

CHIPRA Quality Demonstration Grant Program Webinar Series

Improving Behavioral Health Care Quality
for Children and Adolescents

September 25, 2013

Colorado/New Mexico – A Focus on School-Based Health Centers

Pennsylvania – Electronic Screening and Referral Linkages in Primary Care

Maryland/Georgia/Wyoming – Using Care Management Entities

CHIPRA Quality Demonstration Grant Program Webinar Series

- CMS-sponsored series of five webinars designed to share findings and lessons learned from the CHIPRA Quality Demonstration Grants:
 1. August 14 - Understanding the CHIPRA Quality Demonstrations
 2. August 20 - Patient-Centered Medical Home
 3. September 12 - Stakeholder Engagement
 4. September 25 - Improving Behavioral Health Care Quality
 5. October 15 - Health Information Technology
- Open to all interested parties
- Dates/times posted on: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html>

CHIPRA Quality Demonstration Grant Program

- Congressionally mandated program
- \$100 million in funding
- Focus is on children in Medicaid/CHIP
- Goals
 - Evaluate promising ideas
 - Identify strategies that can drive improvements
 - Multi-state collaborations encouraged

Webinar Agenda

- Welcome
- Introductions
- Presentation of State Project Spotlights
 - Colorado/New Mexico
 - Pennsylvania
 - Maryland/Georgia/Wyoming
- Questions

Improving Behavioral Health Care Quality for Children and Youth

A Focus on School-Based Health Centers

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CHIPRA Quality Demonstrations
Strengthening the Quality of Children's Health Care

Agenda

- Overview of Colorado and New Mexico Demonstration
- Setting the Stage
 - Background on School Based Health Centers (SBHCs)
 - Behavioral health services provided in SBHCs
 - Behavioral health risks for SBHC users
- School-Based Health Center Improvement Project (SHCIP) quality improvement efforts
- Project Outcomes
- Questions

Partners



Colorado Department
of Public Health
and Environment

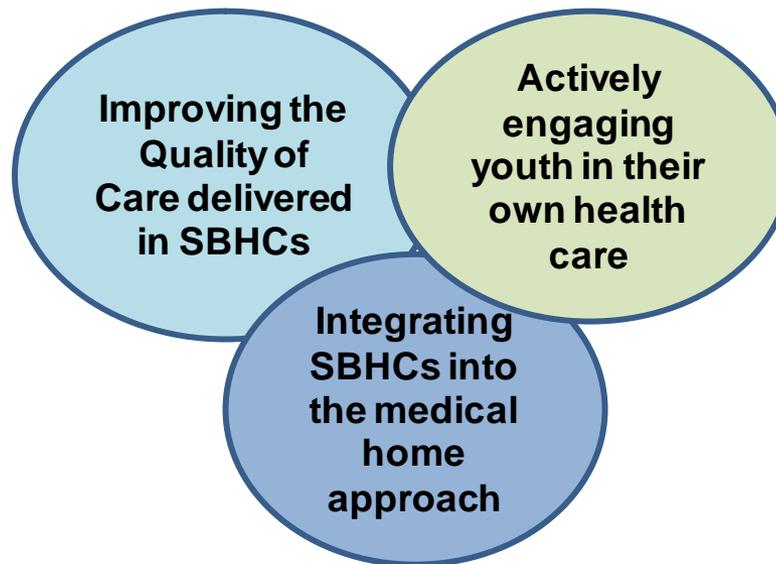


CHIPRA Quality Demonstrations
Strengthening the Quality of Children's Health Care

Overview of Colorado and New Mexico Quality Demonstration Projects

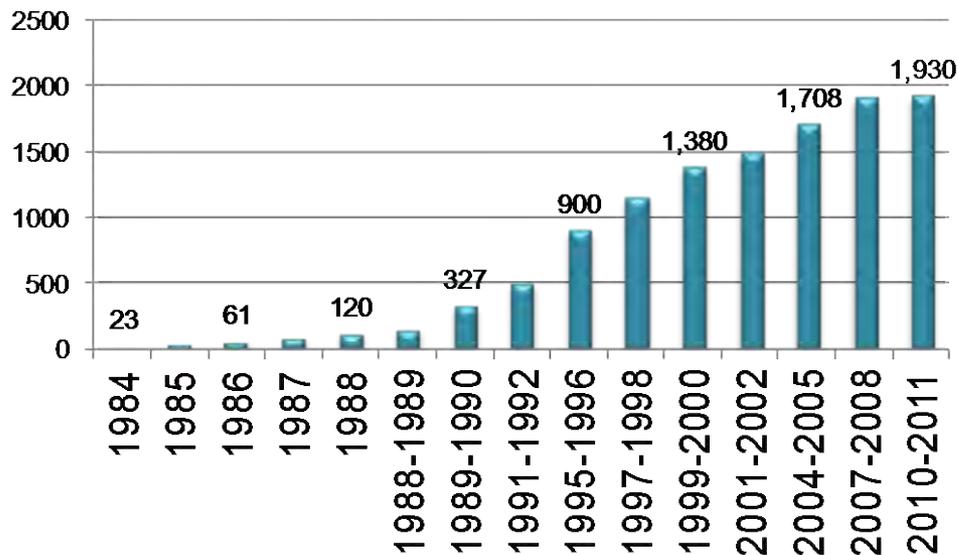
The School-Based Health Center Improvement Project (SHCIP) aims to:

- Showcase the ability of SBHCs to address the health care needs of adolescents in Medicaid and CHIP;
- Demonstrate how the SBHC model strengthens the health care delivery system by:

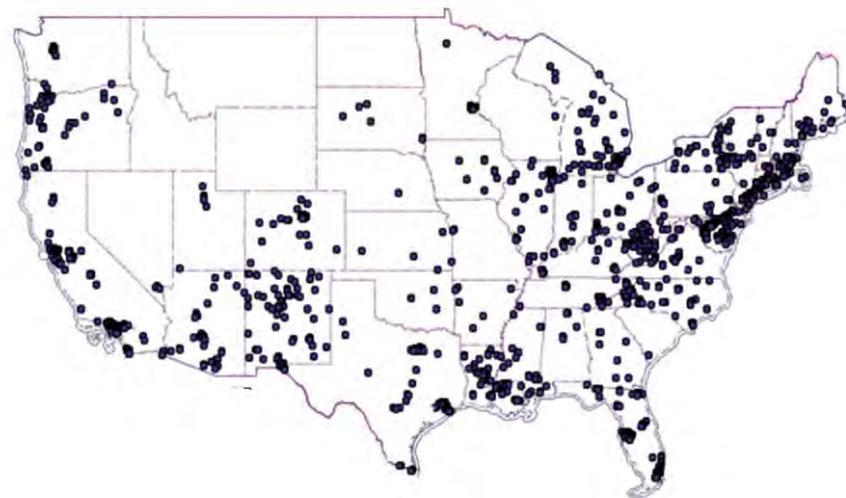


Dramatic Growth in SBHCs

School-Based Health Center Growth In the U.S.



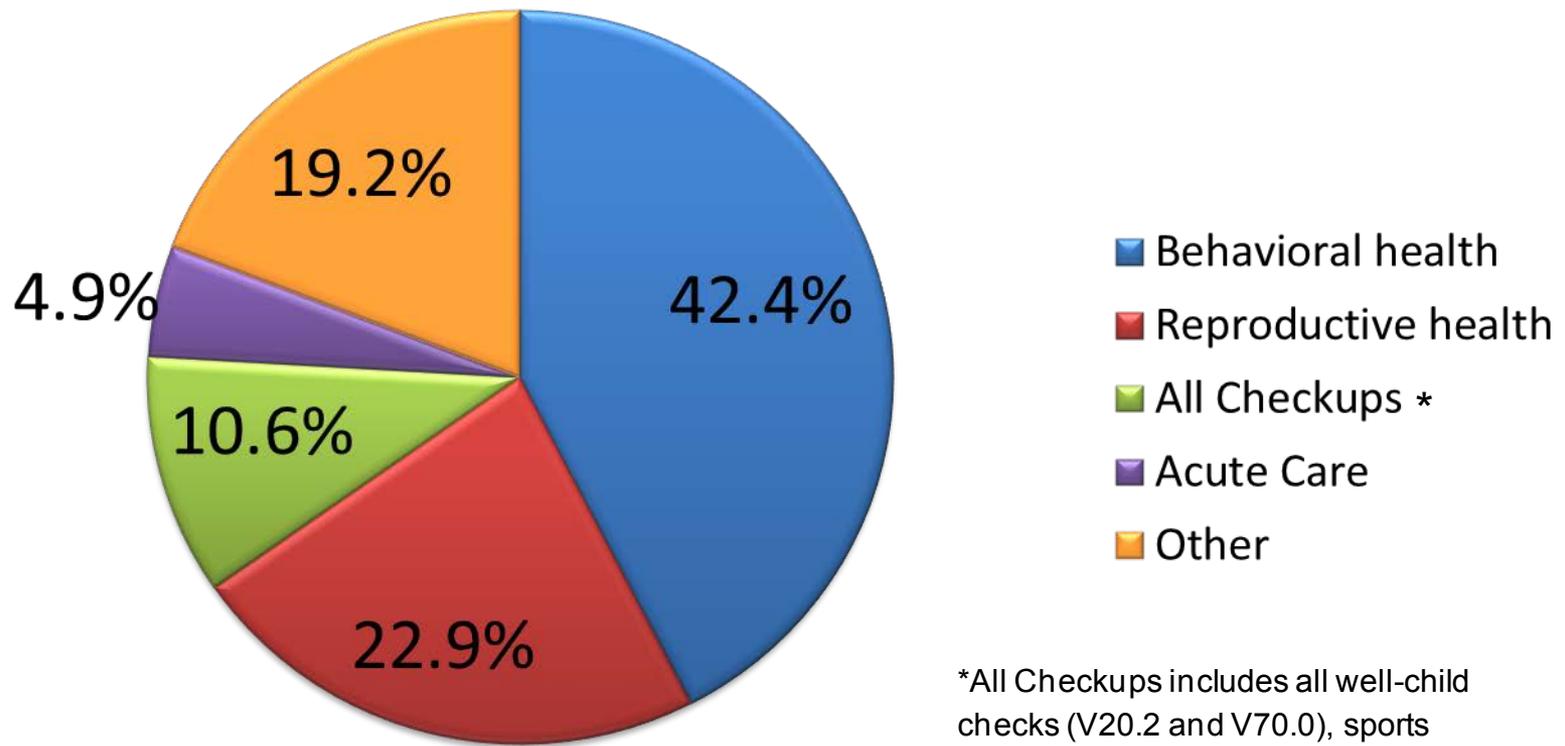
- There are currently over 2,000 SBHCs around the country
- SBHCs are present in 46 states



Source: Lofink, H., Kuebler, J., Juszczak, L., Schlitt, J., Even, M., Rosenberg, J., and White, I. (2013). 2010-2011 School-Based Health Alliance Census Report. Washington, D.C.: School-Based Health Alliance.

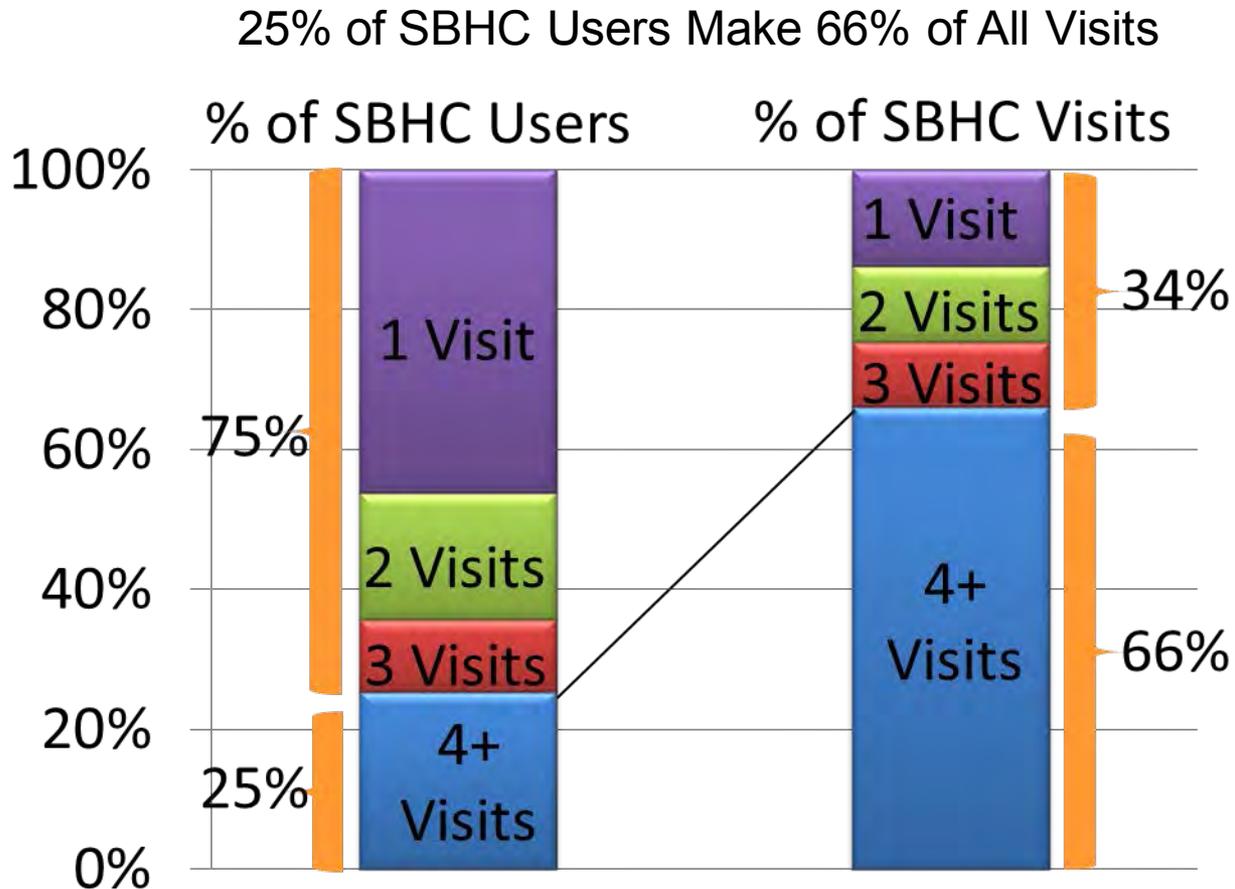
Almost Half of Visits to SBHCs are for Behavioral Health

Percentage of Total Visits for New Mexico Adolescents Ages 14-19 by Major Category of Care Based on Primary Medical Diagnosis (N= 7,885)



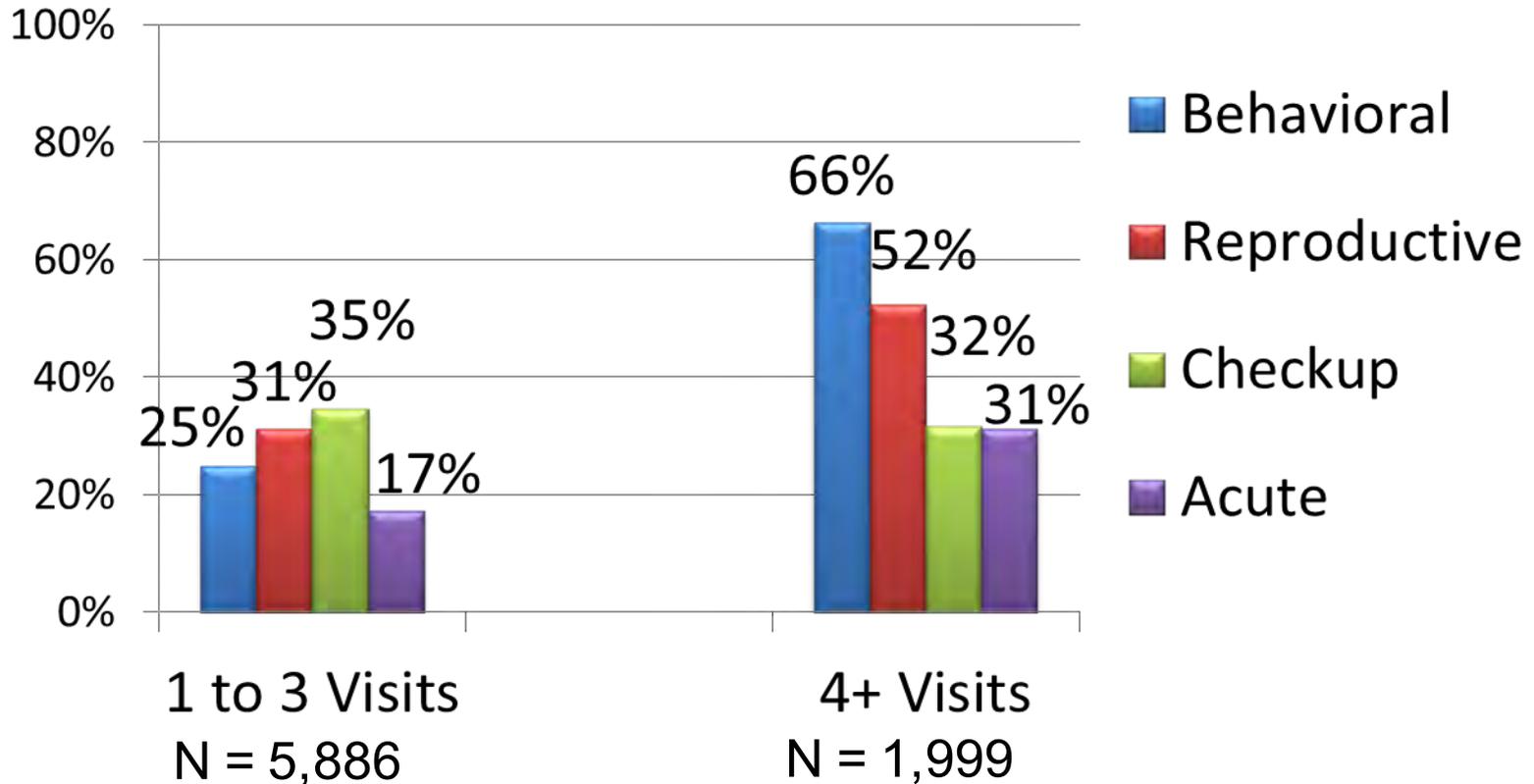
*All Checkups includes all well-child checks (V20.2 and V70.0), sports physicals (V70.3), and unspecified medical exams (V70.9)

A Few Adolescents Account for Most of the Visits



Medical encounter data based on 7,885 SBHC users ages 14-19 during the 2011-2012 school year, accounting for 26,379 visits

High Frequency Users Have Behavioral Health Needs



Note: Low frequency users were defined as 1-3 visits during the year, while high frequency users defined as ≥ 4 visits during the year. Chi-square tests showed that high users had significantly more behavioral ($p < 0.001$), reproductive ($p < 0.001$) and acute care ($p < 0.001$) visits than low frequency users.

Comprehensive Risk Screen Development and Use in SBHCs

- The Electronic Student Health Questionnaire (eSHQ):
 - Is a comprehensive tool used to screen for adolescent health risks and protective factors
 - Was adapted by the project team from a paper SHQ used in New Mexico SBHCs and is based on Bright Futures, GAPS, and others
 - Contains 7 domains: home and school life, health behaviors, safety/injuries, behavioral health, sexual health, substance use and future plans
 - Is administered on an iPad
 - Gives SBHC providers immediate alert reports on risks, helping them identify treatment and follow-up needs

Behavioral Health Questions in the eSHQ

- Feelings/Well-Being Domain
 - Do you often worry about or feel like something bad might happen?
 - Are you often tense, stressed out, and/or have difficulty relaxing?
 - Over the past 2 weeks, have you noticed feeling down, depressed, irritable, or hopeless?
 - Over the past 2 weeks, have you noticed less enjoyment or interest in doing things?
 - Have you ever purposefully hurt yourself without wanting to die, such as cutting or burning yourself?
 - Have you ever seriously thought about killing yourself, made a plan and/or actually tried to kill yourself?

Over Half of Adolescents Screened Have a Behavioral Health Risk

Question	Colorado (N=694)	New Mexico (N=1,354)	Total (N=2,048)
Percentage of adolescents that have any type of behavioral health risk.	59.2%	59.4%	59.3%

eSHQ data from 2011-2013 for adolescents 14-19 years of age

SHCIP's Quality Improvement Efforts

- Ten SBHCs each in CO and NM
- Quality improvement (QI):
 - Coaching in-person, by phone and email using Plan Do Study Act cycles
 - Webinars, conference calls, and learning collaboratives
- Data collection
 - Visit data
 - Medical record reviews
 - Risk screening tool (eSHQ)
 - Youth engagement survey
 - Medical home assessments

Behavioral Health Quality Improvement Projects

- Improving communication and coordination
 - Holding regular care coordination meetings
 - Establishing data-sharing systems
- Improving workflow and tracking to ensure best practice implementation
 - Developing protocols to streamline behavioral health referrals
 - Implementing systems for tracking and follow-up
- Standardizing the use of assessment tools for students with positive screenings
 - Implementing standardized depression and anxiety assessment tools by primary care physicians (PCPs) and behavioral health providers
 - Training PCPs on assessing suicide risk

Spotlight Grant Activity: Increasing Comprehensive Risk Screening

- Screening for risk, including risk for depression and anxiety, is part of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) exam
- All SHCIP sites aimed to increase the use of a comprehensive risk screening tool with youth on an annual basis
- Sites evaluated their progress using medical record reviews in fall and spring

SBHCs in Both States Increased their Use of a Comprehensive Screening Tool

	Fall of First Year in SHCIP	Spring of First Year in SHCIP
Colorado (N = 7)	64%	94%
New Mexico (N = 7)	71%	95%
Total (N = 14)	68%	95%

Medical record review data from 2011-2013 for youth 9-19 years of age

SBHCs are Leaders in Integrated Care

- The integrated primary and behavioral health care model is the standard of care for SBHCs in Colorado and New Mexico, meaning that SBHCs have qualified primary care and behavioral health providers on-site
 - 100% of SBHCs in Colorado
 - 83% of SBHCs in New Mexico
 - All 20 SHCIP sites adhere to the standard

Implementing Best Practices for Youth at Risk for Depression and Anxiety

- In 2012-2013, three SHCIP sites selected depression and anxiety as their advanced QI focus areas
- Those sites aimed to implement best practices for youth who screened positive for depression and/or anxiety
- Sites evaluated their progress using medical record reviews in fall and spring

SBHCs in Both States Improved Integration of Best Practice Guidelines for Behavioral Health Care

Best Practice Guideline	Fall	Spring
Completed depression assessment tool	0%	95%
Completed anxiety assessment tool	2%	92%
If diagnosed, receiving care at SBHC or in community	51%	97%
Documented care coordination	46%	97%

N = 3 SBHCs who selected the behavioral health QI area
Medical record review data from 2012-2013 for youth 9-19 years of age

Lessons Learned

- SBHCs serve a Medicaid/CHIP population with high behavioral health needs
- Behavioral health-focused QI projects have led to systemic changes, improved documentation, and increased utilization of best practice guidelines by primary care and behavioral health providers
- SBHCs provide accessible, comprehensive, and coordinated behavioral health and primary care services to youth

Questions

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Improving Children's Health Care Delivery through Health Information Technology

Electronic Screening and Referral Linkages in Primary Care for Medicaid/CHIP Enrolled Children

Kelli Sebastian

Pennsylvania Department of Public Welfare

Elizabeth Brooks, MPH, MSSP

PolicyLab at The Children's Hospital of Philadelphia

Agenda

- Highlights of Pennsylvania's Quality Demonstration
- Overview of the electronic screening project
- PA Department of Public Welfare's goals for the electronic screening project
- Electronic screening in action: Children's Hospital of Philadelphia's experience in developing and implementing the project

Overview of Pennsylvania's CHIPRA Quality Demonstration

- PA Department of Public Welfare is partnering with six hospitals and one federally qualified health center (FQHC)
- Category A – Testing and reporting on the CMS pediatric core measures of quality
 - Quality measure data extracted directly from electronic health records
- Category B – Promoting the use of health information technology in children's healthcare delivery
 - Electronic screening project
- Category D – Implementing the CMS/AHRQ pediatric electronic health record (EHR) model format
 - Building and testing a pediatric specific EHR

Grantee Spotlight: PA Department of Public Welfare's Electronic Screening Project

Goals:

- Improve the quality of care for children with developmental and behavioral needs in Pennsylvania's Medicaid/CHIP program
- Leverage health information technology to maximize early identification of children with developmental and behavioral health concerns
- Increase care coordination for children identified through the screening process
- Enable timely and accurate diagnosis and appropriate referral/feedback

Grantee Spotlight: Electronic Screening Project

- Standardized screeners built into the EHR system
- System flags alert staff to age appropriate screen at patient check-in
- Patients utilize computer technology to answer screening questions
- System automatically scores the screen and loads results into the patient's EHR
- Results available when patient sees physician at current visit

Electronic Screening in Action

- Since July 2011, The Children's Hospital of Philadelphia has implemented e-screening in eight primary care pediatric practices
- Families have completed over 30,000 screenings using this process
- Planning phase: How to convert the inconsistent paper screening process to an electronic system?
- Planning team brought together pediatricians, informaticians, child psychologists, computer programmers, primary care leadership, and practice managers

Screening Ages and Tools

Well Visit	Age Eligibility ¹	Screening Domain(s)	Screening Tool(s)
2 months	47-107 days (1.5-3.5 months)	Postpartum depression	Edinburgh Postnatal Depression Scale (EPDS)
9 months	261-364 days (8.5-12 months)	Developmental delay	Survey of Well-Being of Young Children: Developmental Milestones (SWYC Milestones) ²
18 months	505-640 days (16.5-21 months)	Developmental delay and autism	SWYC Milestones & Modified Checklist for Autism in Toddlers (M-CHAT)
24 months	641-819 days (21-27 months)	Developmental delay and autism	SWYC Milestones & M-CHAT
30 months	820-1,003 days (27-33 months)	Developmental delay	SWYC Milestones
9 years	3,101-3,469 days (8.5-9.5 years)	School-age behavioral concerns	Pediatric Symptom Checklist (PSC-17)
16 years	5,475-6,024 days (15.5-16.5 years)	Teen depression	Patient Health Questionnaire (PHQ-9) Modified for Teens

¹ Based on Pennsylvania 's Medical Assistance Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program visit windows.

² Sheldrick, R.C. & Perrin, E.C. (in press). Evidence-based milestones for surveillance of cognitive, language and motor development. *Academic Pediatrics*. See <https://sites.google.com/site/swycscreen/>.

How e-Screening Works: Registration Staff and Families

- Registration staff see an alert at check-in showing that the patient meets the age and visit type rules
- A staff member logs the caregiver/patient onto the mobile computer
- The age-appropriate questionnaire(s) appears and the caregiver/patient answers questions
- Questionnaires are also available before the visit in the EHR's patient portal



How e-Screening Works: Providers

- Questionnaires are completed in the waiting room or exam room.
- When the provider opens the patient's EHR chart in the exam room, the passed/failed summary result(s), individual responses, and appropriate decision support and billing links are visible.

Screening for Developmental Delay: Next Steps

Today your child was screened to see how your child is developing. There might be some potential concerns. This was just a screening and may not show everything about your child. But, it does suggest that your child needs further evaluation. Getting help early can have a big impact.

What You Should Do Next

- Use these phone numbers to call Early Intervention (EI):

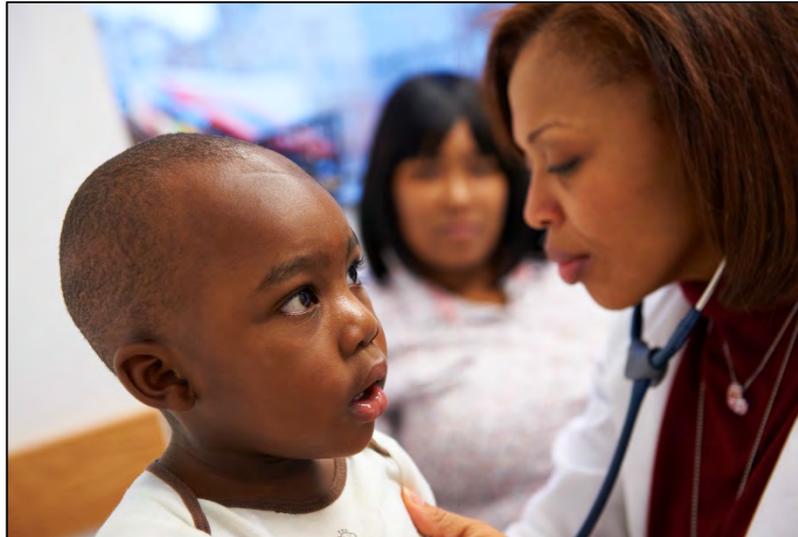
Call the Pennsylvania CONNECT phone line staff. They can help you find EI services nearby. The toll free number is 1-800-692-7288.

You could also call the EI phone number for your county:

Birth to Three	Three to Five
Bucks County: 215-444-2800	800-770-4822, ext. 1716
Chester County: 610-344-5948	484-237-5183
Delaware County: 610-713-2406	610-938-2830, ext. 6503
Montgomery County: 610-277-7176	610-755-9400
Philadelphia County: 215-731-2110	215-222-8054

They will set up a time to evaluate your child for a delay. They will decide whether your child can receive EI services. These are free to the family in Pennsylvania.

Please do not give up if you have trouble scheduling this appointment. Call the doctor's office for help.



Screening for Teen Stress or Depression: Next Steps

Today you or your child were screened for stress or depression. The screening found that you or your child could benefit from an evaluation. An evaluation will show whether there is a problem and how to get help.

What is depression? Why is it important to seek help?
Depression is a common problem that can be from stress or other factors. You or your child may feel sad or tired, not want to be with friends, feel hopeless, or have trouble sleeping. Depression is nothing to be ashamed about. It is a medical problem that can be helped.

How is depression treated?
The good news is that depression can be treated. Treatment can help you or your child feel better and cope with stressful situations. Depression may be treated with counseling, medication, or both.

What You Should Do Next

- Call a behavioral health provider for evaluation and treatment:
 - If you or your child have CHIP or private health insurance, call your insurance plan to find providers who are covered. You can find the mental health services phone number on the back of your insurance card.
 - If you or your child have Medical Assistance, call the number below for your county:
 - Berks: 1-866-292-7886 (Community Care Behavioral Health)
 - Bucks: 1-877-769-9784 (Magellan Behavioral Health)
 - Chester: 1-866-622-4228 (Community Care Behavioral Health)
 - Delaware: 1-888-207-2911 (Magellan Behavioral Health)
 - Lancaster: 1-888-722-8646 (Community Behavioral Health/Care Network of PA)
 - Lehigh: 1-866-235-2311 (Magellan Behavioral Health)
 - Montgomery: 1-877-769-9782 (Magellan Behavioral Health)
 - Northampton: 1-866-333-3333 (Magellan Behavioral Health)

Improving Referrals to Community Services

- Referral form templates are built into the EHR in the event a provider decides to refer a child to Early Intervention or for behavioral health services
- Most of the form's information is pre-populated by EHR data
- The provider uses the EHR's fax software to send the form directly to the Early Intervention or behavioral health agency



- Working on a pilot model to close the feedback loop to primary care from outside agencies agencies using DIRECT secure messaging

Implementation Findings

- Electronic screening has dramatically increased screening rates and made the referral process more smooth
- Developmental screening in the first three years of life
 - 2010 – 6.7% 2011 – 31.2% 2012 – 42.7%
 - Reporting rates are not based on claims data – all data are extracted from the EHR
 - Reporting from all sites (e-screen or paper) is limited to screens captured as discrete data in the EHR with complete information (date, result/score, tool name)
- The electronic process is now used at eight practices of varying size, patient population, insurance mix, and attending/resident providers with few complaints or disruptions
- Electronic screening did not negatively impact overall provider workflow and usually helped speed up the process by gathering some information before the visit

Stakeholder Reaction to the e-Screening Project

- Families liked the new process
 - Some reported feeling more involved in assessing their children's development and more useful while waiting for appointments
- Front desk staff and nurses liked the automation of screening alerts and standardized ages
- For providers, having screening results at their fingertips immediately leads to a more informed and tailored conversation about development/behavioral health and referral needs
- Ongoing concerns:
 - EHR/computer downtime
 - Low literacy
 - Limited English proficiency (questionnaires are available only in English and Spanish)

Questionnaire Results To Date

Screening Tool	Number Completed ¹	Results
Edinburgh Postnatal Depression Scale (EPDS)	4,307	12.9% failed for depression and/or suicidal thoughts
Ages & Stages Questionnaire, 3 rd edition (ASQ-3™)	16,430	15.4% failed in one or more domain
Modified Checklist for Autism in Toddlers (M-CHAT™)	9,212	10.4% failed on the initial screening; electronic M-CHAT Follow-Up Interviews™ were filed by providers in 47% of the failed cases
Pediatric Symptom Checklist (PSC-17)	287	15.3% failed in one or more domain
Patient Health Questionnaire (PHQ-9) Modified for Teens	175	10.9% showed borderline symptoms of depression and 5.1% failed for depression or suicide risk

¹Numbers include universal screening of all eligible children regardless of insurance type from July 2011-July 2013.

Sustainability of Electronic Screening

- Billing and reimbursement
 - Developmental screening reimbursement, especially at sites with a mix of insurance types, has exceeded the cost of the electronic system so far
 - Still need a billing mechanism for postpartum depression screening at pediatric visits, especially since providers are very supportive of continuing to use this tool
- Staff are needed to manage occasional IT troubleshooting and on-site issues, but the buy-in of office managers and providers is strong
- Partnering community agencies like the smoother electronic referral processes
- There are linkages with meaningful use requirements around patient portal usage and electronic exchange of referral information

Next Steps

- The national evaluator is beginning to link screening results with referral/service enrollment data to examine the effectiveness of e-screening for early identification of developmental and behavioral concerns
- We are working with the other Pennsylvania CHIPRA grantees to share screening lessons learned and ideas for various EHR systems

Questions

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Improving Health Care Quality for Children in Medicaid/CHIP with Serious Behavioral Health Challenges

Using Care Management Entities to Improve Health Care eQuality for Children with Serious Emotional Disturbance

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Agenda

- Welcome and Introductions
- Overview of Maryland, Georgia, and Wyoming's Demonstration Projects
- Overview of Care Management Entity Approach
- State Models, Preliminary Outcomes and Tools
- Lessons Learned
- Resources
- Questions

MD, GA and WY Collaborative CHIPRA Grant Project

- Overall (3-state) collaborative goal:
 - Improve the health and social outcomes for children in Medicaid/CHIP with serious emotional disturbance (SED) by implementing and/or expanding a Care Management Entity (CME) approach to improve the quality and better control the cost of care for children who are enrolled in Medicaid or CHIP
- Through the implementation or expansion of a CME provider model, MD, GA and WY will demonstrate:
 - Improved clinical and functional outcomes
 - Improved access to home- and community-based services
 - Improved cost outcomes per capita
 - Increased resiliency for youth and families

What is a CME?

- A CME is an organizational entity (e.g., nonprofit) that provides enhanced/intensive care coordination and serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems who have historically experienced high-costs and/or poor outcomes
- Core Functions of a CME:
 - Provide intensive care coordination (at low ratios) using the wraparound practice model
 - Facilitate child and family team meetings
 - Manage a plan of care
 - Provide access to home- and community-based services and supports, including:
 - Family and youth peer support
 - Mobile crisis response and stabilization
 - Other professional and natural supports (e.g., intensive in-home services, individual therapy, expressive therapies, mentoring)
- CMEs also provide resource development functions and utilize standardized assessment tools and management information systems

University of Maryland, 2008

Mean Health Expenditures for Children in Medicaid Using Behavioral Health Care,* 2005

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/Disabled**	Top 10% Most Expensive Children Using Behavioral Health Care***
Physical Health Services	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
Behavioral Health Services	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
Total Health Services	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790

S. Pires, K. Grimes, K. Allen, T. Gilmer, R. Mahadevan. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies. Forthcoming, 2013.

* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201

** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)

***Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323

Why Use Wraparound as the Foundation of and Practice Model for CMEs?

- The values and principles of Wraparound are integral for CMEs: potential for cost effectiveness for complex youth is based on its integrated system of care approach and focus on needs across life domains¹
- High-fidelity Wraparound is a research-based intervention for youth with serious emotional disturbances (SED) based on a meta-analysis of published studies ²
- Examples of how Wraparounds lower costs and improve care:
 - The cost of serving youth in CMS's 1915(c) Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Waiver Grant Program was 25% of what it would have cost to serve them in a PRTF. In addition, state Medicaid agencies' annual costs per child were reduced significantly within the first 6 months of the program³
 - The PRTF Demonstration and Substance Abuse and Mental Health Services Administration's Children's Mental Health Initiative programs both had cost savings with improved behavioral health and functional outcomes through the use of intensive care coordination, peer support services, respite services, intensive in-home services, crisis services, and flexible funding⁴

¹ Grimes, Schulz, Cohen, Mullin, Lehar, & Tien, 2011; ² Washington State Institute for Public Policy, 2013;

³ Bruns, Zabel, Pires, & Simons, 2013; ⁴ CMS & SAMHSA, 2013

Why Use Wraparound as the Foundation of and Practice Model for CMEs?

- New Jersey: Estimated to have saved over \$30 million in inpatient costs alone in 3 years¹
- Youth served through Massachusetts Mental Health Services Program for Youth (MHSPY):
 - Used lower intensity services and had substantially lower claims expenses, particularly for inpatient hospitalization and Emergency Room utilization; and
 - Were more likely to remain in a less restrictive setting and more likely to show improved clinical functioning²
- Wraparound Milwaukee:
 - Average daily population in residential treatment centers decreased from 375 to 50
 - Psychiatric inpatient days decreased from 5,000 days/year to less than 200
 - Improvements in school attendance (from 71% to 86% days attended) and reduction in placement disruption rate (from 65% to 30%) for child welfare-involved children
 - 60% reduction in recidivism rates for delinquent youth (from prior to one year post enrollment)
 - Average monthly cost of \$4,200 (compared to \$7,200 for residential treatment center, \$6,000 for juvenile detention, \$18,000 for psychiatric hospitalization)³

¹Pires, Anderson, Dowd, Harburger, McCrary & Simons, 2012; ²Grimes, Schulz, Cohen, Mullin, Lehar, & Tien, 2011; ³ Milwaukee County Bureau of Children's Behavioral Health, 2010

State Approach: Maryland

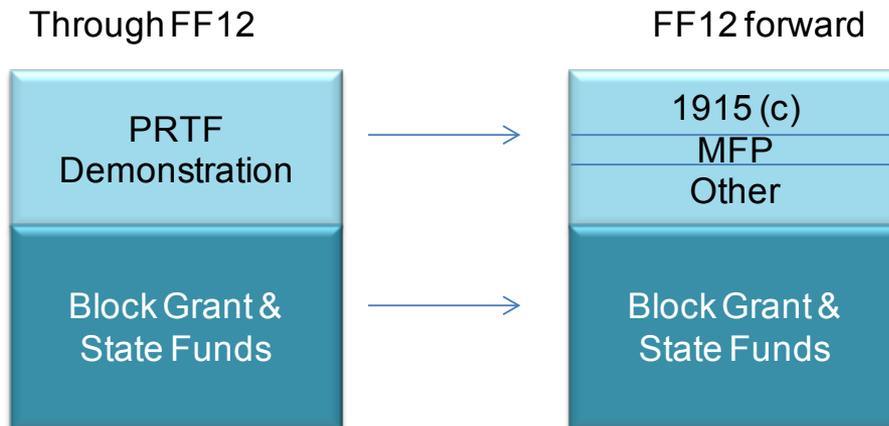
- Current Model: One statewide CME (peer support is provided through a contract with the Maryland Coalition for Children and Families, the statewide family network)
- Youth Currently Served: Capacity for 450
- Current Target Population(s): Psychiatric Residential Treatment Facilities (PRTF) Demonstration Waiver, juvenile services detention diversion, child welfare group home diversion, System of Care grants, Children's Cabinet's Stability Initiative
- Unique element(s) of the Maryland approach:
 - Blended funding from various sources using Children's Cabinet Interagency Fund, SAMHSA grants, and PRTF Waiver
 - Development of the Wraparound Team Monitoring System (Wrap-TMS) software platform to support CME and Wraparound practice model in partnership with the National Wraparound Initiative
 - Strong technical assistance to support, train, coach and enhance high fidelity Wraparound practice model through the Wraparound Practitioners' Certificate Program at the University of Maryland

State Approach: Maryland (continued)

- Future Model: Adding a new Medicaid financed tiered care coordination approach using existing Targeted Case Management providers within the public mental health system as network
- Medicaid Financing Strategy for Sustainability: 1915(i) State Plan Amendment with existing state plan services (potential use of 1915(c) authority if statutory changes are made based on PRTF Demonstration findings)
- Outcomes: Cost of serving PRTF Waiver youth in the CME is 35% of the cost of serving youth in PRTFs, and include either maintained or improved functional outcomes in juvenile justice, school functioning, substance abuse, and child protective services involvement domains

State Approach: Georgia

- Current Georgia CME model:
 - Two CMEs that provide statewide coverage
 - Peer support provided under contract with local family run organizations
- Youth served: ~1,272 (State FY12)
 - 41% waiver covered youth (who meet PRTF level of care)
 - 59% non-waiver youth (Child and Adolescent Functional Assessment Scale level 110-130)
- Medicaid financing strategy for sustainability:



State Approach: Georgia (continued)

- Unique Factors:

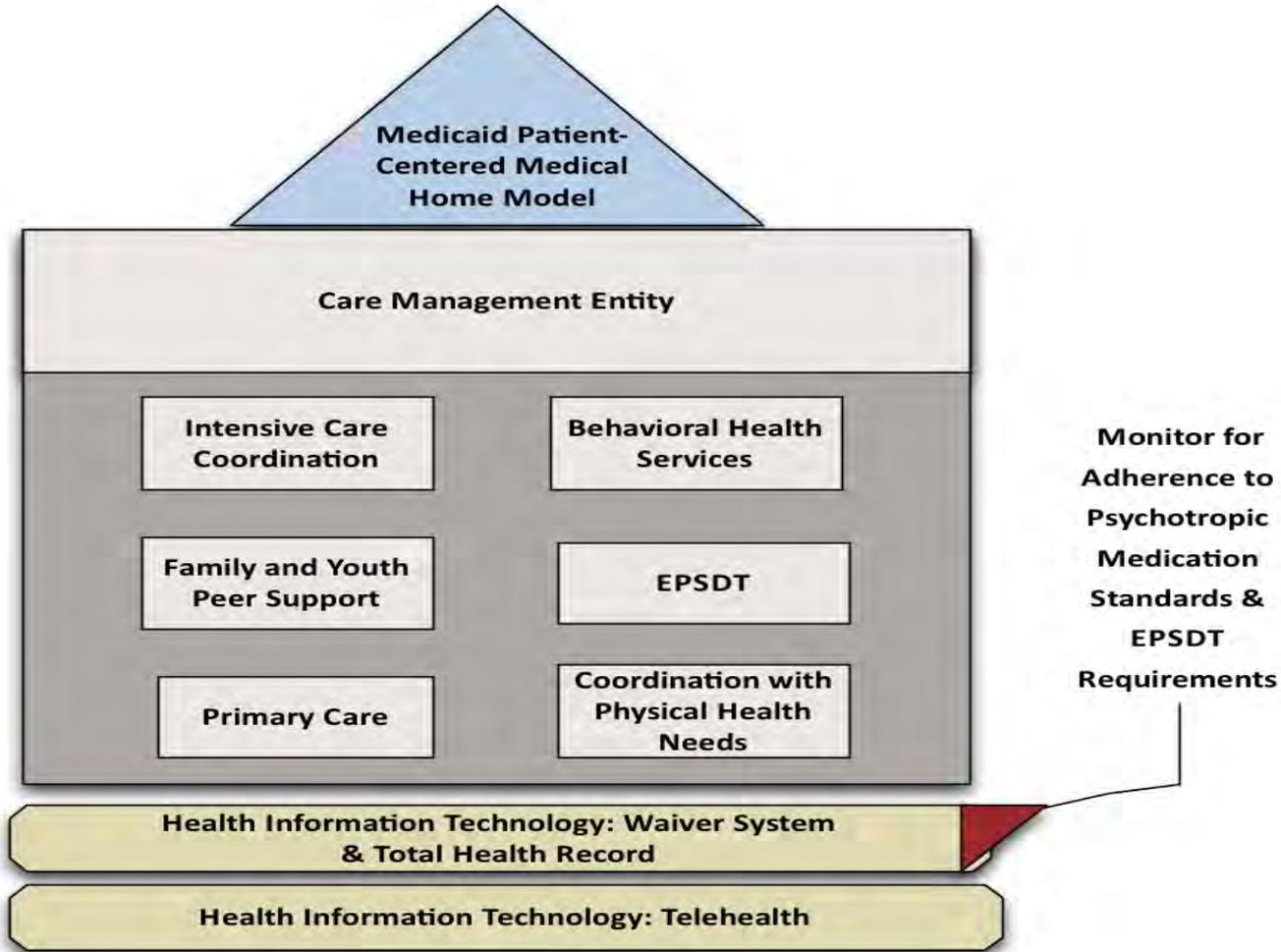
- GA is a leader in lived experience workforce for Adult Certified Peer Support Specialists (family peer support partners/specialists) and is working to expand to include CME “Family/Youth Peer Support Partners” with a full certification and approval for Medicaid billing by the end of the CHIPRA grant

- Outcomes:

- Medicaid annual average cost for a PRTF waiver CME youth is \$44,008 less than average annual cost for PRTF (CME = \$34,398, PRTF = \$78,406)
- Comparing youth out-of-home placements in the 6 months pre-CME engagement to the 3-8 months post-CME engagement and services showed decrease in:

Inpatient hospitalization for PRTF waiver youth	86%
Inpatient hospitalization for non-waiver youth	89%
PRTF stays for demonstration waiver youth	73%
PRTF stays for non-waiver youth	62%

State Approach: Wyoming



Tools Used by MD, GA, and WY

- **Assessment:**
 - Child Adolescent Needs and Strengths (CANS)
 - Child and Adolescent Service Intensity Instrument (CASII)
- **Outcomes:**
 - **Clinical/Functional:**
 - Child Adolescent Needs and Strengths (CANS)
 - Child and Adolescent Functional Assessment Scale (CAFAS)
 - **Resiliency:**
 - Family Empowerment Scale (FES)
 - California Healthy Kids Survey (CHKS) Resilience and Youth Development Module

Collaborative Lessons Learned and Shared: MD, GA, and WY

- Remain cognizant of the complexity and interwoven nature of the child- and family-service delivery system
- Develop standard requirements for services being incorporated into the Medicaid State Plan that reflect the Wraparound and Systems of Care values base
- Devote the necessary time and resources to pulling and analyzing data in order to facilitate contracting, rate-setting, and implementation processes
- Conduct continuous assessment and re-assessment of the potential for CMEs to serve as health homes, the relationship between CMEs and Accountable Care Act health homes, and the interface of the CME with primary care

Resources

CHIPRA CME Collaborative

- http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1250388

CHIPRA Quality Demonstration Webinars

- http://www.chcs.org/info-url3966/info-url_list.htm?cat_id=2335

Care Management Entities: A Primer, March 2011

- http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261240

Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs, May 2012

- http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261373

Customizing Health Homes for Children with Serious Behavioral Health Challenges, Sheila Pires, Human Service Collaborative, March 2013

- http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261488

Joint CMCS and SAMHSA Informational Bulletin (issued May 7, 2013) on Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions:

- <http://www.medicaid.gov> click on *Federal Policy Guidance*

Resources

Child Adolescent Needs and Strengths Assessment (CANS)

- <http://www.praedfoundation.org/About%20the%20CANS.html>

Child and Adolescent Service Intensity Instrument (CASII)

- http://www.aacap.org/AACAP/Member_Resources/Practice_Information/CASII.aspx

Child and Adolescent Functional Assessment Scale (CAFAS):

- <http://www2.fasoutcomes.com/Content.aspx?ContentID=12>

Family Empowerment Scale (FES):

- www.pathwaysrtc.pdx.edu/pdf/FES.pdf

California Healthy Kids Survey (CHKS) Resilience and Youth Development Module:

- <http://chks.wested.org/about>

Questions

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