



To: Madeline Biondolillo,
Department of
Public Health

MD, Associate Commissioner, MA

From: Nancy Allen Scannell, Director of Policy and Planning, MSPCC

Re: Informational Survey – 2014 Health Resource Planning for Behavioral Health Services

Date: February 5, 2014

The Children's Mental Health Campaign (CMHC) is an innovative children's mental health system reform effort led by five partner organizations – Massachusetts Society for the Prevention of Cruelty to Children, Boston Children's Hospital, Parent/Professional Advocacy League, Health Care For All, and Health Law Advocates – and uniting more than 140 organizations in mental health, healthcare law, child welfare, family advocacy, and health policy into a dynamic coalition working together for systemic change. On behalf of the CMHC, I want to thank you for the opportunity to provide input into the 2014 resource planning process for behavioral health.

The CMHC has identified the following four priority areas for children's behavioral health resource planning, which are detailed herein:

- **Children's acute care access issues**, from emergency room "boarding" due to lack of access to inpatient acute beds, to children "stuck" in inpatient beds awaiting availability of community-based placements;
- **Inadequacy of Rates**; reimbursement rates which do not cover the expense of providing care are a barrier to developing and maintaining a robust system of care including training and supporting a skilled workforce
- **Developmental medicine concerns**; specifically, the growing problem of meeting the needs of children conditions such as ADHD and autism; and
- **Insufficient capacity to treat substance abuse in children**, despite the growing prevalence of young substance abusers.

It is our hope that the health resource planning process will address the significant and specific needs of children, adolescents and their families separately from issues posed by the adult population.

Please feel free to contact me at 617-587-1510 or nscannell@mspcc.org if you have questions about our responses or if we can in any other way be helpful to the Health Planning Council in completing this important work.

1. How do you anticipate health resource planning for Behavioral Health to help you in your work? How do you expect to use the information resulting from the effort?

We will use this information to inform our advocacy efforts for public resources and policies to 1) ensure that all children and their families have access to high quality, effective behavioral health services and supports no matter where they live or who their insurance company is; 2) monitor compliance and enforcement of the legal rights of pediatric behavioral health consumers including compliance with State and Federal mental health parity laws; 3) address gaps and problems in the current system of care for treatment of adolescents with substance use disorders (SUDs); and 4) partner with policy makers in the development and implementation of strategies to address long standing, often cyclical, issues with so called “choke points” in the system of care which keep children from gaining access to the appropriate level of care; and, 5) engage with experts in the development and promotion of new and emerging evidence based models of care

2. Are there specific services within Mental Health & Substance Abuse that you would like to see studied, and were not already included in the list of services on page 6? Please describe with as much specificity as possible. Please indicate how they can be addressed through health resource planning.

Children are not simply “little adults.” Children have unique, biological, psychosocial and environmental vulnerabilities which must be taken into account in designing systems to support child wellbeing and treat illnesses. Further, half of all lifetime mental illnesses begin by age 14; three quarters by age 24.

Therefore, any plan to meet the prevention and clinical needs of children and to accurately predict the needs of the adults with behavioral health disorders must be informed by a separate and **specific examination of the pediatric behavioral health system** of care with an explicit analysis of the acute care needs of children and adolescents: those with autism and developmental needs, substance use disorders, and youth transitioning from the child system to the adult system.

Because most individuals’ access to behavioral health care is determined by what type of health insurance the consumer has, and is generally inconsistent, the analysis of the current system of care should **break out access to care by insurance carrier** and include limits on the delivery of medically necessary services based on location (i.e. clinic, home, school or other community site).

In addition, strategies for effective prevention and treatment of **trauma-based** mental health disorders and **biologically-based** disorders have some important distinctions. A clear understanding of the capacity and need for care in both categories of care is vital to planning for meeting children’s needs for behavioral health care.

Also, for children with ADHD, autism and other developmental disorders, there is a growing body of evidence of worrisome mental health co-morbidities: *60% of such patients have an associated learning disorder; 60% have an associated other psychiatric problem; risk of*

suicide is 5 times greater than average by age 21 years. Meeting the complex needs of these children faces extraordinary problems, including significant shortages in developmental medicine MDs (only 500-600 nationally), waits for evaluations ranging from 6-12 months, refusal of insurers to authorize payment for evaluations.

Finally, the following services, which are key components of the children's mental health system of care, to the list of **mental health services** should be studied:

- **Primary Care Pediatrics** to capture screening, behavioral health integration, and the MA Child Psychiatry Access Program (MCPAP) services.
- **Specialized Pediatric Behavioral Health Care** to include developmental specialists, neuropsychological specialists and testing, and behavioral health assessments for serious co-morbid physical health conditions.
- **Specific services for children age birth to five** including:
 - Mental Health Consultations Services through the Department of Early Education and Care;
 - EOHHS/DPH pilots of LAUNCH and MyChild; and
 - Adult Primary Care specifically to capture post-partum depression screening and treatment.

We also recommend inclusion of the following among the **substance abuse services to be studied**:

- Brief Intervention – minutes of substance abuse counseling provided during routine healthcare
- Brief Treatment – short-term counseling for adolescents with less severe disorders.

3. **Given the importance of prevention and also “post-acute” services for mental health & substance abuse, what critical evidence-based services & programs are available, should be expanded, or need to be developed? Are there specific models you suggest we study?**

Preventive Services:

The **Mental Health Consultations in DEEC child care programs** should be restored to pre-2009 service capacity levels and, if possible, expanded to make the services available to all preschool children who need it.

In 2009 the Mental Health Consultations program operated through a two-pronged approach. One prong was an embedded model where mental health clinicians were located on-site at child care programs that had supportive child care contracts with DEEC. These clinicians provided staff support and training and connected families with needed clinical services at the partnering clinic. The second prong was a consultation model where clinicians provided on-site consultation including observation, crisis intervention support, and case management in order to enhance staff competencies to work with behaviorally challenged children, thereby benefitting all children enrolled in the program. The consulting clinicians also focused on strengthening parenting skills and parent involvement and promoting collaboration for better access to services for children and families.

Both the **Children's Hospital Neighborhood Partnerships Program (CHNP)** and **Assabet Valley Collaborative** are successful model programs that provide a comprehensive array of services in schools, including crisis management, individual therapy, small group work focused on social skills and peer relationships, classroom-based interventions, teacher consultation and training, family intervention, advocacy and support. Their work places both programs (and others statewide) at the critical juncture of schools and behavioral health and trauma sensitivity.

We strongly urge continued support for **Safe and Supportive School Pilot Programs**. The FY 2014 budget provided \$200,000 to pilot implementation of the safe and supportive schools framework to: "promote supportive school environments where children with behavioral health needs can form relationships with adults and peers, regulate their emotions and behaviors, and achieve academic and nonacademic school success and reduces truancy and the numbers of children dropping out of school." The first year data from these programs should be analyzed for consideration of funding to expand the program state wide.

Post Acute Services:

Children's Behavioral Health Initiative (CBHI) Services including in-home therapy, in-home behavioral services, intensive care coordination, mobile crisis, family partners and therapeutic mentors should be available to commercially-insured children.

Also, services to support a child returning to school after an absence due to a behavioral health condition should be expanded and made uniformly available state wide.

Promising practices include the **MA Child Psychiatry Access Project (MCPAP) in Schools**. Beginning in July 2007, MCPAP conducted a pilot project offering six (6) public schools in Western Massachusetts the opportunity to become affiliated with the Baystate MCPAP team. The pilot was designed to explore the use of MCPAP to improve access to mental health services for children through collaboration with schools. These six schools had access to the MCPAP hotline, and the MCPAP team provided telephone consultation, care coordination, and face-to-face consultation.

Staff members at participating schools included principals, adjustment counselors, school nurses, and guidance counselors. They were very pleased to be enrolled in the pilot program, and the analysis of encounter data with the pilot suggested that the service was feasible, cost effective, and clinically valuable. Funding to expand the pilot was approved in the FY 2009 budget but were rescinded in the first round of 9c cuts.

Finally, **capacity for telepsychiatry and telemedicine should be expanded.**

Telepsychiatry delivers quality behavioral health services through the use of television/video, telephone and other communication equipment to address workforce shortages, meet cultural and linguistic needs, needs for specialized care or to mitigate transportation issues. Examples of model programs that have successfully used telepsychiatry are: MCPAP and MA General Hospitals' Home Base Program which serves military members and their families.

- 4. Obtaining capacity, workload/volume, and demand data for outpatient & community mental health & substance abuse services is a challenge. Do you have ideas for data sources or suggestions for collecting data now or in the future? Are there specific "data gaps" that you feel are important for future data collection?**

Current Data Collection:

- Understanding capacity in behavioral health care must include understanding current workforce capacity and limitations. While it is four years old the 2009 Blue Cross Blue Shield of MA study *Assessing Children's Mental Health Services in MA- Workforce Capacity Assessment* provides data that is regrettably unlikely to have changed much if at all. More importantly it contains good recommendations for addressing workforce shortages which are key to any resource planning effort.
- When examining inventory of a particular service such as bed availability, it must be clear that the bed inventory is “on-line”; this may be accomplished by conducting several *point in time* surveys of providers in the coming months. Truly understanding inventory requires knowing, for example, how many beds of a certain type are licensed, how many are actually full or available, why an “off-line” bed is not available, and if or when it is expected to come back “on-line”.
- Analysis of the burden of behavioral health/mental health disorders in children and adolescents by diagnosis/health status, insurance type (e.g. MassHealth and commercial) and geography.
 - Total Medical Expenses (TME), risk adjusted, for pediatrics population by payor
 - TME , risk adjusted for peds BH population by payor
 - For the following categories, PMPM (plus pediatric benchmarks), utilization rates (plus pediatric benchmarks):
 - Emergency Department admissions: Diagnosis, disposition, medical diagnosis
 - Inpatient including inpatient psych care, (would like to be able to get at readmissions)
 - 24-hour diversionary services (e.g. ICBAT, CBAT, etc.)
 - Intensive community-based outpatient services
 - Pharmacy
 - Pediatric screenings with results (modifiers)
 - Primary care visits with BH diagnosis
 - Penetration rate of members under 21 in behavioral health services by plan
 - Explain variations
 - Analysis of children receiving MassHealth Secondary and behavioral health services
 - Analysis of why commercial payors are not covering high end BH services
- The problem of seasonal fluctuations in need for children's inpatient services is at a crisis level and has exacerbated over the past 3 years. The period during which unacceptably high numbers of children are boarding in emergency rooms or on medical surgical units for as many as three weeks while waiting for an appropriate placement now extends from September-May. While there must be immediate plans in place to mitigate the issue, a more thoughtful long term solution must be analyzed.
 - We recommend convening a panel of experts to talk through the steps in typical client progression through the system of care, with the goal of mapping the typical flow pattern to identify potential sticking points and to make recommendations about how to address these. The impact of seasonal

fluctuations and staffing of acute care units must be addressed from a facilities and staffing standpoint. In addition we recommend conducting a survey of all inpatient child and adolescent units in the state over a two-week period. Ideally, the survey would produce a “snapshot” of each child in a bed: where did they come from, and where did they go. Survey results should be categorized by (1) insurer, (2) diagnosis, (3) state involvement (DMH, DCF, DYS), and (4) other appropriate open-ended questions.

- Defining the population of children and adolescents needing school-based behavioral health services should include sub-sets of the DCF and DYS populations. Data on school drop-out rates and grade retention rates may also be of value.

Future Data Collection:

- The biggest gap in data collection is in outcome data. The Commonwealth has invested significant resources in the development of pediatric-specific community-based CBHI services. We must collect outcome data to measure the quality of CBHI services.
- It is fair to assume that the children receiving intensive services are likely to be receiving services in other sectors. To best understand the effectiveness of particular services for children with serious emotional needs, we may want to consider the following data collection model:
 - With our state partners, identify a specified number of children and look at four domains of interest: (1) health care, contacts, and utilizations; (2) whether they are going to school and, if so, the kinds of classes they are in and if they have an IEP and other supports; (3) information about the families in terms of what supports they are receiving; and (4) a data point reflecting a dimension within the child, such as the capacity to accomplish tasks or to have a sense of mastery from accomplishing tasks perhaps a component of a standardized test.