and after the transfer. The report should include detail of the services offered and the number of children, both Medicaid eligible and non-Medicaid eligible, that were served in fiscal 2015 and 2016 as well as an estimate for fiscal 2017.

Background

The Care Management Entity program in Maryland was established as a pilot to serve as the entry point for specific populations of children, youth and families with intensive needs for care coordination using a Wraparound service delivery model. Many of those served were diagnosed with psychiatric illnesses and the majority were involved with the Department of Social Services and/or the Department of Juvenile Services. The goal was to serve youth in the least-restrictive community environment and to prevent restrictive residential placements. The Governor's Office for Children and the Children's Cabinet began the pilot of the Care Management Entity programs in Baltimore City and Montgomery, St. Mary's and Wicomico Counties before implementing the system Statewide in 2009. The pilot began with multiple service providers until 2012 when the Maryland Choices, LLC. served as the State's single Care Management Entity provider. In June 2016 the program was integrated into the Targeted Case Management program at the Department of Health and Mental Hygiene (Department).

Services Offered Under the Care Management Entity and the Structure of the Care Management Entity Program

The Care Management Entity program was designed to pilot a single "locus of accountability" for children and families and supported the organization, management, delivery, and financing of services and resources across multiple providers and systems. The Care Management Entity program utilized a high-fidelity Wraparound service delivery model.

High-fidelity Wraparound prioritizes coordination of collaborative service delivery across all child- and family-serving systems. This model is built to manage care for high service-utilizing populations of children and youth who are typically involved with multiple systems and are in or at high risk for out-of-home placement. Wraparound service delivery includes a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network across systems to meet the changing unique needs of children, adolescents and their families.

Within a Wraparound model of service delivery, service providers across multiple systems work closely with participants and their families as part of a Child and Family Team tasked with the development and monitoring of a plan of care. Each plan of care is individually tailored to the complete and unique service needs of program participants. Resources are maximized to the greatest extent possible, including using services that are available without charge, covered by applicable insurance (private or public), and that leverage federal funds. Wraparound service delivery prioritizes the use of Evidence-Based-Practices where they are appropriate to meet the child's and family's plan of care.

The Care Management Entity program served various populations of children and youth with intensive needs across the State. By definition, these children and youth had involvement with multiple systems and had complex needs. Many youth were at risk of out-of-home placement and/or had emotional and behavioral health challenges that necessitated both clinical services (counseling, medication management, psychotherapy, etc.) and services provided by a para-professional (mentoring, peer-to-peer support, etc.). Services included care coordination and access to discretionary funds in support of the child and family's individualized plan of care for expenditures that were reasonable and necessary.

The pilot initially used multiple providers and was later structured using a single Statewide provider that delivered services in all 24 Maryland jurisdictions. The Care Management Entity was funded by federal grants and waivers and State General Funds. Despite initial significant federal participation, the federal grants ended over a period of time and by fiscal year 2016 the program was entirely funded using General Funds.

Youth Served by Care Management Entity

The Care Management Entity program served an average of approximately 300 youth at any one time. The table below shows the average enrollment on the first day of each month during fiscal years 2015 and 2016 prior to suspension of enrollment on October 1, 2015 as the program transferred to the Department of Health and Mental Hygiene.

Date	Average Enrollment
July 1, 2014	230
August 1, 2014	241
September 1, 2014	281
October 1, 2014	286
November 1, 2014	312

Date	Average Enrollment
December 1, 2014	307
January 1, 2015	317
February 1, 2015	334
March 1, 2015	329
April 1, 2015	331
May 1, 2015	329
June 1, 2015	319
July 1, 2015	297
August 1, 2015	296
September 1, 2015	300
Average	**300**

The Care Management Entity and the "1915(c) Psychiatric Residential Treatment Facility Demonstration Waiver"

The 1915(c) Psychiatric Residential Treatment Facility demonstration waiver (Demonstration Waiver) was a demonstration waiver of five years duration. The federal government specifically encouraged development of alternatives to the standard residential treatment center or "Psychiatric Residential Treatment Facility" in order to promote treatment in the community. The federal government approved Maryland's Demonstration Waiver proposal in FY2009; children and youth meeting the referral criteria were subsequently treated in the community through intensive Wraparound services instead of in a physical residential treatment facility.

All children who required a residential treatment center level of care were eligible to be considered for the Demonstration Waiver treatment in the community, up to the number of individuals specified in the waiver, as long as it had been determined that they could be safely treated in the community with an appropriate plan of care which included all of the necessary Wraparound community-based services managed by the Care Management Entity.

The 1915(c) Psychiatric Residential Treatment Facility demonstration waiver reached its statutory end on September 30, 2012 when it was not reauthorized by the federal government and new enrollments ceased. Although new enrollments in the Demonstration Waiver were not permitted, children and youth already enrolled in the Demonstration Waiver on September 30, 2012 could continue to be served by the Care Management Entity for a maximum of two years (through September 2014), if eligible.

Development of Targeted Case Management and the 1915(i) State Plan Amendments

In 2012, the Department of Health and Mental Hygiene, to capitalize on the success of the federally funded Demonstration Waiver, began to develop a plan to offer services to a similar population of children and youth through a 1915(i) Medicaid State Plan amendment that would offer targeted case management and community-based services. The service mix in the 1915(i) State Plan Amendment is similar to the initial Demonstration Waiver, but has been refined and enriched, based on lessons learned from the process of implementing the original project.

The financial eligibility criteria for the 1915(i) State Plan Amendment restricts eligibility to 150% of the Federal Poverty Level while the previous Demonstration Waiver permitted the State to serve virtually any young person in Maryland based solely on the youth's clinical need and a number of slots approved by the State. For those who are under 150% of the Federal Poverty Level, the program is an entitlement and there is no cap on the number of youth that can be served. In addition to the full range of Medicaid somatic and behavioral health benefits available to all Medicaid-eligible individuals, children and youth authorized for the 1915(i) State Plan Amendment have access to a number of additional specialized services if they meet applicable financial and medical necessity criteria.

The development of the 1915(i) State Plan Amendment led the Department to apply for a second state plan amendment that would create a new Mental Health Targeted Case Management service specifically designed to address the needs of children and youth. Previously, youth were provided case management services through a program and network of providers that also served adults. This new program would operate separately from the existing Targeted Case Management program. Participants previously receiving Targeted Case Management services continued to do so under the new program. In addition to creating a program designed specifically for children and youth, an additional level of care for those with the most intensive needs was created in Targeted Case Management that provided clients with additional supports. (This new Targeted Case Management program is described in more detail in Appendix A.) Approval from the Centers for Medicare and Medicaid Services for both state plan amendments was obtained, effective October 1, 2014.

This revamped Targeted Case Management program serves youth in the community through jurisdiction or regional based providers that deliver care coordination across three levels of intensity using the principles of Wraparound service delivery. Targeted Case Management is Medicaid reimbursed intensive services that work with individuals requiring mental health services to identify goals for the plan of care, provide linkage to services, monitor service

provision, and help the client advocate on their own behalf. Between January 1, 2015 and June 30, 2016, 1,206 youth have been served in Targeted Case Management.

Transitioning the Care Management Entity and Integration with Targeted Case Management

Since the Care Management Entity was an interagency pilot program, the Governor's Office for Children on behalf of the Children's Cabinet initially administered the Care Management Entity program to test the efficacy of the model. Given the five years of Statewide implementation of the pilot, the decision was made to transition the program from the Governor's Office for Children to an operational agency. After thoughtful deliberation, the Children's Cabinet decided to integrate the Care Management Entity with the Department of Health and Mental Hygiene's case management programs over the course of fiscal year 2016 to maximize federal and State funds, maintain the current level of service and ultimately expand service options for youth with intensive needs.

Transitioning the Care Management Entity program to the Department of Health and Mental Hygiene involved merging the eligibility requirements and referral processes, along with transferring $2.875 million in General Funds from the Children's Cabinet Interagency Fund to the Department of Health and Mental Hygiene to cover administrative costs and the cost of services for youth enrolled in the Care Management Entity program who continued to receive Care Management Entity services for the remainder of the fiscal year.

An analysis for fiscal years 2015 and 2016 showed that approximately 80% of youth enrolled in the Care Management Entity were also enrolled in Medicaid and would likely be eligible for Targeted Case Management thus reducing the number of Care Management Entity slots needed. Enrolling these youth in Targeted Case Management maximized federal funds and reduced the utilization of Care Management Entity slots funded with State General Funds. This freed-up State-funded slots for youth who did not meet federal funding eligibility.

Prior to integrating the two programs, youth were referred to either the Care Management Entity or Targeted Case Management based on the program with which the referral source was most familiar. By integrating the two programs, all referrals are managed by the Administrative Services Organization, creating a seamless, streamlined referral system that ensures eligible youth are served by the appropriate program. In short, integrating the programs at the Department of Health and Mental Hygiene reduces the need for General Fund slots by maximizing federal funds.

The Care Management Entity was transferred from the Governor's Office for Children to the Department on October 1, 2015; in order to ensure that youth who were enrolled in the Care Management Entity on that date continued to receive services while also winding down Care Management Entity operations. New additional Care Management Entity enrollments were suspended at that time. Those youth who were eligible for Medicaid were given the option to transition to the Targeted Case Management program as appropriate. The Care Management Entity ceased operations on June 30, 2016.

An Integrated Model – Targeted Case Management Plus

On August 1, 2016, the Department of Health and Mental Hygiene launched a new program called Targeted Case Management Plus (TCM Plus). This new program provides peer-to-peer/family support and customized goods and services (similar in nature to the discretionary funds that were available to youth served by the Care Management Entity) for up to 250 youth. Additionally, these same services, as well as care coordination, are available to 50 youth who do not have Medicaid (e.g., youth with private insurance).

TCM Plus is offered through the existing Targeted Case Management provider structure. Eligibility for TCM Plus is consistent with the eligibility criteria for the SAFETY Initiative (see appendix D) population that was previously served by the Care Management Entity and is available on an on-going basis, Statewide, to 300 youth. This is in line with historic utilization of the Care Management Entity.

Utilization of TCM Plus

As of November 10, 2016, 50 youth not covered by Medicaid and 98 youth receiving Medicaid have been enrolled in TCM Plus. The Department estimates that a total of 300 youth will be enrolled by the end of fiscal year 2017. As of November 10, 2016, 20 jurisdictions have referred youth to the TCM Plus program.

The table below shows TCM Plus Enrollment by Jurisdiction as of November 10, 2016:

Jurisdiction	# of youth enrolled
Alleghany	0
Anne Arundel	4
Baltimore City	22
Baltimore County	16
Calvert	14

Jurisdiction	# of youth enrolled
Caroline	3
Carroll	0
Cecil	7
Charles	9
Dorchester	5
Frederick	2
Garrett	0
Harford	0
Howard	3
Kent	3
Montgomery	0
Prince George's	4
Queen Anne's	3
St Mary's	2
Somerset	7
Talbot	3
Washington	5
Wicomico	35
Worcester	2
Total Current Enrollment	**148**

The integrated Care Management Entity and Targeted Case Management programs allows for a multi-level continuum of care coordination using the principles of Wraparound for Medicaid and non-Medicaid eligible families. This multi-level continuum of care provides care coordination to children and youth to support a transition back to a home environment, remain in their home or current living arrangement, move to a lower intensity of services or restrictiveness of placement, or otherwise maintain and improve functioning and well-being. The integration also maximizes federal Medicaid match for services as the Department of Health and Mental Hygiene is able to draw-down federal dollars for youth enrolled in Targeted Case Management.

Appendix A – Integrated Care Coordination Model

An Integrated Care Coordination Model		
	Non-Medicaid Eligible Children **TCM Plus**	**Medicaid Eligible Children** **TCM, TCM Plus, and 1915(i)**
Services Provided	• Development of a Plan of Care • Face-to-face and phone contact with family and youth • Crisis Plan Development • Ongoing Child and Family Team meetings • Child and Family Team meetings in the event of a crisis • Identifying formal and informal supports • Access to peer or family support specialist • Customized Goods and Services	• Development of a Plan of Care • Face-to-face and phone contact with family and youth • Crisis Plan Development • Ongoing Child and Family Team meetings • Child and Family Team meetings in the event of a crisis • Identifying formal and informal supports *Additional Supports for those enrolled in TCM Plus:* • *Access to peer or family support specialist* • *Customized Goods and Services*
Eligibility Criteria	• Discharge from a Residential Treatment Program or; • Combination of two of the following risk factors: ○ Run away from home ○ Uses substances illegally ○ Significant behavioral problems at school ○ Involvement with the Department of Juvenile Services ○ Failure to complete the terms of a Teen Court Program ○ Victim of child maltreatment	Medicaid-eligible Medical Necessity Criteria • Serious Emotional Disability or Co-occurring Disorder and • Additional criteria such as a history of multiple psychiatric hospitalizations or discharge from a Residential Treatment Program and • A high score on the Child and Adolescent Service Intensity Index (CASII), a service intensity determination tool developed by the American Academy Of Child and Adolescent Psychiatry *Additional TCM Plus Eligibility:* • *Discharge from a Residential Treatment Program or;* • *Combination of two of the following risk factors:* ○ *Run away from home* ○ *Uses substances illegally*

		○ *Significant behavioral problems at school* ○ *Involvement with the Department of Juvenile Services* ○ *Failure to complete the terms of a Teen Court Program* ○ *Victim of child maltreatment*
1915(i) Service Array	General Funds support the use of peer and/or family support as well as customized goods and services which are also present in the 1915(i) service array.	1915(i) Service Array available to family income below 150% of federal poverty level and highest level of TCM intensity. The service array, when fully operational in all jurisdictions, includes Intensive In-Home Services, Respite Care, Mobile Crisis Response and Stabilization, Family/ Peer Support, and customized goods and services.
Funding	State General Funds Only	Federal Reimbursement of 50% for care coordination costs. *State General Funds for TCM Plus services.*
Capacity	Budgeted for 50 slots. Slots are filled on a revolving basis. Youth is eligible for 6 months of service with re-authorizations every 6 months. When slots are full a waitlist is used.	All eligible children are entitled to the TCM service so long as they meet eligibility. *TCM Plus is budgeted for 250 slots. Slots are filled on a revolving basis. Youth is eligible for 6 months of service with re-authorizations every 6 months. When slots are full a waitlist is used.*

Appendix B – Array of Care Coordination Services Available Through Targeted Case Management, TCM Plus, and 1915i – FY17

Level:	I	II	III	1915(i)+Level III	TCM Plus
Care Coordination Organization (CCO) Support Available:	Care Coordination	Care Coordination	Care Coordination using principles of wraparound	Care Coordination using principles of Wraparound	Care Coordination will be informed by wraparound principles and will follow model according to level of need as determined by CCO. Services available to families include: Care Coordination, Family Peer Support & Customized Goods & Services
Care Coordinator # of Hours per Month:	3 hours max	7.5 hours max	15 hours max	15 hours max	**Medicaid:** Youth shall be provided care coordination at the level authorized by Beacon Health Options (Levels I, II, III) **Non-Medicaid**: Youth shall be provided care coordination at a level of intensity that meets their needs.
Minimum Child Family Team (CFT) Frequency:	Every 6 months	Every 3 months	Every 30-45 days	Every 30-45 days	**Medicaid:** CFTs frequency determined by level authorized by Beacon Health Options (Levels I, II, III) **Non-Medicaid**: CFT frequency will be determined by the intensity of the family's needs.
Family Service Available:	Behavioral Health Administration (BHA) funded Family Peer Support on a more limited basis			Medicaid Billable Family Peer Support Authorized by Beacon for 1st 60 days and then by the Maryland Coalition of Families every 6 months.	BHA-funded Family Peer Support

Level:	I	II	III	1915(i)+Level III	TCM Plus
				• 1st 60 days – 88 F2F units, 132 Telephone units • Max for 6 month reauthorization = 264 F2F, 384 telephone	
Additional Services Available:				• Intensive In-Home Services • Mobile Crisis Response • Community Based Respite Care • Expressive and Experimental Behavioral Services • Customized Goods and Services **Available on a jurisdiction-by-jurisdiction basis dependent on provider enrollment.*	BHA-funded Customized Goods and Services
Medicaid Status	Medicaid participant or Medicaid-eligible			Medicaid participant or Medicaid-eligible	250 Medicaid Slots 50 Private Insurance/Uninsured Slots
Additional Eligibility Criteria:	Medical Necessity Criteria (COMAR 10.09.90)	Medical Necessity Criteria (COMAR 10.09.90)	Medical Necessity Criteria (COMAR 10.09.90) Also requires history of hospitalizations or recent RTC stay – contact CCO for more detail	• Youth must meet medical necessity criteria • Requires history of inpatient psychiatric hospitalizations or recent RTC stay • Youth must reside in a home and community-based setting (group homes or other congregate care settings not allowed) • Family must meet financial eligibility (150% of federal poverty level)	See full criteria for TCM Plus to determine eligibility. Must meet 1 of 3 criteria at time of referral: 1. Youth being discharged from RTC with plan for community based services 2. Youth enrolled in Home and Hospital Program 3. Combination of risk factors below (minimum of 2): a. Run away from home b. Uses substances illegally c. Significant behavioral problems at school (see full

Level:	I	II	III	1915(i)+Level III	TCM Plus
					description for additional details) d. Arrested or previous involvement with DJS. e. Failed to complete terms of teen court f. Victim of maltreatment

Care Coordination Organization (CCO) Key Activities:	• Face-to-face and phone contact with family and youth • Crisis plan development • Ongoing CFT meetings • Crisis CFT meetings • Plan of Care development • Developing a network of formal and informal supports and services to meet family needs
Family Peer Support Specialist (FPSS) Key Activities	• A formal member of the Child & Family Team • Support the family and help them to engage and actively participate on the team and make informed decisions • Provide emotional support to the family • Identify people the family wants on the Child and Family Team • Help the family decide what the family wants and needs • Support the family in efforts to get needs met • Work with the family to organize and prepare for meetings so that their voice is heard clearly • Go with the family to meetings, such as at school or court • Connect the family with information and resources • Act as a mediator, facilitator, or bridge between families and agencies when necessary • Offer support groups, educational programs and other family activities. • Work in partnership with the Care Coordinator to ensure the family's needs are met • For families enrolled in Targeted Case Management, educate the team about TCM Plus • For families enrolled in TCM Plus, educate the team about the use of Customized Goods and Services

Appendix C – TCM Plus Eligibility Criteria

Targeted Case Management Plus
Eligibility and Referral Protocol
Effective August 1, 2016

The goal of the program is to provide services to children/youth who have a combination of risk factors and who would benefit from care coordination and additional supports. Referrals will be open on a first-come, first-served basis at the discretion of the Behavioral Health Administration (BHA).

Services will be open to:

- 250 youth with Medical Assistance who are enrolled in Targeted Case Management; and
- 50 youth **without** Medical Assistance which may include youth with private insurance.

Eligibility Criteria for Referrals for TCM Plus

Referrals must meet one of the three following criteria at the time of referral:

A. Child/youth is being discharged from a Residential Treatment Center (RTC) placement with a discharge plan that recommends community-based services.

Or;

B. Child/youth is enrolled in a Home and Hospital Program.

Or;

C. Child/youth is experiencing a combination of the risk factors listed below and would benefit from cross-discipline and multiple agency resources. To be eligible, the child/youth must present with at least two (2) risk factors from those listed below. The risk factors listed under #3 (3a, 3b, 3c, 3d, 3e) are considered separate risk factors that can be counted separately.

1. Child/youth has run away from home.

2. Child/youth uses substances illegally.

3. Child/youth has significant behavioral problems at school which could include the following:
    a. School suspension(s)/expulsion(s);

b. Chronic absenteeism, as defined below:

    i. Chronic absenteeism is defined as a student who is absent more than 20% of school days in the last 12 months.

c. Academic failure (as defined below); or

    i. Academic failure is defined as either receiving lower than a grade of D as a final grade for any class in any marking period or receiving an indication that the student is in danger of receiving a grade lower than a D as a final grade for any class.

d. Displays school avoidance behaviors (a pattern of avoiding or refusing to attend school), including, but not limited to complaints of illness that have no medical basis, school phobia or fear, separation/performance/social and other anxieties, absences or tardiness on significant days (tests, assemblies, speeches), excessive worrying, excessive requests to call/go home/visit the nurse's office, crying to go home, etc.

e. Significant involvement with school support teams.

4. Child/youth has been arrested or has had previous or continuing involvement with the Department of Juvenile Services (DJS).

    a. Involvement with DJS includes the following:

        i. Child/youth who has been through adjudication and may be in pending-placement status in a detention facility or in the community;

        ii. Child/youth who is in out-of-home placement in a group home, therapeutic group home, treatment foster care, or Transition Age Youth program;

        iii. Child/youth committed to DJS; or

        iv. Child/youth who has had a pre-adjudication hearing with DJS.

5. Child/youth has failed to successfully complete the terms or conditions of a Teen Court program.

6. Child/youth has been a victim of maltreatment which may include the following:
    a) Abuse;

    b) Neglect; or

c) A witness to domestic violence.

Referral and Enrollment Protocol

Youth with Medical Assistance

1. Youth are referred using the standard TCM referral form to the Administrative Services Organization (ASO) for Targeted Case Management authorization.

2. The ASO determines the appropriate level of TCM and authorizes an enrollment with a Care Coordination Organization (CCO).

3. The CCO and/or Core Service Agency (CSA) assess the child/youth for additional need and determine eligibility for TCM Plus.

4. The CCO and/or CSA refer the child/youth using the TCM Plus Referral Form to BHA for authorization.

5. After reviewing eligibility, BHA authorizes TCM Plus and notifies the CCO, CSA, and the Maryland Coalition of Families.

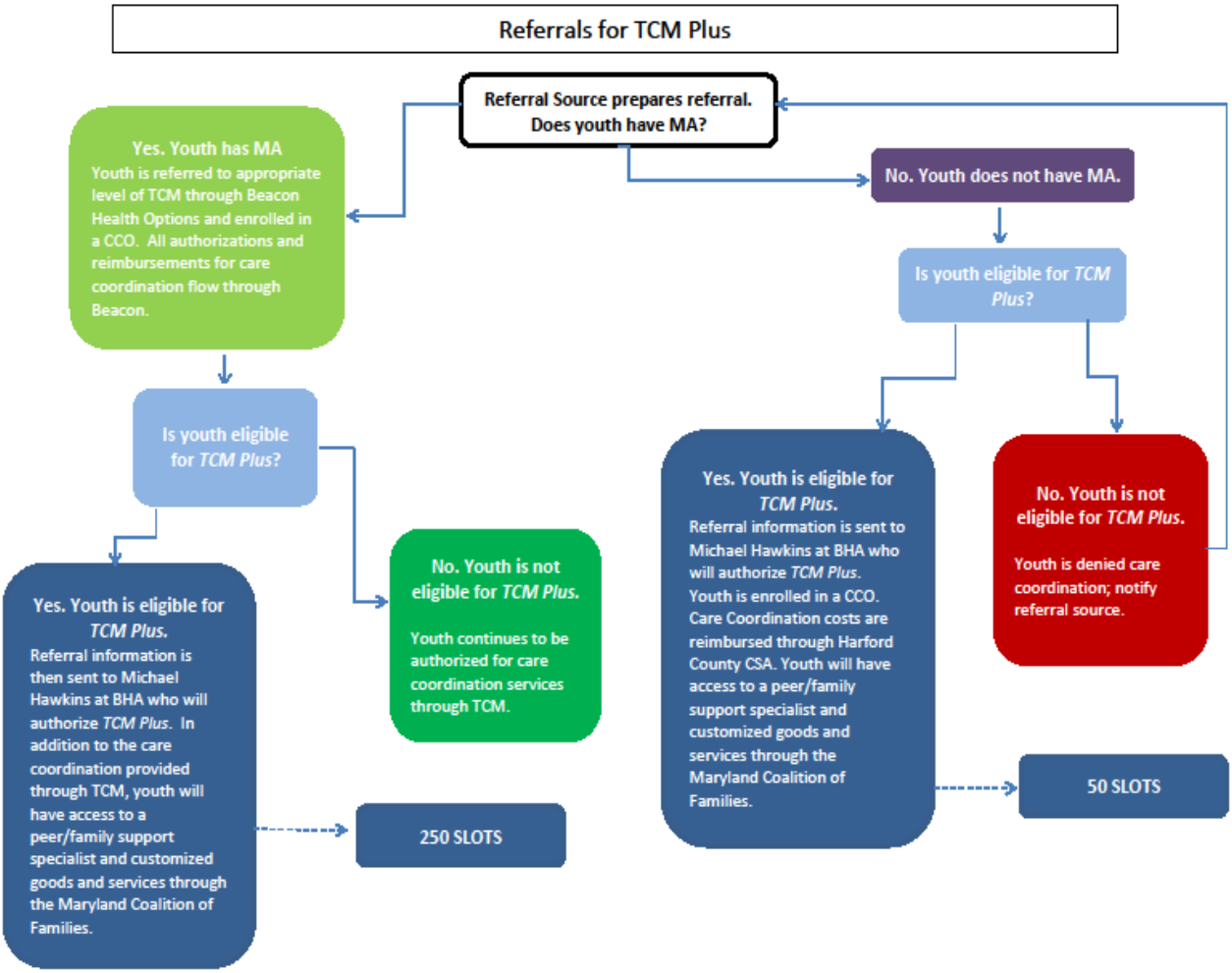
Youth without Medical Assistance

1. Youth are referred using the TCM Plus referral form to BHA for TCM Plus authorization.

2. After reviewing eligibility, BHA authorizes TCM Plus and notifies the appropriate CCO, CSA, and Maryland Coalition of Families.

3. Once a child/youth has been authorized, care coordination services will be provided by the CCO.

Appendix D – TCM Plus Flow Chart



Appendix E – Populations Served by the Care Management Entity

Department of Human Resources Out-of-Home Placement Diversion

Ensured that children in the child welfare system were served in the most appropriate, least restrictive setting, the CME served youth who were being:

- Diverted from a Voluntary Placement Agreement (VPA) to prevent out-of-home placement;
- Diverted from a group home;
- Diverted from out-of-home placement; or
- Reunified with family.

This population was integrated into the Stability Initiative on May 5, 2014.

Department of Juvenile Services Out-of-Home Placement Diversion

Served youth ages 12-19 who were:

- Re-entering the community after an out-of-home placement (in-State and out-of-State); or
- Identified by a Department of Juvenile Services appointed gatekeeper to be at-risk for an out-of-home community residential placement (group home). This population included youth who had been through adjudication and might have been in pending-placement status in a detention facility or in the community.

This population was integrated into the Stability Initiative on May 5, 2014.

Center for Medicare & Medicaid Services 1915(c) Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver Project (Demonstration Waiver)

The Demonstration Waiver provided home and community-based services for children and youth ages 6-21 who would require placement in a Residential Treatment Center (RTC) absent the existence of the Demonstration Waiver.

The Demonstration Waiver ended on September 30, 2012 when the United States Congress did not reauthorize the program.

Maryland Crisis and At Risk for Escalation diversion Services for Children (MD CARES)

A grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Children's Mental Health Initiative Cooperative Agreement, focused on the care management and treatment of children and youth in the Baltimore City foster care system, at the point of initial diagnosis of serious emotional disturbance, in order to prevent out-of-home placement or disruption in current placement when the disability was expected to last in excess of one year.

MD CARES ended on September 30, 2014.

Rural CARES

A grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Children's Mental Health Initiative Cooperative Agreement, focused on the care management and treatment of children and youth located in the nine counties of the Eastern Shore in the foster care system, at the point of initial diagnosis of serious emotional disturbance, in order to prevent out-of-home placement or disruption in current placement when the disability was expected to last in excess of one year.

Rural CARES ended on September 30, 2015

Stability Initiative

The service focus for this population was the care management and treatment of children and youth in the Maryland foster care system and/or Maryland juvenile justice system, at the point of initial diagnosis of serious emotional disability, in order to prevent out-of-home placement or disruption in current placement when the diagnosis of disability was expected to last in excess of one year.

SAFETY Initiative: Schools and Families Empowering Their Youth

The population served was children/youth who had a combination of risk factors and who would benefit from cross-discipline and multiple agency resources.