Transition to Independence Process (TIP) Model®

Lighting the Way for Improving Outcomes with Youth & Young Adults

TIP Model® Funding Study Brief Report:

Funding Mechanisms & Partnerships for Agencies to Establish or Expand Transition to Independence Process for Youth & Young Adults

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Acknowledgements

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Gratitude

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Purpose

In the current US social service and community mental health economic landscape, it is challenging to consistently fund effective, developmentally-attuned mental health services for adolescents and young adults (AYA) with emerging or diagnosed serious mental health conditions (SMHCs). SMHCs include major depressive, bipolar, and schizophrenia spectrum disorders. AYA best-practice is multidisciplinary team-based care that tends to include: proactive care coordinators, employment and education specialists, therapists, and peer support specialists. Providers must braid revenue sources (e.g., Medicaid, commercial insurance, grants, donations), and develop partnerships (e.g., cross-system, community entities) to provide multidisciplinary, coordinated, and tailored care for AYA and their families.

The *Transition to Independent Process (TIP) Model*® (Clark & Hart, 2009) is one of the most widely adopted evidence-informed practices in the US for AYA with SMHCs. The *TIP Model* leverages a *Positive Youth Development* framework to promote AYA wellness and healthy development (Dresser, Clark, & Deschênes, 2014). This brief report details how community mental health providers across the US have built funding streams, partnerships, and mechanisms to sustain *TIP Model* programs.

Although all the providers highlighted in this report currently use multiple funding sources to sustain TIP programs, they initially established or expanded *TIP Model* programs through county, state, or federal grant funding. Further, these sites developed partnerships with other key community or state agencies (e.g., community college, vocational rehabilitation, HUD housing). This report describes how *TIP Model* programs have been sustained through the following funding and partnership arrangements:

Advantages and disadvantages associated with each funding strategy are also detailed. The report concludes with a *Strategic Planning and Advocacy Section* (pg.15) for effectively sustaining and growing *TIP Model* programs, including contact information for nationally-recognized experts in AYA mental health program funding and operation; and *Resources* for preparing grant and contract proposals (pg.17).

Methods & Participating Sites

TIP Model programs from 6 states completed interviews with Stars Training Academy National Consultants and Researchers. Interview questions inquired about funding mechanisms and community partnerships used by a site's TIP Model team to provide its array of supports and services. Notes from trainings were reviewed and summarized in Table 1 below. Then, we describe in depth the 5 most common TIP Model funding sources in the next section of this report. The report concludes with a *Strategic Planning and Advocacy Section* (pg. 15).

Two of these sites also operate TIP-Informed First Episode Psychosis Programs (TN & IL). One of site also uses a TIP-Informed Wraparound approach (OK).

Table 1. TIP Model Sites & their Funding Sources

Site Details	Primary Funding Sources
1. Pennsylvania *Three TIP Model Teams* in Lehigh, Northampton, & Bucks Counties serving 16-26 year olds *Researchers Interviewed Access Services Agency & TIP Team Leadership,* Fort Washington, PA	▪ Medicaid Blended Case Management fee-for-service to cover proactive case management, therapy, & peer support. ▪ One county received a $20K annual grant to cover emergency services & gaps in insurance coverage for services. ▪ From 5/20-9/22, teams received a monthly alternative payment based on average monthly payment received 6-months prior to COVID-19 restrictions (replaced service unit payments to sustain services). ▪ Transitioning from Medicaid fee-for-service to Value-Based Care.
2. Florida *Six TIP Life Coach Teams in* Broward County *serving* 14-29 year olds *Researchers Interviewed Broward Behavioral Health Coalition (BBHC) & Team Leadership,* Fort Lauderdale, FL.	▪ 1% of county's property tax go to County Children's Service Council for mental health services that fund 3-year grants for TIP teams to provide life coaching, individual & group therapy, & community support. ▪ Memorandum of Understanding with 2 other agencies to connect AYA to Supported Employment Specialists who use Individual Placement and Support (IPS) & who have also been trained in the TIP Model. ▪ Florida Department of Children & Families (general revenue for mental health and substance use services) funds some additional TIP team positions at BBHC agencies that have TIP Model teams. ▪ State Department of Health granted technology resource funding to promote telehealth service delivery & communication (e.g., Let's Talk Interactive; BBHC Online) between TIP teams & professionals (e.g., School Social Workers, Child Advocates, Juvenile Probation Officers). ▪ Broward County has SAMHSA System of Care grant which funds TIP Model & IPS Supported Employment training & fidelity assessments. ▪ No reliance on Medicaid or Commercial Insurance to fund TIP services.

3. Michigan **Transition Age Team** serves 14-25 year olds & **Juvenile Justice (JJ) Team** serving 12-18 year olds in **Muskegon County** & throughout West MI CCBHC demonstration site. *Researchers Interviewed: HealthWest Agency & Team Leadership*. Muskegon, MI.	▪ Teams use capitated Medicaid for outpatient therapy, targeted support coordination, supported employment (IPS model), crisis intervention, youth peer support & parent support partners. ▪ Services also billed through 3rd party insurance as relevant & needed. ▪ JJ team has a family court contract with a bundled code to cover services not Medicaid reimbursable (e.g., parent outreach & support). ▪ All primary services (listed above) are CCBHC eligible and AYA are enrolled in the CCBHC demonstration. ▪ Flexible funds available via a federal grant (System of Care) to cover AYA essential needs, however this remains a very important gap within CCBHC and Medicaid funding.
4. Oklahoma ***TIP-Informed Wraparound Teams*** *(16-25 years),* Numerous Teams across the State of Oklahoma. *Researchers Interviewed: Oklahoma Systems of Care Technical Assistance & Training Team*. Oklahoma City, OK.	▪ Medicaid Blended Case Management option includes intensive case management, peer support, family support, medication management, outpatient therapy, community outreach, advocacy, & resource linkage. ▪ Slowly transitioning from Medicaid to CCBHC. ▪ Gradually expanding System of Care from 2 counties to all 77. ▪ State contract funding supports agencies in providing services & resources that are non-Medicaid billable (e.g., transitional housing). ▪ SAMHSA Healthy Transition Initiative grant supports TIP teams, on-going TIP Model training & supported employment services.
5. Tennessee ***Two OnTrack TN First Episode Psychosis Teams.*** (15-30 years), Knox and Hamilton Counties. *Researchers Interviewed:* ***McNabb Center & Team Leadership.*** Knoxville, TN.	▪ Medicaid fee-for-service for therapy, certain levels of case management, medication services & peer support. ▪ Some commercial insurance billing for psychiatric assessment, prescribing, & therapy (e.g., 1 managed care agency does a case rate while others do fee-for service). Fee-for-service are more flexible; case rates require specific number of units & visits to receive full case rate. ▪ State Dept. of Mental Health's "SafetyNet" grants support coordinated & specialty care teams. These grants reimburse for therapy, certain levels of case management, medication services, & peer support. ▪ State Dept. of Mental Health also provides block grant funding to agencies with first-episode psychosis programs.
6. Illinois ***Two Emerge Community Support Teams*** (17-26 years) ***& Two MindStrong First Episode Psychosis Teams*** - (14-40 years), Cook & DuPage Counties. *Researchers Interviewed:* ***Thresholds & Team Leadership***. Chicago, IL.	▪ Medicaid fee-for-service for community support teams that provide in-community coaching & support, individual & family therapy, peer support, social & skills groups & activities, case management, payee-ship services, psychiatry & medication management. ▪ Commercial Insurance Single Case Rate Agreements cover psychiatric assessment, medication management, & individual & family therapy. ▪ 16-26 year olds can use both parents commercial insurance & Medicaid (Affordable Care Act States only). ▪ State passed legislation required commercial & Medicaid coverage of multidisciplinary youth & young adult team-and community-based models, which have not been fully implemented to date. ▪ State Department of Vocational Rehabilitation contract funding for Supported Employment milestones met (e.g., job starts, 15-, 30-, 90-day outcomes) helps to fund Supported Employment Specialists.

	▪ State First Episode Psychosis block grant funds support non-Medicaid/commercial insurance reimbursable activities (e.g., community education & outreach, early screening & assessment, assertive engagement, quality monitoring, evaluation). ▪ Foundation grants fund non-Medicaid/commercial insurance reimbursable activities (Peer Support, Supported Education, Advisory Board).

Five Major Funding Sources Used by TIP Model Sites

This section outlines the 5 most common funding sources for funding TIP Model sites, and the advantages and disadvantages of each funding source.

1. CCBHC Funding

One site (Michigan) leveraged a ***Certified Community Behavioral Health Clinic*** (*CCBHC*) to fund an AYA transition team that uses the TIP Model as its foundational practice. CCBHC is a relatively new federal funding stream to improve integrated and effective physical and behavioral healthcare. There are only 10 states in the CCBHC Medicaid demonstration program, which was created in 2014 to help clinics better serve uninsured and underinsured individuals. However, there are over 400 CCBHCs operating across the US, as either a SAMHSA grantee or clinics participating in their states' Medicaid demonstration. Organizations seeking CCBHC certification typically start as SAMHSA grant sites.

CCBHCs were designed to **provide comprehensive mental health and substance use disorder services to individuals and families in need, regardless of their ability to pay**. CCBHCs ensure individuals who qualify for Medicaid (and/or are living in poverty, uninsured, or are active-duty military or veterans) have access to evidence-based healthcare. CCBHC state demonstration projects showed stronger cross-sector service integration (e.g., mental health, justice system, child welfare, law enforcement) and are moving to create more streamlined and efficient program operations, documentation, and reimbursement systems than achieved under Medicaid and fee-for-service billing models (https://aspe.hhs.gov/reports/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2019-0).

The **TIP Model transition team within a CCHBC demonstration provides a variety of services (e.g., proactive case management, teaching skills, therapy, assessment, treatment planning) which are eligible for the *prospective payment system* (PPS) under CCBHC.** The PPS funding

rate supports the operation of an effective TIP Model program, and also partially supports necessary quality, training, evaluation, and administrative functions. CCBHC can also provide federal grant funding for agencies to initiate or expand programs, regardless of their demonstration status. These are important additional resources CCBHC sites can secure for expanding AYA service efforts using the TIP Model.

Two additional TIP sites are currently meeting with state administrators to learn more about how their states are approaching CCBHC adoption. Both sites plan to advocate for the TIP Model to be listed as a promising practice for transition to adulthood programs within their states' CCBHC plans. As part of their advocacy efforts, these sites are using TIP Model outcome peer reviewed journal articles (e.g., Bohs et al., 2021; Dresser et al., 2014; Klodnick et al. 2020) to make the case for TIP Model integration into the state's CCBHC plan. TIP Model is already listed in the state of Michigan's CCBHC Model.

CCBHC Funding Advantages

- State government administers CCBHCs; federal regulations maximize integrated services.
- Promotes evidence-based practice use including integrated behavioral & physical healthcare.
- Standardizes care through set of criteria for all certified clinics to follow with:
  - -Strong financial & quality metric reporting accountability.
  - -Formal coordination with primary care & other settings (e.g., school, child welfare, justice systems) to provide intensive care management + transition supports.
- CCBHC evaluations demonstrate increased access to mental health & substance use best-practice care, as well as reductions in emergency department and hospital visits among CCBHC clients, leading to return on investment.

CCBHC Funding Disadvantages

- Agency & community partnership infrastructure needed for CCBHC demonstration is extensive. Also, a strategic implementation plan is needed.
- Paperwork requirements & staffing present challenges for successful implementation.
- An agency or community collaborative may be successful in securing different grant funding sources simultaneously, but this can create extreme burdensome documentation & reporting requirements (e.g., Centers for Medicare & Medicaid Services (CMS) CCBHC Demonstration grants and SAMHSA CCBHC Expansion grants have different federal reporting requirements).

For more information regarding CCBHC, visit the National Council for Mental Wellbeing: www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/.

2. Medicaid Funding

Five of the six TIP sites used Medicaid funding to provide community mental health services to sustain TIP programs. Medicaid is a U.S. federal and state-provided government healthcare insurance for individuals meeting a low-income threshold. The federal government matches each state's Medicaid allocation; and monitors state compliance to federal Medicaid regulations. For more info visit: www.Medicaid.gov. **States differ in which types of child (under 18) and adult (18 and older) mental health services are funded through their state Medicaid plans.** For example, in a particular state Integrated In-Home Behavioral Therapy may only be covered for youth under 18 while *Assertive Community Treatment* may only be covered for people 18 and older.

Medicaid is typically regarded as the most available funding stream for TIP-based services as it covers a wide variety of health disciplines, service deliveries, and personnel credentials relevant to the TIP Model. Sites report that most of their AYA and families are connected to Medicaid for insurance coverage. **Provider leadership must fully understand their State's Medicaid plan and rules to determine effective service codes for their use.** Staff with certain licenses or experience can provide certain services under state Medicaid rules. For example, in most states staff must have a counseling or clinical social work license to bill the *Outpatient Therapy option* via Medicaid. Typically for a service to be billable, it also must be at least 15 minutes in length and meet *"medical necessity."* This means that any service delivered must be directly linked to a medical/clinical need. Different services often must be **billed separately as Fee-For-Service per Medicaid rules**, even if delivered by one staff member during one service episode. For example, in some states' Medicaid plans, a *Case Management* activity (e.g., *Targeted Supports Coordination*) cannot occur within the same time unit of an *Outpatient* Therapy activity unless both are documented separately with an associated proportional unit of time reported for each. So, instead of billing for a 45-minute appointment as a 45-minute service, a staff member must bill 15-minutes under the *Case Management option,* and 30 minutes under the *Outpatient Therapy option.* Also, depending on the Medicaid plan, services are reimbursed at different fee-for-service rates.

Some State Medicaid plans allow for a ***bundled rate*** **where an array of different services can be delivered together and billed as one Medicaid service code to meet special population needs**. Each state defines their bundled service packages differently. For example, the Emerge Team at Thresholds in Illinois used the bundled service of Community Support Team (CST) bundled rate code for their TIP service delivery package. The CST bundled code is similar to the Assertive Community Treatment (ACT) bundled code which is for the delivery of an evidence-based service for adults with long-term mental health needs. The CST bundle code also enables the multi-disciplinary Emerge TIP team include a variety of personnel with

their different specialist roles (e.g., TIP Transition Facilitators, Supported Education & Employment Specialists, Peer Support Specialists, Therapists) and yet the team bills Medicaid for one code (CST) instead of different codes per discipline.

Two other TIP sites are working with their State Medicaid office to establish a "*transition to adulthood"* bundled service option. Effective bundled rates must be set high enough to include all activities critical to engaging AYA and families. This includes coverage of: (1) TIP program team members and support staff (e.g., supervision, quality assurance, evaluation, and administrative personnel); (2) engagement tools and technology (staff tablets, smartphones, WIFI, software), individual and group activity costs, travel costs; (3) documentation time and administrative data tracking, and (4) staff workforce development. HealthWest bills under Michigan's *Medicaid Prepaid Inpatient Health Plan (PIHP)* to provide comprehensive services under a prepaid capitation payment contract to arrange for inpatient psychiatric care if needed, and minimize agency fiscal risk based on Medicaid audits.

Medicaid Advantages

- In most states, Medicaid provides substantial funding if the agency adheres to service delivery rules & regulations.
- Medicaid often covers a wide range of relevant TIP Model-related services
- Medicaid covers services delivered by staff with a wide variety of credentials
- TIP sites can work with the local Medicaid authority to negotiate service types covered by Medicaid, pending state and ultimately federal approval.
- Bundled codes described above (CST & PIHP) provide examples of creative Medicaid funding mechanisms that more effectively support TIP Model service delivery.
- Two TIP sites covered *Supported Employment* services using Medicaid.
- Medicaid is available in every state & does cover most of TIP Model services.

Medicaid Disadvantages

- Requires substantial documentation linking each service provided to *medical need.*
- Medicaid eligibility for child & adult services are different. Most AYA will not qualify for the same level of care in adult settings that they qualified for in child settings.
- Medicaid reimbursement rates may not be as substantial as other funding options.
- AYA are not always eligible, depending on State Medicaid rules. Especially if the state has not adopted the federal Medicaid expansion program.
- Does not reimburse for brief engagement contacts, efforts to engage and re-engage AYA, or staff transportation time.
- Text-based services are not typically Medicaid reimbursable.
- Strict documentation rules for each 15-minute service unit that are regularly audited, which can be cumbersome and costly to reconcile.

3. Value-Based Care/Payment

The Pennsylvania site is preparing to transition to ***value-based care*** and the associated ***value-based payment*** system over the next year. The goals of value-based care as it relates to behavioral health is to utilize evidence-supported best practices to address needs and achieve improved outcomes in cost-effective ways. The value-based payment is designed to compensate provider agencies though an efficient payment means that enables them and their personnel to focus on the delivery of these practices in achieving the desired client outcomes (e.g., functioning in work, school, home, and community; reduction in the use of expensive restrictive crisis units and placements). The Centers for Medicare and Medicaid Services (CMS) provided a value-based care grant to test the value-based care/payment systems in behavioral health organizations throughout New York state (www.thenationalcouncil.org/program/value-based-care/about/).This 4-year large scale, collaborative program evaluation findings suggested that:

(1) 75% of organizations implemented value-based care approaches successfully
(2) achieved improved client outcomes
(3) reduced costs substantially by decreasing re-admissions and hospitalization use
(4) improvement in financial management and analysis, and use of organized strategies for quality improvement and community partnerships.

Advantages of Value-based Care/Payment

- Practitioners are empowered to think of client's presenting problem context & address contextual issues (e.g., AYA who presents with substance use & is also homeless).
- Practitioners' activities & documentation are not focused on 15-minute units, rather on application of best practices
- Provider agencies are encouraged to build relevant partnerships and networks to create systems to address client needs.
- Value-based payment rates enable provider agencies to provide services AND cover administrative overhead to ensure that they are training and mentoring practitioners & supervisors in best practices, and tracking progress & quality of their efforts.
- Technical assistance sources help agencies and collaborating partners with value-based care and payment system implementation (www.CareTransitionsNetwork.org)

Disadvantages of Value-based Care/Payment

- Requires collaborating & negotiating with State Medicaid to establish a payment system that covers the valued care cost of individualized, quality, effective services.
- Provider agencies and practitioners may resist the level of change that is needed for transitioning to value-based care and payment approaches.

- Difficult to manage numerous evidence-supported practices, tracking fidelity, outcomes, and fiscal data related to each.
- Requires more focus on integrated data systems to track quality of care, progress and outcome indicators, and costs.
- VBC arrangements are rare but hopefully emerging. It takes substantial negotiation between a state Medicaid authority and provider to make the terms compatible.

For more information regarding value-based care and payment approaches and learn about resources to support these systems, visit the National Council for Mental Wellbeing website: www.thenationalcouncil.org/program/value-based-care/resources/.

4. Commercial & Private Insurance Funding

Three participating sites (Illinois, Tennessee, Michigan) accepted commercial/private insurance from AYAs who either had their own or had caregivers with plans that covered their children. Commercial insurance service reimbursement rates often exceed Medicaid rates, and typically have less restrictions and documentation challenges than Medicaid. However, commercial insurance often only reimburses for services documented by masters-level licensed clinical staff, or sometimes staff working under a masters-level licensed professional. Because TIP Model services are often multidisciplinary, and rarely delivered solely by licensed staff, commercial insurance funding has to be supplemented by other funding for TIP teams. Further, provider agencies need to be *"in network"* to qualify for commercial insurance reimbursement, and rates vary depending on the commercial insurance plan.

Akin to Medicaid, commercial insurance reimbursement requires awareness of plan rules/requirements, and typically only covers clinical activities (e.g., individual & family therapy, psychiatry assessment, prescribing). Commercial insurance does not typically cover other services (e.g., case management, community support, peer support, employment and education services). TIP sites that leverage commercial insurance for some services braid this funding with other funding. With the Affordable Care Act, AYA can remain on their parents/caregivers commercial insurance while also qualifying for Medicaid as an individual until their 26th birthday. This allows provider reimbursement by both funding streams if the provider agency tools up to do so.

Two sites (IL, TN) had TIP teams for AYA diagnosed with SMHCs, in addition to TIP-informed *Coordinated Specialty Care* teams for recent psychosis onset. Sites leveraged commercial insurance service reimbursement to cover individual or family therapy.

Advantages of Commercial Insurance

- Documentation is typically less complex for commercial insurance than for Medicaid, mainly because there is a pre-authorization requirement by a commercial carrier.
- Insurance payment rates are typically higher than Medicaid rates.
- In some circumstances, young adults who are on their parents' commercial insurance can also qualify as a "family of one" for Medicaid.

Disadvantages of Commercial Insurance

- Agency may have to be "in-network" for commercial insurance reimbursement.
- Staff delivering services typically required to be licensed or license eligible.
- Many TIP Model services are not covered by commercial private insurance, so braided funding is needed to supplement cost of service delivery.
- Each insurance company has their own unique reimbursement system, and delays in reimbursement are common.

5. County, State & Federal Grant Funding

Most TIP sites used county, state, or federal grants to initiate, expand, or improve AYA-specific programs. At the U.S. federal level, *SAMHSA Healthy Transitions* grants target 16–25 year-olds for demonstration projects. These grants required states to establish a state level committee to collaborate with the demonstration sites and examine ways to improve policies, training support, and funding for effective AYA service implementation across current and future sites. *SAMHSA System of Care grants* were another source that some TIP sites have used to build and expand AYA services (e.g., establishing a transition team in a rural section of the county, developing a peer-operated drop-in center, expanding transition relevant housing options, establishing a Youth M.O.V.E. chapter or a Federation of Families chapter for peer support, family support, and advocacy). These grants often allowed for increased operational funding (e.g., hiring of peer support specialist and/or supported employment/education specialist, transportation vouchers, flexible funds for AYA essential needs). Four TIP sites secured funding streams for supervised transition apartments and/or AYA-leased apartments.

Although provider agencies typically need to supplement these grants with other funding, the grants provide for an excellent continuity of services and supports with fewer of the fee-for-service billing constraints. The challenge with these 1 to 4-year grants are they have an "end date," and unless agency and community leadership are strategic in their planning for sustainability, funding ends at the close of the grant cycle, then the program weakens or closes. Thus, agency leadership must learn how to use a variety of funding streams to

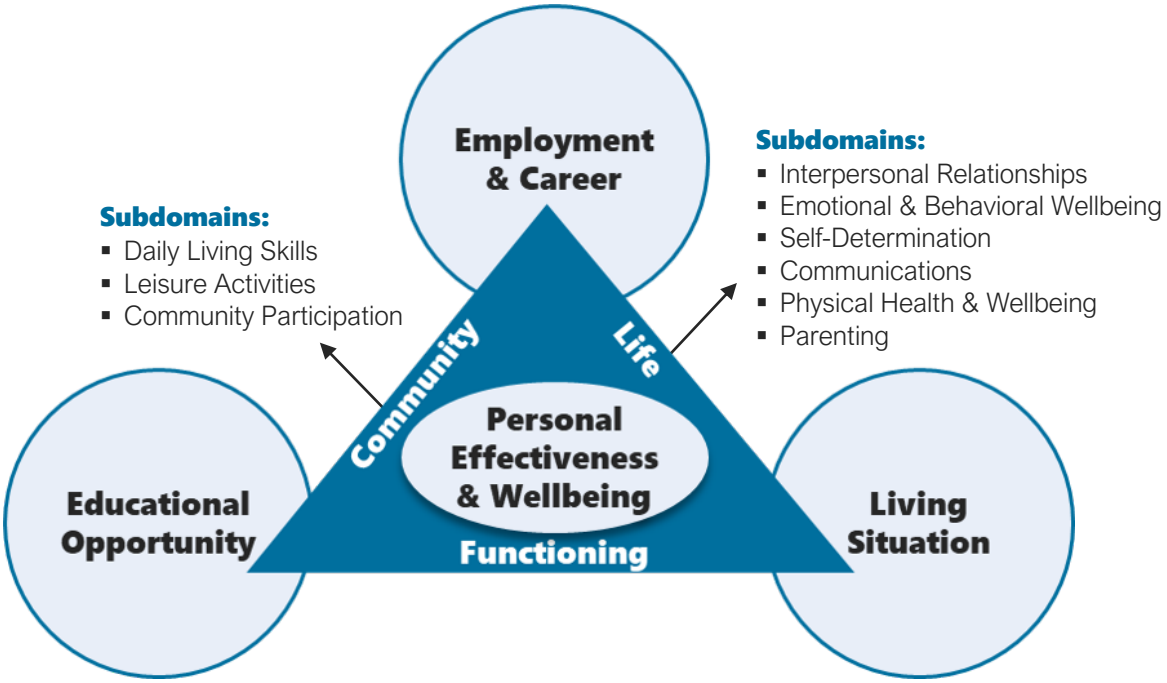
maximize billing opportunities for sustainability. The Florida TIP site benefits greatly from a county grant funding mechanism that enables agencies to apply for operational and expansion funding on a 3-year cycle. Funding for these grants comes from local county taxes allocated to fund youth and family services (www.cscbroward.org/). The Pennsylvania TIP site has a funding stream of $18-$20K though Bucks County to support AYA who have a lapse in eligibility coverage or for funding of an essential item for an AYA.

6. Community Partnerships

All TIP sites built community partnerships with other organizations to provide or link AYA and their families to needed resources, services, and supports. Most TIP sites viewed their partnerships with other provider agencies, community service organizations, advocacy organizations, and local/county/state governmental entities as essential in meeting AYA needs. Partnerships were both informal (i.e., no written agreement/contract; no funding exchange, no specific service delivery requirements) or formal (i.e., written agreement/contract with or without funding and service delivery requirements). The TIP Model supports AYA in directly identifying and addressing their priority needs and goals across the 5 TIP "transition domains" (Figure 1 on next page). These include simultaneously meeting basic and developmental AYA needs: livable income, housing, food, safety, clothing, hygiene, social support, education, and employment. Having partnerships with other community organizations allows TIP sites to better support AYA with various of their needs in a financially feasible way. Here are examples of partnerships:

- Some TIP sites connected AYA to *Supported Employment & Education services* in their agency's adult service sectors. Others relied on community partnerships for supporting career goals. One site had a formal contract with the State Vocational Rehabilitation Department to fund services based on job starts & maintenance.
- Some TIP sites, and the agencies they were housed in, had strong, longstanding connections to the adult mental health housing or state housing programs to secure safe and appropriate AYA transition housing options (e.g., supervised apartments, lease arrangements for scattered-site apartments, housing vouchers).
- All TIP sites and their host provider agencies had strong longstanding partnerships with other community entities such as: community colleges, employers, primary care clinics, discount clothing, gym, food pantry, & social security benefits.
- Some TIP sites expanded their community presence by accessing office or activity space though collaboration with faith-based or other community organizations.

Figure 1. The 5 TIP Transition Domains (www.TIPstars.com)



Strategic Planning & Advocacy for TIP Sustainability

To financially sustain AYA services and supports using the TIP Model, it is essential that **agencies have internal champions who lead service implementation, sustainability planning, financial resource braiding, and community partnership collaboration.** These champions must learn about community resources and currently available funding mechanisms – and creatively cultivate new partnerships and funding sources for AYA services and supports. Access to available resources, partnerships, and funding streams is accomplished through: (1) building relationships with key agency leaders across child and adult provider agencies, divisions, and other community entities to leverage existing resources; (2) investigating sources of possible funding mechanisms at the local, county, and state levels and identify their potential use; (3) *barrier busting* to change a status quo funding mechanism or policy to enable better service provision; and (4) advocating and educating policy makers to create new funding or revised policy, thereby creating resource accessibility previously unavailable.

Examples from TIP sites:

- A site was operating under the notion that an AYA with Medicaid coverage had to transfer to an adult mental health provider at 18 years old, leaving her therapist of the past 2 years. Through their contacts and digging into state Medicaid rules, staff learned that a recently changed Medicaid regulation permitted this AYA to remain with the same therapist and continue her Medicaid coverage to 21.
- Adult and youth champions went to a state legislative day to share their service experience stories and promote a strategic plan to provide funding for AYA services not covered by Medicaid. Based on their efforts that day (& with active follow-up over the next few months), the legislature reformed policy and funding for transition teams to provide a fuller array of relevant supports and services.
- TAY Champions for Change and the AYA-composed YA Advisory Board in Bucks County have led the way in: adapting Certified Peer Specialist training to be more effective in collaborating with AYA; making the county mental health website more AYA and family friendly and useful; and initiating LGBTQ resources for AYA.

TIP sites can benefit from coordinating advocacy efforts to better meet the needs and goals of AYA. **Underscored is the importance of systematically involving individuals with lived and living experience with SMHCs and service involvement, in advocating for additional AYA TIP site resources.** This includes: AYA, families, peer support specialists, and other key community stakeholders who can speak to their experiences with TIP Model services and

supports, and the need for sustaining these multidisciplinary approaches. However, effective advocacy must have a clear goal, strategic plan, and leadership to coordinate the efforts. Building collaboratives and systems of care in a community or county can bring attention and momentum to building AYA service systems (Clark et al., 2008; Sieler et al., 2009). Some sites described how they partnered with state regulatory departments to modify Medicaid rules to support transition services and/or advocated to have the TIP Model listed as an approved practice in their state CCBHC plan.

For advocacy efforts to be successful in securing funding to provide the array of AYA supports and services, **there is also a need for basic data tracking to capture and illustrate the positive impact of TIP Model teams on AYA, families, and community – and cost avoidance** (e.g., reduction in use of expensive, restrictive crisis units or placements). Incorporating data systems for capturing key outcomes (e.g., psychiatric hospital avoidance; work and school engagement) require resources and monitoring. This investment is critical for examining how TIP sites are maximizing funding and service delivery, and where there are gaps in needed supports or services. This meaningful information is essential in cultivating new funding sources and for policy reform. TIP sites often must explain to funders how they strategically braid funding and how they have funding for certain services through one funder (e.g., Medicaid for therapy), but that there are no or limited funding for other key services (e.g., supported employment and education, safe and affordable housing). Some sites find it helpful to also use published research studies on the TIP Model to illustrate the progress and outcomes of AYA (e.g., Bohs et al., 2021).

Further, agency, county, and state leadership and champions can be successful in sustaining TIP Model programs if knowledgeable about *implementation drivers* (Fixsen et al., 2019; www.activeimplementation.org/wp-content/uploads/2021/02/Drivers-Responsibility-Analysis.pdf). **Implementation drivers provide a clear understanding of how evidence-supported practices can be adopted and implemented successfully** – and what barriers can undermine these efforts at the staffing, administrative, evaluation, funding, and community levels (Clark et al., 2015; Fixsen et al., 2019).

Stars Training Academy | Improving the Lives of Youth and Young Adults

Need help navigating the funding maze to start or expand a transition-to-adulthood program?

Our consultants have extensive experience and expertise in initiating, funding, operating, and sustaining *TIP Model* programs, and associated programs related to vulnerable young people with extensive histories of chronic trauma, out-of-home placements, juvenile justice, teen mother programs, mental health, and first episode psychosis treatment. These seasoned professionals are available via consultancy through the Stars Training Academy.

Contact Joseph Solomita, *Managing Director, Stars Training Academy,* to explore solutions to *TIP Model* implementation, expansion, & sustainability.
Email: jsolomita@starsinc.com Cell: 714-336-8363; Work: 310-221-6336 ext.109

Want help in preparing a grant or contract?

Here is a grant and contract writing resource for establishing or expanding your transition-to-adulthood program.

> *Grant Preparation Boilerplate for TIP Model®: Guiding Preparation of Your Proposals for TIP Model® Implementation in Conjunction with SBHG. Version - Sept 18, 2022.*

Email Joseph Solomita to request a copy of this resource -- jsolomita@starsinc.com

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