**To:** Andrew Brown, KDADS

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**RE: Summary of On-Site Technical Assistance Visit, June 17-18, 2019**

The following presents the major themes around each topical area of discussion following the June 17-18, 2019 technical assistance site visit. The event supported the attendance of parents/family members raising children receiving and/or needing mental health/substance abuse services. Keys for Networking coordinated their attendance, helped them be prepared for the meeting and offered opportunities to debrief between sessions. The contributions of families were invaluable toward shaping future plans. Additional commentary from the technical assistance team is also provided.

**Governance**

* The discussion centered around disparities in the availability and accessibility of information on the system of care (SOC). In particular, attendees highlighted challenges in understanding local v. state responsibility and oversight for SOC, the differences between programmatic and administrative management and governance, and the need for increased training and education for families and youth to understand the SOC.
* There was significant focus on the siloed/categorical nature of various child-serving agencies across the state, as well within the behavioral health delivery system based on geographic region and local control.
* *Recommendation: Develop a formalized governance structure*:
	+ (1) The formalized governance body should be responsible for making policy that promotes collaborative practice at the administrative and front-line levels.
	+ (2) The governance body should draw its representation from individual child-serving agencies and must include public payers such as Medicaid, education (e.g. IDEA), and public health (e.g., Block grant dollars and Title IV). The authority and structure for the SOC governance body could be established by gubernatorial order, legislative action (statute), under a cabinet secretary’s direction, via Memoranda of Agreement or Memoranda of Understanding between child-serving agencies, or located in an existing structure or body so long as that body is given the authority to effect change.
	+ (3) The roles and responsibilities for the governance body must be clearly defined in publicly available bylaws. The bylaws must explicitly define roles and responsibilities for family and youth organizations. Attendance alone is insufficient; family and youth organizations should be full participants in developing policy that improves the SOC in the immediate and long term. In addition, meetings should be well-advertised and employ the use of technology to enhance attendance and participation.

**Values**

* They key theme that emerged from this discussion was system variability. Participations highlighted several aspects, including (1) systems navigation, with individual experiences ranging from excellent to poor; (2) the availability versus accessibility of needed services, particularly based on payer, geographic location (with significant differences reported between the four grantee community mental health centers and others, and between urban, rural, and frontier communities); (3) eligibility for services based on diagnosis rather than diagnosis and functional eligibility criteria.
* *Recommendations*: *Review eligibility criteria for SOC and service array*. Under Kansas’ 1915(c) waiver, children and youth are eligible for services only via a mental health diagnosis and scores on two functional eligibility assessments (CAFAS and CBCL). Under changes to the waiver approved by CMS in January 2019, a third party contractor administers the CAFAS alongside the CMHC. The CMHC and third party contractor are charged with working together to schedule assessments for the SED waiver.
	+ Families in the western half of the state face difficulty in accessing assessments and services given distances to the Hays, Great Bend, Greensburg, Garden City, and Liberal CMHCs.
	+ Despite a repeated theme from participants that there was a need for education and assistance navigating child-serving systems, *only* families eligible for the 1915(c) waiver may receive parent support and training and professional resource family care. The state should consider avenues to expand the availability and accessibility of peer support services for parents and youth. Peer support services are delivered by parents/caregivers and youth with lived experience within the child-serving systems. The services include “developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; serving as an advocate, mentor, or facilitator for resolution of issues; and teaching skills necessary to improve coping abilities.”[[1]](#footnote-1)

**Financing**

* The key themes for that emerged were (1) disparities in accessibility and availability of high-quality, culturally and linguistically services by payer (that is, families receiving services via the waiver, Medicaid, Medicaid for foster care children, and commercial insurance report highly variable experiences with the behavioral health system); (2) the cost of medications and need for monitoring via a prior authorization program or PDMP-like system; (3) that resources are available based on diagnosis rather than functional need (i.e., that what a family can access is dependent on the child’s DSM diagnosis and eligibility for assistance flows from that, rather than level of functioning); (4) that success in treatment can lead to the precipitous removal of services and supports by denying continued eligibility, which in turn leads to recidivism; (5) that there is insufficient support for all levels of care, with a perception that resources are heavily allocated to children and families with complex needs with insufficient services and supports available to families transitioning between levels of care, or for stabilization services; and (6) that poor salaries and reimbursement for public system providers exacerbates workforce shortages.
* *Recommendations*
	+ *Conduct an expenditure and utilization review by agency/payer*. At present, it appears that spending is being driven by what is readily available rather than a matching services and supports to functional need. The state should review what services and supports it is buying today, and consider where those services are evidence-based or a promising practice, if it is purchasing duplicative services (e.g. multiple assessments), and how the population, by demographic group, has historically used services.
		- The expenditure and utilization review should be overseen by the SOC governance structure*.*
	+ *Begin reallocating dollars away from ineffective services.* After conducting an expenditure and utilization review, reallocate dollars away from traditional office therapy, residential treatment, and group homes to evidence-based practices in the 2013 Joint CMS/SAMHSA bulletin.
		- *Consider implementing a prior authorization program for antipsychotic medications.* Apart from cost considerations, the state could improve overall health with a program that required monitoring of body mass index and blood lipid levels. A review of pharmacy claims data would likely demonstrate families receiving medication who are disconnected from other behavioral health services and supports.

**Services/Service Array**

* Participants surfaced several themes: (1) Again, attention to uneven availability and accessibility of services available based on (a) geographic location (urban v. rural, with differences by county government as well), (b) proximity to a CMHC, and (c) diagnosis; (2) the lack of access to natural supports, including peers and parent education; (3) services and supports available across the care continuum, including prevention services in community settings such as schools and primary care officers, crisis intervention services, and care coordination with formalized roles for family support; (4) workforce issues, including difficulties with recruitment and retention, opportunities for professional development, and loan repayment.
* Recommendations:
	+ *Conduct utilization and expenditure review.* Given budgetary pressure, the state must know what it is purchasing today and with which funding stream before it develop a plan to improve availability and accessibility.
		- Without new dollars, the state must plan to reallocate its scarce dollars to evidence-based services. Over time, agencies can capture savings from high-cost, low-return services (e.g., residential treatment) and redirect them to new service lines (e.g., crisis services) or as rate enhancement for EBPs.
		- In particular, care coordination, including High Fidelity Wraparound, with formalized roles for family and youth; peer support for system navigation; crisis intervention to avoid residential or inpatient treatment; and respite care were repeatedly mentioned as needed but unavailable or difficult to access in a timely manner.
		- *Increase/Improve Stakeholder Education*: Under the waiver approved in January, the state “must update all provider manuals, participant handbooks, and guides to incorporate the conflict free case management rule…stakeholder input will be required to develop a comprehensive plan for transition. However, all HCBS participants will be afforded education and information about their rights and responsibilities prior to a transition from a non-compliant setting to a compliant setting. The State will establish a transition policy for relocation or transition to compliant settings after public input and comment that will address the process for transition, ensure choice is provided, and identify timeframes for appropriate transition.” Given that materials have to be updated, the state should engage family-serving organizations to review documents with an eye to improving systems navigation.
	+ *Increase cross agency collaboration.* Using a SOC governance structure, increase collaboration and availability of services in community settings. Participants were vocally supportive of Mental Health First Aid, school-based health care, and early intervention; consider leveraging those services to expand referral networks and increase parent/caregiver education.
	+ *Consider tele-initiatives.* Although participants expressed differing opinions about telemedicine, the state could consider replicating some well-tested models to improve access to prevention and early intervention services (e.g., MCPAP or BHIPP) via pediatric primary care.

**Data**

* Key themes included: (1) using existing data for system and quality improvement while reducing family and provider burden; (2) regularly sharing data with system stakeholders to build trust/reinforce transparency; (3) the importance of qualitative data (e.g., family and youth experience of care surveys); and (4) family and youth education on data at a systems level and how to use/interpret data for care planning.
* Recommendations
	+ *Make data a standing agenda item at governance and advisory meetings*. Some participants expressed a level of anxiety about understanding data and feeling as though data was not presented in a strengths-based manner; rather, it was used to highlight shortcomings. Presenting data regularly, particularly in easy-to-interpret graphical format demonstrates a commitment to transparency.
	+ *Cross agency data sharing to reduce burden*: Rather than asking families and providers to collect additional data, or participate in additional surveys, consider what data is being collected by other system partners that could be shared via MOU or MOA. For example, foster care children in the 1915(c) waiver cannot access short-term respite and professional resource family care via the waiver. Instead, those services are offered by the state’s foster care contractor who presumably holds the related data.
	+ *Consider data education programs*. In conjunction with provider organizations and family-run organizations, consider using social media to education families and youth on data. Several families about the role of provider-level EHRs/EMRs in collecting and interpreting data, and/or “service matching” in which caregivers could gain a sense of the services and supports that might best meet their needs, based on assessment scores.

**Next Steps**

* At the close of meeting, several consensus-based action items were discussed, including:
	+ Medicaid Managed Care Organization (MCOs) Workgroup. The state will convene a workgroup focused on leveraging MCO contracts and resources to improve children’s services. The workgroup will focus on identifying gaps in needed services and supports; developing strategies to close gaps; improving care coordination; and aligning service needs with workforce development, including paneling, provider capacity, and training. In addition, the workgroup will explore how to coordinate MCO changes and improvements with statewide SOC work, including any administrative analysis of utilization and expenditure to reallocate dollars to prevention, early intervention, and evidence-based services.
		- The TA team provided the state with several resources to assist as the Workgroup is established, including (1) a paper on primary care integration; (2) a brief outlining various telehealth models to ease provider shortages; (3) a National Association of State Mental Health Program Directors paper on developing a children’s crisis continuum and the offer to connect Kansas to Oklahoma, which developed mobile response services; (4) information on Maryland’s antipsychotic medication monitoring program, including a peer-reviewed study of the program; (5) information on the 2016 Medicaid managed care rule, with particular attention to “in lieu of” services with permits states to leverage Medicaid Managed Care contracts to authorize services that are medically appropriate, cost-effective alternatives to state plan services or value-added services that are not included in the state plan but have been determined to improve health and reduce costs, including those that address the social determinants of health; and (6) examples from 10 other states of innovative contractual provisions (e.g., Florida using “in lieu of” to develop crisis services or Texas including the children of farm workers as those with special health care needs).
	+ The state agreed that all future work, including the MCO Workgroup, must include family and youth from inception to work in partnership on designing, developing, and implementing system changes. This work is, in part, required by changes made to the 1915(c) which required stakeholder engagement for revisions to programmatic materials and guides. In addition to that required by the waiver, the state should formalize roles for families and youth as the state reviews it’s managed care contracts and undertakes initiatives to recruit and retain its behavioral health workforce. Families and youth expressed the need for a cultural shift in which they are not consulted about care but rather engaged as experts and partners at all levels, from developing family- and youth-centered plans of care to conducting needs assessments at the local level to implementing and overseeing new lines of service statewide.
1. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf> [↑](#footnote-ref-1)