I. Introduction

Evidence2Success provides elected officials and public systems with a new way to engage communities and families in making decisions to invest in evidence-based programs that promote healthy child development. This framework focuses on improving child well-being by changing the underlying risk and protective factors in a community – those things that hinder children's potential to grow up to be healthy, productive adults. By creating strong partnerships between public systems, schools and communities and using data to make decisions, leaders can shift investments to programs that are proven to improve outcomes.

The Evidence2Success framework is founded upon the realization that many children and families live in struggling communities without access to good schools, healthy food, affordable housing and good jobs. When crises strike, families should be able to count on programs and services that have a proven record of helping people get back on track.

Currently, public systems tend to invest in programs and practices for which we have too little evidence. In many cases, leaders simply don't know if a program is yielding positive results for children and youth, and most states and localities direct little funding toward programs that are proven to work. For example, a recent study found that less than 5 percent of high-risk juvenile offenders receive an evidence-based treatment.[1]

Compounding these challenges is the fact that public funding tends to support treatment once problems occur, but does little support to prevent problems from occurring in the first place. Evidence2Success seeks to fundamentally alter how public agencies and schools make decisions about investments by:

- putting in place a well-being survey to measure the developmental outcomes, risk and protective factors that influence the well-being of children and youth living in the community and being served by public systems
- creating partnership among public systems, schools and communities to consider survey results and agree on priority outcomes and programs;
- shifting investment toward practices and programs that have strong evidence of producing positive results; and,
- shifting investments from deep-end treatment and remediation to earlier intervention and prevention.

[1] Henggeler, Scott W. and Sonja K. Schoenwald. 2011. "Evidence-based interventions for juvenile offenders and juvenile justice policies that support them." SRCD Social Policy Report 25(1): 3-20.

Developing a strategic financing plan is critical to the effective implementation of Evidence2Success. This brief provides leaders with an overview of strategic financing, outlines the steps involved in creating a strategic financing plan, and presents descriptions and examples of a range financing strategies and structures that public system, school and community leaders can consider to support implementation of Evidence2Success.

The examples are not intended to provide an exhaustive list of these strategies in practice, but an illustrative cross-section of successful innovations. Whenever possible, examples demonstrate the financing strategy or structure supporting evidence-based programs. Some strategies and structures may not have been used in conjunction with evidence-based programs. In those cases, examples illustrate how the financing approach works, and the authors recognize the approach may require some adaptation to support an evidence-based program.

II. A Strategic Approach to Financing

Successful implementation of the Evidence2Success model is dependent on public agency and community leaders adopting a strategic approach to financing. A strategic approach for financing evidence-based programs includes the following principles.

- A commitment to a collaborative decision-making process that includes public agency, school, and community leaders.
- A focus on results: desired results determine program priorities and drive financing decisions. Financing should not drive program priorities.
- A shared commitment by public agency, school, and community leaders to incrementally shift investments from deep-end treatment to early intervention and prevention. Such shifts to invest in prevention before problems require treatment or in early intervention before problems become intractable can result in significant financial savings.
- Thoughtful combinations of diverse funding streams and financing strategies to ensure stable support over time. Given the fragmented and categorical nature of public funding for children and families, public agency, school, and community leaders will need to creatively develop a diverse and coordinated portfolio of financing strategies to support evidence-based programs over time.
- Transparent decision making and reporting to demonstrate how public funds are spent and what results they yield. Evidence2Success requires a strong partnership among public agencies, schools, and communities. An essential component of that partnership is clear and transparent decision-making processes.
- Shared accountability among public agencies, schools, and communities for better outcomes. Just as public agencies, schools, and communities share responsibility for decision making, they also share accountability for implementation.

Importantly, a strategic approach to financing enables public agency, school, and community leaders to better target scarce resources and shift how they invest public funding from a narrow focus on buying or providing units of service to a focus on purchasing or providing quality and well-targeted supports that improve child well-being outcomes.

III. Developing a Strategic Financing Plan

The process of developing a strategic financing plan involves five key steps. Given that Evidence2Success is a unique partnership among public agencies, schools, and communities, the process of developing a strategic financing plan includes steps that occur at both the public agency and community levels. Following are critical questions to consider during each step of a strategic financing planning process:

1. What are your financing goals?

- What are the priority outcomes and protective and/or risk factors you want to address?
- What is/are your population(s) of focus?
- What programs and/or processes do you want to implement? At what level of intensity and scale?
- What capacities and/or infrastructure do you need to implement those programs and processes?

2. What financial resources do you need to implement your goals?

- What is the cost of programs and activities you want to implement?
- What is the cost of supportive infrastructure?
- What is the cost to move from current practice to desired practice?

3. What resources do you have?

- How does funding already in the system align with financing goals?
- How are you investing current resources?
- In proven approaches?
- With accountability in contracts?
- With greatest possible return on investment?
- Are you maximizing federal entitlements?
- Where are the opportunities to redirect expenditures from poor outcomes and/or high costs?
- What additional funding might you need?
- What financing strategies will you design and implement in support of your goals?
- Improving the use of existing public funds
- Allocating state or local general funds
- Maximizing federal funds
- Public-private partnerships
- Debt financing
- Social impact bonds
- Generating new revenue

4. What financing structures will you design and implement in support of your goals?

- Changes to budget structures
- Pooled or braided funding
- Single payer system
- Risk-based financing
- Performance-based incentives
- Reinvestment compacts

IV. Financing Strategies to Support Evidence-Based Practices

Public agency, school, and community leaders can consider a range of financing strategies to support implementation of Evidence2Success. Financing strategies are the means or approaches by which leaders generate or secure dollars to support their work. Financing structures are the mechanisms that leaders use to prioritize, coordinate, and expend dollars on supports and services for families and communities and are discussed in the following section. Some financing strategies require a particular structure in order to implement them effectively.

Success will not be achieved through utilization of one single strategy or by accessing one single funding source. Long-term success is dependent upon strategically combining a diverse set of financing strategies, which will likely need to be coordinated and implemented across public agencies, to support programs and practices aimed at improved results for children. Which financing strategies are most appropriate in a given locale at a specific point in time will depend on the particular outcomes, populations, and programs that are the focus along with the scale of implementation and the unique federal, state, and local funding landscape.

Florida Redirection Program

Florida saved an estimated $51.2 million over five years after the state legislature authorized a community-based, family-centered alternative to residential juvenile justice commitment programs. *Find out how on page 21.*

The vast majority of the financing strategies and structures described below are necessarily implemented at the public systems level and many require legislative, regulatory, and/or practice change. That is not to say communities do not play an integral role in the selection and design of financing strategies – indeed the Evidence2Success initiative is founded on a strong community-systems partnership – but that system leaders are vital to successful implementation of these approaches.

Additionally, implementation of Evidence2Success starts at a community-level, with the expectation that evidence-based practices and the financing strategies that support them will be scaled up system-wide. Financing strategies that support the initial “early adopter” communities may look somewhat different than the more ambitious, systemic and long-term financing strategies required to take the initiative to scale.

1. Improving the Use of Existing Public Funds

Within challenging fiscal environments, public agency and community leaders will first want to make sure they are making the most strategic use of public funds already in the system. Current investments in children are significant. In fiscal year 2010, federal spending on children totaled over $266 billion.[2] States and localities invest significant additional funds. A recent analysis calculated that the 50 states spend over $467 billion annually on supports and services for children and families.[3]

A critical first step in implementing Evidence2Success is to fully understand how current investments are being made and what results they are achieving.[4] If current investments are not aligned with priority goals and/or are not producing good results, opportunities exist to make better use of current funding. Leaders can consider several distinct approaches to shift how current investments are made.

- **Redirection:** redirection involves shifting funding from *lower priority* services to *higher priority* services. In the context of Evidence2Success, leaders might shift investments from programs with lower levels of evidence to those with higher levels of evidence.
- **Reinvestment:** reinvestment involves shifting funding from *higher cost* services to *lower cost services* and then *reinvesting the savings*. Savings can then be used to expand the number of children served as well as to expand the range of available services, including more preventative programs. In the context of Evidence2Success, this approach may involve shifting from more expensive placement settings to less expensive options – such as moving children from congregate care placements within the child welfare system to more community-based care settings – or shifting from more expensive treatment approaches to less costly front-end prevention services. As the Maryland Opportunity Compact example on page 40 highlights, reinvestment strategies require significant technical capacity to capture savings and accountability structures to ensure those savings are reinvested according to agreed-upon terms.

RECLAIM Ohio

In 1992, Ohio housed over 2,500 young people in juvenile facilities designed to serve 1,400 youth. At the time, counties did not pay any of the costs when county judges committed youth to secure facilities. RECLAIM Ohio created incentives for juvenile courts to reduce the number of youth in secure facilities and expand community-based services. A recent evaluation found that each dollar invested in RECLAIM Ohio saves between $11 and $45 dollars in program and recidivism costs. *Read more on page 22.*

[2] Chris Kelly, *Children's Budget 2010,* First Focus, Washington DC: July 2010.
[3] Patricia Billen, Donald Boyd, Lucy Dadayan, and Thomas Gais, *State Funding for Children: Spending in 2004 and How it Changed from Earlier Years,* The Nelson A. Rockefeller Institute of Government, Albany, NY, October 2007.
[4] To support analysis of current investments, Evidence2Success is developing a series of fund mapping tools at both the systems and community level.

Strategies to improve the use of public funding necessarily involve shifting funds from lower priority, less-evidence-based, and/or higher cost programs to higher priority, more evidence-based, and/or lower cost programs. De-funding current programs can be difficult politically, especially if current service providers have strong relationships with those who make allocation decisions. Good data that demonstrates the need for shifting investments and broad-based partnerships can help reduce transition difficulties. Leaders may also consider providing training and support to assist current providers in transitioning to new, proven programs.

2. Allocating State or Local General Funds

Another category of financing strategy is allocating state or local general funds through regular state or local budget processes to support evidence-based practices and programs. States spend over $467 billion states spend on children with an estimated 90 percent of that funding invested in elementary and secondary education.[5]

States and localities have significant discretion in how they set funding priorities, with budget decisions typically made at the legislative level with input from public agencies. Efforts to establish evidence-based programs as a budget priority can result in direct allocations for proven programs. Alternatively, leaders may also consider "earmarking" a percentage of state or local budget streams for evidence-based programs. Leaders can also incentivize the utilization of evidence-based practices by awarding additional points in grant applications or weighting funding formulas to encourage use of proven approaches. The success of this type of strategy depends on how effective leaders are in cultivating supporters for evidence-based programs and establishing funding priorities to support them.

Creating Incentives for Evidence-Based Programs in the Juvenile Justice System

A 2009 law passed by the Washington state legislature required that all state dollars for local juvenile courts be administered by the Juvenile Rehabilitation Administration as a block grant and that funding priorities be given to evidence-based programs and alternatives that divert young people from institutions. In 2010, approximately 30 percent of youth who were eligible participated in a state-funded evidence-based program. *Read more on page 24.*

5 Billen et al op cit.

3. Maximizing Federal Funds

Federal funding represents a sizable portion of total resources available to support children. Different federal funding programs vary in how they are structured and how funding flows to states and localities. Given the diversity in the types of federal funding available for children's services, multiple approaches warrant consideration.

- **Maximizing Entitlements:** Entitlement programs provide support for specified services for everyone who meets eligibility requirements. Important entitlement programs include Medicaid and Title IV-E, which funds child welfare services. System leaders can maximize entitlement funding by:
    - Ensuring all eligible recipients are enrolled for services;
    - Expediting enrollment processes to reduce the time during which recipients are covered with state-only funds;
    - Effectively capturing and billing entitlement funding for all covered services;
    - Expanding the categories of services covered in the state Medicaid plan allowable under federal regulations; and,
    - Identifying all state and local spending that qualifies for federal reimbursement.
- **Directing Formula and Block Funds**: These funds are allocated to states and/or localities based on set formulas, typically created using population characteristics, such as average household income or population size. State and/or local leaders have flexibility in allocating the funding within broad federal guidelines, and are generally required to develop a plan for how they intend to spend block grant funds. Block grants typically require some level of state or local matching funds. These funding sources provide important opportunities to invest in evidence-based programs.
- **Applying for Discretionary Grants: The** federal government also administers competitive discretionary grants. Funding flows from federal agencies to eligible applicants, such as state or county agencies, local education agencies, community-based and faith-based

Maximizing Medicaid Matching Funds

Following settlement of a class action lawsuit, state officials in Arizona worked with child welfare officials to determine how to finance behavioral health services for youth using Medicaid rather than state funding. *Read more about how Maricopa County, Arizona, developed processes to maximize Medicaid enrollment so that more youth would have access to care on page 27.*

Success for All Investing in Innovation Grant

The Success for All Foundation was awarded a $50 million Investing in Innovation grant from the U.S. Department of Education to double the number of schools implementing its evidence-based whole school reform approach for high-poverty elementary and middle schools. *Learn more about Success for All on page 26.*

organizations, as well as community partnerships and collaboratives. Discretionary grants typically run three to five years. These grants tend to be highly competitive but provide direct and sizable funding. Many of these discretionary grants are highly aligned with prevention goals. Several new grants, such as funding for evidence-based home visiting programs and the Substance Abuse and Mental Health Services Administration's Implementing Evidence-Based Prevention Practices in Schools, place an emphasis on evidence-based programs. The Affordable Care and Patient Protection Act (i.e., health reform) also includes over 100 discretionary grant programs, including Community Transformation grants that are focused on primary prevention and health and mental health promotion.

Important Formula and Block Grants for Evidence2Success

- **Title I –** Financial assistance to school districts and schools serving low-income students who are at risk of failing, or are failing, to meet state academic standards. Additionally, schools that enroll at least 40 percent of students from poor families may operate a “school-wide” Title I program to serve all children in the school.
- **IDEA: Parts B & C –** Funding for state and local education agencies to provide early intervention and special education services for children aged 0 – 2 (Part C) and for children aged 3 – 21 (Part B).
- **Child Abuse Prevention and Treatment Act -** Funding for community-based grants for the prevention of child abuse and neglect. These grants support efforts to develop, operate, expand, or enhance community initiatives aimed at preventing child abuse and neglect and provide a range of services designed to strengthen families.
- **Title IV B: Subparts 1 & 2 –** Funding for two formula grant programs aimed at preventing child abuse, supporting at-risk families in caring for their children safely at home, and promoting permanent families for young people involved with the child welfare system.
- **Substance Abuse Prevention and Treatment Block Grants –** Funding for alcohol and drug abuse treatment and prevention services.
- **Community Mental Health Block Grant –** Funding to develop effective mental health systems and for comprehensive community mental health services for adults who have a serious mental illness and children who have a serious emotional disturbance.
- **Temporary Assistance to Needy Families (TANF) –** Funds direct cash payments and work supports, such as job training and child care assistance, for struggling families.
- **Social Services Block Grant –** Highly flexible funds for states to provide social services, which typically includes child care, protective services for children and adults, and home care services for the elderly and handicapped.
- **Child Care and Development Fund -** Funding to states for assistance for low-income families for child care expenses for children 0 to 12.
- **Maternal and Child Health Block Grant –** Funding to improve the health, safety, and well-being of all mothers and children.
- **Juvenile Justice Programs (Juvenile Justice and Delinquency Prevention Act) –** Funding for a variety of improvements to delinquency prevention and juvenile justice programs in states, including the development and implementation of prevention and intervention programs to protect public safety and provide treatment and rehabilitative services tailored to the needs of juveniles and their families.

4. Public-Private Partnerships

Public-private partnerships are collaborations between public agencies, private investors, businesses, and private organizations in support of specific goals. These collaborations generally seek to extend the reach of individual partners by leveraging financial resources and contributing leadership for state and local priorities. In some case, private funding is used to leverage public investments. In others, public funding provides the catalyst for increased private contributions.

Successful public-private partnerships establish clear goals for collaborative action and tend to be supported by skilled facilitators and conveners who help to ensure that all partners contribute and benefit. Effective partnerships also create strong accountability mechanisms that transcend traditional silos of public and private responsibility.

Private contributions can fill investment gaps where no public funds are easily identified. These investment gaps include support for the development of new program models, start-up and transition costs for implementing new programs, technical assistance and training support, data collection and evaluation, and public will building and public education campaigns.

Highmark Healthy High 5

A multimillion dollar investment from the Highmark Foundation and the Pennsylvania Departments of Health and Education established a web-based portal that enabled school nurses to electronically track and communicate students' health information and provided educators access to a research-based curriculum for nutrition and physical activity planning. *Learn about the program's evolution on page 29.*

Home Funders

Private funders and investors in Massachusetts established a limited liability corporation and created a lending pool to fund low-cost loans to affordable housing developers. By the end of 2010, Home Funders had financed a total of 2,121 units of affordable housing and leveraged over $200 million in public and private resources. *Read more on page 30.*

5. Debt Financing

Debt financing is another category of strategies that can be used to support implementation of Evidence2Success. Typically, these strategies entail accessing low- or no-cost loans to support evidence-based practices or administrative infrastructure. These loans require repayment; however, most are structured with favorable term lengths and below-market interest rates.

Debt financing is not appropriate for all aspects of the Evidence2Success initiative. This strategy is best aligned with financing large one-time capital costs – such as constructing a new facility – that make sense to amortize over time. Debt financing also can provide operating capital for a program that has a reliable revenue source – such as providing initial capital to start-up a child care program that will be funded

by reimbursable federal contracts. In the context of Evidence2Success, debt financing also can support the transition costs of shifting from a higher-cost to lower-cost program, such as staff retraining, with cost savings used to pay back the initial loan over time. Approaches include:

- **Municipal Bonds –** These bonds are issued by states, local governments, school districts, power districts, and many other forms of government to raise money for public projects. Municipal bonds have been used to build schools, bridges, hospitals, power plants, and many forms of public infrastructure. Municipal bonds are an attractive investment as the interest received is exempt from federal income taxes and, in some cases, from state income taxes.
- **Program Related Investments –** A Program-Related Investment (PRI) is a financial vehicle used by private foundations to accomplish their philanthropic goals. Unlike grants, a PRI is expected to be repaid over time, and in some cases, generate a modest rate of return. Once repaid, the foundation can then use those funds for other philanthropic purposes.

PRIs enable foundations to extend the reach of their philanthropic giving by attracting other public and private resources, as well as provide another investment option during challenging fiscal environments when lower returns reduce available grant funds. A foundation may set aside a portion of its endowment to fund PRIs or may include them as part of its regular program portfolio.

PRIs are typically used to fund capital projects, provide bridge loans, acquire property, develop new products or expand services, and provide working capital. PRIs can be structured as loans, loan guarantees, linked deposits, and real estate mortgages. To qualify as a PRI, the interest rate must be below market on a risk-adjusted basis. Most PRIs are made with an expectation of a rate of return between zero and three percent.

PRIs require a source of revenue for repayment. Like other debt financing strategies, the transition costs of shifting to evidence-based practices and/or from higher cost to lower cost programs are important candidates for potential use of a PRI.

6. Social Impact Bonds

A Social Impact Bond is a new financing model currently undergoing pilot testing. A Social Impact Bond forms a contract between a private investor and a public agency in which the investor agrees to pay for improved social outcomes. Private investors pay upfront for a variety of interventions that are well calculated to improve results. If outcomes improve, private investors receive payments from the public agency plus a return. The amount of that return is dependent on the degree to which outcomes improve. If outcomes do not improve, private investors risk losing their investment.

Social Impact Bonds can attract new private investments for prevention and early intervention services and can incentivize service delivery focused on outcomes rather than

outputs. Social Impact Bonds are unlike traditional bonds in that 100 percent of the investor's capital is at risk. Social Impact Bonds hold the promise of improved performance at lower costs, as well as potentially accelerating the rate at which improvements within systems take place.

To succeed, the intervention supported by the bond must have sufficiently high net benefits to allow investors an opportunity to earn a return as well as have clear and measurable outcomes. These bonds are currently being piloted in the United Kingdom, and have generated significant interest in the United States at both the federal and state levels and in other countries. Early investors tend to be private foundations, particularly those with a strong focus on evidence-based and prevention programs, and social investors with a particular interest in the outcomes the bond seeks to support.

Peterborough Prison Social Impact Bond

Social Finance, a British nonprofit organization, generated 5 million pounds from 17 outside investors through the purchase of a social impact bond that supported rehabilitation services for prisoners serving sentences of less than 12 months. Recidivism must fall at least 7.5 percent by 2014 for investors to recoup their investment. *Learn about social impact bonds on page 31.*

Florida's Children's Services Councils

Florida's Juvenile Welfare Services empower counties to create special districts with the authority to levy taxes for children's services. CSCs collectively invest $400 million a year in hundreds of local programs and have demonstrated a commitment to funding evidence-based programs. *Read about CSCs on page 22.*

7. Generating New Revenue

Mechanisms to generate new revenue and to set aside funding for specific populations or sets of services take a variety of forms, and include the following.

- **Special taxing districts.** These independent units of government typically generate revenue through a property tax levy requiring authorization by the state legislature and, in some cases, local voters. School districts, water districts, and wildlife conservation districts are common types of special taxing districts.
- **Special tax levies.** Special tax levies increase the tax rate of an existing tax, and generally have been based on property, sales, and business taxes. New revenues generated through the levy are earmarked for specified programs or specific populations. For example, the Washington State Legislature created an option for counties to raise the local sales tax by 0.1 percent to augment state funding for mental health and chemical dependency services and therapeutic courts. More than a dozen counties in Washington have implemented the sales tax increase.
- **Prevention-focused taxes and fees.** Several jurisdictions generate funding for prevention services by imposing fees or "sin taxes" on products that have social costs, such as tobacco and alcohol use. Revenue generated from these taxes can be

significant. California's Proposition 10, which imposes a 50-cent per pack tax on cigarettes to fund early care and education services, generates $590 million annually.

Research has shown that "sin taxes" can be effective at preventing negative outcomes. A recent study found that alcohol taxes and prices have a significant and negative relationship to alcohol-related violence, traffic crash fatalities and drunk driving, rates of STDs and risky sexual behavior, other drug use, and crime.[6] Because these taxes are effective at reducing the use of the product, leaders should also anticipate that this revenue source will likely decline over time.

Income Taxes Fund Evidence-Based Mental Health Services

California Proposition 63 expanded county mental health programs by increasing income taxes for individuals earning more than $1 million a year. *Read more on page 33.*

Seattle Families and Education Levy

Seattle voters first passed the Families and Education Levy in 1990 to help all Seattle's children grow up safe, healthy and ready to learn. The levy has been renewed three times, most recently in 2011. The most recent levy is expected to generate $231 million over 7 years. *Learn more about the Levy Oversight Committee's focus on evidence-based programs on page 34.*

[6] Alcohol Tax and Price Policies Decrease Alcohol-Related Morbidity and Mortality Outcomes, CADCA's National Coalition Institute, January/February 2011.

V. Financing Structures to Support Evidence-Based Practices

> **Tennessee "Evidence-Based Law"**
>
> Tennessee law enacted in 2007 requires the Department of Children's Services to transition all juvenile justice investments to evidence-based programs. In 2010, 27 percent of a total $119 million budget funded evidence-based programs. *Learn more on page 35.*

Financing structures are the mechanisms that leaders use to *prioritize, coordinate, and expend dollars* on supports and services for families and communities. Whereas financing strategies are the means by which leaders generate dollars for their work, financing structures enable them to spend those dollars efficiently to support their priority outcomes, populations, and evidence-based programs. Traditional financing structures in public agencies are often built around siloed public agency programs and funding streams and focus on accountability for delivery of units of service to eligible populations based on policy mandates.

The financing structures highlighted in this section support the coordinated use of funding streams across multiple agencies, shift the accountability focus to outcomes rather than units of service, and promote and incentivize efficiency by carefully managing the provision of services and limiting the total level of spending available for particular populations or services. Leaders working to increase the use of evidence-based programs in their agencies should consider which financing structures best support their particular priority outcomes and programs and what must be done to put new structures in place. In many cases changes in policy, regulations, and/or contracting processes are necessary to implement new financing structures. While establishing new financing structures can be a complex and political process, once in place they can enable leaders of public agencies and schools to use their existing funding streams in much more efficient, effective, and coordinated ways.

1. Changes to Budget Structures

Changes to state and local budget structures can be used to ensure that existing public investments are coordinated and directed toward evidence-based programs. State and county governments can create interagency pools that support collaborative efforts. They also can opt to put in place budget structures such as set-asides or earmarks that direct existing resources within public agencies toward evidence-based programs or allow savings in one part of the budget – for example, in out- of- home spending – to be used in another part of the budget, such as home and community services. Several states have or are considering setting aside a portion of their juvenile justice budgets for evidence-based programs. The success of this strategy depends on aligning political support to pass legislation requiring investments in evidence-based programs, defining "evidence-based" programs in a specific and rigorous way that will actually lead to improvements in practice, and holding providers accountable to meet the requirements of the law.

2. Pooled or Braided Funding

Pooled or braided financing structures support more coordinated service delivery by bringing together multiple funding streams in support of particular results, populations, or evidence-based programs. Pooled funding structures combine various funding streams for allocation to providers of services. While the eligibility restrictions and reporting requirements of each individual funding source must be tracked, the pool typically is administered by one entity and overseen by a cross-agency body. Because pooling requires the capacity to track the different funds, this is a structure typically put in place by state or local agencies with administrative authority over funding streams and managed by an entity with strong data tracking and management capacity.

A pooled structure is often used to support improved efficiency and effectiveness of services targeted to populations who are involved in multiple public agencies where there is historically duplication of services or lack of clarity regarding which agency is responsible for providing services. Pooling also is an attractive structure to support interagency priorities that each individual agency has limited resources to support. For example, child welfare, juvenile justice, education, and substance abuse and mental health agencies all can benefit from primary prevention strategies but have limited resources to invest in these interventions. By pooling small amounts of funds from each agency, leaders can develop a large enough base of resources to support community-based prevention efforts. Each of these systems also can benefit from home and community alternatives to out-of-home or out-of-school placements; by pooling resources they are able to develop a broader, more coordinated array of community-based services.

Wraparound Milwaukee

Milwaukee County was spending large sums of money on residential treatment, juvenile detention and inpatient psychiatric care for youth with serious emotional and behavioral challenges, but getting poor results. Funding from four agencies was pooled to create a public managed care entity with an annual operating budget of $47 million called Wraparound Milwaukee. *Read more on page 36.*

Braided funding structures support more coordinated service delivery by bringing together multiple funding sources, not literally in a “pool” but virtually through such vehicles as interagency memoranda of understanding. In a braided funding approach, each funding source remains in its “home agency” budget with leaders of that agency committing funds to support a coordinated service package or innovative program. This structure is often used by local providers and agencies to coordinate resources in support of evidence-based programs. For example, an individual school implementing an evidence-based teen pregnancy prevention program could potentially bring together state and federal education agency professional development funds for training, private funds for initial curriculum purchases, in-kind teacher time for delivery of training modules, and state pregnancy prevention funds from the health department for coordinator staffing.

3. Single Payer System

A single payer system is a structure used hand-in-hand with pooled funds in which a single entity administers funds pooled from multiple sources, and plays an active role in managing and coordinating the services paid for with those funds. A single payer structure can help to improve continuity of care and decrease costs for populations with complex service needs that cut across multiple agencies. The single payer can be a public or private entity. In the United States, a single payer structure is used in the health arena with the government acting as the single payer for Medicare. Some states and localities also have successfully implemented single payer systems, particularly in the behavioral health arena. The federal Substance Abuse and Mental Health Services Administration's (SAMHSA) System of Care initiative, with its focus on creating a continuum of services and effectively coordinating services provision has helped to spur the development of single payer systems for behavioral health in some jurisdictions.

New Jersey's Contracted System Administrator

Children's System of Care originated from efforts to develop a system that offered an array of flexible, community-based mental health support and services that was easy for youth and families to navigate and cost effective. To accomplish its objectives, the state uses a Contracted System Administrator that acts as a single point of entry for youth in need of behavioral health services. *Learn more on page 37.*

Using Risk-Based Financing to Support Comprehensive Behavioral Health Supports

From 2001-2009, Nebraska's Region 3 Behavioral Health Services saved an estimated $6.1 million dollars by establishing the Integrated Care Coordination Unit and used case rates to finance behavioral health. *Read more on page 38.*

4. Risk-Based Financing

Risk-based financing structures offer an alternative to traditional fee-for-service payment systems. Rather than providing payment for every service provided, risk-based financing provides a fixed payment for every person enrolled in a program or health plan, known as capitation financing, or for every person who presents for service who meets certain criteria, known as case rate financing. Within this structure, providers of services take on some of the financial risk of service costs that exceed expected or reasonable levels based on historical trends in costs of care. The level of financial risk to providers can be reduced through the use of differential rates for high need populations and/or the use of risk pools that make funding available for certain high need cases where the cost of services exceeds set rates. Case rates, as opposed to capitation, also mitigate the risk for providers. Risk-based financing structures incentivize efficient service delivery as opposed to incentivizing greater volume of services as fee-for-service structures do. Accountability for positive results must also be a strong focus

when risk-based financing structures are utilized in order to avoid cost cutting without attention to the well-being of those served.

5. Performance-Based Incentives

Performance-based incentive structures reward or penalize those who administer and/or deliver services based on how they perform on measures of quality of service, or outcomes. The federal government has used financial incentives to reward states for outcomes in areas such as teen pregnancy prevention and adoptions for those in foster care. State and county government agencies are also increasingly using performance-based contracting with providers of services. Performance-based contracts tie contract renewal, extension, and payment to meeting specific targets for outputs, quality of services, and outcomes. In essence, a performance contract does what any regular contract should do: it specifies what is required of the parties. It embeds incentives in the contract; there are rewards for beating the performance standards and consequences for not meeting them.

Performance contracts vary in the way they are structured financially with some models providing more upfront payment to cover administrative costs and others only providing payment upon achievement of agreed upon performance milestones. Many models provide some initial payment and then phase in payments first based on output targets (e.g., number of clients completing employment training program) and over time based on achievement of short-term and long-term outcomes (e.g., number of clients gaining and retaining employment for six months). Essential to successfully implementing performance-based contracting is agreement among those paying for and providing services on priority performance milestones that can be measured, and then putting in place the data collection and information systems to track and report on outcomes over time.

The Illinois Performance Contracting Model

In Cook County, foster care caseloads have declined 57 percent since 1998 following a shift to performance contracting, which redirected resources from keeping children in foster care to finding them permanent homes. *Find out more on page 39.*

The Maryland Opportunity Compact

When funding from the Crane Foundation allowed the Baltimore County Department of Juvenile Services to expand a proven program, officials also agreed to reinvest the savings in sustaining the program. *Read more on page 40.*

6. Reinvestment Compacts

Reinvestment compacts are legal agreements that specify that funds saved as a result of practice change will be reinvested in a particular population, in particular services, or within a particular agency. This structure was developed and piloted in Maryland by the Baltimore Safe and Sound Campaign and the Family League of Baltimore City, with the sponsorship of the

Annie E. Casey Foundation. A compact involves: 1) the identification of a costly bad outcome for youth; 2) the selection of an evidence-based practice (EBP) that will prevent or reduce the cost impact of the bad outcome; 3) the investment of private funding to initiate the EBP; and 4) a binding agreement with the government entity to reinvest the savings resulting from the use of the EBP in sustaining the EBP and in funding prevention programs for youth. Once a compact is signed, the EBP is implemented and savings are tracked. State budget officials then make the savings available to the implementing jurisdiction to sustain the EBP and invest surplus savings in prevention programs.

A significant advantage of a compact, both for government and the foundation community, is the low risk involved. Government only has to agree to reinvest savings once they are documented; if the EBP fails to produce savings, it is simply ended at no cost to government. For the foundation community, a one-time investment offers the potential for both sustainability of the EBP, as well as funding for prevention.

VI. Conclusion

Evidence2Success offers leaders rigorous tools to assess the developmental outcomes, risk, and protective factors among children and youth in communities. Using that information, public agencies, schools, and communities work in partnership to agree on priority outcomes and programs. In order to implement priority programs and achieve better outcomes, leaders must thoughtfully design a financing approach that will support the costs of transition to new programs and practices, and scale up and sustain effective programs over time. This brief provides a variety of financing strategies and structures leaders can consider in implementing Evidence2Success. Effective combinations of these strategies and structures can shift investments into practices and programs that have strong evidence that they produce good results as well as shift investments from deep-end treatment and remediation to earlier intervention and prevention. In this way, state and community leaders can better invest scarce public resources and improve results for children.

Strategic Financing Case Studies

Project Redirection

The Florida Redirection Program is a community-based, family-centered alternative, operated by Evidence-Based Associates, that diverts youth from residential juvenile justice programs to less expensive in-home treatment programs. In 2004, the state legislature authorized the program to address the growing trend of placing youth who commit "non-law" violations of probation, such as skipping school or breaking curfew.

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In 2006 and 2007, the state legislature expanded the program to include services for youth with a misdemeanor offense and youth considered for placement due to a non-violent third degree felony. Funding was reduced in 2008 due to a state budget shortfall, but restored and increased by $2.1 million in 2009. The program currently serves more than 1,250 youth and their families per year across 18 judicial circuits throughout the state, and has served a total of over 6,200 youth since inception.

The legislature specified that young people served by Project Redirection be provided with evidence-based therapy models that have shown to produce sustained reductions in recidivism for serious and violent offenders. Specified programs include Multisystemic Therapy (MST) – an intensive family-based treatment that addressed multiple causes of serious anti-social behavior; Functional Family Therapy (FFT) – a family-based treatment that focuses on family dynamics and accountability; and Brief Strategic Family Therapy (BSFT) – a short-term problem focused intervention to reduce substance abuse and problem behavior by improving family interactions.

A 2010 report issued by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) found that the program operated at lower-cost than residential facilities and has achieved better outcomes. Youth who successfully completed the Redirection Program were significantly less likely to be subsequently arrested for a felony or violent felony, adjudicated or convicted for a felony, or sentenced to prison after treatment than similar youth who successfully completed residential commitment programs.

According to the Justice Research Center, the average cost of a young person successfully completing the Redirection Program in 2008-09 was $10,550, whereas the average cost for a residential commitment is $41,970. Each "redirected" youth saved the state $31,419. Overall, the program resulted in an estimated $51.2 million in cost savings during its first five years of implementation, according to OPPAGA.

RECLAIM Ohio

In response to a growing need for community-based alternatives for young people involved in the juvenile justice system and overcrowding in juvenile justice institutions, the state legislature created the RECLAIM Ohio initiative in 1993. RECLAIM stands for Reasoned and Equitable Community and Local Alternatives to the Incarceration of Minors. The Initiative encourages juvenile courts to develop or purchase a range of community-based options to meet the needs of young people involved in the juvenile justice systems or at-risk of offending.

Prior to the development of RECLAIM, strong financial incentives encouraged overuse of secure juvenile facilities. Ohio Department of Youth Services (DYS), which manages the State's juvenile corrections facilities, was allocated separate funding for its juvenile institutions. If a county judge committed a young person to a secure facility, it resulted in no cost to the county. On the other hand, the cost of placing a young person in a community-based alternative was charged solely to the county. This incentive resulted in far too many young people being committed to secure facilities, regardless of the nature of their crime. By 1992, juvenile facilities were housing over 2500 young people in facilities designed to serve 1,400.

RECLAIM was piloted in nine counties and resulted in a 43% reduction in commitments to DYS institutions. Based on the successful pilot, DYS expanded the initiative in 1995 to the remaining 79 counties in the state. RECLAIM Ohio allows local juvenile courts to create a series of different services and sanctions appropriate to the juvenile offenders who come before them. A critical piece of the design of the initiative was its financial reforms. Counties receive a funding allocation based on the number of youth adjudicated for acts in the previous 4 years that would have been felonies if committed by adults, and the number of charged bed days used in DYS facilities or in community corrections facilities. DYS distributes the allocations to counties annually in three payments. With those funds, counties contract for or develop community-based programs for youth adjudicated delinquent who would have otherwise been committed to DYS facilities. These programs include day treatment, intensive probation, electronic monitoring, home-based services, offense-specific programs, residential treatment, and reintegration or transitional programs.

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To ensure public safety, DYS guarantees that the juvenile court may commit youth to DYS secure facilities even if that county does not receive RECLAIM dollars due to its number of bed

days used. This "hold harmless" clause guarantees that the juvenile courts will not have to use local funds to house more violent youth who appropriately belong in secure custody. In addition, RECLAIM Ohio includes a provision for "public safety beds" for which counties are not charged for young people who commit violent crimes.

Counties are allocated more than $30 million annually from RECLAIM. Combined with the Youth Services Grant subsidy, funded programs have more than 120,000 admissions annually. A recent evaluation found that, depending on the risk-level of the young person, each dollar invested in RECLAIM saves between $11 and $45 dollars in total program and recidivism costs (with lower-risk young people generating higher savings).
With the state and counties sharing financial responsibility and accountability for the appropriate placement of young offenders, Ohio was able to effectively systematize innovative reform and dramatically change how young people involved in the juvenile justice system are placed and supported.

With an established structure and partnership in place, Targeted RECLAIM was recently added to the program to provide funding for evidence-based and model programs in the community for the purpose of reducing commitments to DYS. The program funds juvenile courts to target a specific reduction in DYS admissions. Coaching and monitoring to ensure program fidelity and to track progress is done through two Ohio universities. Targeted RECLAIM is currently operating in six metropolitan counties, which accounted for 63 percent of DYS admissions for FY2009. Early results have been very positive. Targeted RECLAIM reduced DYS admissions in these six counties by 39 percent the first year.

Washington State's Evidence-Based Initiative: Creating Incentives for Evidence-Based Programs in the Juvenile Justice System

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Washington State's evidence-based initiative began in 1995 when an evaluation of the state's intensive juvenile probation program found that it did not accomplish its goal of reducing recidivism among youthful offenders. In response, the state legislature passed the Community Juvenile Accountability Act with the goal of reducing crime in a cost-effective way by establishing research-based programs in the juvenile courts. The Washington State Institute for Public Policy identified four evidence-based programs that could reduce crime and yield cost savings: Aggression Replacement Training (ART), Coordination of Services (COS), Functional Family Therapy (FFT), and Multisystemic Therapy (MST). In 1998, the state legislature provided funding to implement these programs within juvenile courts statewide. Based on positive outcome evaluations and the state legislature's goal of eliminating future prison construction, in 2007 the legislature increased funding to $26.2 million in the biennial budget for expanded used of evidence-based programs by juvenile courts. Counties submit proposals and are awarded funding through a grant process.

To further expand the number of young people who participate in evidence-based programs in the juvenile justice system, the state legislature passed unique financing reforms to incentivize the use of evidence-based programs. Washington has a decentralized funding system with counties administering juvenile court, detention, and probation, and the state Juvenile Rehabilitation Administration (JRA) managing secure facilities and allocating state funds to counties.

In 2009, the legislature required that all state dollars that passed to local juvenile courts be administered by JRA as a block grant. The legislature required that funding priorities be given to evidence-based programs and alternatives that divert young people from confinement at JRA. A "block grant committee" was convened to establish the formula for allocating block grant funds. Two new criteria were added to the original funding formula:

1. Risk -based adjustment: the formula is weighted based on the average assessed risk level of the court's caseload at a weight of 15 percent. Jurisdictions with higher risk youth are weighted more heavily, and therefore receive more funding than those with lower risk youth.
2. EBP Incentive: the formula also incentivizes juvenile courts for placing young people in evidence-based programs at a weight of 25 percent.

In addition, Washington State Institute of Public Policy helped the block grant committee to develop a protocol to allow the use of state funds for “promising programs” in areas of need that are not addressed by the current portfolio of evidence-based programs. To be eligible, the court must first identify an area of need and develop a program proposal. An outcomes evaluation is then conducted to determine if it qualifies as an evidence-based program.

The number of participants in evidence-based programs has continued to increase, indicating that the new funding formulas have successfully incentivized their use. In 2010, approximately 30 percent of youth who were eligible participated in a state-funded evidence-based program.

Success for All: National Expansion with an Investing in Innovation Grant

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Success for All (SFA) is an evidence-based whole school reform approach for high-poverty elementary and middle schools that is currently operating in over 1,000 schools in 47 states. The program has been evaluated in 47 experimental-control studies and has consistently demonstrated strong results.

SFA is disseminated by the Success for All Foundation, a not-for-profit organization, which maintains a national network of coaches. Most schools implementing SFA have used their Title I funds to pay for start-up and ongoing operating costs. Many schools use state compensatory education funding. Funds for special education, bilingual/ESL, professional development, early childhood, and other special purposes can be combined with Title I to fully fund SFA in a school. The facilitator is often the Title I Coordinator in a school. SFA provides Title I Coordinators a framework and approach that helps them to play a proactive and central role in comprehensive school improvement efforts.

The Success for All Foundation was recently awarded a $50 million Investing in Innovation (I3) grant from the U.S. Department of Education to double the number of schools served by the program over the next five years. I3 grants sought to expand the utilization of evidence-based programs. I3 grants were awarded in three categories: “scale-up” grants of up to $50 million for programs that have been proven through extensive research to work; “validation” grants of up to $30 million for programs with emerging evidence of success; and “development” grants of up to $5 million for untested but promising research-based ideas.

With support from its I3 grant, the Foundation plans to add 1,100 schools over five years. The Foundation will partner with several school districts to create local coaching support centers in high-poverty districts as well as offer $50,000 sub-grants to defray the start-up costs for individual schools seeking to implement SFA. In addition, the grant will support a large third-party, cluster randomized evaluation of SFA in high-poverty elementary schools.

Maricopa County, Arizona—Maximizing Medicaid Matching Funds*

In 1993, a class action lawsuit, Jason K. v. Dillenberg, was filed against the state of Arizona on behalf of Medicaid eligible youth with serious emotional disturbance (SED). The suit, referred to as "Jason K.", alleged that Arizona had failed to comply with the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) provision of federal Medicaid law. EPSDT is Medicaid¹s comprehensive child health program that requires states to provide any medically necessary health care services to Medicaid eligible youth under 21, even if the service is not in the state¹s Medicaid plan.

The suit was settled in 2001, and resulted in the "Arizona Vision", a set of 12 guiding principles for the children¹s behavioral health system. These principles drove a variety of improvements, such as the development of an expanded array of community-based treatment services, greater family and youth voice in the system, and employment of wraparound, an approach to care coordination.

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As part of the comprehensive financing strategy for achieving the Arizona Vision, state officials worked across agencies to maximize federal Medicaid matching funds. The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), worked with child welfare officials to identify utilization and costs of behavioral health services provided to youth that could be financed under Medicaid rather than using state dollars. Working with Medicaid actuaries, leaders analyzed behavioral health spending on all services including residential treatment centers and acute inpatient hospital care for child welfare-involved youth. Differential funding was allocated to the Regional Behavioral Health Authorities – a behavioral health managed care company – to cover all treatment for these youth, essentially setting a higher capitation rate than the non-child welfare population. Operationally, this also required a change in the definition used to determine medical need for 24-hour treatment services to include not only a mental health diagnosis, but also the lack of an appropriate community placement option. The analysis identified a number of child welfare-involved youth in need of community-based, behavioral health treatment services.

Additional funding was subsequently allocated to cover a comprehensive array of services such as therapeutic foster care and mobile crisis intervention. For therapeutic foster care, only foster homes licensed by the state child welfare agency or tribal authorities are utilized so that Title IV-E funds can be used to pay room and board costs for eligible youth.

ADHS also worked closely with juvenile justice officials to develop a process for systematically checking Medicaid eligibility and facilitating enrollment in Medicaid for youth involved in that

system. By maximizing enrollment in Medicaid and facilitating access to Medicaid-covered services, the juvenile justice agency is able to preserve treatment funding for youth who are not Medicaid eligible.

*Adapted from Stroul, B.A., Pires, S.A., Armstrong, M.I., McCarthy, J., Pizzigati, K., & Wood, G.M. (2008). Effective financing strategies for systems of care: Examples from the field – A resource compendium for developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children’s Mental Health.

Highmark Healthy High 5

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Highmark Healthy High 5 is a unique public-private partnership that seeks to encourage children to adopt lifelong healthy behaviors by providing tools and resources to educators to improve children's health. The initiative supports the use of evidence-based practices in nutrition, physical activity, grief support, self-esteem, and bullying prevention throughout schools and communities.

Highmark Healthy High 5 is an initiative of the Highmark Foundation in partnership with the Pennsylvania Department of Health and the Pennsylvania Department of Education. In early 2005, Highmark, the state's largest health insurer, had made several grants for obesity prevention programs and was interested in developing an electronic student health record to improve health services in schools. At the same time, then Governor Ed Rendell convened a workgroup of experts from several state departments to develop a children's health initiative. Building off of the state's obesity prevention plan, the state Maternal and Child Health Block Grant application, and other state efforts, the workgroup developed several recommendations, including the creation of a web-based portal.

Through additional conversations, leaders from Highmark and the state Departments of Health and Education recognized their common goals and made plans for close collaboration and alignment of efforts. In September 2006, Highmark Foundation launched Healthy High 5, a five-year $100 million initiative to improve children's health and well-being. Health eTools for Schools became a core component of the initiative.

Health eTools for Schools provides a secure web-based portal that enables school nurses to electronically track and communicate students' health and fitness information and provides a portal for educators to access evidence- and research-based curriculum for nutrition and physical activity planning. Health eTools evolved through significant collaboration with professional and advocacy groups in the state including the state Departments of Health and Education; the state association for Health, Physical Education, Recreation and Dance; the state Association of School Nurses and Practitioners; Advocates for Nutrition and Activity; and, the state School Boards Association.

The Departments of Health and Education both formally endorsed Health eTools and requested that Highmark make the tools available statewide – which include schools outside of the Foundation's 49-county service region. Highmark provided the start-up and development costs for Health eTools with the departments providing significant in-kind resources. Highmark Foundation continues to provide direct funding to schools within its service region.

Program-Related Investment: Home Funders

Home Funders is a collaborative of private funders and investors, formed to address the unprecedented crisis in affordable housing for very low-income families (earning 30 percent of area median income or less) in Massachusetts. Low cost loans to affordable housing developers are expected to create 1,000 rental and ownership units for extremely low income families as part of 4,000 total units over ten years. Home Funders also raises grant funding to support public education and advocacy to ensure adequate local, state and federal resources for extremely low-income housing.

Home Funders created a limited liability corporation (Home Funders Collaborative LLC) through which program-related investments (PRIs) and grants are pooled in order to share risk. All PRI loans to Home Funders are made at 1 percent annual interest for either shorter-term (5-10 year) or long-term (10-20 year). Home Funders directs the funds to two experienced housing finance intermediaries depending on the term to then deploy in housing projects. The Community Economic Development Assistance Corporation (CEDAC) manages all the shorter-term money and provides pre-development and acquisition loans. Massachusetts Housing Partnership (MHP) utilizes the long-term fund to make mortgage loans. Home Funders capital is available for all phases of a project – from feasibility analysis, to land acquisition, to predevelopment – as well as permanent financing for projects that set aside at least 20 percent of the units for extremely low income families (which is double the state mandate) and provides long-term affordability and use restrictions. Home Funders loans are made available to these two intermediaries at a 1 percent interest rate in order to promote a deep level of affordability. As a result, Home Funders loan funds are easily accessed and combined with available public resources. Home Funders' loans typically represent 5-10 percent of total project costs.

Home Funders has raised over $22 million from over 12 foundations to create the new lending pool. The majority of this funding is through PRIs. In addition to making loans to CEDAC and MHP, Home Funders made small grants to provide occupancy-related assistance and services to ELI families in Home Funders units.

The collaborative continues to make significant progress toward its goal of 1,000 ELI units and has reached almost 65 percent of its goal. As of December 31, 2010, Home Funders had financed a total of 2,121 units of affordable housing including 684 ELI units. These loan funds have leveraged over $200 million in public and other private resources since 2003 to address the ongoing housing crisis for ELI families in Massachusetts.

Peterborough Prison Social Impact Bond

The United Kingdom's Ministry of Justice is currently conducting a pilot Social Impact Bond to provide services aimed at reducing prisoner recidivism at a prison in Peterborough, England. Social Finance, a British nonprofit organization, bought a social impact bond from the Ministry. Funding targets a population of 3,000 prisoners serving sentences of less than 12 months. Previously, these individuals typically receive little to no follow-up support after their release and have a re-offense rate of 60 percent.

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With funding from the bond, these prisoners will receive rehabilitative services based on a model created by St. Giles Trust, which has been shown to reduce re-offense rates by as much as 40 percent. Social Finance worked to attract private investors for the six-year bond, generating 5 million pounds from 17 outside investors. The bond is backed by Big Lottery Fund and the Ministry of Justice. For private investors to get back their initial investment, the recidivism rate must fall at least 7.5 percent compared to a control group by 2014. If the rate falls below 7.5 percent, investors will get a return based on the level of success, capped at 13 percent per year. If the rate falls less than 7.5 percent, private investors will not get any payment. The program is voluntary for short-sentence prisoners. Early data show a relatively high level of participation.

Florida's Children's Services Councils

Florida Children's Services Councils (CSC) are countywide special taxing districts to fund programs and services that improve the lives of children and their families. The councils originated in 1945 when the Florida Legislature passed a bill allowing Pinellas County to establish a special district for children called a "juvenile welfare board," and levy a property tax. In 1946, Pinellas County voters approved both the special district and its taxing authority, creating the Juvenile Welfare Board (JWB) of Pinellas County. In 1990, county voters approved raising the district's millage rate from 50 cents to a maximum of $1 per $1,000 of taxable property value.

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Today, the CSC of Pinellas County is the oldest and longest-running of the CSCs in Florida.
Nearly 40 years after the Pinellas County CSC was approved, the state legislature passed the Juvenile Welfare Services Act in 1986, which provides that any county in Florida whose voters agree through referendum, can create a special district for children's services and the authority to levy taxes. To date, 11 Florida counties have created CSCs that invest in the well-being of their community's children and families. CSCs collectively invested nearly $400 million a year in hundreds of local programs and services for children and their families. While the services offered and age groups served vary depending on the needs of the community, the primary focus of all CSCs is to invest in prevention and early intervention programs that produce measurable results.

CSC has demonstrated a growing commitment to funding evidence-based programs in recent years. Each CSC has historically invested in discrete evidence-based programs. For example, Palm Beach County is one of 33 Nurse Family Partnership sites across the country, serving 511 new mothers and Broward County funds Future First, an evidence-based early care program. More notably, the statewide organization of Children's Services Councils created the Policy Group for Florida's Families and Children -- an independent group of statewide leaders that develops and supports public policies focusing on the well-being of families and children that are grounded in evidence-based research. Palm Beach County has also been a leader in building the capacity of the local providers it funds to expand their knowledge and skills to work within an evidence-based environment.

California Proposition 63 – Income Tax Surcharge to Fund Evidence-Based Mental Health Services

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California voters approved Proposition 63 (the Mental Health Services Act) in 2004 to expand county mental health programs by imposing an extra 1 percent income tax on people who have annual taxable incomes of more than $1 million. Since its passage, Prop 63 has raised $6.3 billion. An estimated 25,000 to 30,000 taxpayers are subject to the income tax surcharge.

The Mental Health Services Act seeks to support a diverse and culturally competent workforce that provides evidence-based services that support wellness, recovery and resilience. Each county drafts and submits a three-year plan for the delivery of mental health services. In addition, the state Department of Developmental Services receives and allocates funding to support regional centers to develop and oversee innovative training on early intervention and treatment for children and families impacted by mental health issues. Several regional centers received funding to support training on the use of evidence-based practices. For example, the Golden Gate Regional Center was funded to develop training on infant mental health using evidence-based service models and the Harbor Regional Center was funded to conduct training on two evidence-based psychotherapeutic practices.

Revenue generated through the surcharge is deposited in the Mental Health Services Fund. As funding is not provided through the annual state budget process, it is generally less vulnerable to political transitions. The state is prevented from reducing financial support for mental health programs below the 2003-2004 level to ensure new funding doesn't supplant existing state support.

Seattle Families and Education Levy

Seattle voters passed the first Families and Education Levy in November 1990 and have renewed it two times since. Funding provided support to children and their families, both in and out of school, in an effort to help all Seattle's children become safe, healthy, and ready to learn. In the 20 years the levy has been in place, it has generated a total of $254 million for education and children's services.

The 1990 levy set a property tax rate of .23 per $1,000 of assessed valuation, generating approximately $10 million per year over its seven-year term. As the levy is based on the property tax, the revenue generated varies due to changes in property values. Levy funding is allocated by a Levy Oversight Committee that sets funding priorities and makes funding decisions.

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The current levy was renewed in 2004 for another seven-year term and has generated approximately $116 million. The 2004 levy is focused on achieving three overarching goals:

- School Readiness
- Academic Achievement and Closing the Achievement Gap
- Increasing High School Graduation Rates

The current levy is set to expire in the fall of 2011. Due to anticipated cuts in state education funding, the mayor proposed doubling the millage rate of the new levy. The Seattle City Council recently approved placing the new levy on the November 2011 ballot. The new levy is expected to generate $231 million over seven years. If approved by voters, the 2011 levy would fund expanded support for early education and kindergarten readiness; extra learning programs at 23 elementary schools with high poverty rates; support for struggling students transitioning from middle to high school; and academic support and career and college planning for at-risk high-school students. The levy also would continue funding for high-school health centers.

The use of evidence-based programs directly aligns with the Levy Oversight Committee's strong focus on accountability and results. In the past, funding from the levy has gone to support discrete evidence-based programs, notably programs focused on family support and engagement. In its 2011 report, the Levy Advisory Committee formalized a strong endorsement of evidence-based programs, recommending that levy investment priorities shall "reflect evidence-based best practices that have been shown to measurably improve academic success."

Tennessee "Evidence-Based Law"

In 2007, Tennessee enacted legislation known as the "evidence-based law," which requires the Department of Children's Services (DCS) to transition all of their juvenile justice investments to evidence-based programs over a period of five years. Specifically, the law required DCS to document that 25 percent of juvenile justice investments supported evidence-based programs during fiscal year 2009-2010. In 2010-2011, the requirement rose to 50 percent, followed by 75 percent in 2011-2012, and 100 percent in 2012-2013 and all-future years. The law defines "evidence-based" as "a program or practice that is governed by a manual or protocol that specifies the nature, quality, and amount of service that constitutes the program; and, that scientific research using at least two separate client samples has demonstrated improvement in the client outcomes that are central to the program." The law also requires DCS to include language in juvenile justice contracts requiring contractors to use evidence-based services, and to monitor the quality of implementation of evidence-based services and offer "corrective action" if providers are not implementing programs with fidelity to the model. Finally, the law tasked DCS, along with the Tennessee Commission on Children and Youth, the Administrative Office of the Courts, and other experts appointed by the commissioner to determine which programs meet the requirements of the law. DCS created a committee and contracted with experts to gather data on and certify whether existing programs are evidence-based. In 2010, the Committee reported that 27 percent of a total $119 million was spent on evidence-based juvenile justice programs, exceeding the 25 percent requirement for 2009-2010. The committee is continuing its work to determine and report on whether investments in juvenile justice programs meet the increasing requirements for the proportion invested in evidence-based programs.

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Wraparound Milwaukee: Blending Funding*

Milwaukee County was spending large sums of money on residential treatment, juvenile detention, and inpatient psychiatric care for youth with serious emotional and behavioral challenges, but getting poor results. In 1995 with a six-year, $15 million dollar grant from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, Milwaukee County decided to try something different.

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Funding from four agencies – the Bureau of Milwaukee Child Welfare, the Milwaukee County Children's Court, the Division of Health Care Financing (Medicaid), and the Milwaukee County Behavioral Health Division – were pooled to create a unique type of public managed care entity called Wraparound Milwaukee. Each of the payers contributes to a pool of funds that are used to pay service providers and administer the program. Medicaid pays a fixed rate per youth per month ($1,843 in 2011), child welfare pays a case rate, juvenile justice pays a case rate for diversions from juvenile corrections and contributes a fixed annual amount, and mental health contributes block grant funding. A new federal grant supports a transitional program for youth ages 17 to 24 with serious emotional disturbances. Together these funds provide an annual operating budget of $47 million.

Through use of an approach to care coordination called Wraparound, employment of utilization management strategies such as requiring prior authorization for out-of-home care, and creation of a diverse provider network, Wraparound Milwaukee has achieved its original goals of reducing costs while also improving outcomes for youth and families. Since its inception, Wraparound Milwaukee has reduced its average daily census for youth in residential care from 375 to 80 placements; decreased psychiatric inpatient utilization from 5,000 days per year to less than 200 days; and decreased juvenile correctional placements from 385 to 185 per year. The average monthly cost for a youth participating in the program is $3,700 per month compared to $8,600 per youth per month for residential care, or $8,000 per youth per month in a juvenile correction facility.

*Adapted from Kamradt, B. (2010, June). Options for Financing Care Management Entities: Wraparound Milwaukee' Pooled Funding Model. Presentation for the Center for Healthcare Strategies, CHIPRA Care Management Entity Quality Collaborative TA Webinar series.

New Jersey's Single Payer Systems*

In 1999, the New Jersey Department of Human Services used funding from a SAMHSA System of Care grant to change how services for youth with serious emotional and behavioral challenges were delivered, financed and accessed. The New Jersey Children's System of Care initiative aimed to develop a system that offered an array of flexible, cost-effective and easy-to-navigate community-based mental health supports and services for youth and families.

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www.state.nj.us/dcf/behavioral

To accomplish its objectives, the state uses a Contracted System Administrator (CSA), which acts as a "virtual" single point of entry for youth needing behavioral health services. The CSA conducts a telephone assessment of a youth's medical needs and facilitates referrals for community-based assessment and treatment. The CSA also authorizes care, tracks and reports on outcomes, maintains electronic records for each youth, and coordinates quality improvement activities.

The state also created locally-based Care Management Organizations, nonprofit agencies that serve as the locus of accountability for children with complex behavioral health challenges who are involved in multiple systems. In addition, locally-based Family Support Organizations provide peer support and advocacy for youth and families in the system of care.

Through the initiative, youth have access to a continuum of services including: care coordination, family support and advocacy, mobile crisis response and stabilization, therapeutic group home care, Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), in-home behavioral therapy, therapeutic foster care, and intensive residential care.

Several funding streams, including Medicaid dollars and state appropriations for child welfare and children's mental health services, pay for services. Providers of care management and mobile crisis can make youth eligible for Medicaid on a short-term basis so service delivery is not delayed. If youth are ineligible for Medicaid, state funding pays for services. This single entity approach to managing claims submission and payment for both Medicaid and non-Medicaid beneficiaries reduces the administrative burden on providers. It also ensures access to home and community-based services available under the System of Care for youth who are not eligible for Medicaid.

*Adapted from Hancock, B. (2010, June). New Jersey System of Care Financing Overview. Presentation for the Center for Healthcare Strategies, CHIPRA Care Management Entity Quality Collaborative TA Webinar series.

Using Risk-Based Financing to Support Comprehensive Behavioral Health Supports in Nebraska*

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Region 3 Behavioral Health Services, a body that administers and coordinates behavioral health services for a 22 county region in South Central Nebraska, piloted a case rate approach to financing behavioral health services in 1998 that has been replicated in five of the six regional behavioral health regions authorities in Nebraska. The Region 3 Behavioral Health authority created a system of behavioral health care services by partnering with the regional office of Nebraska Department of Health and Human Services (DHHS) that administers child welfare and juvenile justice, and developmental disabilities services; local school districts and educational cooperatives; and Families CARE, a family support organization. A variety of services, from prevention to wraparound and intensive care management services, are collaboratively funded and provided through the system of care. Region 3 pools funds to offer two levels of case rates to support behavioral health services. The Integrated Care Coordination Unit (ICCU) operated from 2001 through 2009 and provided support for over 1100 children in state custody who have significant behavioral health needs.

The ICCU received one monthly rate to pay for placement and support services not covered by Medicaid. Medicaid funds were not pooled to support the case rate, and Medicaid services were billed on a fee-for-service basis. A second, lower case rate is used to pay for services for children who are still at home and who require wraparound services through the Professional Partner Program (PPP). Cost savings from the ICCU program over the course of its operation program are estimated at $6,173,616 and have been reinvested in prevention services and replication of the ICCU concept in other regions. As part of the state's child welfare reform efforts in 2010, the ICCU was integrated into other strategies and no longer functions as a stand-alone unit. The PPP continues to serve children and families and has expanded to serve over 200 children this year.

For more information, see: Stroul, B.A., Pires, S.A., Armstrong, M.I., McCarthy, J., Pizzigati, K., & Wood, G.M. (2008). Effective financing strategies for systems of care: Examples from the field – A resource compendium for developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. # 235-02). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health.

The Illinois Performance Contracting Model for Foster Care

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In 1997, Illinois' child welfare system was in crisis. Its caseload had increased significantly the previous few years, at one point reaching 50,000 children in out-of-home care. "The Chicago Tribune" had just won a Pulitzer Prize for its reporting about the troubles in the system. The Department of Children and Family Services was operating under a federal consent decree. Significant reform was required, but there was no additional money. Performance contracting was one of the important reforms put in place to improve the system in a cost-neutral way.

Illinois' solution exchanged increased performance for the resources needed to achieve that performance. To make sure that raising the level of resources did not just increase the cost to the state, performance improvements in permanency and stability were contractually required. As more children gained permanency and fewer children remained in the system, more could be spent on each remaining child, all while maintaining budget neutrality. In other words, the reinvestments were self-funding through improved performance.

Performance contracting energized the Illinois child-welfare system by shifting the focus from system processes toward better outcomes for children. It aligned the financial incentives in agency foster care contracts with a commitment to protect the best interests of children and their families. Perhaps most important, it redirected resources from mechanisms that kept children in foster care toward those that aimed to find them permanent homes. Typically, foster care contracts are based on per diems, an amount paid for each day of care, which runs counter to the system's goals (i.e., a financial reward for keeping children in foster care rather than returning them home). Rather than focusing on inputs, the Illinois performance contracting model focuses on outcomes and aligns incentives with system goals. This is a simple change with the potential for profound impact.

In its first year, when performance contracting was applied to kinship foster care in Cook County (Chicago), permanence increased by almost 150 percent and placement stability increased by 20 percent. In the following year, the strategy was broadened to include traditional foster care. Since its inception, the number of children in kinship foster care in Cook County declined by 92 percent (from 24,249 in 1997 to 2,050 today). The Cook County foster care caseload decreased 57 percent (from 6,946 in 1998 to 3,003 in 2011). These caseload declines occurred with no increase in re-entry or subsequent abuse. Lower worker caseloads were earned through improved performance while improvements in services to children and families were funded. The financial benefit of this improved performance was shared by the state and private providers.

The Maryland Opportunity Compact

One example of a reinvestment compact is the Opportunity Compact implemented with the Department of Juvenile Services (DJS) in Baltimore County. In this compact, the County recognized that a significant number of youth were spending time away from their families in group home care after being found delinquent. Such youth were not deemed in need of placement in a secure facility as safety risks. Group home placement often further exposed youth to delinquent peers and did not show significant change in delinquent behavior for youth returned to the community. DJS identified 45 youth who, in a recent year, had been placed in group homes, with an average stay of 314 days for in-state placements and 365 days for out-of- state placements. The average cost of placement stay was $52,256 for in-state placements and $100,000 for out-of-state placements.

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Baltimore County already had a Multisystemic Therapy Program (MST) functioning for youth on probation to prevent them from entering deeper into the juvenile justice system. Leaders decided to expand this evidence-based program to youth identified by DJS and the court for group home placement. Experience with MST in the county had shown that it cost approximately $9,000 to serve a youth/family. The Crane Foundation, DJS, and the Department of Budget and Management (DBM) agreed to enter into a reinvestment compact in which the Crane Foundation agreed to invest $400,000 to expand MST and DJS and DBM agreed to reinvest the savings achieved as a result of the intervention. It was projected that potential savings per diverted youth would range from $43,256 to $91,000. The Compact was implemented and did generate adequate savings to sustain the MST Program for the target population.