Illinois Children's Behavioral Health Association
Annual Winter Conference
December 10-11, 2018

"Is Illinois Truly Embracing a System of Care Model for Children and Adolescents?"

Sheila A. Pires
Managing Partner, Human Service Collaborative
Core Partner, National Technical Assistance Network
for Children's Behavioral Health
Senior Consultant, Center for Health Care Strategies, Inc.

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Let's begin by talking about children and families ….and why they need a system designed for them.

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Prevalence and Utilization

How Many Children Face Mental Health Challenges?

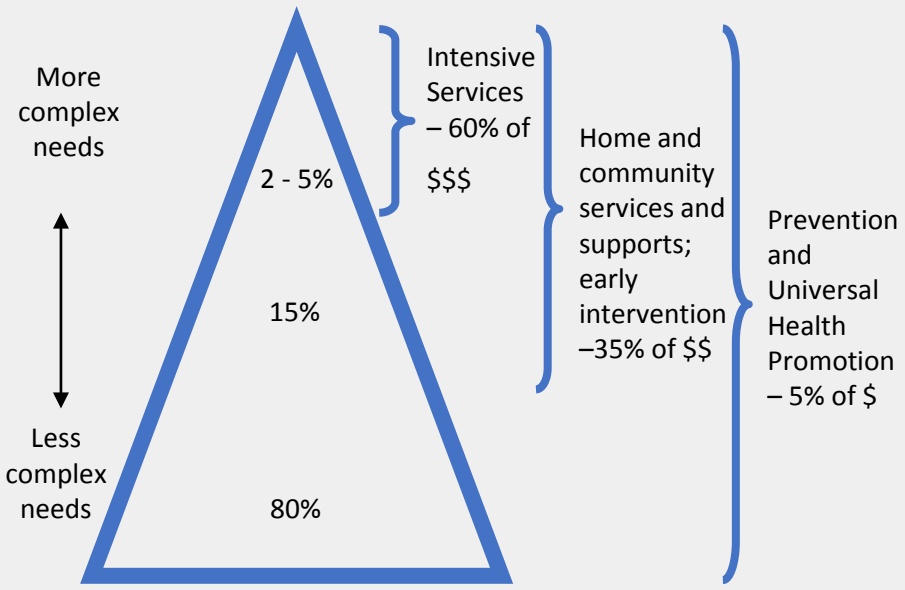
"An estimated 13-20% of children in the US (up to 1 out of 5 children) experience a mental disorder in a given year…"

Centers for Disease Control and Prevention. *Mental health surveillance among children – United States 2005-2011*. MMWR 2013;62 (Suppl; May 16, 2013):1-35. The report is available at www.cdc.gov/mmwr

About one out of every ten youth is estimated to meet the SAMHSA criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally

Costello, EJ, Egger, H, Angold, A. *10-year research update review: The epidemiology of child and adolescent psychiatric disorders*: 1. Methods and public health burden. J Am Acad Child Adolescent Psychiatry. 2005. Oct; 44 (10): 972-86

Prevalence/Utilization Triangle



Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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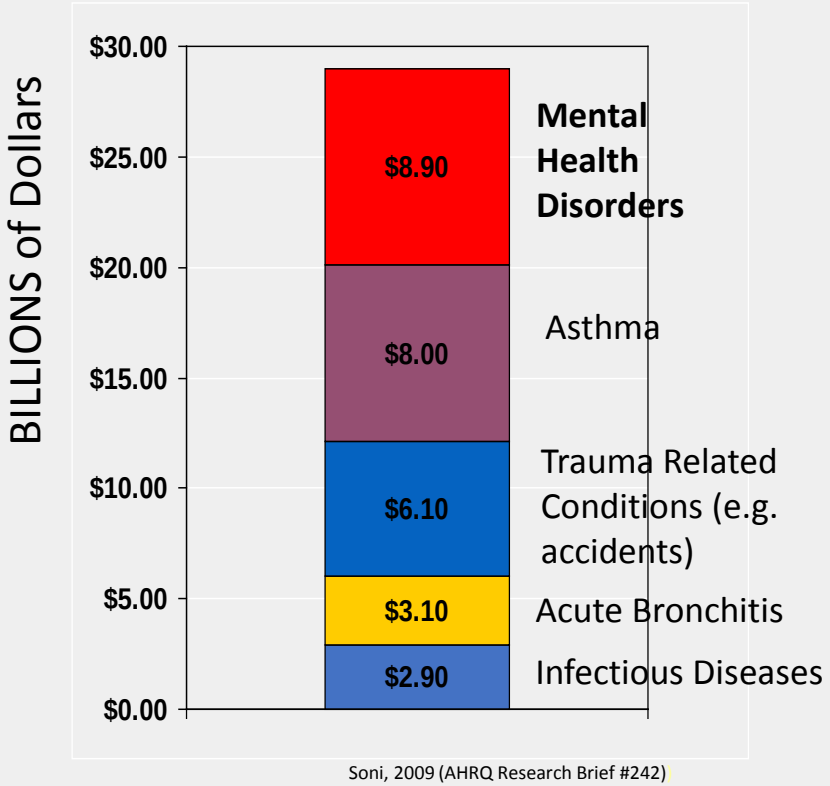
Costs

Mental Health Costliest Health Condition of Childhood



Soni, 2009 (AHRQ Research Brief #242)

Children in Medicaid Who Use Behavioral Health Care Are Expensive Population

- 11% of children in Medicaid use behavioral health care
- Account for 36% of all Medicaid child expenditures
- Mean expense at $10,259 is 4x higher than for children who do not use behavioral health services
- Mean expense for children in foster care at $12,130 is 5x higher
- Mean expense for children on SSI at $15,159 is over 6x higher
- Mean expense for children on TANF at $5,082 is over twice as high

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 2005-2011.* Center for Health Care Strategies: Hamilton, NJ. Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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Children Using Behavioral Health Care in Medicaid with Top 10% Highest Expenditures

- Have mean expenditures of $46,959
  - BH expense: $36,646
  - PH expense: $10,314

Expense is driven by use of behavioral health, not physical health care

- Major cost drivers
  - Residential treatment and therapeutic group homes
  - Psychotropic medications

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 2005-2011.* Center for Health Care Strategies: Hamilton, NJ.
Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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Co-Morbid Physical Health Conditions Among Children in Medicaid Using Behavioral Health Care

Frequency of Chronic Disability Payment System Categories among Children Using Behavioral Health Services in Medicaid, 2005, 2008, 2011						
No. of CDPS Categories	2005		2008		2011	
	No. of Children	% of Total	No. of Children	% of Total	No. of Children	% of Total
0	520219	62.1%	475,316	56.0%	651,952	60.1%
1	219846	26.3%	237,555	28.0%	284,365	26.2%
2	66449	7.9%	83,862	9.9%	92,299	8.5%
3	20012	2.4%	30,197	3.6%	32,072	3.0%
4	6444	0.8%	12,292	1.4%	12,795	1.2%
5	2412	0.3%	5,476	0.6%	5,594	0.5%
6	1028	0.1%	2,563	0.3%	4,045	0.4%
7+	721	0.1%	1,971	0.2%	1,145	0.1%
Total	837131	100.0%	849,232	100.0%	1,084,267	100.0%

- ✓ Most children (60%) do not have co-morbid physical health conditions

Of those that do -

- ✓ High prevalence of asthma
- ✓ Low prevalence of high-cost medical conditions

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 2005-2011.* Center for Health Care Strategies: Hamilton, NJ.
Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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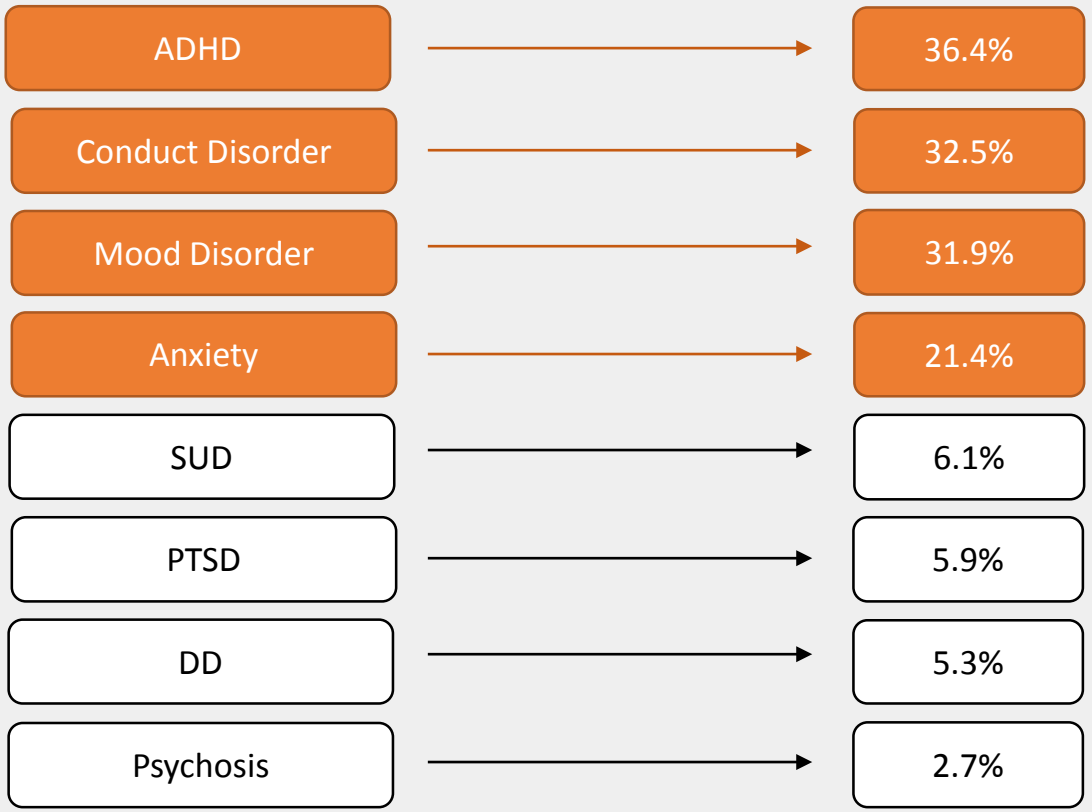
Distribution of Psychiatric Diagnoses among Children in Medicaid Using Behavioral Health Services*



*Do not add to 100% because children may receive multiple diagnoses

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 2005-2011.* Center for Health Care Strategies: Hamilton, NJ.
Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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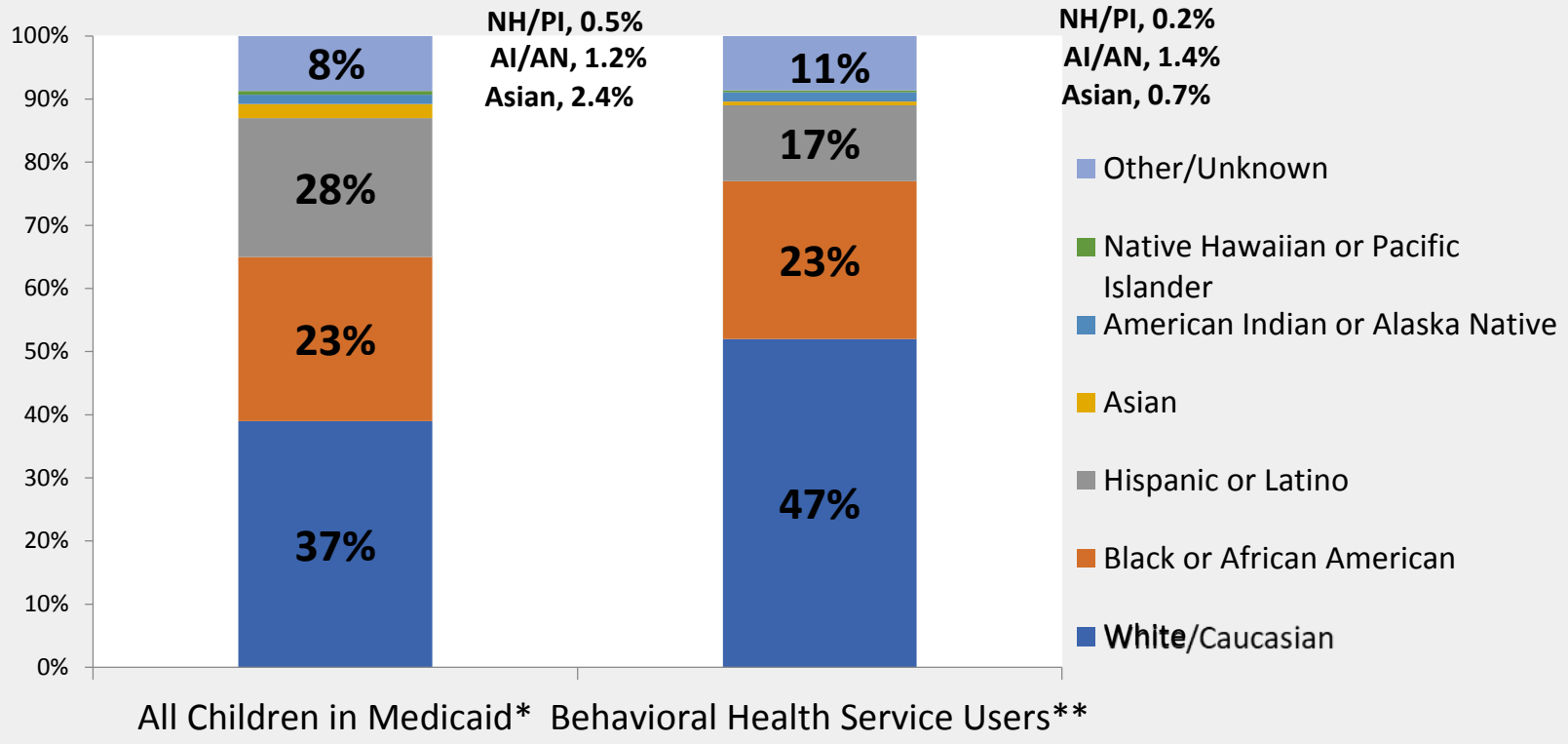
Racial and Ethnic Disparities in Behavioral Health Use



Pires, SA, Gilmer, T, Allen, K., McClean, J. 2017. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures Over Time, 2005-2011*. (In process). Center for Health Care Strategies: Hamilton, NJ

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Children and Youth with Serious Behavioral Health Conditions Are A Distinct Population from Adults with Serious and Persistent Mental Illness

Do not have the same high rates of co-morbid physical health conditions.

Have different mental health diagnoses (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults), and diagnoses change often.

Coordination with other children's systems (CW, JJ, schools) and among behavioral health providers, as well as family issues, consumes most of care coordinator's time, not coordination with primary care, though primary care coordination also important.

Are multi-system involved – two-thirds typically are involved with CW and/or JJ systems and 60% may be in special education – systems governed by legal mandates.

To improve cost and quality of care, focus must be on child and family/caregiver(s) – takes time – implies lower care coordination ratios and higher rates.

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges.* Human Service Collaborative. Washington, D.C.

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Factors Leading to System of Care Reforms

Lack of home and community-based services and supports	Deficit-based/medical models, limited types of interventions	Patterns of utilization; racial/ethnic disproportionality and disparities	Poor outcomes
Cost	Rigid financing structures	Administrative inefficiencies; fragmentation	Knowledge, skills and attitudes of key stakeholders

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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Identified Needs in Illinois*

- Additional care coordination across service systems
- Reduce psychiatric hospitalization and residential placements
- Reduce segregation of funding that results in fragmentation
- Family-driven, youth-guided care
- More flexible array of services
- Culturally competent services
- Maximize funding through blending, braiding, pooling funds
- Transparency in utilization and cost data

**Source: DHS: Pathways – Illinois' Strategic Plan for Children's Mental Health. 2013*

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What is a System of Care?

A broad, flexible array of evidence-informed services and supports for defined populations, which:

- ✓ Is organized into a coordinated network;
- ✓ Integrates care planning and care management across multiple levels;
- ✓ Is culturally and linguistically competent;
- ✓ Builds meaningful partnerships with families and with youth at service delivery, management, and policy levels;
- ✓ Has supportive and collaborative management and policy infrastructure;
- ✓ Is data-driven; and
- ✓ Is co-financed across child-serving systems

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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Illinois System of Care Grants and Recommendations*

System of Care Grants

- State Expansion Grant
- Project Access, Champaign County
- Lake County
- Project Connect, southern tip
- McHenry County
- Chicago
- Proviso
- CASSP grants
- Others?

✓Focal point of management & accountability at the state level

✓Interagency structures to set policy

✓An individualized, Wraparound approach

✓Family-driven, youth-guided services

✓Strong youth and family partnership (e.g., involvement in policy, training, funding)

✓Reduce racial, ethnic, and geographic disparities; improve cultural and linguistic competence of services

✓Increase use of Medicaid

✓Maximize federal grants

✓Redeploy funds from higher cost to lower cost services

✓Ongoing training and TA capacity

✓Use data to track outcomes and cost across systems

✓Cultivate partnerships with providers, MCOs, others

**Source: DHS: Pathways – Illinois' Strategic Plan for Children's Mental Health*

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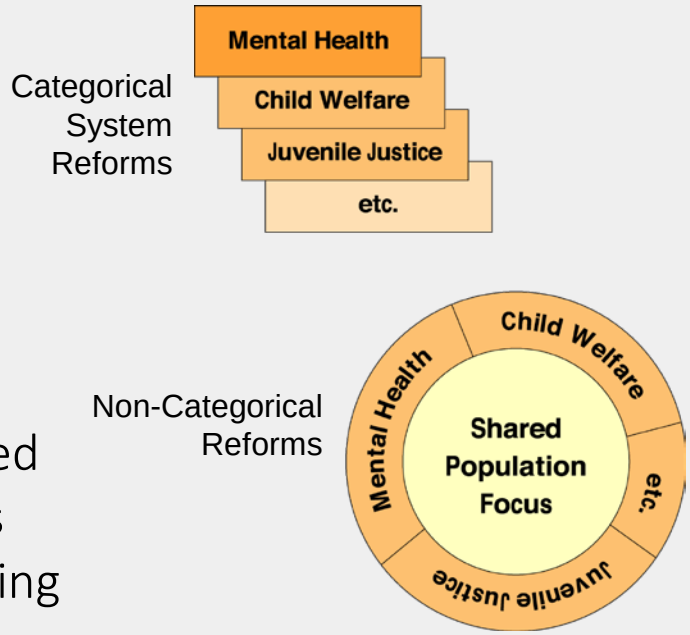
System of care is, first and foremost,

a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.

- Family-driven and youth-guided
- Home and community based
- Strengths-based and individualized
- Trauma-informed
- Commitment to health equity through cultural and linguistic competency
- Connected to natural helping networks
- Resiliency-and recovery-oriented
- Data-driven, quality and outcomes oriented
- Coordinated across providers and systems
- Takes a population focus across child-serving systems



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Illinois *NB v. Bellock* Population

All Medicaid-eligible children under the age of 21
in the State of Illinois:
(1) who have been diagnosed with a mental health or behavioral disorder; and
(2) for whom a licensed practitioner of the healing arts has recommended intensive home-and community-based services to correct or ameliorate their disorders.

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Why Pay Particular Attention To Medicaid?

Medicaid is the largest funder of behavioral health care for children and youth

Most – not all, but most – children who turn to public systems for behavioral health care are Medicaid-eligible

To be effective and sustainable, system of care reforms must impact Medicaid delivery systems

There are opportunities within Medicaid to:

- Maximize Federal match dollars
- Re-direct dollars from high-cost, poor outcome spending - e.g. from facility-based care to more effective home/community-based services and supports

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System of Care Reforms are Occurring within a Changing Medicaid Landscape

- Managed care, including for populations with high use/cost (e.g., chronic conditions, foster care, SSI)
- Integrated care- medical homes, health homes, comprehensive managed care organizations
- Accountable Care Organizations
- Medicaid Waivers and Affordable Care Act Options (e.g., 1115, 1915b, 1915i, Money Follows the Person, health homes)
- Value-based payment – bundled rates, case rates, performance incentives – tied to quality
- Person-centered care - peer consumer and family involvement
- Data-Driven systems focused on Triple Aim: quality, cost, consumer experience
- Evidence-informed practices – home and community based services
- Diversion from facility-based care
- Trauma-informed systems and practices
- CLAS Standards - Health care Disparities
- Social determinants of health
- Mobile response and stabilization capacity
- Telehealth– remote capabilities, use of mobile apps
- Web-based communication – with providers, with consumers/families
- Substance use disorder treatment

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Medicaid Managed Care Organizations are Critical to System Reform

What Can MCOs Do?	
Put families and youth with lived experience on their advisory bodies and quality review teams	Engage families and youth with lived experience as system navigators and peer mentors
Pay for Wraparound, peer support, respite, and mobile crisis services – if not in State Plan or Waiver, as "substitution services" to prevent higher costs	Use reinvestment dollars to support evidence-informed approaches
Partner with State and providers on delivering quality care and tracking outcomes	Implement the CLAS Standards for behavioral health
Provide data on child behavioral health service utilization	Join System of Care initiatives

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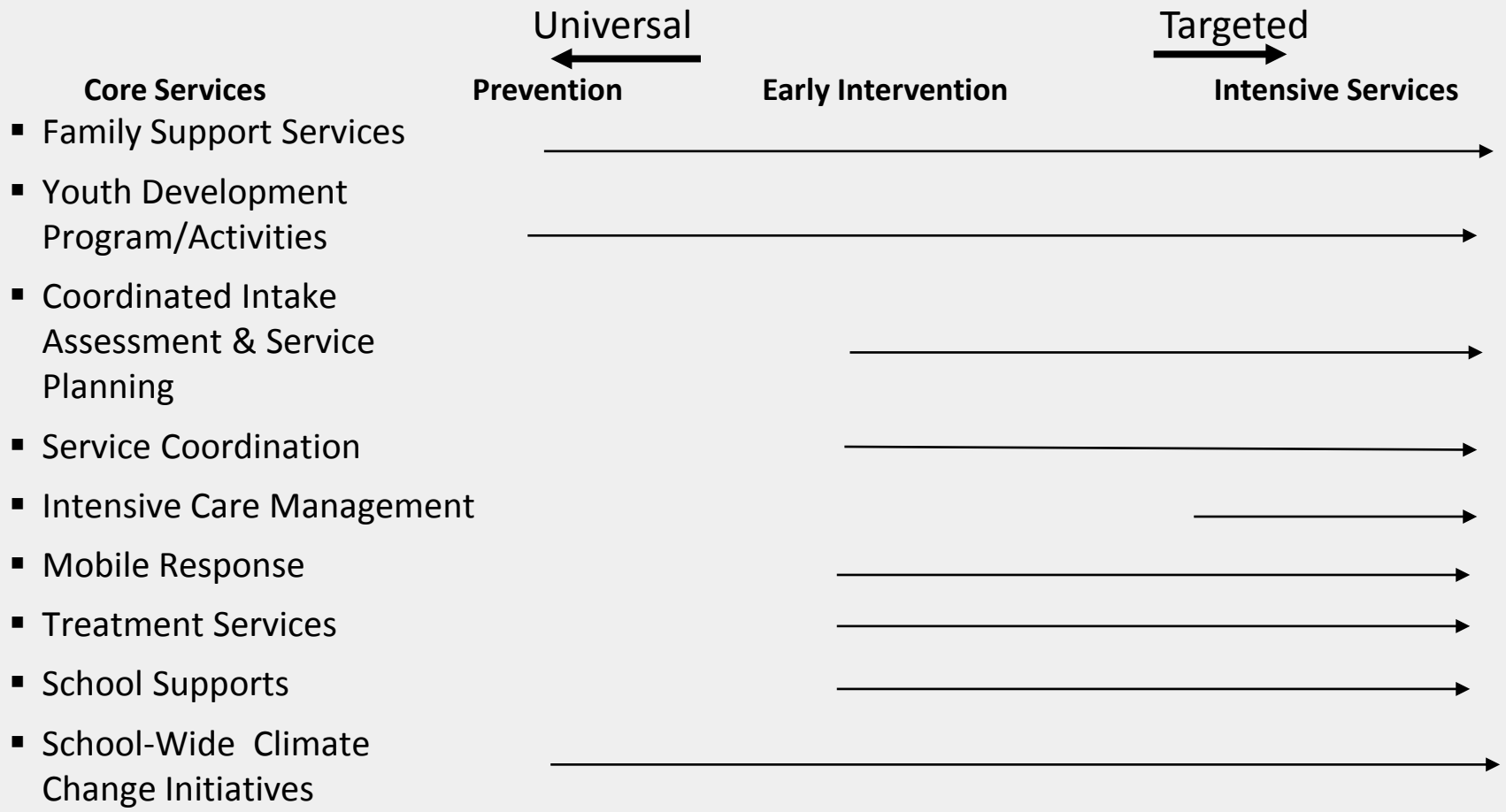
Pires, S. 2017. Human Service Collaborative

Core System of Care Components
Broad, Flexible Array of Services and Supports



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Pires, S. & Isaacs, M. (1996, May) *Service delivery and systems reform*. [Training module for Annie E. Casey Foundation Urban Mental Health Initiative Training of Trainer Is Conference]. Washington, DC: Human Service Collaborative.

Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration May 2013 Joint Information Bulletin

- Intensive Care Coordination: Wraparound Approach
- Parent and Youth Peer Support Services
- Intensive In-Home Services
- Respite
- Mobile Crisis Response and Stabilization
- Flex Funds
- Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma

Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions

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Intensive In-Home Services and Respite

✓ Covered through 1115 Medicaid Waiver

➢ Both to be implemented initially as pilots

➢ Eligibility criteria - overly restrictive?

These are key services to help families support their children at home.

Example

- Many states cover intensive in-home services in Medicaid
- New Mexico's implementation of Multisystemic Therapy showed

a 60% reduction in average cost per month in paid claims for Medicaid behavioral health care resulting from a reduction in residential treatment and psychiatric inpatient claims *New Mexico Department of Children, Youth and Families, Center for Effective Interventions*

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Mobile Crisis Response and Stabilization

✓ Covered through Medicaid State Plan Amendment

➢ Is there widespread understanding of newer generation MRSS models?

Examples

- New Jersey has MRSS capacity for children statewide; 95% of children who use MRSS remain at home or in current community-based placement
- Connecticut MRSS saved $4m in one year in inpatient and ED expenditures
- Milwaukee County, WI MRSS reduced placement disruption rates in child welfare by 35%
- Seattle/King County WA MRSS diverted over 90% of psychiatric hospitalizations, saving $7.5m in inpatient and $2.8m in out of home expenditures in Medicaid

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Family and Youth Peer Support

- ➢ Is it covered under psychosocial rehabilitation services?
- ➢ Who can provide family and youth peer support?
- ✓ Youth & Family Peer Support Alliance – recipient of a SAMHSA Statewide Family Network Grant to expand youth and family voice and peer capacity statewide

Family and youth peer support has been shown to improve engagement in services, reduce caregiver strain, increase social supports, increase family and youth resiliency

Hoagwood et.al. 2010; Kutash et.al. 2011, Leggatt & Woodhead, 2015

Examples

- AZ, GA, NJ, and PA are examples of states that cover family and youth peer support in Medicaid and involve family-run organizations to provide and/or supervise peer partners

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Meaningful Family and Youth Involvement at Policy and Management Levels

- N.B. Subcommittee recommendation that the State establish a mechanism for N.B. families and youth to have ongoing input
- MCO contract requirement for Family Leadership Councils
- MCO contract requirement that each MCO develop a plan for Family-Driven Care

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Core System of Care Components

Structuring Care Coordination – Integrated Care and Health Homes

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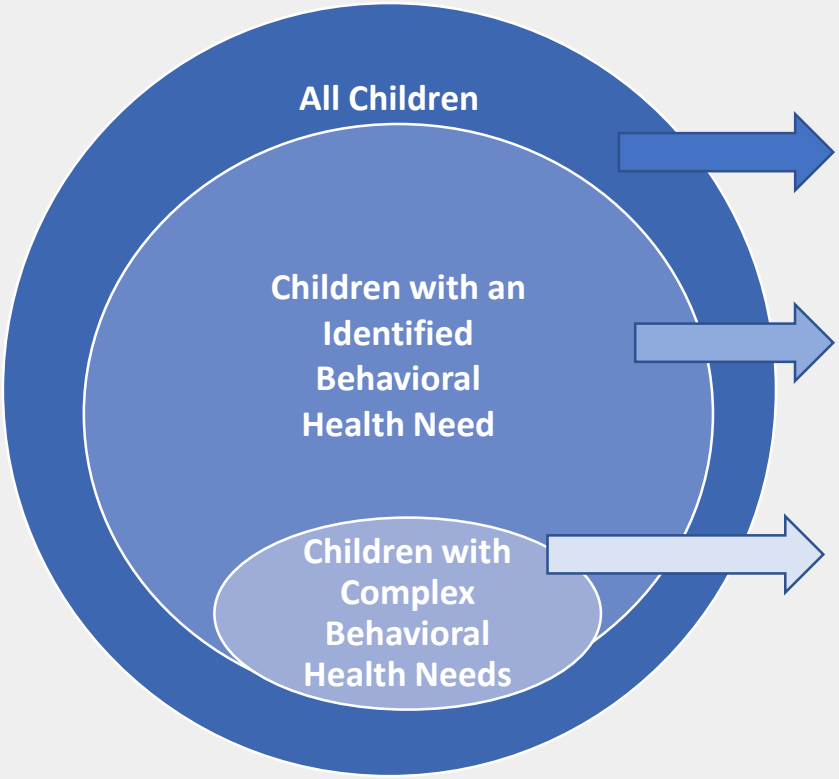
Care Coordination Continuum – What Belongs Where?



Screening, Information and Referral on an as Needed Basis/ During Well Child Visits

Service Coordination and System Navigation To Support Effective Response to Identified Need

Intensive Customized Care Coordination To Provide Extended Support To Multi-Modal Needs

Unmet need for care coordination is high for children and youth with mental health conditions

American Academy of Pediatrics (Brown, N. et. al. 2013)

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Role of Primary Care

75% of children with diagnosed mental health disorders are seen in the primary care setting.

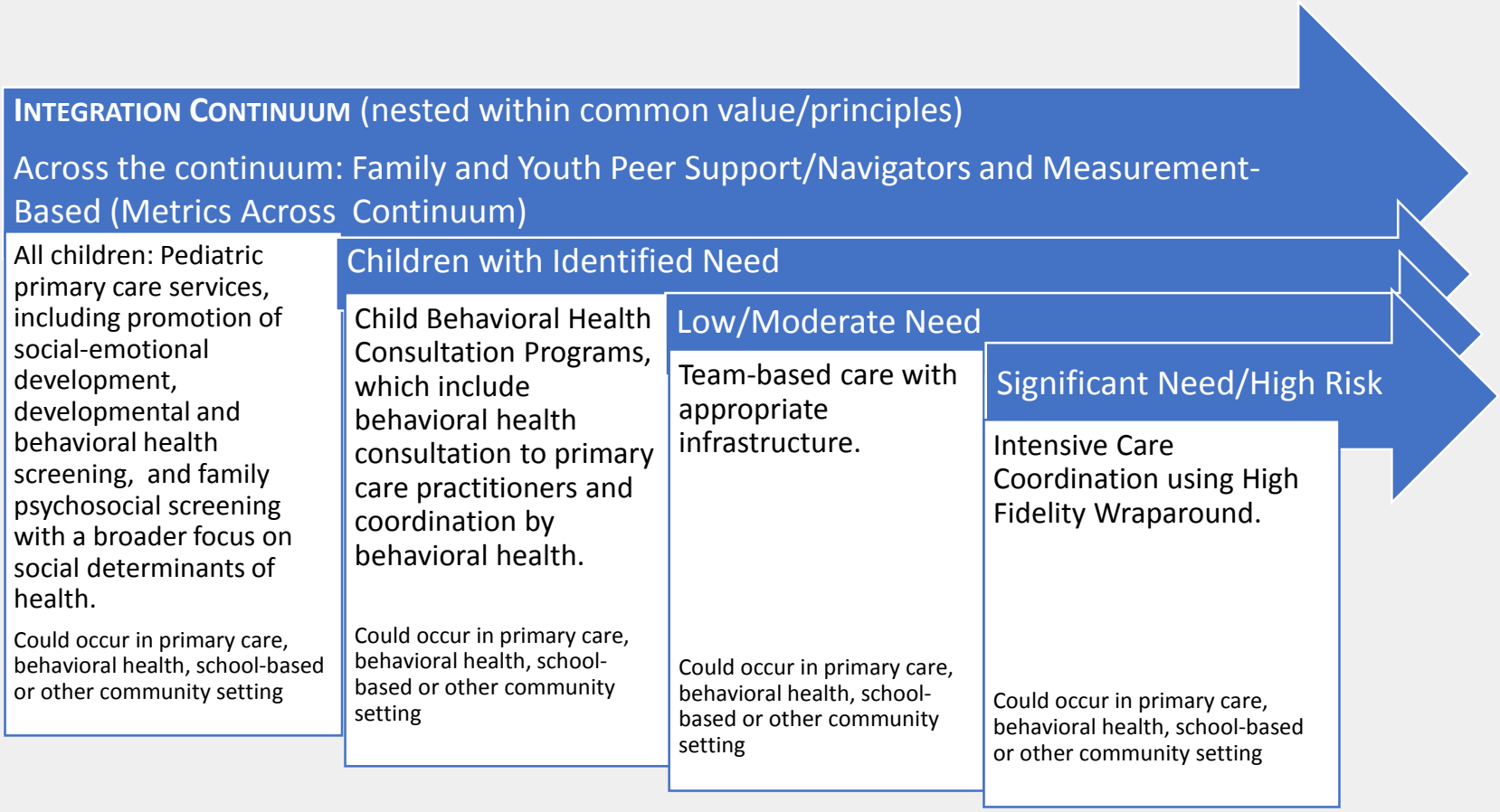
- Racially and ethnically diverse families especially feel less stigma in pediatric settings than with specialty behavioral health providers.
- Pediatricians play a key role in early detection for children enrolled in Medicaid through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive screening and health care services for children under age 21.
- The persistent shortage of behavioral health specialty providers further contributes to the increased role of primary care.

Yet, numerous studies have found that primary care practices often struggle with managing child behavioral health conditions and access to a medical home is uneven.

- One study found that "all behavioral health conditions except attention deficit hyperactivity disorder (ADHD) were associated with difficulties accessing specialty care through the medical home."
- A 2013 study in *Pediatrics* found that youth of color, lower-income youth, youth from households with limited English proficiency, and those with mental (as opposed to physical) health conditions were less likely to have a medical home where they could obtain routine, family-centered care. There have been similar findings with respect to Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth.

Pires, S., Fields, S, et.al., 2018 (in process) *Care Integration Opportunities in Primary Care for Children, Youth and Young Adults with Behavioral Health Challenges: Expert Convening* .National Technical Assistance Network for Children's Behavioral Health

Expert Convening: Care Integration Continuum



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Screening and Assessment

- ✓ N.B. requires that notice be given to primary care physicians to offer mental health and behavioral health screens to families during EPSDT screenings
- *Massachusetts <u>requires</u> that PCPs conduct behavioral health screens using standardized screening tools*

- ✓ IM+CANS – incorporates ACES, physical health assessment, behavioral health strengths and needs assessment, addendum specific to child welfare, and Adult Needs and Strengths

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Behavioral Health Consultation Programs

- ✓ *Clinical Services in Psychopharmacology at University of Illinois at Chicago*
  - Independent review and monitoring of psychotropic medications for children in foster care
  - Consultation on complex issues
  - Dissemination of information on new pharmacologic developments
  - Guidance and training on best practices

Massachusetts Child Psychiatry Access Program (MCPAP)

- Regional children's BH consultation teams support integration of BH and PH
- Services are free and available through primary care practices for all children and families, regardless of insurance

Goal: increase access to BH treatment

http://www.mcpap.com

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Infant and Early Childhood Behavioral Health Consultation

- ✓ Illinois Early Childhood Mental Health Consultation Initiative
- ✓ State Board of Education – funding for mental health consultation in Preschool and in Prevention Initiative sites
- ✓ 1115 Medicaid Waiver – Evidence-Based Home Visiting and language pertaining to Infant/Early Childhood Mental Health Consultation
  - ➢ Evidence-based Home Visiting is a pilot

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Integrated Team-Based Models for Children with Moderate Behavioral Health Needs

Behavioral Health Integration Program -Montefiore Medical Center, Bronx, NY

- 90,000 children served by 20 pediatric practices; $3m global payment plus billing for specific components; reaches 13,000 children with moderate BH needs; refer out 10%-children with serious, complex BH challenges

Universal BH, developmental screening; use of ACES; attention to parental BH

Healthy Steps 0-5

Child & Adolescent Psychology and Psychiatry Program (CAPP) – 5+

Modularized tx for ADHD, anxiety, conduct, depression and trauma – CBT, MI, DBT
Average = 4-6 sessions

➢ *Receive shared savings through Accountable Care Organization – from adult savings*

www.montefiore.org/bhip

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Care Coordination: Especially High Unmet Need for Children with Significant Behavioral Health Challenges

Not Met by Usual Approaches

Neither traditional case management, MCO care coordination, nor health home approaches for adults are sufficient for children and youth with significant behavioral health needs

Need:

- Lower case ratios (*MO health home care coordination ratio is 1:250*; Wraparound is 1:10)*
- Higher payment rates (*MO health home per member per month rate is $78*; CHCS national scan of Wraparound care coordination rate ranges from $780 pmpm to $1300 pmpm)*
- Approach based on evidence of effectiveness, i.e. fidelity Wraparound
- Intensity of approach that is largely face-to-face, not telephonic
- Intensity of involvement with family, schools, other systems like child welfare

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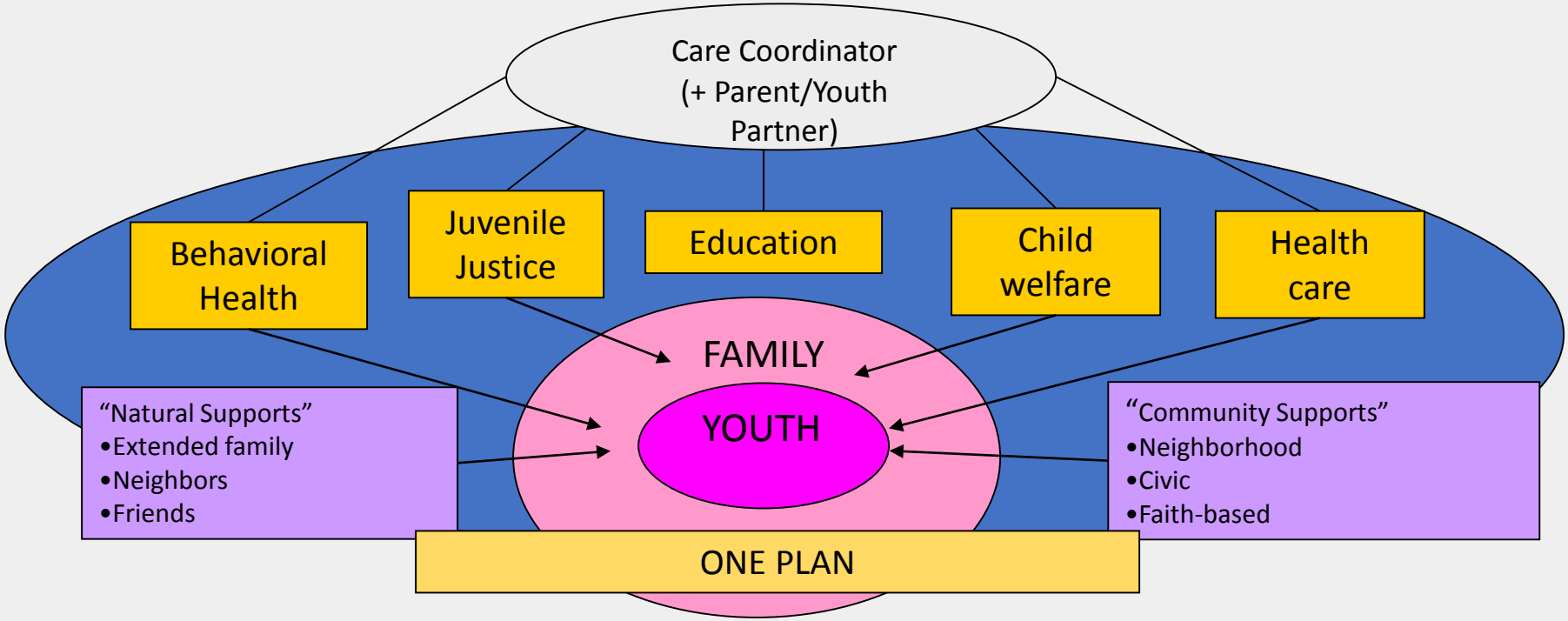
L. Alexander, B. Druss, and J. Parks. "A (Health) Home Run: Operationalizing Behavioral Health Homes." Webinar, Center for Integrated Health Solutions, U.S. Substance Abuse and Mental Health Services Administration, January 2013.

Intensive Care Coordination Using Fidelity Wraparound

Wraparound is an evidence-based, defined, team-based service planning and coordination process. The goal is to improve outcomes, per capita costs of care, and family and youth experience. In Wraparound, a dedicated care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan.



Adapted from Laura Burger Lucas, ohana coaching, 2009

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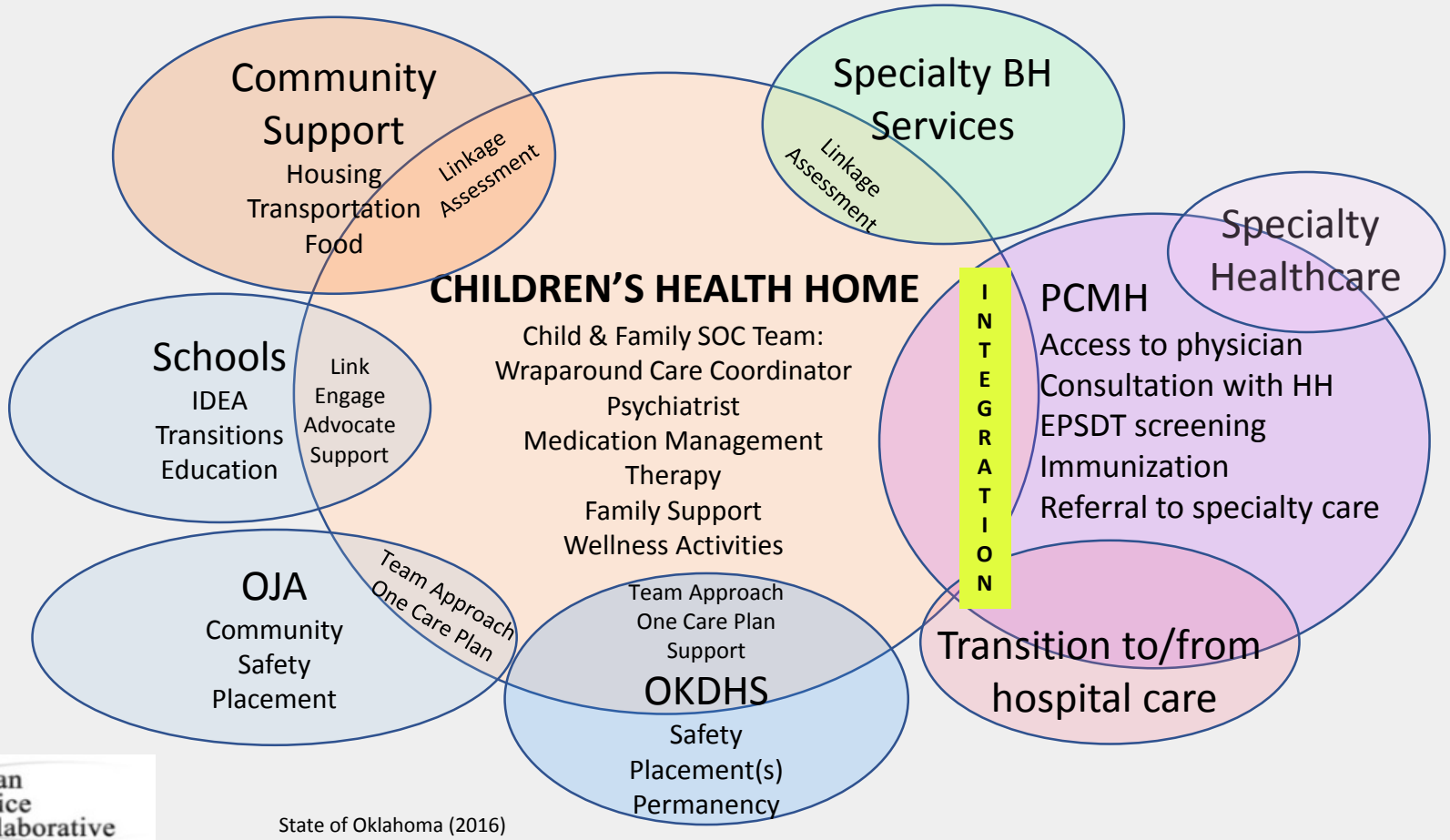
Outcomes and Return on Investment with Intensive Care Coordination Using Fidelity Wraparound

9 States	Cost Savings
Evaluation of Medicaid PRTF Waiver Demonstration – 9 States	• Waiver expenditures cost 32% of services provided in PRTFs (home- and community- based services with wraparound process) • Average savings of 68% • Average per child savings of between $35,000 and $40,000 • Improved clinical and functional outcomes • Improved family and youth experience
Community	**Cost Savings**
California: Los Angeles – Child Welfare Population	• 56% of youth graduating from SOC approach with Wraparound had subsequent out-of-home placements vs. 91% of youth graduating from services in a residential treatment setting • Average post-graduation costs nearly 60% less for Wraparound group than comparison group ($10,737 versus $27,383) • Placement costs for residential treatment group were 2.5 times greater than the cost for Wraparound group
Massachusetts Mental Health Services Program for Youth (MHSPY) Human Service Collaborative	• Total per-child per-month Medicaid claims expense Wraparound group less than half of that of comparison group (both physical and behavioral health) • Claims 31% lower for ER, 73% lower for inpatient • Clinical/functional improvement; high family/youth satisfaction

Outcomes Depend on Implementation - Fidelity is Critical

- Research shows
  - Provider staff whose families experience better outcomes score higher on fidelity tools (Bruns, Rast et al., 2006)
  - Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)
- Much of wraparound implementation is in name only
  - Don't invest in workforce development such as training and coaching to accreditation
  - Don't follow the research-based practice model
  - Don't monitor fidelity and outcomes and use the data for CQI
  - Don't have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)

Oklahoma Children's Health Home Model - Wraparound



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State of Oklahoma (2016)

Oklahoma Health Home Rates

HEALTH HOME CORE SERVICES			
Adult			
Urban	Moderate Intensity (PRM, or Levels 1-3)	G9002	$127.35 / Per Month
	High Intensity (Level 4)	G9005	$453.96 / Per Month
Rural	Moderate Intensity (PRM, or Levels 1-3)	G9002TN	$146.76 / Per Month
	High Intensity (Level 4)	G9005	$453.96 / Per Month
Child			
Urban	Moderate Intensity (Level 3)	G9009	$297.08 / Per Month
	High Intensity (Level 4)	G9010	$864.82 / Per Month
Rural	Moderate Intensity (Level 3)	G9009TN	$345.34 / Per Month
	High Intensity (Level 4)	G9010TN	$1,009.60 / Per Month

State of Oklahoma (2016)

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New Jersey Health Home Model - Wraparound

What it is:

- Care Management Organizations (which provide fidelity Wraparound) are the designated BHH for Children)
- Enhancement to the Child Family Team to bring medical expertise to the table

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Integrated Health Homes in IL

- Serve all populations with complex needs, adults and children, physical and behavioral health
- No specified practice approach for children with significant behavioral health conditions – reference to Wraparound in N.B. but not required
- Tiers – most children with significant behavioral health conditions will fall into Tier B (high BH costs/needs, low PH costs/needs), not Tier A (high PH and BH costs/needs)
- Rates in all tiers do not match necessary rates for intensive care coordination using fidelity Wraparound (Tier B rate is $80 pmpm compared to national scan for Wraparound of $780 pmpm-$1200 pmpm; Tier A is $240 pmpm)
- Care coordination ratios do not meet specified ratios for intensive care coordination using fidelity Wraparound (Tier B is 1:72; Tier A is 1:25. Wraparound for high-need youth is 1:10)

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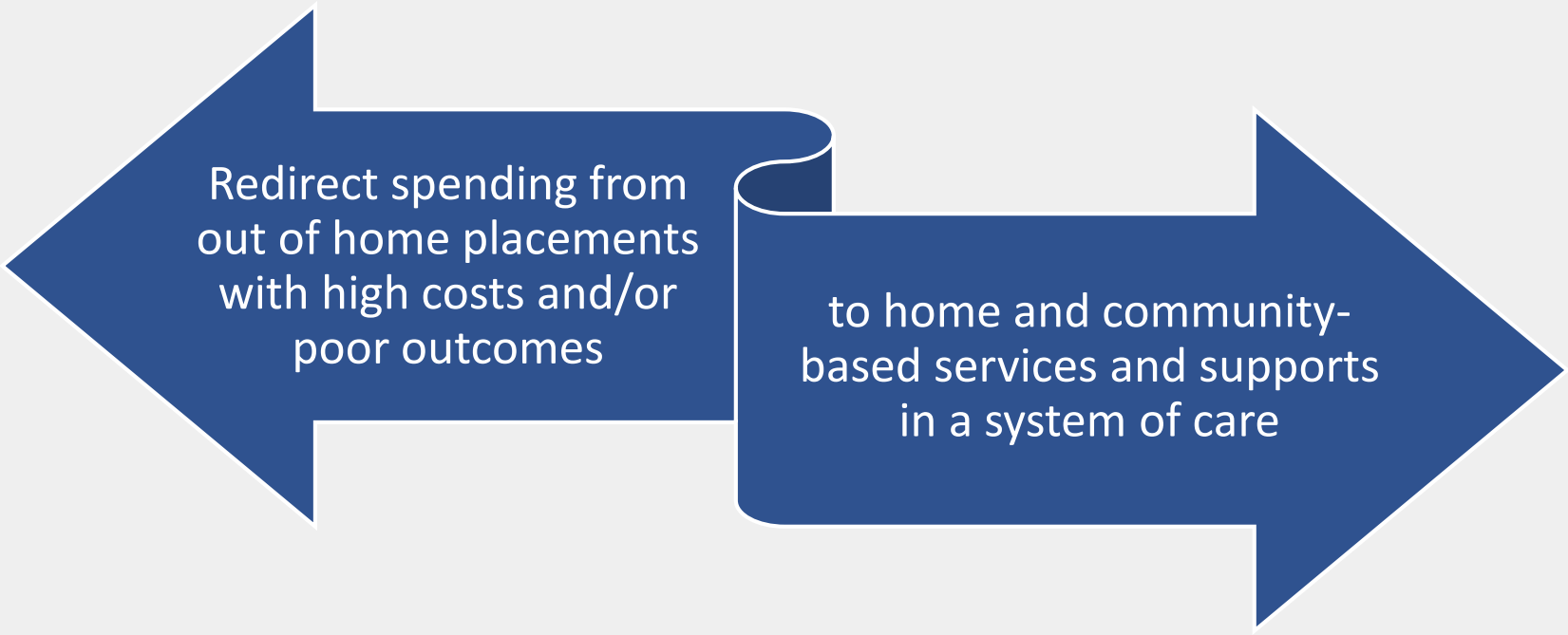
Fundamental Concept in Systems of Care



Pires, S. (2006). *Primer Hands On* . Washington, D.C.: Human Service Collaborative.

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Illinois by the Numbers

Expenditures on residential treatment, shelter care, inpatient psych, and other congregate care settings for child welfare, Medicaid, and mental health

Child Welfare

$220M annually for about 2200 children daily $8,333 per youth per month (pypm)

Medicaid - Inpatient Psychiatric Hospitalization

$150M annually on approximately 15,000 inpatient psychiatric hospitalization stays for youth in crisis

$9,750 per youth per month ($750 per day for 13 days)

Mental Health – Individual Care Grants (Note. Now HFS)

•$12.4M for 174 youth received residential treatment at an average cost of $71,134 per youth per year $5,928 per youth per month

HFS – Psychiatric Residential Treatment Facilities (PRTFs)

*$190M estimated annually on future expenditures for PRTFs (2000 youth * 270 days * $350 per day - $10,645 per youth per month)*

Van Deman, S. Jan 2015. System of Care Technical Assistance Center of Illinois

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Core System of Care Components
Residential Treatment Best Practice - *Building Bridges Initiative*

- Movement away from "placement" orientation and long lengths of stay
- Residential as part of an integrated continuum, connected to community
- Shared decision making with families/youth and other providers and agencies
- Family and youth engagement and provision of aftercare
- Individualized treatment approaches through a child and family team process
- Trauma-informed care

Building Bridges Initiative: www.buildingbridges4youth.org

- **Family First Prevention Services Act –** focus on home and community-based services, reduction of use of residential care, and quality standards

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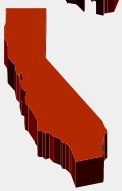
Core System of Care Components
Practice Improvement: State/Local Centers of Excellence

Maryland Institute on Innovation and Implementation- University of Maryland



California Institute of Mental Health

Ohio Center for Innovative Practices – Case Western University

Georgia Center of Excellence in Child and Adolescent Behavioral Health - Georgia State University

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health

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Practice Improvement in Rural Communities – Egyptian Health

- *Managing Adaptive Practices*
  - Can train providers of all levels and types
- *Functional Family Therapy*
  - Allows for teams and supervisors to work within a SOC "network" framework
  - Can train BS and MS clinicians
- *Parent Child Interaction Therapy*
  - Allows for training clinicians within a system of care "network" framework as a Level 1 trainer
- *Trauma Focused Cognitive Behavioral Therapy*
  - Allows for "agency" supervisors to provide consultation/supervision within a system of care "network" framework

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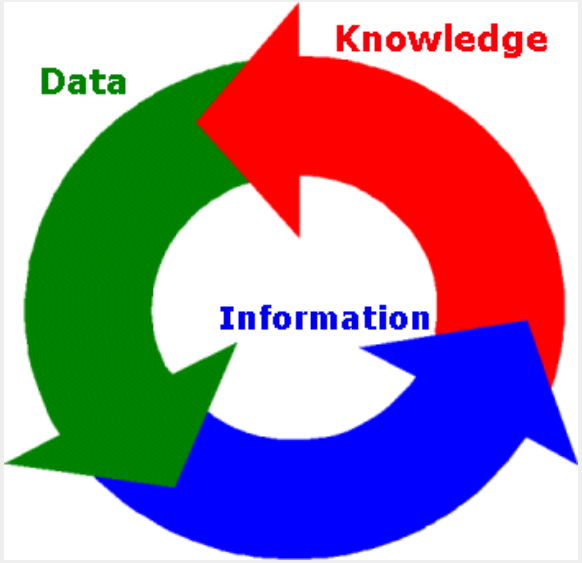
Core System of Care Components
Data and Continuous Quality Improvement

"If we have data, let's look at data.
If all we have are opinions,
let's go with mine."

Jim Barksdale, former CEO, Netscape



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Value-Based Purchasing
Performance-Based Payment Structures

Value Based purchasing refers to any purchasing practices aimed at improving the value of health care services, ***where value is a function of both quality and cost****…(Source: Agency for Healthcare Research and Quality)*

Incentive Payments – Providers are rewarded (bonuses, share in savings) or penalized (reductions in payments) based on meeting pre-established targets or benchmarks for measures of quality and/or efficiency and/or outcomes.

CT: enhanced FFS payments to BH clinics for weekend/off-hours; screening targets for co-occurring	MI: payments over and above the capitation rates for Medicaid-enrolled children involved with child welfare who have serious mental health conditions	Wraparound Milwaukee – population case rates with shared savings and risk for reducing use of residential treatment and psych inpatient

Pires, S. 2017. National TA Network for Children's Behavioral Health.

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Illinois Integrated Health Homes Performance-Based Bonus Payments

- 18 quality measures pertaining to both physical and behavioral health, adults and children
- Align with national quality measures (HEDIS, NCQA) – not robust for children with behavioral health challenges
- Health homes must report on all 18 measures to qualify for bonus and meet a specific performance level for any single measure
- Example of child BH-specific measure for reporting:
  - ✓ Metabolic monitoring for children on antipsychotics
- Examples of BH-related measures that affect performance payments, apply to adults and children:
  - ✓ Initiation and engagement of substance use disorder treatment
  - ✓ Screening for clinical depression
  - ✓ Antidepressant medication management

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Wraparound Milwaukee Quality and Outcome Measures – Beyond National Quality Measures

- *Functioning* – uses CANS to assess
- *Living Environment* - compares % of days in a restrictive setting (inpatient, RTC, detention, group home, shelter facility to % of days in a community-based setting (home, foster care, living with relative, independent living) - 2x/year
- *Community Safety* – compares enrollment entry adjudications and formal charges to number of adjudications and formal charges during enrollment
- *School attendance* – compares total number of school days possible to total number of school days attended – at monthly intervals
- *Family and youth satisfaction with care coordination*– surveys mailed to every family and youth at I month, 6, 12, disenrollment; threshold is average score of 4.0 out of 1-5 scale; compiled and reported 2x/year on care coordination agency performance report
- *Family and youth satisfaction with provider network* services – surveys mailed to every family and youth at 4 and 9 mos; threshold is 4.0 out of 1-5 scale; results provided to providers with request to respond to negative comments and results reported in 2x/year QI report

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New York State Medicaid Managed Care Organization Data Requirements

MCO BH QM must review and analyze data and develop/approve interventions related to:

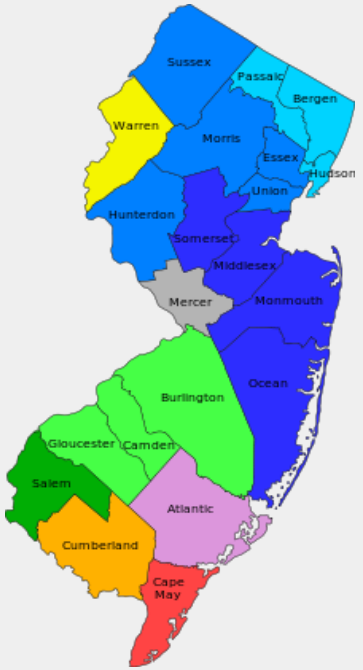
- **Under and over utilization of BH services** and cost data
- Inpatient admission and readmission rates, trends and ALOS
- Inpatient and outpatient civil commitments
- Follow-up after discharge from MH inpatient, SUD inpatient and residential
- SUD initiation and engagement
- ER and crisis service use
- BH prior auth/denial and notices of action
- **Psychotropic medication use with a separate analysis for foster care**
- Rates of initiation and engagement of individuals with FEP
- Addiction medication use
- **Transition issues for 18-23 yr olds, focusing on continuity of care**

For children eligible for home and community-based services:

- Use of crisis and crisis diversion services
- Prior auth/denial and notices of action
- **HCBS utilization**
- **HCBS quality assurance performance measures** as determined by the State and pending CMS requirements
- **Enrollment in Health Home**

New Jersey Tracking & Reporting Evidence of Progress

- ✓ Increase in access to behavioral health care for children and youth
- ✓ Decrease in over reliance on out of home treatment
- ✓ Decrease in over reliance on detention with 9 centers closing
- ✓ Decrease by 70% the population of youth who are on Probation
- ✓ The only state hospital has closed
- ✓ Have brought all children with behavioral health challenges home to NJ
- ✓ Decrease in use of restraint, seclusion and coercion in all out of home treatment interventions.



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Core System of Care Components
State & Local-Level Leadership for Systems of Care

- Multiple state and local agencies are responsible for children and youth with behavioral health challenges.
- When everyone is responsible, it is too easy for no one to be responsible.
- States and localities create cross-agency governance bodies for systems of care.

State Level Examples

All use subcommittee structures to bring in additional perspectives –
e.g. families, youth, providers, schools, advocates, county reps

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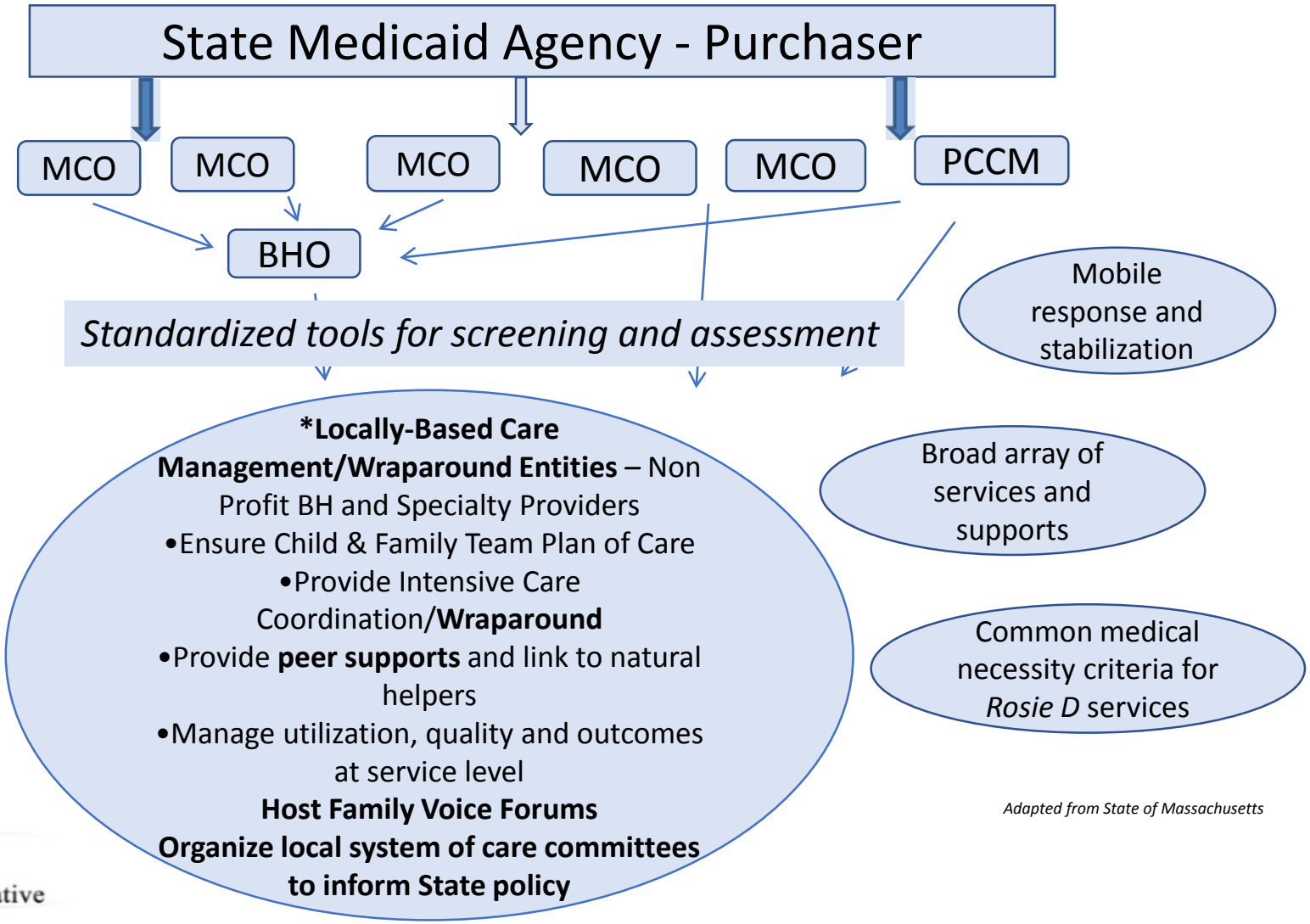
Massachusetts – Response to *Rosie D*

Children's Behavioral Health Initiative

Provides leadership and policy direction, ensures training, shares data, QI

Children's BH Advisory Council



Adapted from State of Massachusetts

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“Ours is not the task of fixing the entire world all at once, but of stretching to mend the part that is within our reach”

Clarissa Pinkola Estes

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