Pediatric Care Integration Best Practices: Consensus Findings from an Expert Convening

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July 31, 2019

TA NETWORK

DEPARTMENT OF HEALTH & HUMAN SERVICES, USA

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This webinar 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 for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS280201500007C with SAMHSA, U.S. Department of Health and Human Services (HHS). The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

Care Integration Best Practice Series

Webinar #1 *July –Overview, Issues and Expert Convening Consensus Framework.*

Webinar #2-August- Comprehensive Screening and Behavioral Health Consultation.

Webinar #3 October –Care Coordination Approaches for Children with Moderate to Intensive Behavioral Health Challenges.

Webinar #4 To Be Announced–Early Childhood Strategies.

Webinar #5- To Be Announced- Peer Support.

Subscribe to the TA Telegram for additional details.

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Learning Objectives

- Understand how the needs of children, youth and young adults with behavioral health conditions are different from the needs of adults with behavioral health conditions.
- Learn about the most effective integrative approaches for children.
- Understand the recommendations from the national expert convening.
- Learn about best practice approaches from states, counties and localities for integrating physical and behavioral health services and supports.

Topics to be Covered

I. **Population and Contextual Issues**
II. **Integrated Care Concepts**
III. **Expert Convening**
IV. **Care Integration Continuum**

- Components
- Examples

Population and Contextual Issues

Many Children & Youth Experience Mental Health Challenges

- One in five children or youth will experience a mental health disorder in a given year. [1]

- One in 10 children is estimated to meet the federal criteria for a serious emotional disturbance, defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally. [2]

- One in 6 children and youth have mental health challenges that do not meet the criteria for a diagnosis but who need support to address emerging risk issues in which intervening early is paramount.
  - particularly for children ages 0-5, who often do not meet criteria for a diagnosis or for whom professionals and families are reluctant to "label" an issue as a disorder at such a young age. 3

[1] Centers for Disease Control and Prevention. Mental health surveillance among children – United States 2005-2011. MMWR 2013;62 (Suppl; May 16, 2013):1-35.

The report is available at www.cdc.gov/mmwr

[2] Costello, EJ, Egger, H, Angold, A. 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: 1. Methods and public health burden.
3 J Am Acad Child Adolescent Psychiatry. 2005. Oct; 44 (10): 972-86
Burns, B.J., Costello, J., Angold, A., Tweed, D., Stangl, D., and Farmer, E.M. Children's Mental Health Service Use Across Service Sectors. *Health Affairs*, Volume 14 (3).
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.14.3.147[1]

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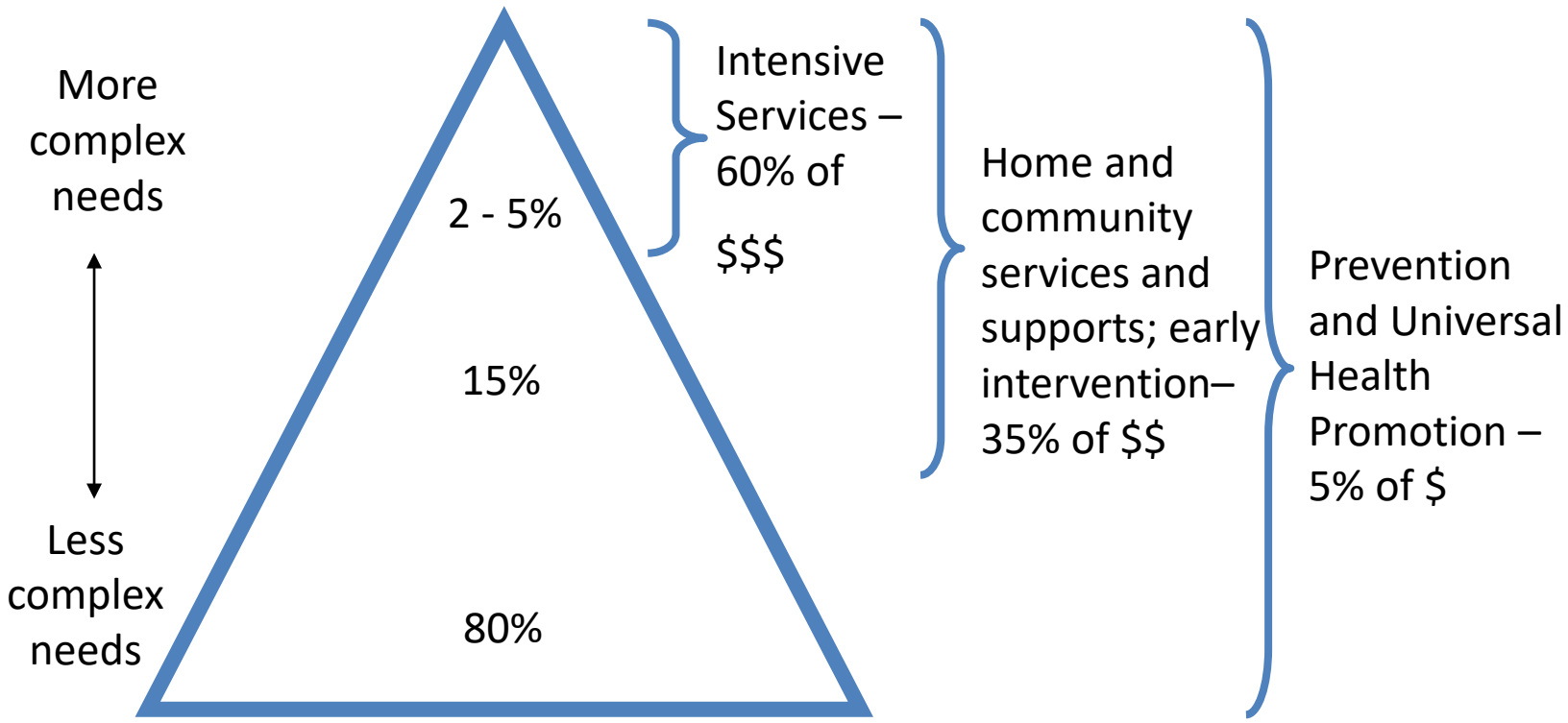
Prevalence/Utilization Triangle



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

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Children in Medicaid and Other Safety Net Programs Who Use Mental Health Care Are An Expensive Population

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

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

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Children Using Mental 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 mental health, not physical health care.

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 2005-2011*.
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Co-Morbid Physical Health Conditions Are Low Among Children in Medicaid Using Mental Health Care Relative to Adults with Serious Mental Illness

Exhibit 23. Frequency of CDPS Categories among Children Using Behavioral Health Services in Medicaid, 2005, 2008, 2011

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

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

Of those that do -

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

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

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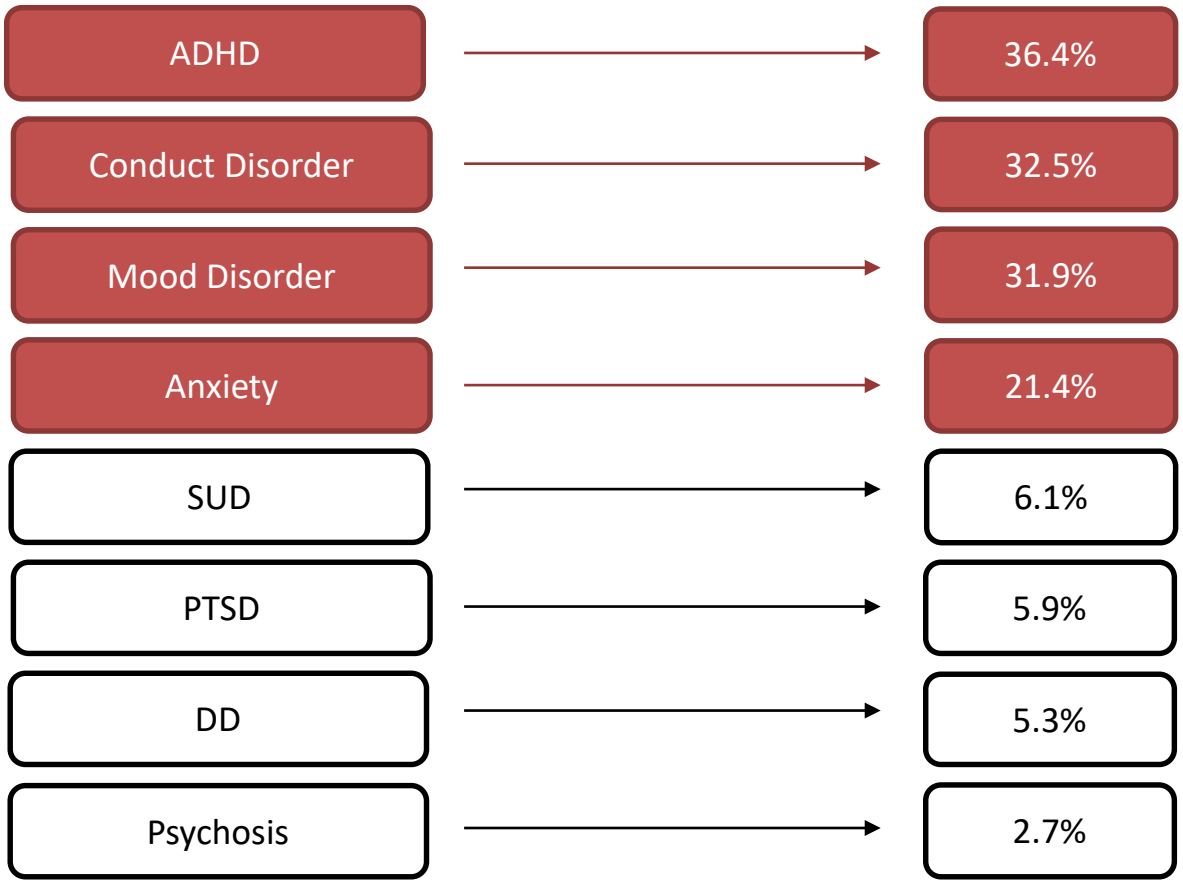
Distribution of Psychiatric Diagnoses Among Children in Medicaid Using Mental Health Services



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Children, Youth, and Young Adults With Mental Health Challenges Are Not a Homogeneous Population

- Social factors that determine health, such as poverty and adverse experiences.
- Range of needs: at risk of or experiencing brief, moderate, or intensive treatment needs.
- Differ in age from very young children to youth who are transition-age.
- Many involved with multiple child-serving systems, such as child welfare.
- Diverse racial and ethnic groups.

Children and Youth with Serious Mental 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 mental 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.

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

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High Unmet Need for Care Coordination

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

- Family-centered care can be mitigating.

(Brown, N. et. al. 2013)

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Unmet Need for Children with Significant Mental 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 mental 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.

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges .Washington, DC:* Human Service Collaborative for Center for Health Care Strategies, Inc.

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

Integrated Care Concepts

Primary Care-Behavioral Health Integration

- Integration occurs at different levels.
- Integration of behavioral health (BH) and physical health primary care (PC) financing and administration – Medicaid managed care:
  - Health Care Reform Tracking Project found less attention to children's BH services and expertise in integrated financing/administrative models unless there is a concerted focus in design and implementation.

- Integration or coordination at the practice level:
  - Screening for BH problems in PC settings.
  - Coordination of BH and PC services through PC or BH settings (e.g., Medical Homes, Health Homes).
  - BH consultation for primary care practitioners (PCPs).
  - Co-location of BH and PC providers.
  - Team-based care; practice transformation.

Coordinated Care: minimal to basic collaboration.

Co-Located Care: basic collaboration on-site or close collaboration on-site.

Integrated Care:

- Close collaboration: beginning to function as a true team, frequent communication, seek system solutions to improve integration.
- Full collaboration: entails greatest amount of practice change to achieve single transformed or merged practice; “whole person” focus.

There Is A Need for a Clear Lexicon

- The American Academy of Pediatrics (AAP) Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee distinguished between care coordination and case management: case managers “work with and guide services intrinsic to their specific agency,” and care coordinators “work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community.”

- Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee (2014). Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems. *Pediatrics,* 133(5): e1451-1460.

- The SAMHSA/HRSA Center for Integrated Health Solutions (CIHS) defined integrated care as “the care that results from a practice team of primary care and mental health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

- The Rural Health Information Hub defines care integration as “providers jointly plan and execute goals, develop integrated care plans, co-manage patients, and maintain shared schedules. Integrated practices use a systematic clinical approach to identify patients who need mental health services and engage providers and patients in shared decision-making.”

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Lack of Consensus in the Pediatric Primary Care and Behavioral Health Fields About the Most Effective Integrative Approaches for Children

- Examination of integrated care approaches has been devoted to adult populations (e.g., adults with serious mental illness or co-morbid conditions).

- Less known about which methods or models of care integration yield optimal clinical and functional outcomes across the population of children, youth, and young adults with mild, moderate, and/or complex mental health challenges:
  - Collaborative Care Management model has shown promise with adolescents with depression receiving treatment in office-based settings.
  - Intensive care coordination using fidelity Wraparound has proved effective for children and youth with serious mental health challenges who often have multi-system involvement.
  - More knowledge is needed to understand which children could benefit from which integrative approach.

Pires, S., Fields, S, et.al., 2018 *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

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Pediatric Primary Care Does and Can Play A Key Role in Behavioral Health

- Seventy-five percent of children with diagnosed mental health conditions are seen in the primary care setting.
- Many families are comfortable accessing care through their pediatricians.
- Studies have found that racially and ethnically diverse families especially feel less stigma in pediatric settings than with specialty mental health providers.[1]
- Pediatric primary care providers are well-positioned to detect problems early, and they play a key role in the promotion of healthy social-emotional development, prevention, and early detection.
- The persistent shortage of mental health specialty providers further contributes to the increased role of primary care in the management of behavioral health conditions.

1 Lazear, K., Pires, S., Isaacs, M., Chaulk, P & Huang, L. (2008). *Depression among Low Income Women of Color: Findings from Cross-Cultural Focus Groups*. Journal of Immigrant Minority Health 10:127-133. https://www.ncbi.nlm.nih.gov/pubmed/18236157;

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Pediatric Primary Care Must Address Certain Challenges To Be Most Effective With Behavioral Health

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- Studies have found that primary care practices often struggle with managing child behavioral health conditions.
  - Studies suggest that medical homes have struggled with coordinating the mental health care needed by children with serious mental health conditions.
  - For example, one study found that "all behavioral health conditions except attention deficit hyperactivity disorder (ADHD) were associated with difficulties accessing specialty care through the medical home." [1]
  - A 2013 study in *Pediatrics* found that youth of color, lower-income youth, youth from households with limited English proficiency, and those with mental (as opposed to physical) health conditions were less likely to have a medical home where they could obtain routine, family-centered care. [2]
  - Similar findings with respect to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth.[3]

1. Sheldrick, R.C. & Perrin, E.C. *Medical home services for children with behavioral health conditions*. Journal of Developmental Pediatrics 31(2): 92-99. https://www.ncbi.nlm.nih.gov/pubmed/20110825
2. Strickland, B., Jones, J., Ghandour, R., et. al. (2011). *The Medical Home: Health Care Access and Impact for Children and Youth in the United States.* Pediatrics 127(4): https://www.ncbi.nlm.nih.gov/pubmed/21402643
3. Kates, J., Usha, R., et. al. (Nov. 2015). *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the United States.* Kaiser Family Foundation.
http://files.kff.org/attachment/issue-brief-health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-2

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Expert Convening

Expert Panel on Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs

- Agency for Healthcare Research & Quality (AHRQ) (Westat)
- Allegheny County (Pa.) Health Department
- American Academy of Pediatrics
- Amerigroup Georgia
- Beacon Health Options
- Boston Children's Hospital
- Bronx Behavioral Health Integration Project/Montefiore Medical Center
- Center for Health Care Strategies
- Centers for Medicare & Medicaid Services
- Cherokee Health Systems
- Egyptian Health FQHC
- Family-Run Executive Director Leadership Association (FREDLA)
- Health Resources and Services Administration (HRSA)
- Human Service Collaborative
- Johns Hopkins, Bloomberg School of Public Health

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Expert Panel

- Management & Training Innovations
- Massachusetts Parent Professional Advocacy League
- National Council for Behavioral Health
- Nationwide Children's Hospitals Research Institute
- New Jersey Department of Children and Families, Children's System of Care
- Oklahoma Department of Mental Health and Substance Abuse Services
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- University of Colorado School of Medicine
- University of Florida College of Medicine-Jacksonville
- University of Maryland School of Social Works Institute for Innovation & Implementation
- University of Washington
- University of Wisconsin Madison School of Medicine and Public Health's Pediatric and Adolescent Transgender Health (PATH) Clinic
- Yogman Pediatric Associates
- Youth MOVE National
- Wraparound Milwaukee

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Purpose of the Expert Convening

- Examine best-practice approaches (literature and in practice).

- Achieve consensus on the elements of a care integration continuum for children, youth, and young adults with mental health challenges enrolled in Medicaid, the Children's Health Insurance Program (CHIP), and other safety net programs.

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Peer Review Process

- **Review of the literature and field work:**
  - Peer-reviewed and gray literature.
  - Definitions of pediatric behavioral health care integration and care coordination from leading programs and providers.
  - Work with states and localities.

- **Deliberations on five areas:**
  - Understanding the population and its care integration needs;
  - Defining effective approaches for children and youth with behavioral health needs in primary care and in behavioral health care settings;
  - Defining and using meaningful measures to strengthen accountability and improve outcomes;
  - Financing and value-based approaches that support care integration and appropriately attribute accountability; and
  - Supporting practice change at the provider and system levels via training and infrastructure enhancements.

Consensus Findings

Care Integration Continuum

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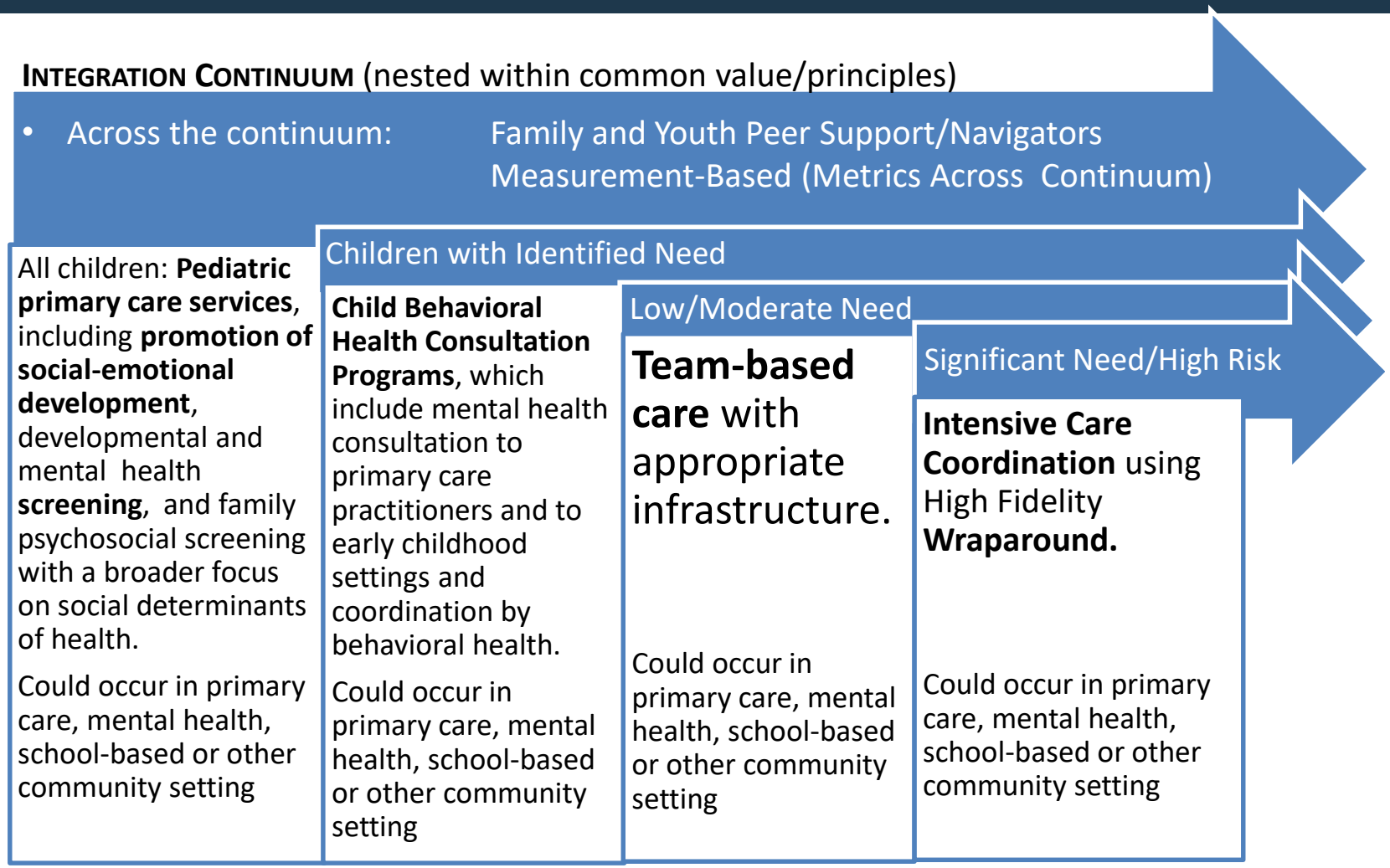
Expert Convening: Care Integration Continuum



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Common Values Across Integration Continuum

- Family-driven and youth-guided, with the strengths, needs, natural supports and goals of the child/family determining intensity of care coordination, service mix, duration, choice of provider.
- Community-based.
- Prevention (as opposed to diagnosis-based) system.
- Culturally and linguistically competent with services and supports that reflect the cultural, racial, ethnic, linguistic needs with active monitoring and ameliorating of disparities.
- LGBTQ welcoming.
- Continuous quality improvement (CQI) planning based on clinical and family-driven outcome measures.
- Trauma-informed across all providers and staff; familiarity with ACEs (Adverse Childhood Experiences).
- Shared commitment to, and responsibility for, recovery across BH/PH/child-serving systems.

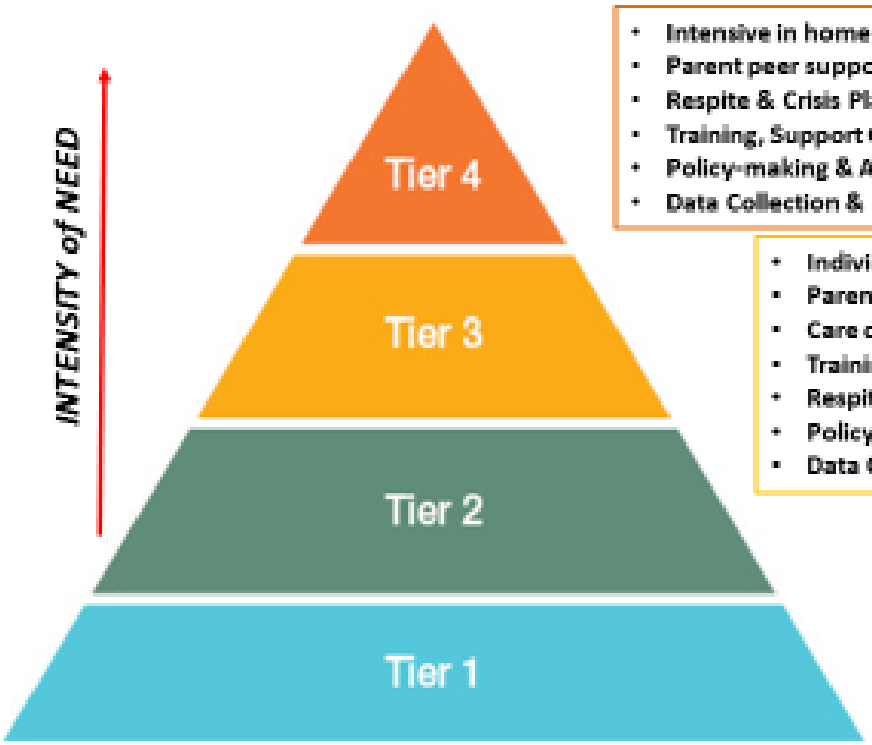
Pires, S., Fields, S, et.al., 2018. *Care Integration Opportunities in Primary Care for Children, Youth and Young Adults with Behavioral Health Challenges: Expert Convening* .National Technical Assistance Network for Children's Behavioral Health

Common Principles Across Integration Continuum

- Availability of broad array of individualized, evidence-based, whole-person services and supports.
- Partnerships -- not merely linkages – between child-serving systems and agencies.
- Promote mental and physical health wellness, and child development, including early identification/ prevention/intervention.
- Data- and accountability-driven.
- Sufficiently financed/resourced to have appropriate care ratios for low/moderate/complex child BH populations.
- Oversight/accountability/transparency.

Pires, S., Fields, S, et.al., 2018. *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

Roles for Parent Peer Support Providers Based on Intensity Level of Service Need/Use



- 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

- 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

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

- Education, information & referral
- Policy-making & Advocacy
- Data Collection & Evaluation

fredla

(FREDLA 2016) www.fredla.org

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Social Determinants of Health

(HealthyPeople.gov)

National Snapshots

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Developmental and Behavioral Health Screening

In January 2015, CMS added a "brief emotional/behavioral assessment with scoring and documentation" in response to the Affordable Care Act's federal mandate to include mental health services as part of the essential benefits in all insurance plans offered in individual and small group markets.

- Requirements at a systems-level through state purchaser (e.g. State Medicaid agencies)

  - **MassHealth** requires EPSDT screeners (primary care practitioners) to incorporate developmental and mental health screens using one of any state-recommended, standardized screening instrument.

  - **North Carolina** recommends structured screens for emotional and mental health risks as part of EPSDT screens with guidance to providers from the American Academy of Pediatrics list of screening instruments:

    - https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/MentalHealth/Documents/MH_ScreeningChart.pdf

  - **District of Columbia** requires Medicaid managed care organizations to ensure all children receive mental health screens using approved screening instruments:

    - www.dchealthcheck.net/documents/Approved-MH-Screening

Behavioral Health Consultation Programs
Massachusetts Child Psychiatry Access Program (MCPAP)

- **Regional children's behavioral health (BH) consultation teams support integration of BH and physical health:**
  - Help primary care providers (PCPs) promote and manage BH of pediatric patients as a fundamental component of overall health and wellness.
  - Consult with PCPs, BH clinicians and others working in primary care settings.
  - Three teams of two full-time child & adolescent psychiatrists, independently licensed mental health clinicians, resource and referral specialists, and program coordinators.
  - Rapid Response to inquiries from primary care providers and/or on-site behavioral health clinicians within 30 minutes.
- **Services are free and available through primary care practices for all children and families, regardless of insurance.**
- **Not meant to replace necessary emergency services.**
- **Goal: improve access to BH treatment.**
  - Making child psychiatry services available to PCPs across the Commonwealth.

Massachusetts Child Psychiatry Access Program (MCPAP) : http://www.mcpap.com

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Early Childhood Mental Health Consultation Programs

- Minnesota Early Childhood Mental Health System of Care.

Coordination across Dept of Human Services, State Medicaid, Medicaid health plans, and mental health:

- Prevention/Screening.
- Early Intervention, e.g. consultation to Head Start.
- Intervention, e.g. Trauma-Informed Child Parent Psychotherapy.

(Minnesota Early Childhood Mental Health System of Care mn.gov/.../early-childhood-mh-system-care)

Team-Based Care: Mental Health Integration Program
Montefiore Medical Center, Bronx, NY

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

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

Healthy Steps 0-5

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

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

1 FTE child psychologist/social worker per 5,000 children
1 FTE child psychiatrist per 20,000 children
Include 26 BH practitioners

- *Receive shared savings from ACO – from adult savings*

(Montefiore Behavioral Health Integration Program: www.montefiore.org/bhip)

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Team-Based Care Integration: Collaborative Care Management for Adolescents with Depression

A Collaborative Care team is led by a primary care provider (PCP) and includes care managers, psychiatrists, and frequently other mental health professionals all empowered to work at the top of their license.
The team implements a measurement-guided care plan based on evidence-based practice guidelines, and focuses particular attention on patients not meeting their clinical goals.
*(*American Psychiatric Association and Academy of Psychosomatic Medicine)

- Care management
- Cognitive behavioral therapy
- Psychopharmacological consultation

Essential Elements of Collaborative Care

Team-Driven: A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.
Population-Focused: The Collaborative Care team is responsible for the provision of care and health outcomes of a defined population of patients.
Measurement-Guided: The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making.
Evidence-Based: The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.
(American Psychiatric Association and Academy of Psychosomatic Medicine)

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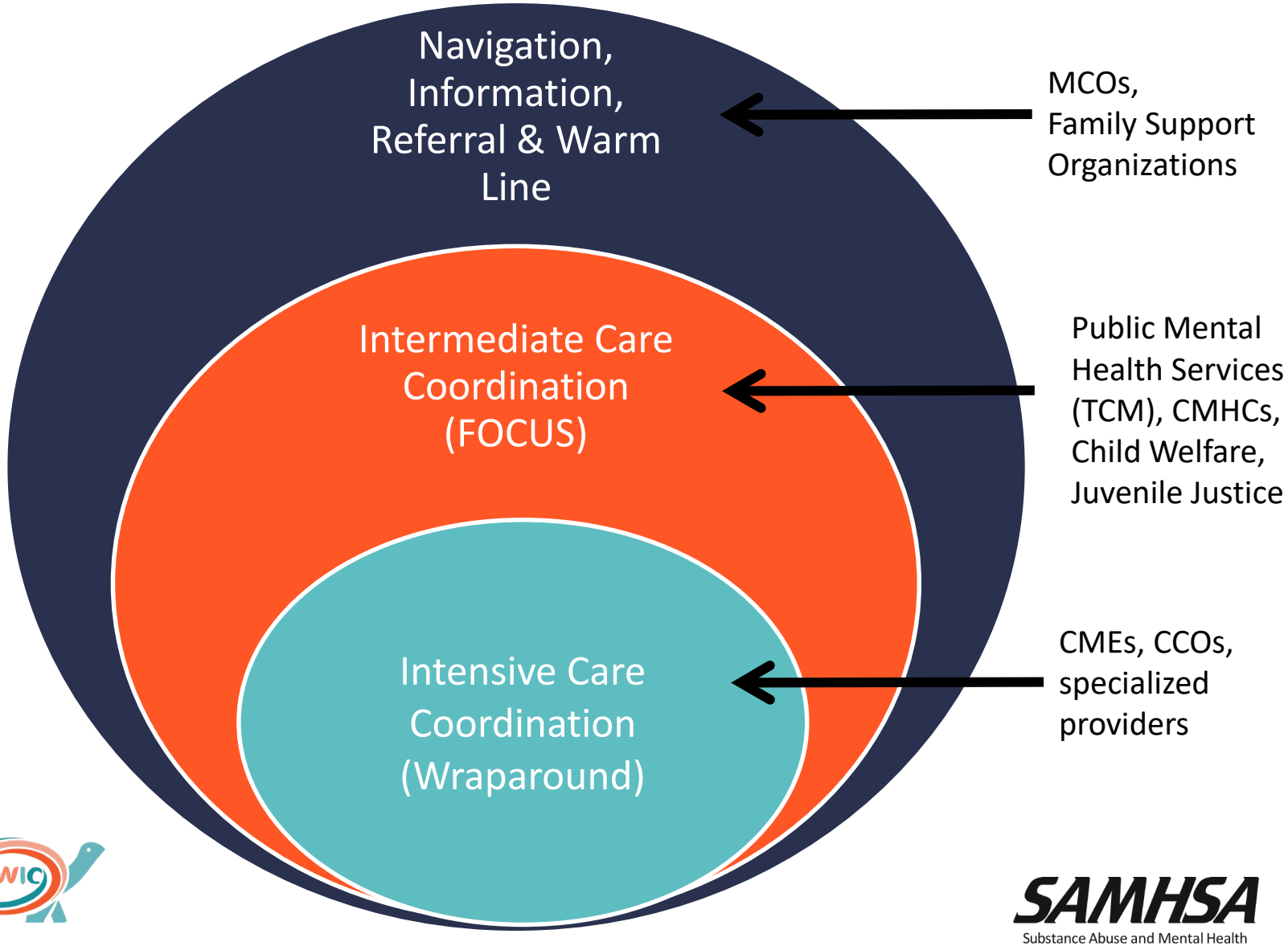
Developing Model: FOCUS



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Risk Factors are Different

FOCUS: Intermediate Care Coordination:

- Mental Health Needs.
- Social Determinants of Health:
  - Economic Stability;
  - Education;
  - Social and Community Context;
  - Health and Health Care;
  - Neighborhood and Built Environment.
- Developmental Delays.
- System Involvement.

Wraparound: Intensive Care Coordination:

- Multi-System Involved;
- High risk of OHP;
- Complex Mental Health Needs.

May be compounded by:

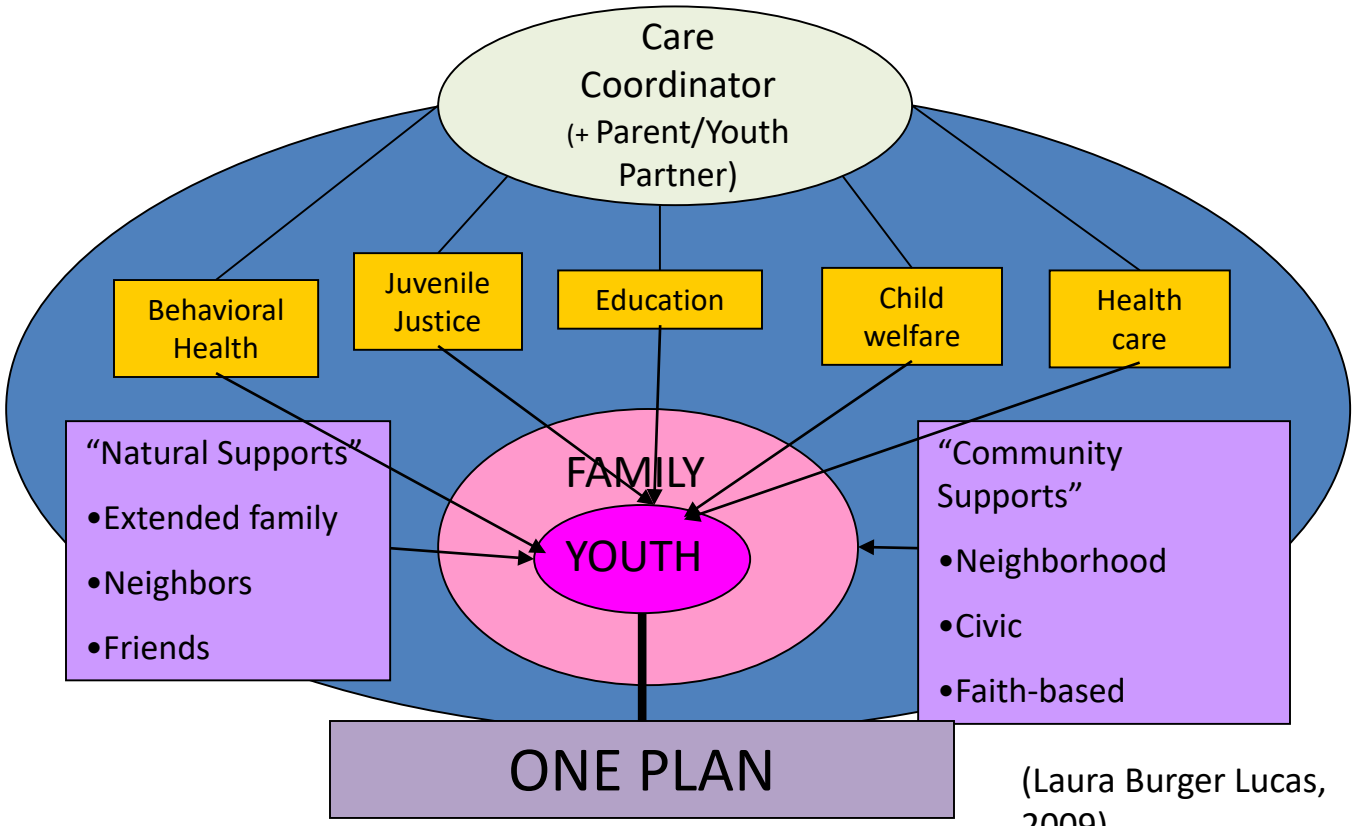
- Social Determinants of Health;
- Developmental delays.

FOCUS in Nevada

- Part of broader system reform efforts that include Wraparound to support youth with complex mental needs, divert youth from costly out of state placements, and support the return of youth from placements.
- Creating a consistent care coordination model across juvenile justice, child welfare, and mental health.
- Update to traditional case management practices:
  - Evidence based, model specific practices.
- Better outcomes for youth and their families.

Care Integration for Children with Complex Needs
Intensive Care Coordination Using Fidelity Wraparound

In Wraparound, a dedicated care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan



(Laura Burger Lucas, 2009)

Important Points About the Wraparound Process

- Wraparound is a defined, team-based service planning and care coordination process with fidelity monitoring standards.
- 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.

(Bruns, E. National Wraparound Initiative)

Wraparound is Associated with Improved Outcomes Across Life Domains

- 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.
- Greater family and youth resiliency.

(See Bruns & Suter, 2010; Coldiron, Bruns, & Quick, 2017)

Structuring Wraparound

Care Management Entities:

Organizations providing intensive care coordination at low ratios (1:10) using high quality Wraparound approach.

- **New Jersey** – Care Management Entities (fidelity Wraparound, peer support, wellness) – Health Home.

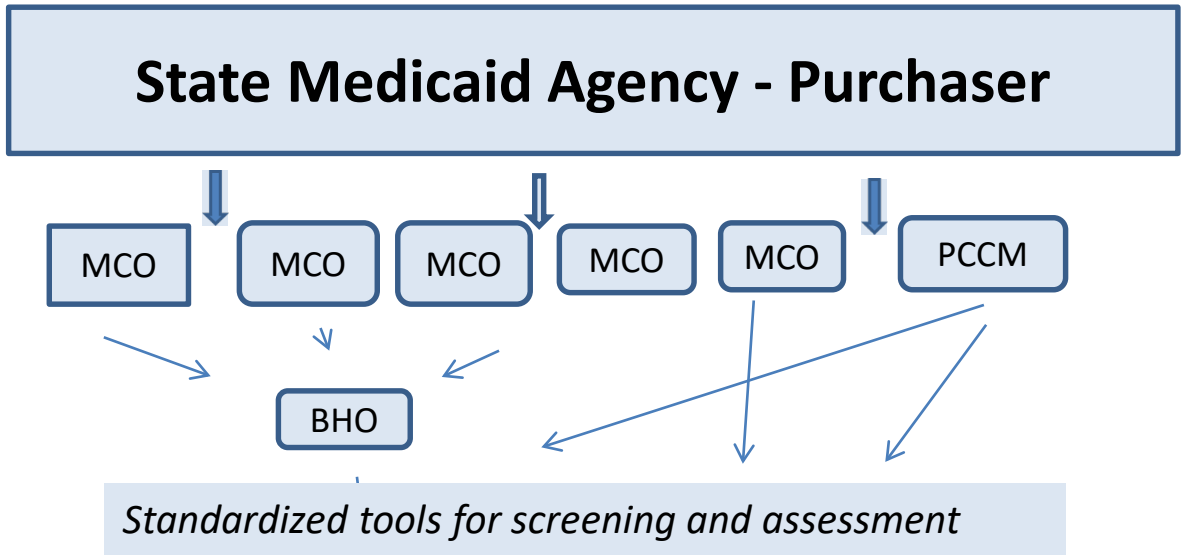
High Quality Wraparound Teams:

Embedded in supportive organization, such as CMHC, FQHC or school-based mental health center, providing intensive care coordination at low ratios.

- **Oklahoma** – System of Care Team (fidelity Wraparound, peer support, wellness) – Health Home Team.

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges .Washington, DC:* Human Service Collaborative for Center for Health Care Strategies, Inc.

Massachusetts – Care Management Entities



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

- 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

Adapted from State of Massachusetts

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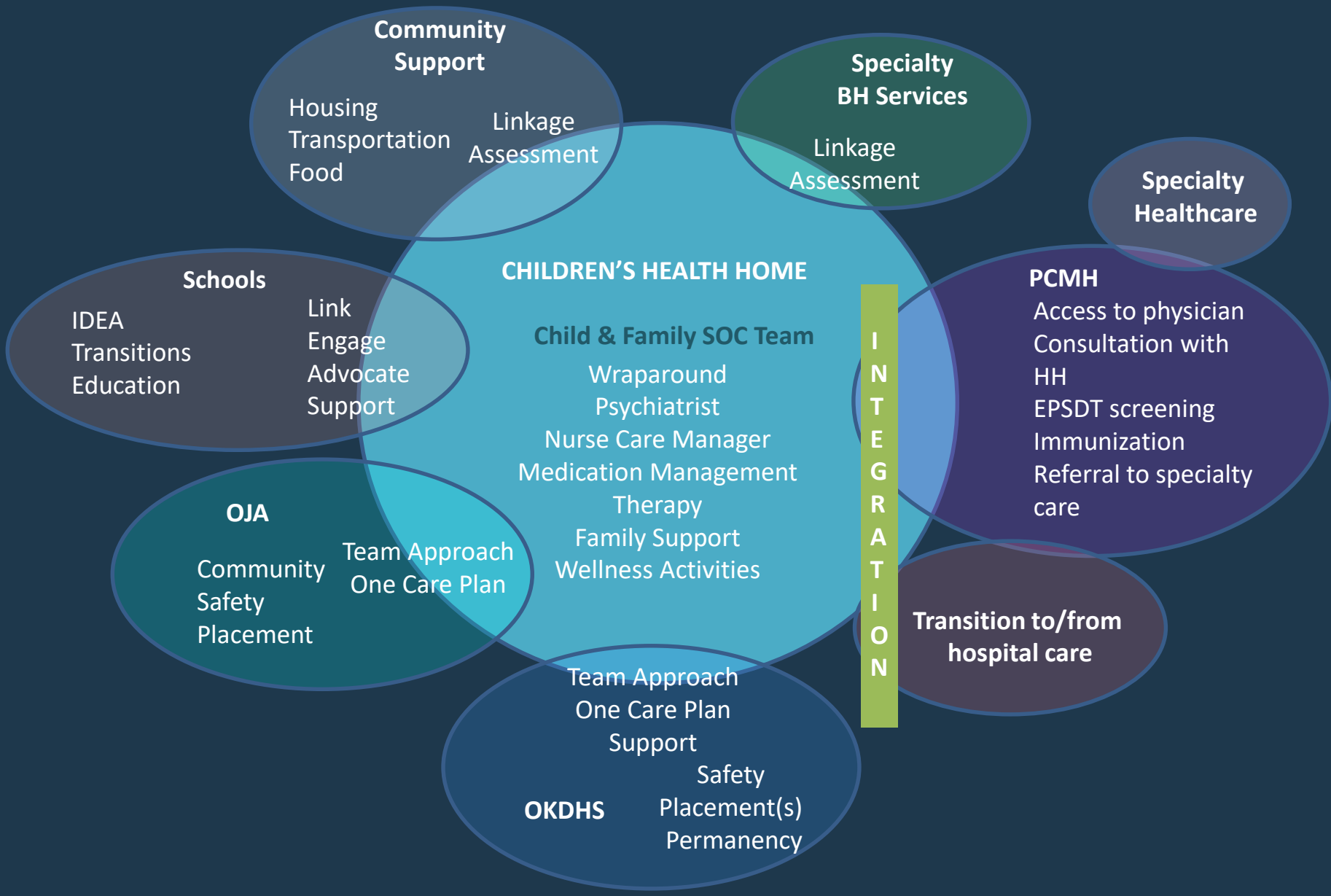
OK Children's Health Home Model



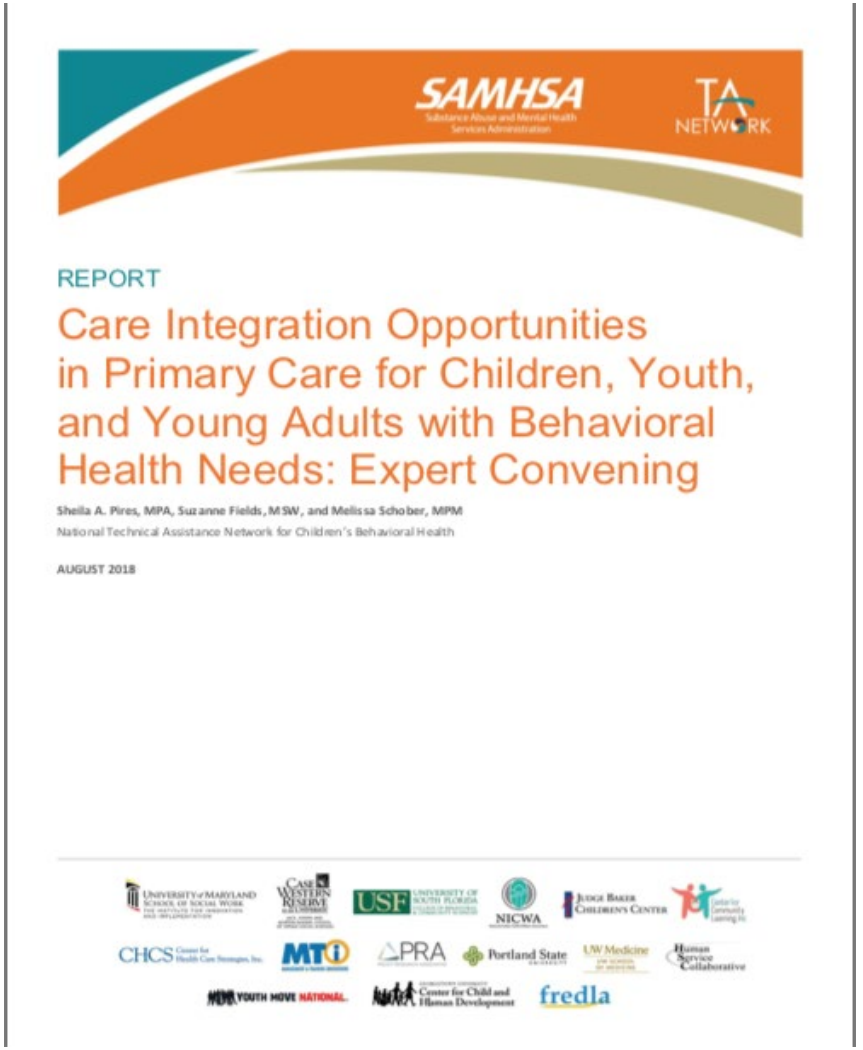
OK Health Home

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

Discussion

Care Integration Expert Convening Report

Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs: Expert Convening.



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Reminder: Care Integration Best Practice Webinar Series

Webinar #1 July –Overview, Issues and Expert Convening Consensus Framework.

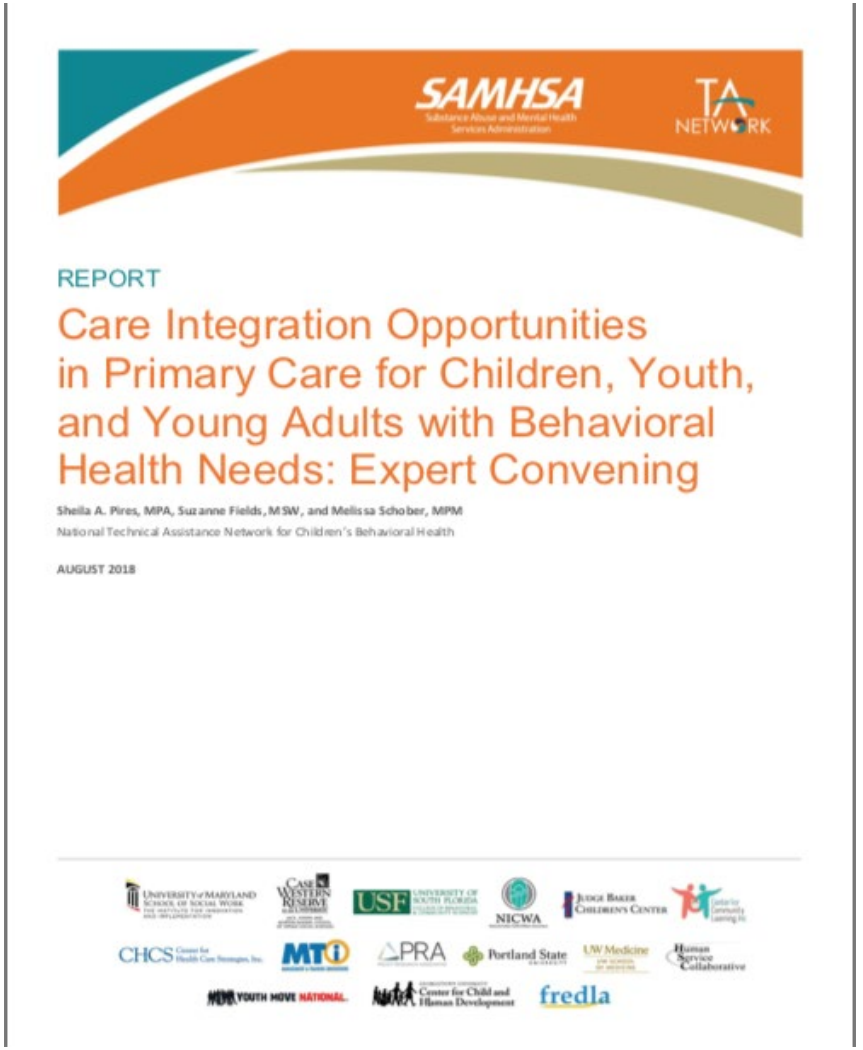
Webinar #2-August- Comprehensive Screening and Behavioral Health Consultation.

Webinar #3 October –Care Coordination Approaches for Children with Moderate to Intensive Behavioral Health Challenges.

Webinar #4 To Be Announced– Early Childhood Strategies.

Webinar #5- To Be Announced- Peer Support.

Subscribe to the TA Telegram for additional details.



SAMHSA
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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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