Bridging the Silos:
Care Coordination for Kids with Serious Behavioral Health Conditions

FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

James Wotring, MSW
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Georgetown University

Bruce Kamradt, MSW
Administrator
Wraparound Milwaukee

Sheila A. Pires, MPA
Partner
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Kimberly Eaton Hoagwood, PhD
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Senior Program Officer
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FRIDAY, DECEMBER 16, 2011
8:45AM–9:15AM—Breakfast
9:15AM–11:00AM—Discussion

LOCATION

Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(*Across from the Dirksen Senate Office Building*)

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Policymakers at all levels are searching for ways to provide needed health care services at an affordable price, especially to populations where the need for a broad range of services is always going to be high, such as the elderly and those with disabilities. Most often, children are viewed as largely healthy, free of chronic disease, and therefore fairly inexpensive to serve. However, a significant subset—children and adolescents with serious behavioral health problems—has always comprised high utilizers of clinical and support services. This population is the focus of one of the demonstration programs being funded under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Children with serious behavioral health problems, which may encompass both mental health and substance abuse issues, often face commensurately serious problems in finding the care and support services they need. Such children frequently come into contact with a variety of institutions, agencies and programs, from their schools to the child welfare and mental health systems, foster care, juvenile justice, and more. Research indicates that many of these children receive no mental health services at all. For those that do, care received from multiple unconnected sources tends to be fragmented, expensive, and far from optimally effective. Researchers who study this population suggest that improved care coordination and increased access to services offer "substantial opportunities to improve health outcomes, increase resiliency among youth and their families/caregivers, and, ultimately, decrease spending."[1]

The Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration (SAMHSA) defines children with serious emotional/behavioral disturbance as those under 22 years of age who have a diagnosable emotional, behavioral, or mental disorder that has the potential to last more than one year; who display poor functioning in their home, school, and/or community; and who have multi-agency involvement with public child-serving agencies.[2] Between 9 and 13 percent of children in the United States are estimated to fall into this category. Prevalence is somewhat greater in the 12- to 13-year age group (as compared with the high and low ends of the age range) and among children at lower income levels.[3] Child welfare, juvenile justice, and foster care populations have a particularly high incidence of behavioral disorders. Because many of these children are Medicaid-eligible, both state and federal policymakers are interested in finding more cost-effective ways to treat them.[4]

The care and treatment of mental disorders represents the highest category of expense among all children's health expenditures, accounting for $8.9 billion in 2006.[5] This figure represents medical care only; that is, it includes such cost drivers as psychiatric hospitalization, residential treatment, and psychotropic medication as well as more routine care, but does include not other types of support services that may be provided to children with such disorders, or the costs of their incarceration or court-ordered residential placement.

SYSTEMS OF CARE AND CARE MANAGEMENT ENTITIES

Efforts to integrate care for children with serious behavioral health conditions date back to the early 1980s, when the "systems of care" concept began to take shape. A system of care was defined in 1986 as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families."[6] It was conceived as including care planning, multicultural competence, and the building of meaningful partnerships with families and youth at both service delivery and policy levels.

Legislative action, foundation and federal grant support, and a growing family movement generated various programs designed to create and foster systems of care around the United States. Pioneers included the Child and Adolescent Service System, for which funding was provided to all 50 states by the National Institute of Mental Health (beginning in 1983) and the Mental Health Services Program for Youth, funded in 12 locations by the Robert Wood Johnson Foundation. SAMHSA's Comprehensive Community Mental Health Services for Children and Their Families Program has also provided funding to numerous states and communities.[7]

Out of the systems of care philosophy has grown the "wraparound" model, defined by one such program as "a family-driven, strengths-based team approach in which all children and youth are connected to caring adults and have access to appropriate services and supports so they can be healthy, experience positive development, and live and thrive in their homes and communities."[8] To administer this model, the concept of the care management entity (CME) has developed.

As defined by the Center for Health Care Strategies, a CME is an organization that "serves as a centralized accountable hub to coordinate all care for youth with complex behavioral challenges who

are involved in multiple systems, and their families."[9] Its goals are to improve access to services and support, reduce unnecessary use of costly services (such as out-of-home placement), employ health information technology to support decision-making, and engage children and their families as partners in care decisions. CMEs increasingly look to approaches also being tested in medical practice, such as quality improvement, performance metrics geared to outcomes, and redesigned financial incentives.

An Example: Wraparound Milwaukee

Wraparound Milwaukee is a non-profit managed care entity with a primary focus on serving children and adolescents who have serious emotional disorders. Many are identified by the child welfare or juvenile justice system as being at immediate risk of residential or correctional placement or psychiatric hospitalization; others enter the program on a voluntary basis without being involved in these systems. The program serves 1,400 families annually. Among children receiving service, boys outnumber girls by a significant margin, and the average age is about 14 for the court-involved children and 11-and-a-half for the voluntary participants. The majority are children of color. Most families served are low income and most are headed by a single parent.[10]

Several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the State Division of Heath Care Financing (which operates Medicaid) provide funding for the system. Funds from the four agencies are pooled and managed by Wraparound Milwaukee to create maximum flexibility and provide sufficient funding to meet the comprehensive needs of those served. Wraparound Milwaukee contracts with eight community agencies for more than 100 care coordinators who facilitate the delivery of services and other supports to families. It has a provider network of more than 200 agencies offering some 70 different services, and also operates a Mobile Urgent Treatment Team that ensures families have access to crisis intervention services. Wraparound Milwaukee has a strong partnership with a family advocacy organization that provides peer-to-peer support.

Wraparound Milwaukee assesses the effectiveness of its services by tracking a number of measures, including reported improvement in a child's functioning, youth self-reports, school enrollment, and family satisfaction with services. Permanency, a key measure, is considered

achieved if a child leaving the program is living at home with a parent or relative, in subsidized guardianship, or in sustaining care; has been adopted; or lives independently. Financial success is assessed by comparing program expenditures to those of alternatives. In 2009, the average monthly cost per child served was $3,786, compared with $38,100 for inpatient care, $8,493 for a residential care center, and $5,986 for a group home.

CME Demonstrations and Aspirations

As noted above, among the projects being funded as demonstrations under CHIPRA is one focused on children with serious behavorial health challenges. The state of Maryland, in partnership with Georgia and Wyoming, is funded over five years to implement and/or expand a CME model to improve the quality and better control the cost of care for such children who are enrolled in Medicaid or CHIP.

CME proponents point out that CME goals are consistent with those of the health homes created under the Patient Protection and Affordable Care Act of 2010 as a state option for providing coordinated care to Medicaid beneficiaries with chronic conditions or a serious and persistent mental health disorder. The health home functions include:

- comprehensive care management
- care coordination and health promotion
- comprehensive transitional care from inpatient to other settings
- patient and family support
- referral to community and social support services
- use of health information technology to link services

Proponents hope that the Centers for Medicare & Medicaid Services (CMS) will approve CMEs to serve as health homes for children with serious behavioral health conditions, thus making them eligible for federal matching funds at the enhanced rate of 90 percent.

CME Challenges

As noted, CME development projects have been undertaken by numerous states and communities, and more are planned. All face common challenges that nevertheless may have to be addressed differently in different markets. Among the most obvious are pulling

funding together for a sustainable program and remaining accountable to the various funders for program outcomes. Although CMEs may provide some services directly, much of their effort centers on developing and managing networks of providers, who are often in short supply. Issues of provider training will be increasingly important, particularly in areas where mainstream primary care physicians have no choice but to play a lead role in caring for the CME's target population. Integration of physical and behavioral health care is drawing renewed interest with respect to both adults and children, but will require a reversal of the common practice of carving out behavioral services.

SESSION

This Forum session will review the development of the systems of care philosophy, describe an operating example, and consider the issues that the architects of similar programs may wish to keep in mind. The outlook for the CHIPRA demonstration states and the potential role of CMEs as health homes will be discussed.

SPEAKERS

James Wotring, MSW, director of the National Technical Assistance Center for Children's Mental Health at Georgetown University, will describe the needs of children with serious behavioral health conditions and how systems of care were developed and refined to respond to these needs. **Bruce Kamradt, MSW**, administrator of Wraparound Milwaukee, will discuss the factors that have made the program a success and its ongoing challenges, with particular attention to funding considerations. **Sheila A. Pires, MPA**, a partner in the Human Service Collaborative, will talk about what the CHIPRA demonstration states are doing to implement CMEs and the prospects of CMEs serving as health homes. **Kimberly Eaton Hoagwood, PhD**, professor of child psychiatry at Columbia University, will comment on the evidence base for integrated care for children with mental health issues, differences between adult and child mental health services with implications for care coordination, and prime targets for regulatory and policy improvements to support integrated models. **Dayana Simons, MEd**, senior program officer at the Center for Health Care Strategies, will be on hand to provide additional information about the CHIPRA demonstration and its associated learning collaborative.

KEY QUESTIONS

- What factors are critical to the success of a wraparound program? What are the greatest challenges?

- To what extent can savings be documented from treating children with serious behavioral conditions in wraparound programs administered by care management entities (CMEs)? What further savings might be possible through developing and standardizing better ways of treating these children? Could savings be used to prevent more children from coming into the child welfare, foster care, and juvenile justice systems?

- What effect does the ongoing shift to managed care for Medicaid populations have on wraparound programs and CMEs?

- What is the role of the Centers for Medicare & Medicaid Services in providing guidance, approval, or regulation of wraparound programs and CMEs?

- What kinds of providers are needed to serve this target population? What education and training changes are needed to ensure a supply of such providers?

- What resources are available to finance new modes of service, such as mobile response teams and youth peer counselors?

ENDNOTES

1. Center for Health Care Strategies, Inc., "Care Management Entities: A Primer," fact sheet, March 2011, available at www.chcs.org/usr_doc/CHIPRA_CME_Primer_v5.pdf.

2. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Comprehensive Community Mental Health Services for Children and Their Families Program, Evaluation Findings: Annual Report to Congress, 2005*, p. 24, available at http://store.samhsa.gov/shin/content//SMA10-4536/SMA10-4536.pdf.

3. Tami L. Mark and Jeffrey A. Buck, "Characteristics of U.S. Youths With Serious Emotional Disturbance: Data From the National Health Interview Survey," *Psychiatric Services*, 57 (November 1, 2006): pp. 1573–1578, available at http://ps.psychiatryonline.org/article.aspx?articleID=97246.

4. According to the Kaiser Family Foundation research (Vernon K. Smith *et al*., "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010," September 2009, available at www.kff.org/medicaid/upload/7985.pdf), Medicaid pays for over half of all publicly financed mental health services and more than one-quarter of all mental health services nationally.

5. Anita Soni, "The Five Most Costly Children's Conditions, 2006: Estimates for the U.S. Civilian Noninstitutionalized Children, Ages 0-17," Medical Expenditure Panel Survey, Statistical Brief #242, Agency for Healthcare Research and Quality, April 2009, available at www.meps.ahrq.gov/mepsweb/data_files/publications/st242/stat242.pdf.

6. Sheila Pires, *Building Systems of Care: A Primer,* for the National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, p. 4, based on the work of B. Stroul and R. Friedman, *A system of care for children and youth with severe emotional disturbances*, rev. ed., Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health. Pires, *Building Systems of Care: A Primer,* is available at http://gucchd.georgetown.edu/72377.html.

7. For a more detailed discussion and history, see Pires, *Building Systems of Care: A Primer.*

8. CHRIS Kids (Atlanta, GA), "Overview of Choices," available at www.chriskids.org/strong-communities/choices-a-care-management-entity-/overview-of-choices-.

9. Center for Health Care Strategies, Inc., "Care Management Entities: A Primer," p. 1.

10. Wraparound Milwaukee, "2009 Year End Report," p.9, available at http://county.milwaukee.gov/ImageLibrary/Groups/cntyHHS/Wraparound/2009WraparoundAnnualReport.pdf.