Building Systems of Care: A Primer on Designing and Implementing Effective Systems of Care

The TA Network for Children’s Behavioral Health
The National Wraparound Implementation Center
The Institute for Innovation and Implementation

Topeka, Kansas
June 17-18, 2019
This training is hosted by the National TA Network for Children’s Behavioral Health, operated by and coordinated through the University of Maryland.

This presentation was prepared by the National Technical Assistance Network for Children’s Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201500007C. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).
Definition,
History,
Values,
Populations
A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, has supportive policy and management infrastructure, and is data-driven.

Milestones in Evolution of Systems of Care

1982 Unclaimed Children

1984 CASSP – interagency coordination

1989 Federation of Families – family movement

1992 Annie E Casey Foundation Urban Mental Health Initiative

1992 SAMHSA CMHI – services and supports

1993 President Clinton’s Health Care Reform Task Force - children’s plan

1997 Robert Wood Johnson Foundation Mental Health Services Program for Youth – introduction of managed care approaches to SOC

2002 President Bush’s New Freedom MH Commission - children’s recommendations

2003 YouthMove – youth movement

2003 Children’s Bureau - child welfare system of care grants

2010 Health Reform - system of care principles in health care

2010 CMS CHIPRA Quality grants – fidelity Wraparound through Care Management Entities

2011 SAMHSA SOC Expansion grants

2013 FREDLA – family-run organizations

2013 SAMHSA Behavioral Health Disparity Impact Statements - required of SOC Expansion and other grantees

Historic/Current Systems Problems

- 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

### Characteristics of Systems of Care as Systems Reform Initiatives

<table>
<thead>
<tr>
<th><strong>From:</strong></th>
<th><strong>To:</strong></th>
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<tbody>
<tr>
<td>- Fragmented service delivery</td>
<td>- Coordinated service delivery</td>
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<td>- Categorical programs/funding</td>
<td>- Blended resources</td>
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<td>- Limited services</td>
<td>- Comprehensive service array</td>
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<tr>
<td>- Reactive, crisis-oriented</td>
<td>- Focus on prevention/early intervention</td>
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<td>- Focus on “deep end,” restrictive</td>
<td>- Least restrictive settings</td>
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<td>- Children/youth out-of-home</td>
<td>- Children/youth within families</td>
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<tr>
<td>- Centralized authority</td>
<td>- Community-based ownership</td>
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<tr>
<td>- Foster “dependency”</td>
<td>- Build on strengths and resiliency</td>
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Frontline Practice Shifts

**From:**
- Control by professionals (*I am in charge*)
- Only professional services
- Multiple case managers
- Multiple service plans (meeting needs of agencies)
- Family/youth blaming
- Deficits focused
- *Mono Cultural*

**To:**
- Partnerships with families/youth (*acknowledging a power imbalance*)
- Partnership between natural and professional supports/services
- One care coordinator
- Single, individualized child and family plan (meeting needs of family and youth)
- Family/youth partnerships
- Strengths focused
- Cultural/linguistic competence

System Change/Transformation Focus

Policy Level

Management Level

System Transformation

Frontline Practice Level

Community Level

(e.g., financing; regulations; rates)

(e.g., data; quality improvement; human resource development; system organization)

(e.g., assessment; service planning; care management; services/supports provision)

(e.g., partnerships with families and youth; natural helpers; community buy-in)

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
- Coordinated across providers and systems
- 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

**Definition of Family-Driven**

*Family-driven means* families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- choosing culturally and linguistically competent supports, services, and providers
- setting goals
- designing, implementing, and evaluating programs
- monitoring outcomes
- partnering in funding decisions

Osher, T., Osher, D. and Blau, G. FFCMH and CMHS, SAMHSA.
“Youth Guided means to value youth as experts, respect their voice, and to treat them as equal partners in creating system change at the individual, state, and national level.”
Family Members and Youth: Shifts in Roles and Expectations

*Recipients of information
*Unheard voice in program evaluation
*Recipients of services
*Uninvited key stake holders in training initiatives
*Anger adversity & resistance

*Passive partners in service planning
*Participate in program evaluation
*Partners in planning and developing services
*Participants in training initiatives
*Self- advocacy

*Service planning team leader
*Partner (or independent) in developing and conducting program evaluation
*Service providers
*Partners and independent consultants
*Advocacy & peer support

Family & Youth Roles in Systems of Care

<table>
<thead>
<tr>
<th>Roles</th>
<th>Descriptions</th>
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</thead>
<tbody>
<tr>
<td>Peer Support Services</td>
<td>• Information and referral&lt;br&gt;• Parent/Peer education&lt;br&gt;• Family &amp; youth mentors&lt;br&gt;• Supervisor/management</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>• Peer navigators&lt;br&gt;• Care coordinators&lt;br&gt;• Family &amp; youth support partners&lt;br&gt;• Project directors</td>
</tr>
<tr>
<td>Outreach &amp; Public Awareness</td>
<td>• Presentations&lt;br&gt;• Testimony&lt;br&gt;• Community Resource Fairs</td>
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<tr>
<td>Quality Assurance</td>
<td>• Evaluation interviewers&lt;br&gt;• Board representation</td>
</tr>
<tr>
<td>Training &amp; Technical Assistance</td>
<td>• Curriculum development&lt;br&gt;• Workshops&lt;br&gt;• Co-trainers&lt;br&gt;• Consultants&lt;br&gt;• Certification</td>
</tr>
</tbody>
</table>
National Culturally and Linguistically Appropriate Services (CLAS) Standards

www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandards
Example of Cross-Agency Responsibility for Behavioral Health Care Delivery for Children/Youth

**Dept. of Mental Health**
- CMHCs
- State Hospitals
- Residential Treatment Centers

**Dept. of Health and Human Services - Medicaid**
- 3 PCCMs
- 4 MCOs
  - Office-based OP
  - Psychiatric inpatient in community hospitals
  - PRTFs - soon

**Dept. of Alcohol and Other Drug Abuse Services**
- Contracted adolescent SUD OP
- SUD Prevention

**Dept. of Public Health**
- Maternal and Child Health
- Part C – Early Intervention

**Dept. of Social Services – Child Welfare**
- Intensive Foster Care & Clinical Services
  - Treatment Foster Care
  - Intensive Case Management
  - Contracted Residential Treatment
  - Therapeutic Group Homes

**Dept. of Juvenile Justice**
- Assessment Center
- Contracted MST, DBT

**Dept. of Education**
- IDEA
- School-based health centers
- School psychologists and social workers

**Voc Rehab, Housing, Employment**
Categorical vs. Non-Categorical System Reforms

Creating “Win-Win” Scenarios

Exercise/Discussion on Values
Planning and Governance
Prevalence of Child Mental Health Disorders

- An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year...”¹

- About one out of every ten youth is estimated to meet the Substance Abuse and Mental Health Services Administration (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.²

FACES OF MEDICAID: CHILDREN’S BEHAVIORAL HEALTH CARE UTILIZATION & EXPENDITURES

Of the 32 million children covered by Medicaid, about **1-in-10** use behavioral health care services

... and those children account for **over 1/3** of all costs for children in Medicaid — totaling over $30.2 billion

These children have **mean expenditures 4x higher** than children in Medicaid who only use physical health care

Children using only physical health care: $2,492
Children using both physical and behavioral health care: $10,259

Children covered by **foster care and SSI/disability** account for...

- Over **1/4** of behavioral health service use among children in Medicaid
- Half of total behavioral health care costs for children in Medicaid
- Only a small portion of children covered by Medicaid

Center for Health Care Strategies, Inc.
www.chcs.org

Made possible with support from the Annie E. Casey Foundation.


Substance Abuse and Mental Health Services Administration
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

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.
- 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.
- 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.
- 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.

Prevalence/Utilization Triangle

More complex needs

2-5%

Intensive Services – 60% of $$$

15%

Home and community services and supports; early intervention – 35% of $$

80%

Less complex needs

Prevention and Universal Health Promotion – 5% of $

Functions

Planning

Governance

System Management

Effective System-Building Process

- Leadership & Constituency Building
- A Strategic Focus
- Orientation to Sustainability

Importance of Federal & State Reforms

➢ Health Reform
  – Medicaid expansion?
  – Managed Care (KanCare)
  – Focus on “whole person,” person-centered care
  – Funding for community mental health centers and regional care centers

➢ Child Welfare Reforms
  – Family First Prevention Services
  – Child welfare oversight

➢ Juvenile Justice Reforms
  – Diversion and alternatives to detention
  – Restorative justice
  – Focus on reduction in out of home placement

➢ Education Reforms
  – Positive Behavioral Supports and Interventions
  – Safe and Healthy Schools
  – Early childhood improvements

Factors That Impact Design

**Financing**
- Title XIX Funding
- Rehab Option
- Targeted Case Management
- Child Welfare
- Juvenile Justice
- 1915 like (i) or (c)
- 1115 Waiver
- CHIP/SCHIP
- State Funds

**Priorities**
- Increase Access to Care
- Addressing Urgency
- Evidence Informed Care
- Care Management
- System Coordination
- Reduce Institutional Care
- Meet the Needs of Particular Populations

**NJ CSOC**

**Final System of Care Design**

**Values & Principles**

**Environment**
- Political Perspectives of Leaders
- Lawsuits/Settlements
- Crisis/Tragedy
- Mandates
- Community Will
- Economy

**Structure**
- Government
- State and County
- Existing Reality
- Envisioned Ideal
- Medicaid Agency
- Locus of Control
- Leadership Structure

**SAMHSA** Substance Abuse and Mental Health Services Administration
System of Care Functions Requiring Structure

- Planning
- Governance-Policy Level Oversight
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development at all Levels
- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management & Communications Technology
- Quality Improvement
- Evaluation

Structuring Planning

- Leadership
- Staffing
- Time and place of meetings
- Stakeholder involvement and supports
- Committees, work groups, focus groups
- Communication and dissemination of information
- Outreach to and involvement of families and youth
- Outreach to and involvement of diverse and disenfranchised constituencies, use of cultural brokers
- Linkage to related reform/planning initiatives
- Resources

Critical Steps in a Planning Process

✓ Identify your population(s) of focus.
✓ Agree on underlying values and intended outcomes.
✓ Identify services/supports and practice model to achieve outcomes (map existing strengths and needs)
✓ Identify how services/supports will be organized (so that all key stakeholders can draw the system design).
✓ Identify the administrative/system infrastructure needed to support the delivery system and capacity building reqs (e.g., training)
✓ Conduct an expenditure and utilization analysis (e.g., how population has used services and can be expected to) - Cost out the system of care.
✓ Develop a strategic financing and sustainability plan.
Governance

Decision making at a policy level that has legitimacy, authority, and accountability.

System Management

Day-to-day operational decision making

For the Governance Body to be effective, its members must have decision making authority regarding resources and policies needed to build and sustain the System of Care.
Key Issues for Governing Bodies

- Has authority to govern
- Is clear about role, scope, operational practices and procedures
- Is representative

- Has the capacity and credibility to govern
- Has training and coaching on conflict resolution, effective working relationships

- Assumes shared accountability across systems for population(s) of focus
- Operates in a transparent manner to assure public confidence

Key Issues

• Is the reporting relationship to the governing body clear?
• Are expectations clear regarding what is to be managed and what outcomes are expected?
• Does the system management structure have the capacity to manage?
• Does the system management structure have the credibility to manage?
Governance and System Management to Address Cultural and Linguistic Competence (CLC)

- Identify/recruit members for the governing body that are reflective of the population(s) of focus.
- Create/revise policies to affirm support of CLC perspective.
- Conduct annual demographic analysis and needs assessment.
- Develop formal partnerships with cultural community agencies (e.g., faith-based entities, traditional cultural providers).
- Develop strategies to support and retain diverse board members and establish a plan for retention of a diverse workforce (e.g., training, mentoring, partnerships).
- Allocate adequate funds.
- Develop policy for timely provision of interpretation services and allocation of bilingual staff.
- Organize CLC committee with authority to assess capacity of service delivery system to be culturally competent.
- Assess (and modify if necessary) physical facilities to reflect the population of focus.
- Locate services geographically accessible and acceptable.
- Recruit, hire, train youth and their families reflecting the diversity throughout the system of care.
- Review/modify job descriptions to include requirements for development of cultural knowledge and cross-cultural practice skills.

Adapted from Sample Cultural and Linguistic Competency Plan (2008) Technical Assistance Partnership: www.tapartnership.org/cc
• Work on the recruitment of families being served or reflective of the population – work with family organizations and front-line staff
• Provide assistance with transportation, child care, lodging, food and...
• Invite families and youth to...
• Implement...
• Support...
Family and Youth Partnership in Governance and System Management

- Input/evaluation of key management
- Input/evaluation of quality of services and programs
- Local system of care input
- Input into resource allocation decisions
- Service planning and implementation
- Policies and procedures
- Grievance and resolution procedures

Structuring the Array of Services and Supports
# Services/Supports Array Focused on a Total Population

**Core Services**
- Family Support Services
- Youth Development Program/Activities
- Coordinated Intake Assessment & Service Planning
- Service Coordination
- Intensive Care Management
- Mobile Response
- Treatment Services
- School Supports
- School-Wide Climate Change Initiatives

**Universal**
- Prevention
- Early Intervention

**Targeted**
- Intensive Services

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Intensive Care Coordination: Wraparound Approach

Parent and Youth Support Services

Intensive In-Home Services

Respite

Mobile Crisis Response and Stabilization

Flex Funds

Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma
Home and Community-Based Services, Peer and Recovery Supports, Evidence-Informed Practices, Trauma-Informed Approaches

Emphasized in..

- Medicaid: CMCS/SAMHSA May 7 2013 and January 26 2015 Joint Information Bulletins
- IV-E (Child Welfare) Waivers and Family First Prevention Act
- Juvenile Justice Reform Act of 2018 (H.R. 6964)
- SUPPORT Act (H.R. 6)
- Federal Discretionary Grant Programs
- EPSDT (Medicaid) and Child Welfare Lawsuits
Service Array Considerations

Trauma-Informed Systems and Evidence-Based Trauma Treatments

- Increased awareness of the impact of trauma
- Children and youth with most challenging mental health needs often have experienced significant trauma

Telehealth and Mobile Technology

- Using communications technology to provide access to:
  - health/behavioral health assessment, diagnosis, intervention,
  - consultation, supervision, education, care coordination and
  - peer support across distance

Managing and Adapting Practice

Systemic approach to raising the quality of “usual care”
Roles for Parent Peer Support Providers

- Tier 4
  - Intensive in-home services (such as HFW, HomeBuilders, etc.)
  - Parent peer support (part of tx team or additional service)
  - Respite & Crisis Planning
  - Training, Support Groups
  - Policy-making & Advocacy
  - Data Collection & Evaluation

- Tier 3
  - Individual advocacy, information & system navigation, intake and assessment
  - Parent peer support (individual and/or team)
  - Care coordination
  - Training, Support Groups
  - Respite & Crisis Planning
  - Policy-making and Advocacy
  - Data Collection & Evaluation

- Tier 2
  - Training, Support Groups
  - Information & referral, intake
  - Data Collection & Evaluation
  - Policy-making & Advocacy

- Tier 1
  - Education, information & referral
  - Policy-making & Advocacy
  - Data Collection & Evaluation
Growing Conclusion by State, Tribal and Local Purchasers

Redirect spending from out of home placements with high costs and/or poor outcomes to home and community-based services and supports in a system of care

Implications for Residential Interventions

• 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
• Individualized treatment approaches through a child and family team process
• Trauma-informed care

For more information, go to Building Bridges Initiative: www.buildingbridges4youth.org
SOCs should pay attention to
- Service Array
- Quality of service implementation (MYPAC)
- Network Adequacy

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
- Join the System of Care initiatives in their area
Unmet need for care coordination is high for children and youth with mental health conditions, especially among families with public insurance or who are uninsured.

“Parents...who receive family-center care report better...partnerships which are foundational to optimizing care coordination.”
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

INTEGRATION CONTINUUM (nested within common value/principles)

Across the continuum: Family and Youth Peer Support/Navigators and Measurement-Based (Metrics Across Continuum)

All children: Pediatric primary care services, including promotion of social-emotional development, developmental and behavioral health screening, and family psychosocial screening with a broader focus on social determinants of health

Could occur in primary care, behavioral health, school-based or other community setting

Children with Identified Need

Child Behavioral Health Consultation Programs, which include behavioral health consultation to primary care practitioners and coordination by behavioral health

Could occur in primary care, behavioral health, school-based or other community setting

Low/Moderate Need

Team-based care with appropriate infrastructure (could also be in school-based health setting).

Could occur in primary care, behavioral health, school-based or other community setting

Significant Need/High Risk

Intensive Care Coordination using High Fidelity Wraparound (could be in primary care, behavioral health, or school-based health settings).

Could occur in primary care, behavioral health, school-based or other community setting

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
Important Points About the Wraparound Process

- **Wraparound is a defined, team-based service planning and coordination process**
- The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
- **Wraparound is not a service per se, it is a structured approach to service planning and care coordination**
- The ultimate goal is both to improve outcomes and per capita costs of care
In Wraparound, a dedicated care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan.

- Behavioral Health
- Juvenile Justice
- Education
- Child welfare
- Health care

“Natural Supports”
- Extended family
- Neighbors
- Friends

“Community Supports”
- Neighborhood
- Civic
- Faith-based

ONE PLAN

Adapted from Laura Burger Lucas, ohana coaching, 2009
What’s Different in Wraparound?

• High quality **Teamwork**
  – Collaborative activity
  – Brainstorming options
  – Goal setting and progress monitoring
• The plan and the team process is **driven by the family and youth and “owned” by the team**
• Taking a strengths based approach
• The plan focuses on the **priority needs as identified by the youth and family**
• **A whole youth and family focus**
• A focus on developing **optimism and self-efficacy**
• A focus on developing **enduring social supports**

Bruns, E. National Wraparound Initiative
Figure 2
Social Determinants of Health

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<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<td>Literacy</td>
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<td>Language</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social support systems</td>
<td>Provider availability</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Community engagement</td>
<td>Provider linguistic and cultural competency</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Discrimination</td>
<td>Quality of care</td>
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<td>Support</td>
<td>Walkability</td>
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**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
Social Determinants of Health

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE

UPSTREAM
SOCIAL INEQUITIES
- Class
- Race/Ethnicity
- Immigration Status
- Gender
- Sexual Orientation

INSTITUTIONAL INEQUITIES
- Corporations & Businesses
- Government Agencies
- Schools
- Laws & Regulations
- Not-for-Profit Organizations

LIVING CONDITIONS
- Physical Environment
  - Land Use
  - Transportation
  - Housing
  - Residential Segregation
  - Exposure to Toxins
- Economic & Work Environment
  - Employment
  - Income
  - Retail Businesses
  - Occupational Hazards
- Social Environment
  - Experience of Class, Race, Gender, Immigration, Culture - Ads - Media - Violence

RISK BEHAVIORS
- Smoking
- Poor Nutrition
- Low Physical Activity
- Violence
- Alcohol & Other Drugs
- Sexual Behavior

DISEASE & INJURY
- Communicable Disease
- Chronic Disease
- Injury (Intentional & Unintentional)

MORTALITY
- Infant Mortality
- Life Expectancy

POLICY

Strategic Partnerships Advocacy
Community Capacity Building
Community Organizing
Civic Engagement

Individual Health Education
Health Care
Case Management

Emerging Public Health Practice
Current Public Health Practice

SAMHSA
Substance Abuse and Mental Health Services Administration
Wraparound is Associated with Improved Outcomes

Better functioning and mental health outcomes

- Reduced recidivism and better juvenile justice outcomes
- Increased rate of case closure for child welfare involved youths
- Reduction in costs associated with residential placements

See Bruns & Suter, 2010; Coldiron, Bruns, & Quick, 2017
## Lower Costs and Fewer Residential Stays

### Wraparound Milwaukee
- Reduced psychiatric hospitalization from 5000 to less than 200 days annually
- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

### Controlled study of Mental Health Services Program for Youth in Massachusetts (Grimes, 2011)
- Reduced psychiatric hospitalization from 5000 to less than 200 days annually
- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

### CMS Psychiatric Residential Treatment Facility Waiver Demonstration (Urdapilleta et al., 2011)
- Reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008)

### New Jersey
- Saved over $30 million in inpatient psychiatric expenditures over 3 years (Hancock, 2012)

### Maine
- Reduced net Medicaid spending by 30%, even as use of home and community services increased
- 43% reduction in inpatient and 29% in residential treatment expenses (Yoe, Bruns, & Ryan, 2011)

### Los Angeles County Dept. of Social Services
- Found 12 month placement costs were $10,800 for wraparound-discharged youths compared to $27,400 for matched group of residential treatment center youths
Studies indicate that Wraparound teams often fail to:

- Engage key individuals in the Wraparound team
- Connect youth in community activities and things they do well; activities to help develop friendships
- Use family/community strengths
- Incorporate natural supports, such as extended family members and community members
- Use evidence-based clinical strategies to meet needs
- Continuously assess progress, satisfaction, and outcomes
“Full 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)
Outcomes Depend on Implementation

Percent of youth showing improvement on the CANS:

- **High Fidelity (>85%)**: 82%
- **Adequate Fidelity (75-85%)**: 69%
- **Borderline (65-75%)**: 65%
- **Not Wraparound (<65%)**: 55%
• Build relationship based on mutuality and trust
• Promote self-advocacy: voice & choice
• Identify and build natural supports
• Bridge of communication with providers
• Service navigation and securing community resources
• Connect to support groups and education-skills based trainings
• Assist with completing care plan goals and action steps
• Celebrate accomplishments
Mobile Response and Stabilization Services

• Can effectively *deescalate, stabilize, and improve treatment outcomes.*

• Are specifically designed to *intercede before urgent behavioral situations become unmanageable emergencies* and are *instrumental in averting unnecessary emergency department visits, out-of-home placements and placement disruptions, and in reducing overall system costs.*

• Emergency Departments (ED):
  – Lack specialized expertise to respond to pediatric psychiatric emergencies leads to “boarding”
  – Expensive for payers
  – Time consuming and traumatic for parents and children
Better outcomes in both cost and quality of care are achievable through community-based initiatives that redefine the meaning of ‘crisis’ and address and stabilize behaviors prior to escalation to the level of requiring inpatient care.
1. Diverting unnecessary ED admissions

2. Instituting evidence-based home- and community-based services that provide meaningful alternatives to inpatient treatment


The Value of MRSS within a Crisis Continuum

• Designed to intercede upstream, before urgent behavioral situations become unmanageable emergencies
• Instrumental in averting unnecessary ED visits, out-of-home placements and placement disruptions, and in reducing overall system costs.*
• Keep a child, youth or young adult safe at home, in the community, and in school whenever possible.
• Viable alternative to acute care and residential treatment because they consistently demonstrate cost savings while simultaneously improving outcomes and achieving higher family satisfaction.

MRSS Common Elements:

• Crisis is defined by the caller
• Services are available 24 hours a day, seven days a week
• Able to serve children and families in their natural environments, for example, at home or in school
• Include specialized child and adolescent trained staff and do not rely on predominantly adult-oriented crisis response workers
• Build on natural support structures and reduce reliance (and therefore costs) on hospitals and formal crisis response systems.
• Connect families to follow-up services and supports, including transition to needed treatment services
End of Day 1
Financing
Strategic Financing Agenda

Move from a mentality of “funding programs and providing grants” to “collaborative financing to support a strategic agenda”

How do you want to use your dollars to promote a unified agenda and achieve outcomes for shared populations of focus?
Strategic financing begins with cross-system and community stakeholders answering two questions:

**Financing for whom??**

**Financing for what??**

Financing for Whom?

• Identify and understand population(s) of focus
  • Demographics, e.g., culture/race/ethnicity, economics, etc.
  • Size
  • Strengths, issues and needs

• Analyze Data
  • Quantitative – numbers or things that can be measured or counted.
  • Qualitative – things you can observe but are not typically in number form – social interactions, feelings, etc.

The more you understand about your population(s) of focus, the more strategic you can be about financing.
What are the **outcomes** you want to achieve with respect to your identified population(s) of focus?

This is governed by your **values** – is there consensus?
Does your SOC include/need the SAMHSA/CMMS recommended Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions?

- Intensive Care Coordination/Wraparound
- Mobile Response and Stabilization Services
- Youth and Family Peer Support
- Intensive In-Home Services
- Respite Service
- Flex Funds (Customized Goods and Services)
What *outreach and engagement strategies, services and supports, and care coordination approaches* will lead to effective outcomes for your identified population(s) of focus?

Is there a common “*practice approach*” you want to promote? (SOC approach — strengths-based, family-driven, youth-guided, culturally and linguistically competent, individualized, effective, comprehensive)
Financing for What?

How will services/supports be organized? What is the system design?

- Customization within Medicaid delivery system?
- Changes in what child welfare, juvenile justice, schools, behavioral health systems provide?
- Specialized cross-system capacity? (e.g., Care Management Entities; Family-Run Organizations; Youth-Run Organizations; screening and assessment)

What is the administrative/system infrastructure needed to support the delivery system?

- Training and capacity development?
- IT systems?
- Cross-agency governance?
- Social marketing/strategic communications capacity?
- Quality oversight and outcomes tracking?
How Many Will the System of Care Cost?

- How many children/youth can you expect to use services and supports?
- How much of what are they likely to use and for how long?
- What are the costs of the services/supports in your array and of your care coordination approaches?
- What are infrastructure costs to support the system (e.g., training, IT, governance, support for family-run organizations and youth movement)?
If You Have Answered the Questions:
Financing for Whom? Financing for What?

- Identified your population(s) of focus
- Agreed on underlying values and intended outcomes
- Identified services/supports and practice model to achieve outcomes
- Identified how services/supports will be organized – system design
- Identified the administrative/system infrastructure needed to support the delivery system
- Estimated costs

Then You Are Ready To Talk About Financing Strategies!
<table>
<thead>
<tr>
<th>Who Controls Dollars for Your Populations of Focus?</th>
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</table>

**Medicaid**
- Medicaid Inpatient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Options

**Child Welfare**
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support
- CBCAP

**Education**
- ED General Revenue
- ED Medicaid Match
- Student Services
- Federal Grants
- Title I

**Mental Health**
- MH General Revenue
- MH Medicaid Match
- MH Block Grant
- MH Prevention

**Substance Abuse**
- SA General Revenue
- SA Medicaid Match
- SA Block Grant
- SA Prevention

**Juvenile Justice**
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

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<tr>
<th>Other</th>
<th>Education</th>
<th>Mental Health</th>
<th>Substance Abuse</th>
<th>Juvenile Justice</th>
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<tr>
<td>TANF</td>
<td>Maternal and Child Health</td>
<td>MH General Revenue</td>
<td>SA General Revenue</td>
<td>JJ General Revenue</td>
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<tr>
<td>Developmental Disabilities</td>
<td>Public Health</td>
<td>MH Medicaid Match</td>
<td>SA Medicaid Match</td>
<td>JJ Medicaid Match</td>
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<tr>
<td>Homeless Programs</td>
<td>Rural and community health</td>
<td>MH Block Grant</td>
<td>SA Block Grant</td>
<td>JJ Federal Grants</td>
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<td>Domestic Violence</td>
<td>HIV/AIDS Prevention</td>
<td>MH Prevention</td>
<td>SA Prevention</td>
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<td>Vocational Rehabilitation</td>
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<td>Housing</td>
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Expenditure and Utilization Questions:

1. Which state and/or county agencies spend dollars on your population(s) of focus?
2. How much do they spend? In total and by service type?
3. What types of dollars are spent (e.g., entitlement, general revenue, block grant)?
4. How many children and youth use services? In total and by service type?
5. How much service do they use? What is average length of stay/tenure by service type?
6. What are the characteristics of these children and youth (e.g., by age, gender, race/ethnicity, diagnosis, region)?
Expenditure and Utilization Questions:

• Have you identified administrative challenges or barriers that need to be addressed?
• How do current financing structures support or impede SOC development?
Using Financial Analysis Data

Example: What Drives Costs (and often poor outcomes) for Youth with Behavioral Health Challenges?

• Use of Residential Treatment, Group Homes, Psychiatric Inpatient (and Day Treatment)
• Inappropriate use of psychotropic medication
• Use of traditional outpatient therapies – lack of evidence of benefit
• Duplication of Services, e.g., multiple assessments and care coordinators
Potential Opportunities

1. Braiding or coordinating funds across systems for financing services, Medicaid match, etc.
2. Using Medicaid financing to increase coverage of home- and community-based (HCB) services, shift funds from inpatient and residential care to HCB care by using guidance (e.g., joint SAMHSA-CMS Informational Bulletin, waivers such as 1915(c), etc.)
3. Leveraging innovative opportunities to finance HCB services (e.g., health homes, Money Follows the Person, 1915(i) State Plan Amendments, Medicaid and CHIP expansion)
4. Increasing the use of Mental Health Block Grant funds to fill gaps in services not covered by Medicaid or other sources
5. Opportunities across systems (e.g., Substance Abuse Block Grants, child welfare, juvenile justice, education, early childhood, etc.)
Collaborative Financing

- **Blending/pooling** – combining funds from multiple sources into one funding pool
- **Braiding** – “virtually combining” funds from multiple sources that remain administratively separate
- **Intentionally Coordinating** – agreeing across agencies to use separate funding streams for the same goals
## Financing Strategies to Support Improved Outcomes for Children, Youth and Families

**FIRST PRINCIPLE: Strategic Agenda for Populations of Focus Drives Financing**

<table>
<thead>
<tr>
<th>REDEPLOYMENT</th>
<th>REFINANCING</th>
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</table>
| Using the money we already have  
The cost of doing nothing  
Shifting funds from high cost/poor outcome services to effective practices  
Moving across fiscal years | Generating new money by increasing federal claims  
The commitment to reinvest funds for families and children  
Foster Care and Adoption Assistance (Title IV-E)  
Medicaid (Title XIX) |

<table>
<thead>
<tr>
<th>RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN</th>
<th>FINANCING STRUCTURES THAT SUPPORT GOALS</th>
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</table>
| Donations  
Special taxes and taxing districts for children  
Fees and third party collections including child support  
Trust funds | Seamless services: Financial claiming invisible to families  
Funding pools: Breaking the lock of agency ownership of funds  
Flexible Dollars: Removing the barriers to meeting the unique needs of families  
Incentives: Rewarding good practice |

Where are you spending resources on high costs and/or poor outcomes?

- Residential Treatment?
- Group Homes?
- Detention?
- Hospital admissions/re-admissions?
- Too long stays in therapeutic foster care?
- Inappropriate psychotropic drug use?
- “Cookie-cutter” psychiatric and psychological evaluations?
Flex Funds: Customized Goods and Services

- Purchase non-recurring set-up expenses (furniture, bedding, clothing)
- One-time payment of utilities, rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses
- Academic coaching, memberships to local girls or boys clubs, etc.
- Particularly useful when a youth is transitioning from residential treatment setting to family or independent living
- Available to individuals participating in various Medicaid waivers and/or the 1915(i) program

Financing Family- and Youth-Run Organizations

- State or county contracts with government agencies such as mental health, juvenile justice, child welfare, etc.
- Subcontracts with larger organization initiatives (e.g. TA Network and FREDLA)
- Medicaid reimbursement for covered services (peer support)
- Medicaid managed care organizations – reinvestment funds, “in lieu of” funds, admin dollars
- Accountable Care Organizations – system navigation, outreach, peer support, care coordination
- Private foundations
- Public awareness fundraising activities: annual campaigns, events, and donors/sponsor relationships
- Federal grants (e.g., SAMHSA Initiatives, Statewide Family Network grants, Child welfare etc.)

What are the Opportunities for...

➤ Redirection of dollars to more effective approaches

➤ Revenue maximization

➤ Blending, braiding funds

➤ Showing a return on investment
Summary of Financing Strategies

- Maximize Medicaid
- Blend, braid or intentionally coordinate funding streams across systems
- Redirect spending from high cost and/or poor outcome services to effective practices
- Manage dollars through managed care arrangements that are tied to values and goals
- Risk adjust payment for complex populations of children (e.g., risk-adjusted capitation rates to MCOs; case rates to providers)
- Finance:
  - Locus of accountability, e.g., care management entities for most complex, cross-system
  - Family and youth partnerships at policy, management and service levels
  - Training, capacity building, quality and outcomes monitoring
  - Broad, flexible array of services and supports
WORKSHEET
Data

“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
The Importance of Data

Understanding the data = Understanding opportunities to improve the quality and cost of care

Using Data

Source: https://xkcd.com/1831/
Different Uses of Data in SOCs

- Planning
- Guiding implementation
- Assessing impact – outcomes and cost
- Accountability
- Promoting and sustaining – demonstrating value
- Informing policy- and decision-makers
Presenting Data

• Simple graphs, not lists of numbers
• Clearly observable so the untrained eye can easily see the point of the data

• Data to show the importance and impact of family voice and choice
Quantitative Data
Administrative and claims data can tell you:
• How many children use which services
• How long children stay in each type of service
• Demographics of children served in each service type (gender, race/ethnicity, geographic area)
• Health disparities (e.g. underrepresentation of Hispanic/Latino children in home and community based services) and disproportionalities (e.g. overrepresentation of African American youth in residential treatment)
• How much is being spent on each type of service, in total and on average per child served
Sources of Quantitative Data

• Medicaid Management Information System (MMIS)
• Statewide Automated Child Welfare Information System (SACWIS)
• State and/or local behavioral health authority data
• State and/or local juvenile justice agency data
• State (e.g. special education) and/or local education data
• Data warehouses that link data elements across systems
• Provider-level data
Using Data to Identify Eligibility for Services

- Standardized screening and assessment tools
  - MD-CASII
  - SC- CAFAS
  - GA, LA, NJ- CANS
- Standardized medical necessity criteria -MA
- State- or county-developed screening/eligibility tools-NE, Cuyahoga County, OH
Referrals and enrollment by geographic area and by agency tracked over time
Wraparound provider certification and quality review
Use of peer support services
Network development of key services - number and distribution of providers
Number and length of stay in inpatient settings
Use of home and community based services
Qualitative Data Can Tell You

• How families and youth experience the system
• Strengths and weaknesses in the provider network
• How providers experience the system
• How key system partners experience the system (e.g. child welfare workers, juvenile probation officers, school personnel, court personnel)
• Recommendations for improvement
Types of Measures

- **Structure** - assesses features of delivery organizations, the capabilities of their professionals and staff, and the policy environment in which health care is delivered.

- **Process** - assesses the activities carried out by health care professionals to deliver services.

- **Outcome** - includes health states, mortality, laboratory test results, patient reported health states.

Data Collection

A variable is something that can be measured or counted. It is something that can increase or decrease depending on the situation that you are measuring.

Cross-sectional Data is something that is only measured once. It is a snapshot of variables at one point in time.

Longitudinal Data is something that is measured repeatedly over time. You can look at the same variable at different times.

Accountability Functions

- Utilization Management
- Quality Improvement
- Cost and Outcome Monitoring
Performance Dashboards

• Benefits: fosters alignment, continuous quality improvement (CQI), transparency

• Considerations
  – Purpose: audience & use; strategy or operations?
  – Metrics: <10, actionable, simple, agreed upon, linked to goals, use credible data
  – Timing: past snapshot, now, predictive
  – Visualization: trends, “meters”, pie/bar charts, hot spots/heatmaps. Show relationships? Interactive or static?

• Can’t be everything to everyone. Dashboards provoke questions and further investigation
Section IV: Children’s System of Care

Children in Care Management
April 2019

Rate of Children in Care Management by County
April 2019
n=13,463

Children in Out of Home Treatment Settings
March 2019

Children in Out of Home Treatment Settings
March 2019
n=968

Mobile Response Stabilization Services (MRSS) Dispatched

PerformCare Total Calls
Behavioral Health Related Calls
IDD Related Calls
Washington and Vermont Dashboards

Referral Source 2018 Cohort
2018 Cohort – n = 4,096

- Mental Health Provider-Outpatient Tx (RSN) - 25%
- Self and Family - 24%
- School - 9%
- Children’s Administration/Non-BRS - 7%
- Mental Health Provider-Outpatient Tx (Non RSN) - 6%
- Children’s Administration/Pre-BRS Services (Initial Screen) - 3%
- Medical Provider - 3%
- Mental Health Provider-Other Inpatient Tx - 3%
- Mental Health Provider-Crisis Services - 3%
- Other - 3%
- Mental Health Provider-other - 3%
- Juvenile Justice other (non-JJ&R) - 2%
- Juvenile Justice & Rehabilitation Admin - 1%
- Community Organization - 1%
- Children’s Administration/Currently in BRS Services - 1%
- Mental Health Provider-CLIP/Discharge from CLIP - 1%
- Developmental Disabilities Administration - 1%
- Chemical Dependency Provider - 1%
- Children’s Administration/Discharge from BRS - 1%
- Mental Health Provider-CLIP/Pre-CLIP Services (Initial screen) - 0%
- Mental Health Provider-Tribal Mental Health - 0%
- Mental Health Provider-CLIP/Currently CLIP Service - 0%

Percent of Initial Screeners

% of CRT clients receiving follow up services within 7 days of psychiatric hospitalization discharge

82% EPI 2018

Data Source: Department of Mental Health Monthly Service Report, CRT Hospitalization Spreadsheet

SAMHSA
Substance Abuse and Mental Health Services Administration
Demonstrating Value

Build support for sustainability and expansion

• Educate leadership and funders
• To build internal staff support
• Build stakeholder support
• Support of agency leadership
• Show return on investment
Gathering Data

- Questionnaires
- Surveys
- Interviews
- Focus groups
- Clinical outcome data
- Claims/administrative data

- Participatory action research
- Network analyses
- Financial analyses
- Chart reviews

Continuous Quality Improvement (CQI)

Plan, Do, Study, Act (PDSA) Cycle

- Accountability
- Driven by good management...not crisis
- Driven by input from all levels of staff and stakeholders including families and youth
- Teamwork
- Continuous review of progress
Why Analyze Medicaid Data

- Medicaid is the largest funder of behavioral health care for children and youth
- To be effective and sustainable, system of care reforms must impact Medicaid delivery systems
- Understanding child behavioral health utilization and expense in Medicaid can guide quality improvement efforts affecting most children and youth involved with systems of care
Why Analyze Medicaid Data

➤ Can Identify Opportunities to:

Maximize Medicaid and re-direct spending from high-cost, poor outcome spending – e.g. from facility-based care to home and community-based services, peer support and effective care coordination using fidelity Wraparound

Address appropriate use of psychotropic medications

Address disparities and disproportionality in access, in type of service used, in psychotropic medication rate and use - based on gender, age, race and ethnicity, aid category (TANF, Foster Care, SSI/Disabled) and geography
Why Analyze Medicaid Data

- Can project number of children with co-morbidities by examining physical health use and expense among children who use behavioral health care.
- Can identify children with top 10% most expensive use to project numbers for health homes and intensive care coordination using Wraparound.
- Can compare your State’s utilization and expenditures to national child behavioral health use and expense.
- Can establish benchmarks related to system of care goals (e.g., access, reduced disparities, increased use of home and community based services and peer support, reduced use of facility-based care).

Faces of Medicaid: Examples of Promising Findings

- Penetration rates ↑ overall
- Greater access by most racial/ethnic groups
- Greater access by girls
- Greater access by 0-5 population
- Use of broader range of home and community-based services
Faces of Medicaid: Examples of Concerning Findings

- 8% penetration rate for use of BH services (while up), remains well below prevalence estimates of need
- Disproportionately low rates of use for Hispanic/Latino, Asian, and Native Hawaiian/Pacific Islander children
- Disproportionately low utilization rates for girls
- Disproportionately low rates of use for 0-5 population
- Residential treatment
- Inpatient psychiatric
- Persistently high rates of residential treatment and inpatient psych use for foster care population
- Rate of psychotropic medication use, and close to half of children on meds did not receive accompanying behavioral health services
- Utilization rates of peer support, MST, Wraparound (while up) remain very low

Most frequent diagnosis for 0-5 population was Conduct Disorder – May mask learning problems? Trauma?

Rate of PTSD diagnosis at 6% may be low?

ADHD remains most frequent diagnosis – are children being over-diagnosed?

Black/African American children most likely to receive ADHD diagnosis and least likely to receive diagnoses of Mood Disorder, Anxiety and PTSD – are these children being misdiagnosed?

Children in Medicaid using BH care are 11% of the Medicaid child population and consume 36% of all Medicaid child expenditures, and their mean expense is over 4x that of children who do not use BH care – what are the best value-based strategies for improving the cost and quality of care for these children?
WORKSHEET
Final Thoughts?
SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

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