Pediatric Integrated Care
Welcome, Introductions, Overview
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Care Integration in Primary Care: Expert Convening Consensus Framework

Sheila A. Pires
Human Service Collaborative/National TA Network for Children’s Behavioral Health
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.”¹

• 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.²

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

11% 36%

... 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

$2,492 $10,259
Children using only physical health services Children using both physical and behavioral health services

Children covered by foster care and SSI/disability account for...

28% 49% 8%

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

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:

- 3-12 yrs. old: 52%
- 0-5 yrs. old: 19%
- 6-12 yrs. old: 8%
- 13-18 yrs. old: 11%

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.

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.

OPPORTUNITIES 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.

Center for Health Care Strategies, Inc.
www.chcs.org

#LEADINGCHANGE
Children Using Behavioral 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 behavioral health, not physical health care

Co-Morbid Physical Health Conditions Among Children in Medicaid Using Behavioral Health Care


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- 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

Distribution of Psychiatric Diagnoses among Children in Medicaid Using Behavioral Health Services

- ADHD: 36.4%
- Conduct Disorder: 32.5%
- Mood Disorder: 31.9%
- Anxiety: 21.4%
- SUD: 6.1%
- PTSD: 5.9%
- DD: 5.3%
- Psychosis: 2.7%

Children and Youth with Serious Behavioral 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 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 – implies lower care coordination ratios and higher rates.

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

American Academy of Pediatrics (Brown, N. et. al. 2013)
Unmet Need for Children with Significant Behavioral 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 behavioral 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

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
Integrated Care Framework
SAMHSA-HRSA Center for Integration Health Solutions

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
Social Determinants of Health

- Neighborhood and Built Environment
- Economic Stability
- Health and Health Care
- Education
- Social and Community Context

HealthyPeople.gov
National Snapshots
Role of Primary Care

75% of children with diagnosed mental health disorders are seen in the primary care setting.

- Racially/ethnically diverse families, especially, feel less stigma in pediatric settings than with specialty behavioral health providers.

- Pediatricians play a key role in early detection for children enrolled in Medicaid through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive screening and health care services for children under age 21.

- The persistent shortage of behavioral health specialty providers further contributes to the increased role of primary care.

Yet, numerous studies have found that primary care practices often struggle with managing child behavioral health conditions and access to a medical home is uneven.

- 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.”

- 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. There have been similar findings with respect to Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth.

Pires, S., Fields, S, et al., 2018 (in process) 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
One Size Does Not Fit All: Designing a Care Integration Continuum

- Much of the literature examining integrated care approaches has been devoted to adults with SMI or co-morbid conditions with less known about which methods or models yield optimal clinical and functional outcomes for children, youth, and young adults.
  - Collaborative Care Management model has shown promise with adolescents with depression receiving treatment in office-based settings
  - Intensive care coordination using fidelity Wraparound has proven effective for children and youth with serious behavioral health challenges who often have multi-system involvement.

- Knowledge is still needed to understand which children could benefit from which integrative approach, including those with brief, moderate, and intensive treatment needs, those with mild, moderate and/or complex behavioral health conditions, very young children to transition-age youth, children and youth involved with multiple child-serving systems such as child welfare, and diverse racial and ethnic groups.

Pires, S., Fields, S, et.al., 2018 (in process) 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
INTEGRATION CONTINUUM (nested within common value/principles)

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

All children: Pediatric primary care services, including promotion of social-emotional development, developmental and behavioral health screening, and family psychosocial screening with a broader focus on social determinants of health.

Could occur in primary care, behavioral health, school-based or other community setting

Children with Identified Need

Child Behavioral Health Consultation Programs, which include behavioral health consultation to primary care practitioners and coordination by behavioral health.

Could occur in primary care, behavioral health, school-based or other community setting

Low/Moderate Need

Team-based care with appropriate infrastructure.

Could occur in primary care, behavioral health, school-based or other community setting

Significant Need/High Risk

Intensive Care Coordination using High Fidelity Wraparound.

Could occur in primary care, behavioral health, school-based or other community setting

Pires, S., Fields, S, et.al., 2018 (in process) 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 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 (in process) 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 behavioral 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 (in process) 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

- Tier 4
  - 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

- Tier 3
  - 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

- Tier 2
  - Training, Support Groups
  - Information & referral, intake
  - Data Collection & Evaluation
  - Policy-making & Advocacy

- Tier 1
  - Education, information & referral
  - Policy-making & Advocacy
  - Data Collection & Evaluation
Massachusetts Child Psychiatry Access Program (MCPAP)

- Regional children's BH consultation teams support integration of BH and PH
  - help 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 behavioral 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: access to BH treatment
  - making child psychiatry services available to PCPs across the Commonwealth.

http://www.mcpap.com
Behavioral 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

www.montefiore.org/bhip
## HEALTH HOME CORE SERVICES

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State of Oklahoma (2016)