Building Systems of Care for Children and Youth with Behavioral Health Challenges in Illinois

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Illinois Children’s Healthcare Foundation
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Topics to be Covered

I. Population Characteristics and System Issues

II. System of Care Definition and Characteristics

III. System of Care Planning

IV. System of Care Governance

V. Services and Supports in Systems of Care

VI. Care Coordination in Systems of Care

VII. Sustainability
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…”


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

Mental Health
Costliest Health Condition of Childhood

Mental Health Disorders
Asthma
Trauma Related Conditions
Acute Bronchitis
Infectious Diseases

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 is 4x higher than for children who don’t use behavioral health services
- Expense for top 10% most expensive children = $47,000 – expense driven by use of behavioral health care, not physical health

Major Child Behavioral Health Cost Drivers in Medicaid

- Residential treatment/group care #1
- #2 used to be office-based outpatient; now is psychosocial rehab – What are the models; Are they based on evidence, best practice?
- Psychotropic medications #3
- Also costly – Duplication of Services (e.g., multiple assessments, multiple care coordination)

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 services
Children using both physical and behavioral health services

$2,492
$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

28%
49%
8%

OPPORTUNITIES FOR STATES TO IMPROVE QUALITY

Expand access to evidence-based therapeutic interventions
Invest in care coordination models that use a wraparound approach to facilitate service delivery
Ensure collaboration across child-serving systems to improve care coordination and oversight

Made possible with support from the Annie E. Casey Foundation.
FACES OF MEDICAID: CHILDREN RECEIVING PSYCHOTROPIC MEDICATIONS

Between 2005 and 2011, the number of children covered by Medicaid increased by nearly 12% to 32 million.

Over the same period, children in Medicaid getting psychotropic medications increased by 28%.

Over 2.1 million children in Medicaid received psychotropic medications in 2011. Prescribing rates were distributed, by age, as follows:

- 6-12 yrs. old: 52%
- 13-18 yrs. old: 39%
- 0-5 yrs. old: 8%

Although 8% of children receiving these medications are ages 0-5, prescribing for this group increased by 130% from 2005 to 2011 — from 77,812 to 178,599.

Of these children receiving psychotropic medications, nearly half did not receive any accompanying behavioral services.

And almost one-third are getting more than one of these medications — 47% for children in foster care.

Psychotropic medication expenditures increased by 70% for children in Medicaid between 2005 and 2011.

That is an increase of over $1 billion in expenditures — from $1.6 billion to $2.7 billion.

OCCURRINCES FOR STATES TO IMPROVE QUALITY

Expand access to a comprehensive array of psycho-social interventions.

Implement clinically informed oversight and monitoring for assessing the appropriateness of care.

Establish data-sharing agreements across agencies to monitor medication use.

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

**Children and Youth with Serious Behavioral Health Conditions - Distinct Population from Adults with Serious Mental Illness**

- Different mental health diagnoses (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar) and diagnoses change often

- **Are multi-system involved**: two-thirds typically are involved with child welfare and/or juvenile justice systems; high rates of co-occurring MH/DD and MH/SUD; and 60% may be in special education

- Children do not have the same high rates of co-morbid physical health conditions as adults with SMI

- Coordination with other children’s systems – child welfare, juvenile justice, 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

Pires, S. March 2013  *Customizing Health Homes for Children with Serious Behavioral Health Challenges*. Human Service Collaborative
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/geographic disproportionality and disparities
- Poor outcomes
- Cost
- Rigid financing structures
- Administrative inefficiencies; fragmentation
- Knowledge, skills and attitudes of key stakeholders

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
Illinois NB v. Hamos 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.
Rosie D. Remedy - Massachusetts

- Amended Medicaid State Plan to cover:
  - Intensive care coordination using Wraparound
  - Family peer support
  - Intensive in-home services
  - Behavioral management therapy and monitoring
  - Therapeutic mentoring
  - Mobile response and stabilization ...with
  Service definitions tailored to children

- Mandated screening by primary care providers for BH issues, use of standardized screens, higher rates, training

- Care management entities for children with intensive needs

- Common UM criteria across MCOs

- Training and TA

- Interagency governance through Children’s BH Initiative – Exec. Off. HHS
Illinois Recommendations*

✓ Focal point of management and 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 and 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 t.a. capacity
✓ Use data on outcomes and cost across systems
✓ Cultivate partnerships with providers, MCOs, others

*Source: DHS: Pathways – Illinois’ Strategic Plan for Children’s Mental Health
Children’s Services Subcommittee Recommendations

• Develop strategies consistent with System of Care principles
• Enhance delivery system to ensure a full continuum of care for children with behavioral health needs
• Fulfill requirements under EPSDT and inform the NB settlement

Key stats
205 bi-partisan participants
84 organizations and 7 state agencies
38 meetings
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

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.*
# System of Care Core Values

<table>
<thead>
<tr>
<th>Public Heath Approach</th>
<th><strong>SOC Core Values</strong></th>
<th>Child Welfare Principles</th>
</tr>
</thead>
</table>
| Systems of care have moved closer to a public health framework: focusing not only on treatment for individual children with serious conditions but also encompassing promotion, prevention, early intervention, and education to improve outcomes and health, developmental and behavioral health status for identified populations of children. |  • Coordinated care  
• Family-driven and youth-guided  
• Home and community based  
• Strengths-based and individualized  
• Trauma-informed  
• Culturally and linguistically competent  
• Connected to natural helping networks  
• Data-driven, quality and outcomes oriented |  Child and Family Services Review (CFSR):  
• Family-centered practice  
• Community-based services  
• Strengthening the capacity of families  
• Individualizing services |

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
Definition of Youth Guided

“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.”

www.youthmovenational.org
How Systems of Care Are Structuring Family and Youth Involvement at Various Levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Meaningful representation on governing bodies; as members of teams to write/review requests for proposals and contracts; as members of system design workgroups and advisory boards; raising public awareness; state and local committees</td>
</tr>
<tr>
<td>Management</td>
<td>As administrators; part of quality improvement processes; as evaluators of system performance; as trainers; as advisors in selecting personnel; full time youth and family coordinators</td>
</tr>
<tr>
<td>Services</td>
<td>As members of team for own children/youth; service delivery providers, such as family support workers, care managers, peer mentors, youth group development, system navigators</td>
</tr>
</tbody>
</table>

Medicaid Enrollment and Behavioral Health Service Use by Race/Ethnicity

- All Children in Medicaid*
  - 37% White/Caucasian
  - 23% American Indian or Alaska Native
  - 28% Asian
  - 8% Other/Unknown
  - NH/PI, 0.5%
  - AI/AN, 1.2%
  - Asian, 2.4%

- Behavioral Health Service Users**
  - 47% White/Caucasian
  - 23% American Indian or Alaska Native
  - 17% Asian
  - 11% Other/Unknown
  - NH/PI, 0.2%
  - AI/AN, 1.4%
  - Asian, 0.7%

National CLAS Standards

- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to:
  - advance health equity
  - improve quality
  - help eliminate health care disparities
  - (2010) National CLAS Standards Enhancement Initiative launched to revise the Standards to reflect the past decade’s advancements, expand their scope, and improve their clarity to ensure understanding and implementation.

Characteristics of Systems of Care as Systems Reform Initiatives

**FROM**
- Fragmented service delivery
- Categorical programs/funding
- Limited services
- Reactive, crisis-oriented
- Focus on “deep end,” restrictive
- Children/youth out-of-home
- Centralized authority
- Foster “dependency”

**TO**
- Coordinated service delivery
- Blended resources
- Comprehensive service array
- Focus on prevention/early intervention
- Least restrictive settings
- Children/youth within families
- Community-based ownership
- Build on strengths and resiliency

Frontline Practice Shifts

Control by professionals  Partnerships with families/youth
(I am in charge) (acknowledging a power imbalance)

Only professional services Partnership between natural and professional supports/services

Multiple case managers One care coordinator

Multiple service plans Single, individualized child
(meeting needs of agencies) and family plan (meeting needs of family and youth)

Family/youth blaming Family/youth partnerships
Deficits focused Strengths focused
Mono Cultural Cultural/linguistic competence

System Change/Transformation Focus

- **Policy Level**: (e.g., financing; regulations; rates)
- **Management Level**: (e.g., data; quality improvement; human resource development; system organization)
- **Community Level**: (e.g., partnerships with families and youth; natural helpers; community buy-in)
- **Frontline Practice Level**: (e.g., assessment; service planning; care coordination; services/supports provision)

Categorical vs. Non-Categorical System Reforms

Categorical System Reforms

- Mental Health
- Child Welfare
- Juvenile Justice
- etc.

Non-Categorical Reforms

Shared Population Focus

Prevalence/Utilization Triangle

- More complex needs:
  - 2 - 5%: 60% of $$
  - 15%
  - 80%

- Less complex needs:

- Intensive Services:
  - Home & community services and supports; early intervention – 35% of $$

- Prevention and Universal Health Promotion:
  - 5% of $$

### Example: Transition-Age Youth

**What outcomes do we want to see for this population?**

<table>
<thead>
<tr>
<th>Policy Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What systems need to be involved? (e.g., Housing, Vocational Rehabilitation, Employment Services, Mental Health and Substance Abuse, Medicaid, Schools, Community Colleges/Universities, Physical Health, Juvenile Justice, Child Welfare)</td>
</tr>
<tr>
<td>• What dollars/resources do they control?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How do we create a locus of system management accountability for this population? (e.g., in-house, lead community agency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frontline Practice Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are there evidence-based/promising approaches for this population (e.g., FEP)</td>
</tr>
<tr>
<td>• What training do we need to provide and for whom to create desired attitudes, knowledge, skills about this population?</td>
</tr>
<tr>
<td>• What providers know this population best in our community? (e.g., culturally diverse providers)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are the partnerships we need to build with youth, young adults and families?</td>
</tr>
<tr>
<td>• How can natural helpers in the community play a role?</td>
</tr>
<tr>
<td>• How do we create larger community buy-in?</td>
</tr>
<tr>
<td>• What structures and processes will create ongoing opportunities for youth and young adults to contribute and feel a part of the larger community?</td>
</tr>
</tbody>
</table>

Process
How system builders conduct themselves

Structure
What gets built (i.e., how functions are organized)
Effective System-Building Process

- Leadership & Constituency Building
- Being Strategic
- Orientation to Sustainability

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
- System Exit
- Technical Assistance and Consultation
- Cultural and Linguistic Competence

Cuyahoga County Planning Process Structure

System of Care Oversight Committee
Chaired by Deputy County Administrator for Human Services
Includes a Broad Representative Stakeholder Group, e.g., major child serving systems, families and youth, Neighborhood Collaboratives, providers, researchers

- Cultural & Linguistic Competence
- Design & Sustainability
- Family & Youth Involvement
- Training & Coaching
- Social Marketing
- Evaluation & Research

Staffed by
System of Care Office

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.

Planning for Sustainable Change

*The more that planning is directed to making systemic or structural change, the more sustainable the changes will be.*

<table>
<thead>
<tr>
<th>Example #1</th>
<th>Good Goal</th>
<th>Structural Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launching a newsletter for families</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Amend the State Medicaid Plan to cover family peer support</td>
<td>✓ ✓</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example #2</th>
<th>Good Goal</th>
<th>Structural Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time legislative appropriation to expand home and community services</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Amend the State Medicaid Plan to cover an array of home and community-based services</td>
<td>✓ ✓</td>
<td></td>
</tr>
<tr>
<td>Pool or braid dollars to maximize array of services/supports and create a locus of accountability for children who are multi-system involved</td>
<td>✓ ✓</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Example #3</th>
<th>Good Goal</th>
<th>Structural Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educating providers about partnering with families and with youth</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Contractual requirements for child/family teams</td>
<td>✓ ✓</td>
<td></td>
</tr>
</tbody>
</table>

Governance

Collaborative decision-making at a policy level that has legitimacy, authority, and accountability.

System Management

Day-to-day operational decision making

Cuyahoga County Governance and Management Structure

**System of Care Oversight Committee**

**Deputy County Administrator for Human Services**

**System of Care Office***

*Functions as an in-house Administrative Services Organization

**Subsets of Children & Families**

- Children in or at risk for residential placement
- Children with serious behavioral health challenges
- Youth with status offenses
- 0-3 population Early Intervention engagement challenges

**Care Coordination Partnerships at Neighborhood Level**

Wicomico County, MD
System of Care Structure

Local Management Board

SOC Community Advisory Board

Service Coordination/Systems Navigation - CANS

211 System (screening)

Families and Youth

Agencies/Court

Care Management Entity
Care Coordinators
Family Partners

Family Partners Center

Adapted from Wicomico County, MD
Wraparound Milwaukee Partners Council

Mobile Response & Stabilization co-funded by schools, child welfare, Medicaid & mental health

**CHILD WELFARE**
Funds thru Case Rate (Budget for Institutional Care for Children-CHIPS)

**JUVENILE JUSTICE**
(Funds budgeted for Residential Treatment for Youth w/delinquency)

**MEDICAID CAPITATION**
($1557 per month per enrollee)

**MENTAL HEALTH**
- Crisis Billing
- Block Grant
- HMO Commercial Insurance

**SCHOOLS**
Youth at risk for alternative placements

Per Participant Case Rates from CW, JJ, and ED range from about $2000 pcm to $4300 pcm

**Intensive Care Coordination**

**Child and Family Team**

**Plan of Care**

All inclusive rate (services, supports, placements, care coordination, family support) of $3700 pcm; care coordination portion is about $780 pcm

Use CANS

Wraparound Milwaukee. (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.
Governance/Management Structure: Louisiana

Children’s System of Care (CSoC) Governing Body

Medicaid, Behavioral Health and Child Welfare dollars – Medicaid and DMH leads

1915 b and c waivers

Statewide Management Organization (ASO)

State Governance Entity in regulation – staffed by DHH/OBH

Partners: DHH, DCFS, OJJ, Educ

Family and Youth Reps

Magellan

Provider Network

Regional Care Management Organizations

Family Support Organizations

Private non profit orgs – ICC/Wrap

### Services/Supports Array Focused on a Total Population

<table>
<thead>
<tr>
<th>Universal</th>
<th>Targeted</th>
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<tbody>
<tr>
<td>Core Services</td>
<td>Prevention</td>
</tr>
<tr>
<td>Family Support Services</td>
<td></td>
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<tr>
<td>Youth Development Program/Activities</td>
<td></td>
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<tr>
<td>Coordinated Intake Assessment &amp; Service Planning</td>
<td></td>
</tr>
<tr>
<td>Service Coordination</td>
<td></td>
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<tr>
<td>Intensive Care Management</td>
<td></td>
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<tr>
<td>Clinical Services</td>
<td></td>
</tr>
<tr>
<td>School Supports</td>
<td></td>
</tr>
<tr>
<td>School-Wide Climate Change Initiatives</td>
<td></td>
</tr>
</tbody>
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What You Don’t See Listed as Evidence-Based Practice
(though they may be standard practice)

• Traditional office-based “talk” therapy
• Residential Treatment
• Group Homes
• Day Treatment

Implications for How RTCs are Utilized

• 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
The Role of Natural Helpers & Informal Supports

- Emotional support; moral & spiritual guidance
- System navigation
- Concrete help & advocacy
- Decrease social isolation
- Community navigation
- Resource acquisition & education
- Greater understanding of intervention or support strategies
- Create Time Banks
- Open Table

Natural Helpers /Informal Supports are…
- Family and friends
- Neighbors
- Volunteers
- Individuals in the community, e.g. mail carrier, minister, storekeeper, etc.
- People with similar experiences
- Faith-based organizations

Care Coordination Continuum – What Belongs Where?

- **All Children**
  - Screening, Information and Referral on an as Needed Basis/During Well Child Visits

- **Children With a Behavioral Health Need**
  - Service Coordination and System Navigation To Support Effective Response to the BH Need

- **Children With Complex Behavioral Health Needs**
  - Intensive Customized Care Coordination To Provide Extended Support To Multi-Modal Needs
INTEGRATION CONTINUUM (nested within common value/principles)

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

<table>
<thead>
<tr>
<th>All children: Developmental and behavioral health screening</th>
<th>Children with Identified BH Need</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Child Psychiatry Consultation Programs</strong>, which incorporate social work care coordination for SDoH, identification of services, linkage to services</td>
</tr>
<tr>
<td></td>
<td><strong>Low/Moderate Need</strong></td>
</tr>
<tr>
<td></td>
<td>Team-based care in either primary care or behavioral health settings with appropriate infrastructure (could also be in school-based health settings)</td>
</tr>
<tr>
<td></td>
<td><strong>Significant Need/High Risk</strong></td>
</tr>
<tr>
<td></td>
<td>Intensive Care Coordination using High Fidelity Wraparounds (could be in PC, BH, or school-based health setting)</td>
</tr>
</tbody>
</table>

For Children with Significant Behavioral Health Challenges: Customized Intensive Care Coordination Approaches Are Needed

- Neither traditional case management, MCO care coordination, nor care coordination approaches for adults are sufficient
  - Need approach based on evidence of effectiveness, e.g. **fidelity** Wraparound
  - Need lower case ratios
    - (MO health home care coordination ratio is 1:230*; Wraparound is 1:10)
  - Need 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)
  - Need intensity of approach that is largely face-to-face, not telephonic
  - Need intensity of involvement with family, schools, other systems, court


Wraparound is an emerging best practice approach for the planning and coordination of services and supports; can be applied to any population of children and families with or at risk for intensive service needs; puts system of care values and principles into practice.

Structuring Intensive Care Coordination Using Fidelity Wraparound

Care Management Entities

• An organizational entity – such as a non profit organization - that serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems

• Is accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes (e.g. GA, LA, MA) NJ Health Home

Wraparound Team embedded in supportive organization – Oklahoma Health Homes
Coordination with Primary Care in ICC/Wrap Approach

- Ensure child has an identified primary care provider (PCP)
- Track whether child receives Early Periodic Screening, Diagnosis and Treatment (EPSDT) screens on schedule
- Ensure child has at least an annual well-child visit
- Communicate with PCP opportunity to participate in child and family team and ensure PCP has child’s plan of care and is informed of changes
- Ensure PCP has (and provides) information about child’s psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

# High Quality Wraparound Team as a Health Team - Oklahoma

## Community Mental Health Center

### Health Team for Adults with SMI:
- Nurse Case Manager
- ACT Team
- Adult Peer Counselor

### Health Team for Children with SED:
- Wraparound Care Coordinator
- Family and youth peer support
- Wellness Coach

## HEALTH HOME CORE SERVICES

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Intensity</th>
<th>Code</th>
<th>Price / Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Urban</td>
<td>Moderate Intensity (PRM, or Levels 1-3)</td>
<td>G9002</td>
<td>$127.35</td>
</tr>
<tr>
<td></td>
<td>High Intensity (Level 4)</td>
<td>G9005</td>
<td>$453.96</td>
</tr>
<tr>
<td>Rural</td>
<td>Moderate Intensity (PRM, or Levels 1-3)</td>
<td>G9002TN</td>
<td>$146.76</td>
</tr>
<tr>
<td></td>
<td>High Intensity (Level 4)</td>
<td>G9005</td>
<td>$453.96</td>
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<td>Child Urban</td>
<td>Moderate Intensity (Level 3)</td>
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<td>High Intensity (Level 4)</td>
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<td>Rural</td>
<td>Moderate Intensity (Level 3)</td>
<td>G9009TN</td>
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<td>High Intensity (Level 4)</td>
<td>G9010TN</td>
<td>$1,009.60</td>
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</tbody>
</table>
Oklahoma Children’s Health Home Model

CHILDREN’S HEALTH HOME

Child & Family SOC Team:
- Wraparound Care Coordinator
- Psychiatrist
- Medication Management
- Family Support
- Wellness Activities

Linkage Assessment

Specialty BH Services
- Linkage Assessment
- Access to physician Consultation with HH EPSDT screening
- Immunization
- Referral to specialty care

PCMH
- Transition to/from hospital care

Community Support
- Housing
- Transportation
- Food

Linkage

Specialty Healthcare

Schools
- IDEA
- Transitions
- Education
- Link Engage Advocate Support

OJA
- Community Safety Placement
- Team Approach One Care Plan

OKDHS
- Safety
- Placement(s)
- Permanency
- Team Approach One Care Plan Support

IDEA
- Transitions
- Education

Human Service Collaborative

SAMHSA
Massachusetts – Care Management Entities
*Locally-Based Care Management Entities (called Community Services Agencies) – Non Profit BH and Specialty Providers - Wraparound

- Ensure Child & Family Team Plan of Care
- Provide Intensive Care Coordination
- Provide peer supports and link to natural helpers
- Manage utilization, quality and outcomes at service level

Standardized tools for screening and assessment - CANS
Coverage of intensive home and community based services, mobile response, and intensive care coordination using fidelity Wraparound

Adapted from State of Massachusetts
Role of the Family or Youth Partner

• A peer with lived experience
• Assist the family/youth to help them engage and actively participate on the team, and make informed decisions that drive the process.

✓ Peer-to-Peer Support
✓ Advocate
✓ Cultural Broker

(National Wraparound Initiative – Resource Guide to Wraparound)

Penn, M. 2010 Pre-Institutes Training Program, National Technical Assistance Center for Children’s Mental Health, Georgetown University Center for Child and Human Development
Wraparound Outcomes
(9 controlled, published studies to date; Bruns & Suter, 2010)

• 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

Wraparound is Increasingly Considered Evidence-Based

- State of Oregon Inventory of EBPs
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: “Full fidelity wraparound” is a research-based practice
- Under review by SAMHSA National Registry of Effective Practices and Programs (NREPP)

Sustainability isn’t just about money

Sustainability requires supportive:

- Leadership
- Policies
- Practices
- Organizational structures

And stakeholder buy-in, especially families and youth
Where to Look for Money and Other Support

Government
Federal, State, County, City

Foundations
National, Regional, Community, Family

Individuals
Contributions or Users Fees

Service Clubs
e.g., Kiwanis, Junior League, Lions

Income Generating Activities
e.g., Youth-run business

System of Care

Business
Corporate Giving Programs or Small Business

Taxes and Levies
State and County

3rd Party Reimbursement

Churches

Unions

Media

## Financing Strategies and Structures to Support Improved Outcomes for Children, Youth and Families

**FIRST PRINCIPLE: System Design Drives Financing**

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

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

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)

HFS - 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

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

➢ Conservative estimate of $250m for redirection across Medicaid, child welfare, mental health

Van Deman, S. Jan 2015. System of Care Technical Assistance Center of Illinois
WHAT ARE THE POOLED FUNDS?

**Wraparound Milwaukee**

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**CHILDLDER WELFARE**
- Funds thru Case Rate
  - (Budget for Institutional Care for Children-CHIPS)

**JUVENILE JUSTICE**
- Funds budgeted for Residential Treatment for Youth w/delinquency

**MEDICAID CAPITATION**
- ($1557 per month per enrollee)

**MENTAL HEALTH**
- Crisis Billing
- Block Grant
- HMO Commercial Insurance

---

**SCHOOLS**
- Youth at risk for alternative placements
  - Per Participant Case Rates from CW, JJ, and ED range from about $2000 pcppm to $4300 pcppm

---

**Wraparound Milwaukee**
- Care Management Organization
  - $47M

---

**Families United**
- $440,000

**Provider Network**
- 210 Providers
- 70 Services

---

**Intensive Care Coordination**

**Child and Family Team**

**Plan of Care**

---

**Use CANS**

---

All inclusive rate (services, supports, placements, care coordination, family support) of $3700 pcppm; care coordination portion is about $780 pcppm

---

EX: Redirection and Braided Funds

DAWN Project - Indianapolis, IN (Marion County)

How Dawn Project is Funded

$4,088 + $166 = $4,254 PMPM

Child Welfare

Juvenile Justice

Department of Mental Health

Special Education

Dawn Project Cost Allocation

DAWN Funding – Utilization

CFT and Care Coordination Structure

90% Direct Services
   550 Vendors

6% Indirect Expenses

4% Administrative

RAINBOWS (Family Organization)
EX: Redirection and “Virtual” Pooled Funds

Cuyahoga County (Cleveland)

System of Care Oversight Committee

County Administrative Services Organization

Neighborhood Collaboratives & Lead Provider Agency
Care Coordination Partnerships

Child and Family Team Plan of Care

Community Providers and Natural Helping Networks

Reinvestment of savings

State Early Intervention and Family Preservation

FCFC $$
Fast/ABC $$
Residential Treatment Center $$
Therapeutic Foster Care $$
“Unruly”/shelter care $
Tapestry/MH $$
SUD $$

New Jersey (1115)

Department of Children and Families
Division of Children's System of Care (CSOC)

Contracted Systems Administrator-
PerformCare – ASO for child BH carve out

Provider Network

Mobile Response & Stabilization Services

Medicaid and DCF-certified providers

➢ Use CANS

*BH, CW, MA $$ - Single Payor

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

UMDNJ Training & TA Institute

• 1-800 number
• Screening
• Utilization management
• Outcomes tracking

Family Support Organizations

Family peer support, education and advocacy
Youth movement

*Care Management Entities - CMOs

Lead non profit agencies managing children with serious challenges, multisystem involvement

Adapted from State of New Jersey 2010
Examples of Refinancing

Milwaukee County, WI

• Schools and child welfare contributed $450,000 each to expand mobile response and stabilization services (prevent placement disruptions in child welfare, prevent school expulsions)

• MRSS is a Medicaid-billable service; contributions from schools and child welfare generate $180,00 to the school contribution and $200,000 to child welfare’s in Federal Medicaid match dollars, creating:
  - A $650,000 program expansion for child welfare
  - A $630,000 program expansion for the schools

Examples: Raising New Revenue

- Prop 63 in California (1% income tax on millionaires)
- Spokane Co., WA – 0.1% sales tax for mental health
- Florida counties – children’s trust funds
- Jackson Co., KN – 1.3% per $100 property tax for mental health
Creating “Win-Win” Scenarios

- **Child Welfare**: Alternative to out-of-home care, high costs/poor outcomes
- **Medicaid**: Alternative to IP/ER/PRTF-high cost
- **Juvenile Justice**: Alternative to detention-high cost/poor outcomes
- **Education**: Alternative to out-of-school placements – high cost

Parent Support Network of RI

Funding Sources

- Fundraising
- Education
- Child Welfare
- State Appropriations
- State MH Block Grant
- Federal Grants
- Foundation
- Local Subcontracts

32%
10%
17%
10%
5%
23%
2%
1%

Family-Directed Outreach and Engagement

- Toll-free helpline for support, information and referral
- Outreach presentations to diverse provider agencies and groups and tracking of referrals
- Informational booth/family contact during visiting hours at corrections
- Information/family contact at family court for emergency petitions/child welfare involvement
- Information/family contact at the hospital emergency rooms to support families with children in acute psychiatric needs.
Strategic Financing Analysis

1) Identify state and local agencies that spend dollars on your populations of focus
   - how much each agency is spending, on what, for how many children
   - types of dollars being spent (e.g., federal, state, local, Tribal, non-governmental)

2) Identify resources that are untapped or under-utilized (e.g., Medicaid)

3) Identify utilization patterns and expenditures, including those associated with high costs/poor outcomes, and strategies for re-direction

4) Identify disparities and disproportionality in access to services/supports, and strategies to address

5) Identify the funding structures that will best support the system design (e.g., blended or braided funding; risk-based financing; purchasing collaboratives)

6) Identify short and long term financing strategies (e.g., Federal revenue maximization; re-direction from restrictive levels of care; waiver; performance incentives; legislative proposal; taxpayer referendum, etc.)

OUTCOMES
Milwaukee Wraparound

- Reduction in placement disruption rate from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily RTC population from 375 to 90
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of $3,700 (compared to $8,000 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)
OUTCOMES

Family/Caregiver Experience Milwaukee Wraparound

*Nearly half had previous CPS referral*

91% felt they and their child were treated with respect (n=191)

72% felt there was an adequate crisis/safety plan in place (n=172)

91% felt staff were sensitive to their cultural, ethnic and religious needs (n=189)

64% reported Wrap Milwaukee empowered them to handle challenging situations in the future (n=188)

Findings: Cost Savings for Education in System of Care Communities

The average annual cost of a student repeating a grade in public education is $9,154.

Only 8% of youth in systems of care for 12 months had repeated a grade, compared to nearly twice as many American students in the general public (15%).

This difference translates to a cost savings of $4,544,412 for 7,092 youth aged 14-18 years who entered systems of care while enrolled in school.

The Cost of Doing Nothing

If *Milwaukee County* had done nothing: the $18m. spent by child welfare would have grown to $48m. for same number of children within next ten years

*Project Bloom (Denver)* “Cost of Failure Study” – Early childhood services at an average cost per child of $987/year save $5,693/year in special education
1. Identify your population(s) of focus.

2. Agree on underlying values and intended outcomes.

3. Identify services/supports and practice model to achieve outcomes.

4. Identify how services/supports will be organized (so that all key stakeholders can draw the system design).

5. Identify the administrative/system infrastructure needed to support the delivery system, including the structures for UM,QI, family & youth partnership etc.

6. Cost out the system of care.

7. Develop a strategic financing plan.

Looking Ahead in Illinois

- 7 new Medicaid MCOs (reduced from 13), including one for foster care population – IlliniCare

- Integrated Health Homes – platform for intensive care coordination using fidelity Wraparound and peer support?

- 1115 Research and Demonstration Waiver – covers intensive in-home services and respite

- Medicaid State Plan Amendments (SPA) – cover mobile response and stabilization; standardized assessment using IM/CANS; Integrated Health Homes

- *NB Consent Decree* – likely to require amended MCO contracts
Illinois SOC-Related Resources

- Youth and Family Alliance (Regina Crider)
  www.ilalliance.org

- SAMHSA System of Care Grants in Illinois
  • State SOC Expansion Grant – IL Dept. of Human Services, Mental Health Division
  • Lake County SOC Grant – Lake County Health Dept. and Community Health Center
  • Saline, White and Gallatin Counties – Egyptian Health Department
National Resources

Building Systems of Care: A primer, 2nd Edition
https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf

Return on Investment in Systems of Care for Children with Behavioral Health Challenges
http://gucchdtacenter.georgetown.edu/publications/RISOCs.pdf

National Technical Assistance Network for Children’s Behavioral Health
• To receive the TA Telegram and other relevant information related to children’s behavioral health, sign up for our communications by clicking here.
• National Technical Assistance Network Contact Information:
  • 525 West Redwood Street, Baltimore, MD 21201    TANetwork@ssw.umaryland.edu
  • 410-706-8300

Family-Run Executive Directors Leadership Association (FREDLA)    www.fredla.org

Youth Move National
www.youthmovenational.org

National Wraparound Initiative    https://nwi.pdx.edu
Federal Policy Guidance

- **CMCS Informational Bulletin - Prevention and Early Identification of Mental Health and Substance Use Conditions**
- **Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions**
- **CMCS Informational Bulletin: Clarification of Medicaid Coverage of Services to Children with Autism**
- **Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Youth with Substance Use Disorders**
- **CMS Informational Bulletin: Medicaid Payment for Services Provided without Charge (Free Care)**
For further information, contact:

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sapires@aol.com