

The FAST\$ Funding Stream: Results of a Statewide Initiative Designed to Increase Family Empowerment and Improve Youth Well-Being

The Ohio State University Center for Family Research Executive Summary

- The Families and Systems Teams (FAST\$) initiative involved the creation of a state-wide funding stream that was designed to better meet the needs of Ohio families containing children and adolescents with significant behavioral health care needs. Over the past three years, FAST\$ funds have been distributed to local service providers in all 88 Ohio counties in order to facilitate a variety of activities not covered under traditional Medicaid reimbursement plans.
- Most importantly, FAST\$-funded activities were designed to promote and develop a sense of *family empowerment* for caregivers of children and adolescents experiencing significant behavioral health issues. In essence, this effort was designed to support efforts that would give family members more “voice and choice” in the services offered to their children and adolescents.
- In addition, the funding stream was meant to *enhance the services being provided* to youth and families, as well as to *encourage greater collaboration* among service providers representing various human service agencies and organizations. In turn, it was anticipated that these activities would impact outcomes variables related to the *well-being* of children and adolescents whose families benefited from the services supported by this funding stream.
- The Center for Family Research (CFR) at The Ohio State University was contracted to conduct an evaluation of FAST\$. The three primary activities of FAST\$ – family empowerment, service enhancement, and systems collaboration – became the main foci of the evaluation effort along with outcomes associated with these activities, and as such are the central components of the final report.
- Both quantitative and qualitative data were gathered in support of the evaluation effort. Quantitative information was obtained through three primary data sources: the OSU enrollment forms and scales, the MACSIS claims database, and the Ohio Outcomes database. Qualitative information was obtained in focus groups that were conducted throughout the state of Ohio with service providers/program administrators, parent advocates, and family caregivers.
- Enrollment figures indicated that – as of May 31, 2007 – there were **4,967 youth that had received FAST\$-funded services over the three years of this initiative’s existence**. The OSU evaluation team received enrollment forms on 83% of all FAST\$ enrollments that were designated in MACSIS over the three years of the evaluation effort. OSU Family Scales were employed with 71% of all FAST\$ youth. Finally, at least one perspective of the Ohio Scales was entered into the Ohio Outcomes database on 87.3% of the youth enrolled in the FAST\$ initiative.
- Of the 4,967 youth enrolled in FAST\$ over the past three years, 63.8% were male and 36.2% were female. Ethnicity was largely Caucasian (80.6%) followed by African American (15.9%). The average age of these youth was 12.4 years. Nearly half of the FAST\$ youth were between the ages of 13 and 17 at enrollment.

- Ohio's 8 largest counties (populations > 300,000) comprise approximately 50% of Ohio's population, yet *accounted for only 26.9% of all FAST\$ enrollments*. The 19 mid-range counties (100-300,000) account for 25% of Ohio's population and *accounted for 21.8% of all FAST\$ enrollments*. The 61 small counties (populations < 100,000) comprise 25% of Ohio's population as well, yet *accounted for 51.4% of all FAST\$ enrollment*. Hence, **the smallest Ohio counties took maximum advantage of FAST\$ funding** for the behavioral health care needs of their youth in terms of enrollment rates that were significantly higher ($\chi^2 = 745.4, p < .001$) than those of the large and mid-range counties.
- Measurement of family empowerment focused on the wants and needs of adult family caregivers. The Top 3 areas where family empowerment was occurring at the highest levels included reports that:
 - 74% of adult caregivers experienced high levels of access to people who seemed to “understand my point of view” in dealing with problems and concerns
 - 73.3% of adult caregivers experienced high levels of access to people who gave “tips” about getting children the help they need
 - 72.9% of adult caregivers experienced high levels of influence in planning for their child's treatment or services.
- In the overall sample, a paired samples t-test indicated a **significant increase in family empowerment by the time of termination** ($t = 5.75, p < .001$). Of the 1,424 terminated cases in the overall FAST\$ database, 58.2% reported an increase in family empowerment between enrollment and termination, 10% reported no change, and 31.8% reported a decrease in family empowerment levels.
- Families residing in small counties reported significantly lower levels of family empowerment than medium and large counties at time of enrollment, $F(2, 3,751) = 11.76, p < .01$, and at time of termination, $F(2, 1,423) = 3.86, p < .05$. Thus, **county size mattered with regard to family empowerment** both at the beginning and at the end of services supported by the FAST\$ funding stream.
- Qualitative data were collected from three categories of focus groups to examine **family empowerment**. The most frequently cited mechanism by service providers and program administrators for bringing about an atmosphere of family empowerment and support was through the role of parent advocates. The parent advocates themselves stated they were most effective in empowering families by giving them useful information about how to help their children and families, in tandem with their transmitting the message that “they have a voice that deserves to be heard.” A general theme across focus groups of family caregivers was that they felt their sense of empowerment came most from the support they received from parent advocates, who were most helpful when they were encouraging family members to become “their own best family advocate.”
- A total of 4,334 FAST\$ youth (87.3% of total FAST\$ enrollment) were in the MACSIS Claims database. Overall non-FAST\$-funded service units represented an average of 415 service units per youth enrolled in FAST\$, or just over 103.7 hours of services recorded in MACSIS throughout the enrollment period. Mental health services were 92.1% and AOD services were 7.9% of the total units. The **Top 3 mental health services** involved: 1) Community support programs-Individual (44.6%); 2) other non-mental health (18.2%); and individual counseling (16.5%). **The top 3 AOD services** included: 1) Group counseling (108,525 units, or 76.8%); 2) Individual counseling (15,167 units, or 10.7%); and 3) Case management (5,722 units, or 4.0%).

- Service units were spread unevenly across large (47.1%), mid-range (19.2%), and small counties (33.6%). Given the total FAST\$ enrollments of the large, mid-range, and small counties (26.9%, 21.8%, and 51.4%, respectively) noted above, **large counties generated substantially more service units per youth** on average than mid-range and small counties, a difference that was statistically significant, $F(2,4330) = 92.6, p < .001$.
- **County size also mattered with regard to type of service.** AOD services were offered predominantly through large counties (61.4%), followed by small (30.1%) and mid-range (8.6%) counties, differences that were significant ($\chi^2 = 7165.3, p < .001$). Mental health service units across large, mid-range, and small counties (38.7%, 24.8%, and 36.1%, respectively) largely mirrored the distribution of total service units and differences were significant ($\chi^2 = 7,165.3, p < .001$). Interestingly, 50% (44) of the counties did not have any claims for AOD services.
- **Race/ethnicity mattered with regard to type of service** as well. Minority youth were significantly more likely to receive an AOD service than Caucasian youth, 9.0% of total service instances versus 5.5% of total service instances ($\chi^2 = 1,687.59, p = .001$).
- Measurement of potential threats to family stability focused on cataloguing the various changes in family circumstances that contributed to the pile-up of stresses and strains experienced by family members. The **“Top 3” issues at enrollment** included reports that: 1) 54.7% of the families had experienced a major change in family routine or schedule during the previous year; 2) 48.5% of the parents had lost their job or a significant amount of their income; and 3) 43.6% of the youth had changed schools. The **“Top 3” issues at termination** included reports that: 1) 31.3% of the families had experienced a another major change in family routine or schedule since they began receiving services; 2) 30.1% of the youth had changed schools since they began receiving services; and 3) 26.6% of the families had moved to a new home or neighborhood.
- Earlier reports regarding the **association between risk of out-of-home placement and other threats to family stability** held up in the final sample of families served by this funding stream. At enrollment, when there were identified issues that placed children at risk of out-of-home placement, family members were significantly more likely to report having faced a major change in family routine or schedule during the previous year ($\chi^2 = 49.03, p < .001$). The findings were similar from the stability data collected at termination; that is, when children were identified as being at risk of out-of-home placement at the end of FAST\$ funded services, family members were significantly more likely to report having faced a major change in family routine or schedule since their enrollment in FAST\$ ($\chi^2 = 56.94, p < .001$).
- Additionally, **county size mattered with regard to reported threats to family stability** at time of enrollment. Families residing in small counties reported significantly higher levels of family stressors than the medium and large counties, and families residing in medium counties reported significantly lower levels of family stressors than small and large counties, $F(2,3748) = 4.029, p < .05$.
- **Gender also mattered with regard to family stability threats.** At time of enrollment, families of female youth reported significantly more overall threats to family stability than did families of male youth ($t = 2.309, p < .05$). At termination, the differences by county size and gender were not significant. However, there was variation in mean family stability change scores (T1-T2) among the 88 counties.

- Qualitative data were collected from three categories of focus groups in order to examine **service enhancement**. Service providers and program administrators reported that many of the services provided to families would otherwise have not been possible without the FAST\$ funding stream. Respite was the most commonly reported service enhancement. Parent advocates consistently reported that the FAST\$ funding stream did enhance service provision through a variety of programs and delivery methods. Respite and camp enrollments were most frequently reported. Family caregivers reported that a variety of services were offered to their families which were beneficial for them, and they consistently noted that these services were further enhanced by the efforts of parent advocates, especially when a wraparound model of service was employed.
- All information regarding the impact of the FAST\$ funding stream on **increased systems collaboration** involved qualitative data generated through the three categories of focus groups. Service providers and program administrators indicated that the structure of the FAST\$ funding stream influenced agencies and organizations to collaborate and otherwise work more closely with each other. Parent advocates stated that FAST\$ funds were the “key ingredient” in getting representatives of various agencies to collaborate in their work with children and families. Family caregivers were explicit in their descriptions of the benefits that their families experienced when collaboration occurred, as lines of communication were improved both quantitatively and qualitatively, which in turn was thought to provide better services to the families.
- Scores from the Ohio Scales were used as the primary source of outcomes data. There was a **surprisingly clear effect associated with FAST\$ enrollment**. Using pre-FAST\$ (Time 0), FAST\$ enrollment (Time 1), and termination (Time 2) scores, there are distinct differences between the time points, which show steady improvements from Time 0 to Time 2 on both Subscales. These differences across the entire time period are significant for both Functioning, $F(2,340) = 4.28, p < .05$, and Problem Severity, $F(2,340) = 4.48, p < .05$. Furthermore, the difference between the two early administrations (0 and 1) is not significant for either functioning, $t(170) = -0.57, p = .57$, or Problem Severity $t(170) = 1.00, p = .32$. Hence, the significant improvement took place during the period of FAST\$ enrollment (Time 1 to Time 2) both for Functioning, $t(170) = , p < .05$, and Problem Severity, $t(170) = 2.15, p < .05$. Hence, although behavioral health progress generally follows a positive trajectory, there was a significant boost to improvement rates associated with the events surrounding FAST\$ enrollment.
- Potential sub-sample differences also were examined in terms of each of the three versions (perspectives) of the Ohio Scales. In the Youth perspective database, the demographic groups generally showed significant improvements, and at the same time were not significantly different from each other. In the Parent perspective database, however, **improvement among White youth is reliably greater than Minority youth** in both Functioning and Problem Severity. In the Worker perspective database, **female youth displayed significantly smaller improvements than males**.
- In addition to group-level averages, individual-level outcomes were examined through **Reliable and Clinically Significant (RCS)** Change scores, or changes in Behavioral Health outcomes scores that are large enough to be considered meaningful (reliable), and result in a shift from clinical to ‘normal’ levels of a measure – or vice-versa (clinically significant change).

- The largest groups among **Youth-reported scales**, both by numbers and proportions, are those that displayed no change. Among youths who began with clinical levels of Problem Severity, more than 40% showed RCS improvement, a rate three times higher than the rate of RCS decline among youth who started off in the normal range. On the Functioning scale, the number of clinically functioning youths showing RCS improvement was almost double that of normally functioning youth showing RCS decline (40% versus 23%).
- The largest groups among **Parent-reported scales**, both by numbers and proportions, also are those that displayed no change. There are more than twice as many examples of RCS improvement than decline on both the Functioning and Problem Severity domains.
- The largest groups among **Worker-reported scales** also are those that displayed no change. However, here the rate of decline among the relatively small number of youths who were in the non-clinical range at Time 1 is actually greater than the rate of RCS improvement among the clinical sample on both the Problem Severity and Functioning domains, obviously a cause for concern.
- In addition to the quantitative data generated through analyses of the Ohio Scales scores, the focus groups also were asked to respond to **questions about outcomes** associated with the FAST\$ funding stream. Numerous examples were given by the service providers/program administrators regarding successful outcomes for youth and families generated through FAST\$ funded services, including reductions in out-of-home placement, child behavioral improvements, and positive gains made in family functioning. Parent advocates cited numerous similar examples of how FAST\$ funded services had specifically helped youth and families. In turn, family caregivers shared numerous stories about how services supported by the FAST\$ funding stream had made a positive difference in the lives of their families through by helping families stay together, through positive changes in children's behavior, and in life skills improvement.
- Further analyses were conducted with 2,176 terminated cases in the FAST\$ database which included 431 (19.8%) cases that had utilized some sort of Parent Advocate. Ohio Scales scores revealed that **parent advocates were beginning their work with youth displaying significantly greater Problem Severity and significantly less Functioning** abilities in comparison to those youth enrolled in FAST\$ that did not have parent advocates assigned to their cases.
- These significant differences prompted more refined comparison of the impact of parent advocate presence on the outcomes measures for groups that were relatively equivalent in terms of where those youth began at the time of their enrollment. There are two key findings that emerge from this further examination of the use of Parent Advocates, both of which generated surprising findings. The first is that **Parent Advocacy did not affect the significant changes in outcomes** as measured by the Ohio Scales, including Hopefulness and Satisfaction with Services. The second surprising finding was that **youth who began services relatively well off tended to show significant declines** in the context of FAST\$ participation.

- The qualitative database contained information gathered through the focus groups regarding the relative **consideration that was given to culture** in FAST\$ funded services. Service providers, program administrators, and parent advocates all viewed culture as an important consideration within FAST\$ funded services as seen in a variety of contexts, including geographical location, race/ethnicity, religion, social class, and unique differences and preferences of individuals. While family caregivers varied widely in their belief that culture was an important issue, those family caregivers that did consider culture to be a central concern most frequently mentioned issues related to race and social class.
- The focus groups participants indicated that future FAST\$ efforts could be enhanced through such **improvements** as: better clarifying the appropriate use of FAST\$ funds, increasing the flexibility of those funds to support basic family needs, expanding the role of parent advocacy (with concomitant increased funding), developing guide-book type materials for caregivers, more training and education for parent advocates themselves, reducing paperwork, and better helping families with school-based problems.
- CFR personnel were asked to contribute to a final installment of “**lessons learned**” as a result of the growing pains, challenges, and subsequent mid-course corrections that the evaluation team (and by extension, our county and state partners) experienced during the course of this evaluation effort. The lessons learned included:
 - *Balance*: Respecting both for the autonomy of local government and the authority of the state
 - *Responsiveness*: Maintaining accessible and consistent communication channels
 - *Symmetry*: Using carrots and sticks in the data collection process
 - *Optimism*: Believing that what “goes up” (into the state database) eventually will “come down” (to the counties) in the sharing of data
- Overall, the available evidence suggests that the funding stream did in fact largely do what it was designed to do. Universally, caregivers are reporting **significant gains in their sense of empowerment** from time of enrollment to time of termination from FAST\$-funded services. In turn, youth, parent, and worker perspectives indicate overall **significant reductions in problem severity levels and significant increases in functioning levels**.
- At the same time, **recommendations** also were made in light of the FAST\$ initiative’s design to provide financial support for activities that would empower families and, subsequently, contribute to the well-being of children and adolescents with significant behavioral health care needs. Within a non-traditional evaluation framework, at least in the sense that the CFR’s efforts were not designed to pass judgment on a program per se, but rather a funding mechanism that supports a multiplicity of programs and activities, these recommendations included:
 - Examine state databases regarding variation in Medicaid service consumption
 - Conduct more research on parent advocacy to better determine the activities and utility of these efforts
 - Support cultural competency training in light of the racial disparities in outcomes
 - Focus attention on the need to know if positive changes are reliable and clinically significant, as well as tracking potential deterioration effects on participants
 - Use baseline Ohio Scales scores to determine service eligibility in order to ensure that those most in need are being reached