Children's Team
MRT Behavioral Health Reform Workgroup

Gail Nayowith, Chair
July 28, 2011

OASAS Staff – Steve Hanson
OMH Staff – Kristin Riley

Agenda

- Welcome and Introductions
- Charge, Deliverables and Timeframes
- Background Materials and Data
- Vision and Values Statements

The Children's Team Charge:

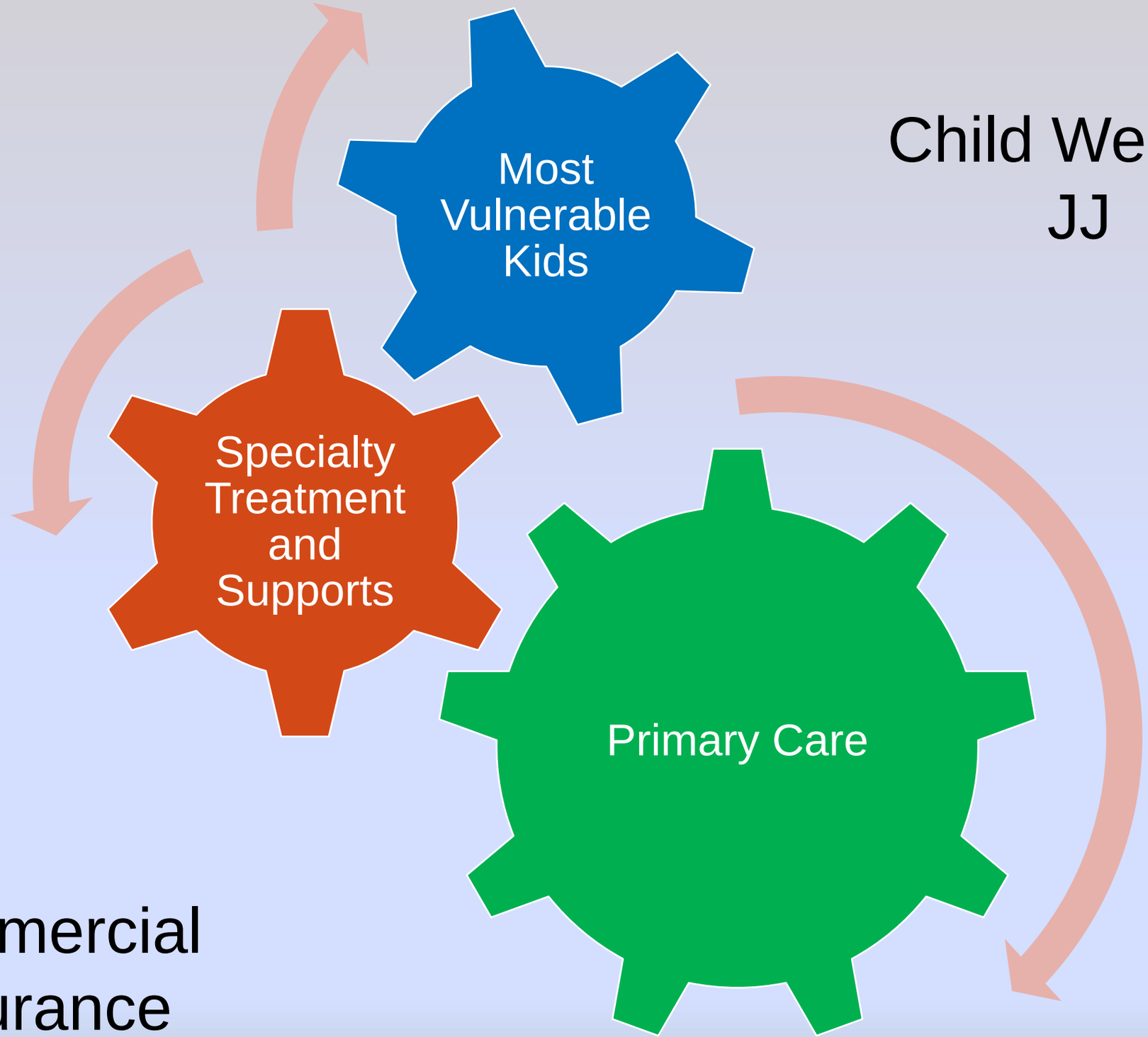
- Involve experts, families and youth with knowledge and experience specific to children with serious emotional disturbances and substance use disorders in the specification of a children's chapter within the Behavioral Health Reform Workgroup report.

Defining the Scope of Our Task

- Think systems level
- Collective responsibility – integration
- Recommendations for Medicaid population while not forgetting the 40% of kids who are not Medicaid but rely on public mental health
  - Managed Care: Mainstream and BHO
  - “Deemed” Populations: Those eligible based upon meeting standards for program admission and being deemed family of one for income

Medicaid

Child Welfare
JJ



SCHIP

Commercial
Insurance

Uninsured

Deliverables and Timelines:

1) Communicate a vision for advancing children's behavioral health through Medicaid Managed Care, BHO and SED children's Health Home/TCM/Waivers. This vision will include how child welfare, education, juvenile justice and courts will interface with Medicaid behavioral health services. DUE: August 10th

2) Identify specific recommendations that are achievable in the current environment for strengthening children's behavioral health in Mainstream Medicaid Managed Care. DUE: September 1st

Deliverables and Timelines

3) Recommendations on BHO Phase II Design.
DUE: September 15th

4) Flowing from the vision and emerging BHO design, identify specific recommendations that are achievable in the current environment for care coordination for children with serious emotional disturbance or substance use disorders. The design and applicability of tools such as Health Homes, TCM and Waiver should be addressed. DUE: late Fall 2011

"Children with serious emotional disturbance are among the most fragile members of our society. ... Prompt coordinated services that support a child's continuation in the home can allow even the most disabled child a reasonable chance at a happy, fulfilling life. Without such services, a child may face a stunted existence, eked out in the shadows and devoid of almost everything that gives meaning to life." U.S. District Court Judge Michael A. Ponsor, *Rosie D. 2006*

A Public Health Paradox

"What are conventionally viewed
as Public Health *problems are often*
personal solutions to long-concealed
adverse childhood experiences."

Its hard to give up something that almost works.

-V. Felitti MD

Vision and Values

The Children's Plan	**Child and Adolescent Service System Program Core Principles**	**Substance Abuse Recovery Principles** from 12 Guiding Principles of Recovery Oriented Systems of Care (CSAT)
Social and emotional development is a foundation for life	Child-Centered	Recovery is Self Directed and Empowering
Every action support families in raising their child	Family-Focused	Recovery involves a process of healing and self-redefinition
Right service, right time, right amount	Community-Based	Recovery is Holistic
Strengths-Based	Multi-System	Recovery exists on a Continuum of improved Health and Wellness
Collective response – one family one plan	Culturally Competent	There are many path ways to Recovery
Resiliency	Least Restrictive/Least Intrusive	Recovery involves a personal recognition of the need for change and transformation
Family and youth peer support		Recovery is supported by peers and allies
Workforce development and excellence		Recovery emerges from hope and gratitude
		Recovery is a reality
		Recovery has cultural dimensions
		Recovery involves (re)joining and (re)building a life in the community
		Recovery involves addressing discrimination and transcending shame and stigma

Children with Serious Emotional Disturbance

- The Need is Substantial, The Complexities Great
  - 1 out of 10 children have a serious emotional disturbance (SED) ***more children suffer from psychiatric illness than from cancer, blindness, autism, mental retardation, and AIDS combined***.
- Only 20%+ of children with SED receive specialty mental health treatment. *Mental health visits are the largest category of pediatric visits but most pediatric care for SED is inadequate*

- Outcomes of poor care are costly:
  - A majority of children & youth in juvenile justice settings and many in foster care have SED.
  - Suicide is the third leading cause of death for 15 to 24-year olds.
  - Emotional disturbance is associated with school failure: Only 30% of children with identified ED graduate.
  - ACE study…a strong, dose-response ($P < .001$) relationship between the number of adverse childhood exposures and each of the 10 risk factors for the leading causes of adult chronic illness death

The Need for Systematic Behavioral Screening

- About half of the youth in the juvenile justice system have substance use problems
- the juvenile justice systems is the leading source of referral among adolescents entering treatment for substance use problems
- Recent studies have generally suggested that 67-70% of the youth in juvenile justice settings have one or more substance or mental disorders (79% with 2 or more, 61% 3 or more)
- This has led to multiple calls for systematic screening of youth in the justice system for substance use and other psychiatric disorders

Adolescent Substance Use Disorders

“America’ #1 Public Health Problem”

- OASAS estimates that 130,000 adolescents (13- 17) in NYS have a Substance Use Disorder, of that 50,000 will seek treatment
- In calendar year 2009, 12,080 adolescents were served in the OASAS treatment system, this represents 4.7% of individuals receiving treatment during this time
- 80% of youth receiving treatment were served in outpatient programs
- In the 2010-2011 Planning Supplement 293 programs self-indentified as treating individuals under 18
- OASAS certifies 826 residential beds for adolescents in 2 regulatory categories

Elements of Effectiveness for Treating Adolescents with Substance Use Disorders

- Common Screening and Assessment
- Treatment Matching
- A comprehensive Integrated Approach to treatment
- Family Involvement
- Developmentally appropriate programs
- Qualified Staff
- Gender and Cultural Competence
- Continuing Care

Medicaid 101: Definitions

Current Medicaid Managed Care:

- Who is eligible to be enrolled (mandatory or voluntary) and who is excluded (attached chart)
- Medicaid Managed Care Behavioral Health Benefit: 30 Days inpatient/Unlimited Outpatient
- Current System….. Carve-in or Carve-out

OMH: Services that can be billed directly (FFS) to Medicaid for a Medicaid Managed Care enrollee: Clinic (IF the child is SED and the clinic is a SED Designated Clinic); Day Treatment, Waiver, State Inpatient, RTF, CR/FBT, SCM/ICM/BCM.

OASAS: Services that are billed Directly (FFS) - All Outpatient Services and Outpatient Rehabilitation Programs, Adolescent Residential Rehabilitation Services for Youth (for the period they are in treatment if they enrolled in a Managed Care Plan at the time of Admissions)

M=Mandated to enroll in Managed Care (MC) V=Exempt but can Voluntarily enroll in Managed Care E=Excluded from participating. Must use "fee-for-service"/traditional LDSS=Local county district may have options to enroll in MC	M	V	E	Local DSS Options
Most Medicaid eligible people in "*Mandatory*" Counties Albany, Cayuga, Dutchess, Fulton, Madison, Montgomery, NYC, Nassau, Orange, Otsego, Putnam, Schoharie, Suffolk, Schenectady, Sullivan, Tompkins, Ulster, Wayne, Washington, Westchester	x			
Medicaid eligible people residing in "*Voluntary*" Counties Chemung, Chenango, Clinton, Delaware, Franklin, Jefferson, Lewis, St. Lawrence, Schuyler, Steuben, Tioga, Warren, Wyoming		x		
Foster care children in the placement of a voluntary agency			x	
Foster care children in direct care of LDSS unless LDSS opts to enroll			x	LDSS has option with approval*
Adults with serious and persistent mental illness and children with serious emotional disturbances who do not receive SSI**		x		** (see notes) ***(see notes)those w/SSI
Children in state psychiatric or residential treatment facilities			x	
Children in the care and custody of OCFS			x	
Developmental/Physical disability HCBS Waiver/CAH Waiver		x		
Blind or disabled child living away from parents			x	
language barrier.				
Medicaid Spend-Down/Excessive Income Program			x	
Medicaid/Medicare dually eligible individuals who are not enrolled Homeless individuals living in shelters in NYS			x x	
Homeless person "Mandatory" County			x	May be mandatorily enrolled

Medicaid Redesign Team (MRT)

Relevant MRT Proposals:

- In 3rd year Medicaid Managed Care phase-in Waiver, RTF, State Op Inpatient, Non-institutionalized Foster Care

- Regional BHO – all specialty mental health services. Physical health through Mainstream Plan. First year(s) focus on utilization management of inpatient and emergency services.

- Health Homes

Medicaid 101: Definitions

Primary Care Medicaid Home (PCMH): According to the principles, patient-centered medical homes should have these characteristics: a personal physician; physician-directed medical practice; whole-person orientation; coordinated care; quality and safety; enhanced access; and adequate payment. Usually have a rate or per member-per month payment for care management. Applicable to all types of payers.

Health Home: (MEDICAID) The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. “Eligible individuals with at least 2 chronic conditions” include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. Health home services to be provided by designated health home providers or health teams include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

States with approved plans can receive up to 8 quarters of enhanced Federal participation (90/10). States can not include age as a limiting factor for Health Home design.

Medicaid Waivers

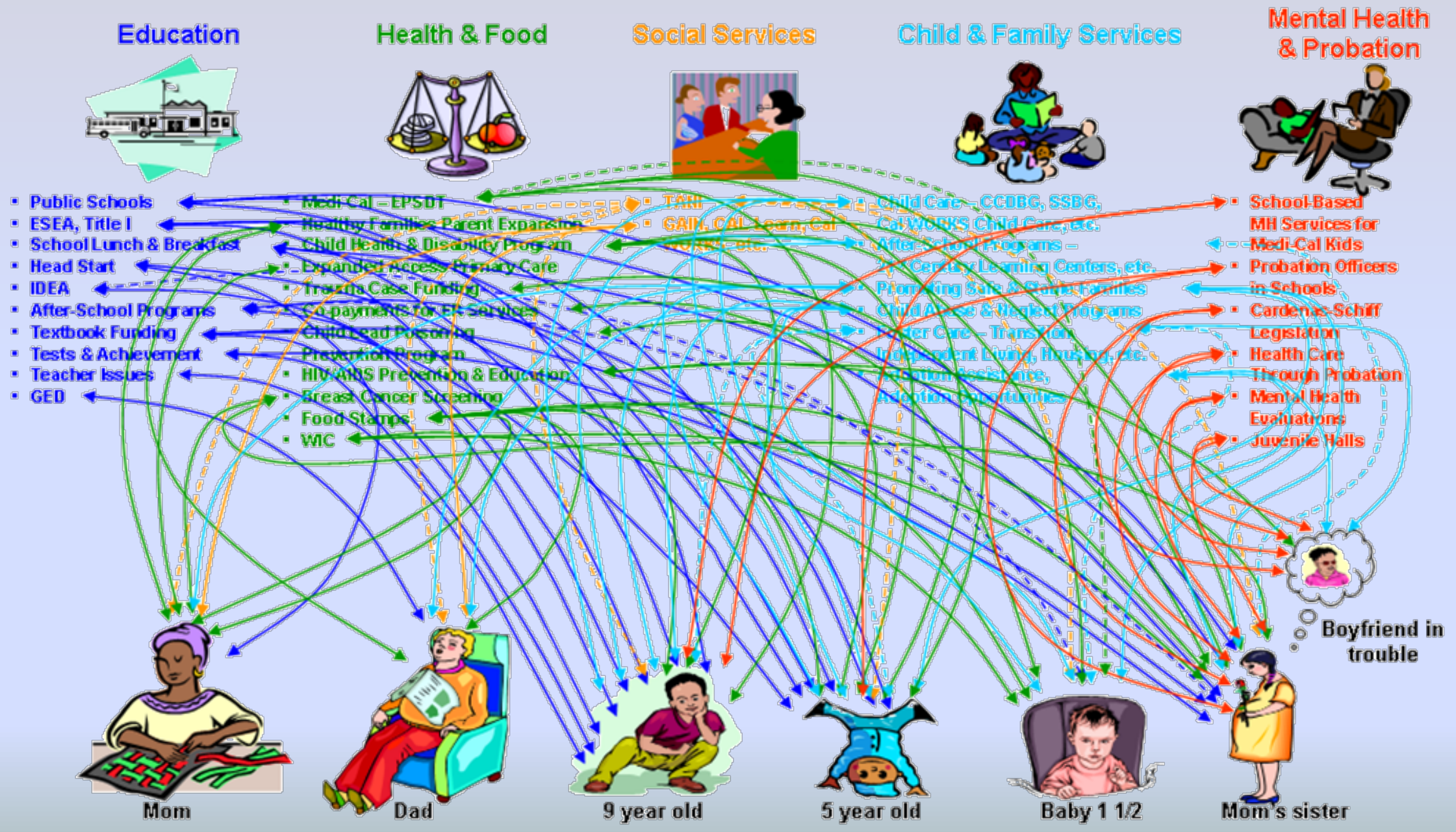
Mental Health…..

- OMH Home and Community Based Waiver
  - 1915c
- OCFS Bridges to Health B2H
  - 1915c

Long Term Care/Medically Fragile…

- OCFS B2H
- OPWDD
- DOH

This is what interdependent looks like NOW… How should it look in the FUTURE?



Eligibility and Access Structures

Office of Mental Health (OMH)

- Pre-Admission Certification Committee: determines clinical and Medicaid eligibility and prioritization for admission to Residential Treatment Facilities (RTFs)
- Children's Single Point of Access: Varies by county. Refers and prioritizes access to RTF, Community Residence, Waiver and Case Management

Office of Alcoholism and Substance Abuse Services (OASAS)

- Admissions Review Team (ART): certifies that those youth who are on Medicaid at the time of admissions to the RRSY programs meet the appropriate admission criteria

OMH
Inpatient Data

Region	Mental Health under 21 years Inpatient					
	# of Persons Admitted	# of Admits	Mean Length of Stay	Length of Stay - Lower Quartile	Median Length of Stay	Length of Stay - Upper Quartile
Western	765	1009	12.3	4	7	13
Central	445	618	7.1	2	5	8
Hudson River	1960	2658	26.2	8	16	30
New York City	2583	3474	21.6	7	14	23
Long Island	954	1314	30.6	9	17	39
Statewide	**6369**	**9074**	**22**	**6**	**13**	**26**

Table 3: Mental Health Inpatient Admissions and Length of Stay to OMH Operated Hospitals for Children by Region and Hospital

REGION	Total Admissions 2009	Total Medicaid Admissions	Length of Stay				Acute Admissions (all payors)	Length of Stay			
			Mean	25 percentile	MEDIAN	75 percentile		Mean	25 percentile	MEDIAN	75 percentile
Western	256	249	92	40	87	129	130	105	65	101	143
Central	965	882	31	15	23	36	128	41	20	30	48
Hudson River	146	107	108	27	49	147	86	119	28	38	167
New York City	265	264	256	132	227	348	200	276	146	249	355
Long Island	244	138	91	15	52	140	214	86	15	42	131
Statewide	**1,876**	1640	**85**	**19**	**35**	**102**	**758**	**136**	**27**	**90**	**189**
HOSPITAL	**Total Admissions 2009**	**Total Medicaid Admissions**	**Length of Stay**				**Acute Admissions (all payors)**	**Length of Stay**			
			Mean	**25 percentile**	**MEDIAN**	**75 percentile**		**Mean**	**25 percentile**	**MEDIAN**	**75 percentile**
Western Region											
Rochester PC	34	33	109	88	104	137	27	109	79	112	137
Elmira PC	106	103	66	28	42	83	24	88	26	75	142
Western NY Children's PC	116	113	112	74	107	145	79	109	72	106	146
Central Region											
Greater Binghamton HC	164	145	29	17	25	35	60	32	19	29	42
St. Lawrence PC	258	235	23	11	18	28	10	33	16	22	46
Hutchings PC	219	195	37	22	34	48	29	33	23	30	39
Mohawk Valley PC	324	307	33	15	22	34	29	69	22	42	73
Hudson River Region											
Rockland Children's PC	146	107	108	27	49	147	86	119	28	38	167
New York City Region											
Queens Children's PC	106	103	278	141	247	390	82	284	144	250	376
Bronx Children's PC	95	98	256	148	252	337	74	275	172	258	343
South Beach PC	27	26	140	71	136	199	14	148	93	141	200
Brooklyn Children's PC	37	37	279	140	230	392	30	313	173	256	411
Long Island Region											
Sagamore Children's PC	244	138	91	15	52	140	214	86	15	42	131

Region	Age Group = Under 21 Years of Age		
	# of Admits	# of readmissions in < =30 days to the same hospital	# of readmissions in <=30 days to ANY hospital
Western	1008	90	128
Central	613	71	106
Hudson River	2664	209	378
New York City	3476	219	536
Long Island	1313	95	191
Statewide	**9074**	**684**	**1339**

Children and Adolescents (Age under 21 as of Jan. 1st, 2009)

Region	Number of Discharges	Having ambulatory follow-up within 7 days after discharge	
		number	Percent
Western Region	894	462	52%
Central Region	551	251	46%
Hudson River Region	2319	941	41%
New York City Region	3002	1080	36%
Long Island Region	911	350	38%
Statewide Total	**7677**	**3084**	**40%**

Calendar Year Medicaid Dollars

OMH Services for Children	
OMH Service Category	**Amount Paid**
Clinic (2009)**	$267,000,000
Day Treatment (2009)	$ 40,000,000
Inpatient – Article 31 (2009)	$ 69,000,000
Inpatient – Article 28 (2009)**	$ 64,000,000
TCM (2010 data ; age 0-20)	$ 21,700,000
RTF (2009)	$ 91,000,000
Waiver (2009)	$ 50,000,000
Children's CR (2009)	$ 28,000,000
Total **Some inpatient and clinic Medicaid paid by Mainstream Managed Care Plan	**$ 386,000,000**

Calendar Year 2009 Medicaid dollars by OASAS Service Category

(Source eMedNY Data Warehouse on July 26, 2011)

Calendar Year 2009 Medicaid Dollars for Individuals with Dates of Birth from 1990 forward By OASAS Service Category	
OASAS Service Category	**Amount Paid**
Inpatient Rehab (Part 818)	$ 990,399
RRSY (Part 817)	$ 16,663,637
CD Outpatient (Part 822)	$ 12,509,541
CD Outpatient Rehab (Part 822)	$ 327,819
OCDY Clinic (Part 823)	$ 726,645
Total	**$ 31,218,041**

How Children's Mental Health Problems Develop *and the Evidence on Intervention*

How Children's Mental Health Problems Develop *and the Evidence on Intervention*

Developmental/Environmental Risks
(Start Early in Childhood)

Risks of Genetically Linked Disorders
(Increase as Children enter teen years)

Maternal Depression: 30-50% of low income moms

Poor parenting

Depresses child's ability to develop relationships and function independently

Child Abuse

Learning Problems

Anxiety, depression

PTSD

ADHD

Depression

Bipolar Disorder

Behavioral/Learning Problems Escalate Including AOD Use

More ER Use for Child Behavior Issues

Neediest kids sent to "residential treatment"; parents give up custody to get care

20% of HS Students Consider Suicide

Conduct Disorder

Many Youth in JJ /CW systems mentally ill

50% of At Risk Students Fail to Graduate

Age

Birth | 3 | 5 | ELEMENTARY SCHOOL | 12 | MIDDLE-HIGH SCHOOL | 18

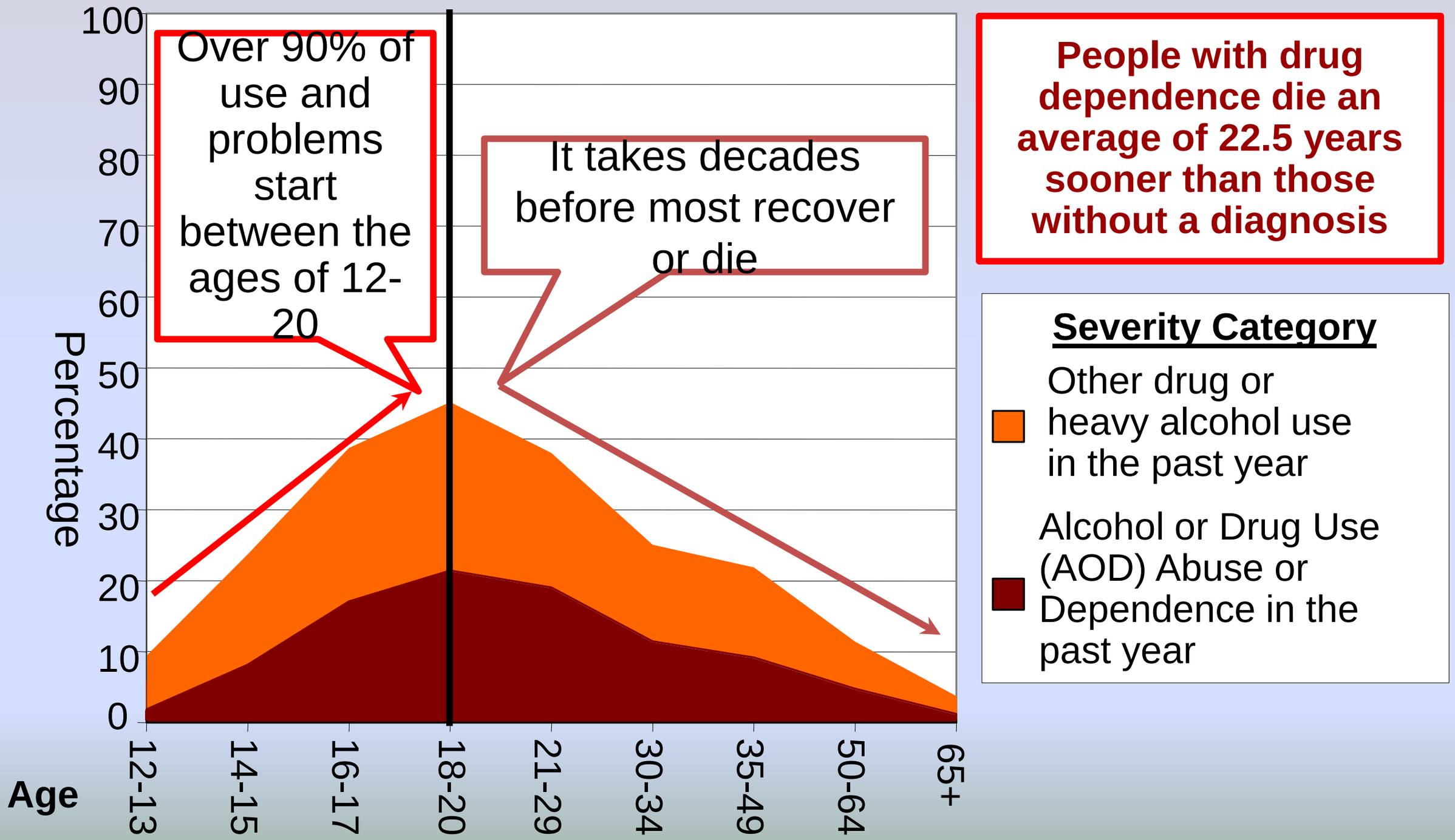
Targeted Prevention e.g.
--Treat Parental Depression
--Intensive Parenting Supports

Targeted Therapies Effective, e.g.:
--Parent/Child Interaction
--Combined Treatment for ADHD, Depression

Team Treatments Effective In Specialty Managed System
--High Fidelity Wraparound
--FFT, MST

How Substance Use Disorders develop in Adolescents and the Evidence on Intervention

Alcohol and Other Drug Abuse, Dependence and Problem Use Peaks at Age 20



Source: 2002 NSDUH and Dennis & Scott, 2007, Neumark et al., 2000

Evidenced Based Treatment (EBT) that Typically do Better than Usual Practice

- Aggression Replacement Training
- Reasoning & Rehabilitation
- Moral Reconation Therapy
- Thinking for a Change
- Interpersonal Social Problem Solving
- **MET/CBT combinations and Other manualized CBT**
- Multisystemic Therapy (MST)
- **Functional Family Therapy (FFT)**
- **Multidimensional Family Therapy (MDFT)**
- **Adolescent Community Reinforcement Approach (ACRA)**
- **Assertive Continuing Care**
- **Seven Challenges**

NOTE: There is generally little or no differences in mean effect size between these brand names

Source: Adapted from Lipsey et al 2001, Waldron et al, 2001, Dennis et al, 2004

Illustrating a Comprehensive Framework for Children's Behavioral Health

Screening Programs

EPSD

Education Funded Student Support Teams and AIS

Prevention/Youth Development Programs

Home Visiting

State Funded Parent Education and Support Programs

Prevent, Screen and Intervene: Maternal Depression; Trauma (ACEs); Chemical Dependency and Social/Emotional Health

Incentivize: Continuity of Primary Care Provider; Prevention; Parent Skill Building and Support; Learning Supports

Mainstream Medicaid Managed Care

CHP, Commercial Insurance

Health Homes

Identification and front-line treatment for behavioral health within primary care or via care coordinated link with specialty treatment system. Access to EBT for ADHD, Depression and Anxiety; behavior specialist and family support

Behavioral Health Organization; State Safety Net

Access to specialty diagnostic, treatment, skill building and support. Wrap-around framework to build natural supports and resilience rather than dependency of formal services. Menu of intensive care coordination; home-based interventions; therapeutic mentoring/behavioral supports, mobile crisis, family support, learning supports, respite.

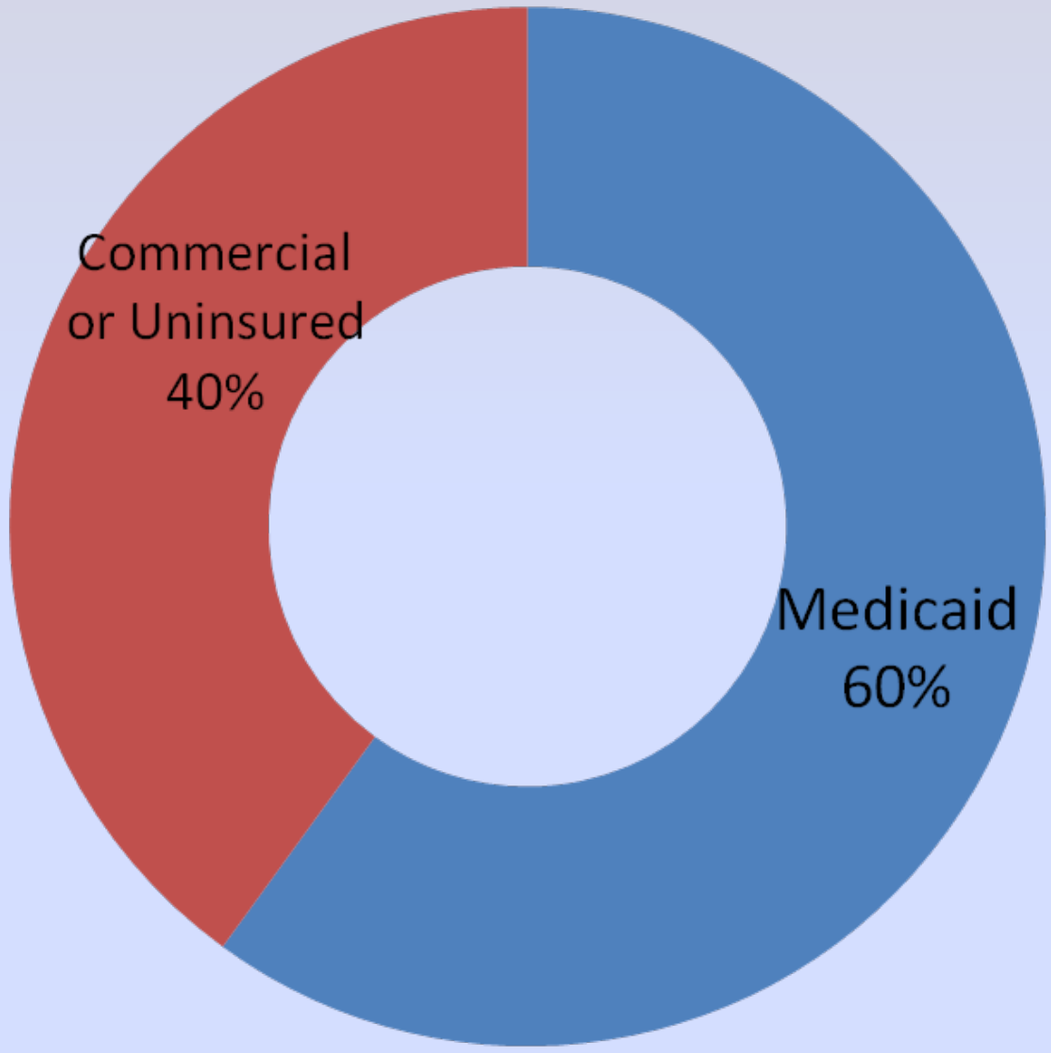
Targeted Prevention
To reduce new cases
(*Incidence*)

Targeted Therapies and Early Care Coordination (*Prevalence*)

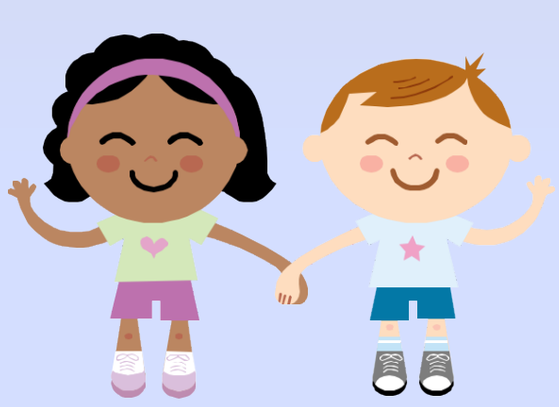
Team Specialty Treatments
To reduce complications
(*Treatment*)

Complexity Considerations…

40% of SED children are not Medicaid eligible *BUT require interventions (e.g. ICM, wraparound) not available outside public system*



Children in Foster Care….Should there be a separate solution or an integrated solution?

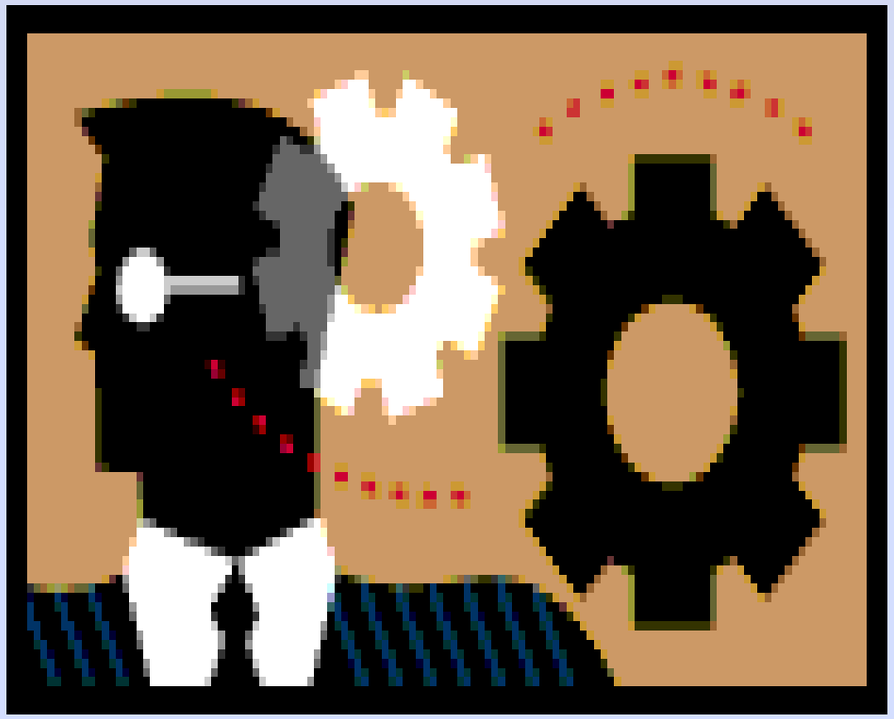


How will the BHO interface with Education, Child Welfare, Juvenile Justice?

We have significant “bricks and mortar”; debt service within current system

Looking at the issue through the lens of…..

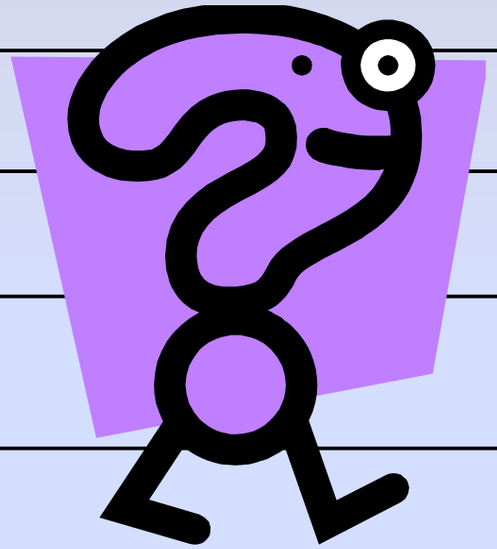
What is best for children and families?



What does this mean for me “WIIFM”

Starting with Values and Vision

The Children's Plan	**Child and Adolescent Service System Program Core Principles**	**Substance Abuse Recovery Principles** from 12 Guiding Principles of Recovery Oriented Systems of Care (CSAT)	**Children's Behavioral Health Principles** BHO Children's Team
Social and emotional development is a foundation for life	Child-Centered	Recovery is Self Directed and Empowering	
Every action support families in raising their child	Family-Focused	Recovery involves a process of healing and self-redefinition	
Right service, right time, right amount	Community-Based	Recovery is Holistic	
Strengths-Based	Multi-System	Recovery exists on a Continuum of improved Health and Wellness	
Collective response – one family one plan	Culturally Competent	There are many path ways to Recovery	
Resiliency	Least Restrictive/Least Intrusive	Recovery involves a personal recognition of the need for change and transformation	
Family and youth peer support		Recovery is supported by peers and allies	
Workforce development and excellence		Recovery emerges from hope and gratitude	
		Recovery is a reality	
		Recovery has cultural dimensions	
		Recovery involves (re)joining and (re)building a life in the community	
		Recovery involves addressing discrimination and transcending shame and stigma	



Vision

- How should we view Medicaid behavioral health for children and their families?
- How to include behavioral health needed by or currently supported through various systems?
- Are there core vision elements that we see that would help to “knit” together a system irrespective of payer?