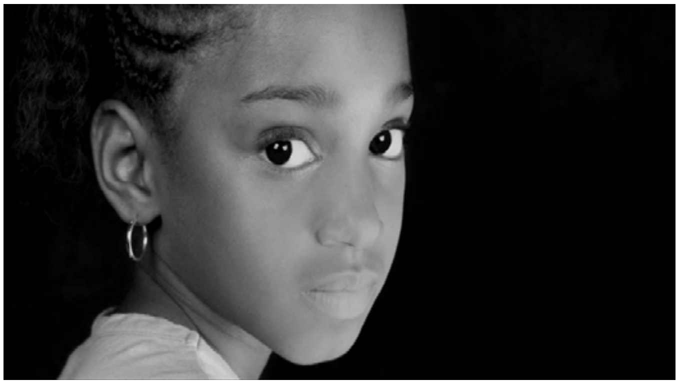
Commonwealth of Massachusetts

Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL



Annual Report

2010

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
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October 1, 2010

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Hon. Gale D. Candaras, Senate Chair, Joint Committee on Children, Families and Persons with Disabilities
Hon. Kay Khan, House Chair, Joint Committee on Children, Families and Persons with Disabilities
Hon. Richard T. Moore, Senate Chair, Joint Committee on Health Care Financing
Hon. Harriett L. Stanley, House Chair, Joint Committee on Health Care Financing
Hon. Steven C. Panagiotakos, Chair, Senate Committee on Ways and Means
Hon. Charles A. Murphy, Chair, House Committee on Ways and Means

I am pleased to transmit the second annual report of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008.

Our initial year (2009) was devoted primarily to developing the organizational framework to create a robust and vibrant Council and reviewing the work of predecessors such as the Children's Behavioral Health Initiative Advisory Group and its sub-committees. During the past twelve months, Council members and the standing committees have immersed themselves in the myriad of complex issues facing children and adolescents with emotional disorders, their families, treatment providers, schools and communities.

Council activities have ranged from viewing initial, (sometimes raw) data on CBHI service utilization and penetration, including In-home Therapy, Intensive Care Coordination and Family Support and Training to a detailed and thorough review of commercial insurance practices; from examining the challenges of workforce development to the research and development of culturally-informed best and promising practices, and the reduction and elimination of racial and ethnic disparities.

Readers of this report should take comfort from the fact that while the challenges facing the child and adolescent behavioral health system are significant and complex, they are exceeded by the energy, dedication and commitment of Council members and many others, who while not members of the Council, have extended their time and expertise to the work of its standing committees. Readers will also gain knowledge and an understanding as to the progress that has been made in the implementation of the remediation plan in the Rosie D. case as well as the breadth and scope of the Council's interests in transforming the children's behavioral health for all children with behavioral health needs.

I hope everyone will take the time to read through the Report and give serious considerations to its recommendations. I urge that you also read the attached reports of the Council's standing committees and work group, as they provide a glimpse of some of the work ahead and to the interests of the Council.

As Commissioner of the Department of Mental Health and *ex-officio* Chair of the Council, I am grateful for the time, energy and commitment Council members have extended. I look forward to the next twelve months as the Council, the Administration, the Legislature and others continue our work to develop a comprehensive, integrated community-based system of care – one that is accessible and responsive. And, one that provides children and adolescents with behavioral, emotional and mental health needs, and their families with the services and supports to succeed at home, at school and in the community.

Sincerely,

Barbara A. Leadholm, M.S., M.B.A.
Chair, Children's Behavioral Health Advisory Council

PART I: EXECUTIVE SUMMARY

Section 1 of Chapter 321 of the Acts of 2008 amended Chapter 6A of the Massachusetts General Laws, by inserting Section 16Q and established the Children's Behavioral Health Advisory Council (Council) and placed the Council, "within but not subject to control of, the executive office of health and human services." Additionally, the language of section 16Q (a) states the Council is to, "advise the governor, the general court and the secretary of health and human services." The broad range of subject areas in which the enabling legislation authorizes the Council to make recommendations provides a clear indication of the breadth of the Council's advisory role and its subject jurisdiction.

The Report provides an overview of the *Rosie D v. Patrick* (f/k/a Rosie D. v. Romney) case and the progress the Commonwealth has made in implementing the remediation plan.

With respect to *Rosie D.* the Council believes:

- Significant and positive work has been done. Clinicians have been trained in the use of a uniform assessment instrument, children and adolescents are being assessed, Children's Behavioral Health Initiative (CBHI) services have been rolled out on time, and there is increasing utilization of these services.

- All who have been involved at any level of the transformation that is occurring should feel very good about and should be congratulated for what has been accomplished to date in an economic environment that would have produced failure but for their efforts.

The Council's purview, however, is much broader than the *Rosie D.* case, and the Report sets forth policy and legislative recommendations in the areas of insurance reform, data collection, workforce development, systems integration, and racial and ethnic disparity reduction and elimination, which the Council believes are responsive to its charge and are targeted towards improving behavioral health care for ***all*** children and adolescents with behavioral health needs and their families.

PART II: LEGISLATIVE AND POLICY RECOMMENDATIONS OF THE COUNCIL

A. Recommendations relative to Insurance

Attached to the Report as part of Appendix B is the complete report of the Council's Insurance Committee, which was accepted by the Council at its August 2, 2010 meeting.
The following recommendations were not endorsed by all members of the Insurance Committee, but were accepted by the Council.

In summary, the Insurance Committee assessed coverage by insurers in five key areas. Interviews were conducted with senior management personnel of eight (8) public and private insurance or third party payers in the five areas the Committee believed the most critical to helping children and families have the most successful outcomes of their treatment. **The five**

areas and the principal findings of the Committee, including the recommendations advanced by the Committee and approved by the Council were:

Case Management

- Case management services are designed to help children and families coordinate services and identify resources to optimize health outcomes. Case management is defined in the Massachusetts Managed Care Regulations: 211 CMR 52.03 as a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- Public payers, in general, pro-actively provide case management services and inform their members of case management services that are available to them.
- For private payers, however, case management programs include those that focus only on transition from inpatient stays or more restrictive levels to other programs that are primarily triggered by certain diagnostic categories or admissions to Emergency Departments (EDs) and inpatient units.
- The private payer case management services, while sometimes available, are not well publicized or easily accessed by plan members and are designed more to assist providers than subscribers.

Recommendation: The Division of Insurance and the Department of Mental Health shall jointly issue a bulletin clarifying the existing regulation that pursuant to 211 CMR 52.13 (3) (a) insurers must include a clear, concise and complete statement of case management services in the evidence of coverage as case management constitutes “any other benefit to which the insured is entitled on a non-discriminatory basis” (211 CMR 52.13 (3)(a). The statement should include both a definition of case management services and a description of how the benefit is accessed by members and publicized by the plan.

Care Coordination

- For children’s behavioral health, care coordination includes the necessary communication between children, families, health care providers and specialists in different settings and schools and the community, state agencies, etc.
- Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing hospital admissions, emergency room utilization, health care costs and improving family satisfaction.
- Strong scientific evidence shows that poor communication, and lack of care coordination, *reduces patient safety and quality of care*.
- The Committee survey of insurers found care coordination to be provided and reimbursed by *all* the public payers. With the exception of Neighborhood Health Plan, none of the private payers, reimburse for care coordination.

Recommendation: Passage of the Coordination of Care legislation. The bill would require all payers to reimburse mental health professionals for the coordination of care or collateral services**.**

Mobile Crisis

- Mobile crisis services are community-based interventions for children and families during a mental health crisis. These services are designed to optimally assist children and families through a crisis situation without a visit to the Emergency Department (ED) or hospitalization, unless necessary.
- A brief review of recent medical literature points to the effectiveness of mobile crisis services in reducing inpatient hospitalization; reducing re-admittance to the hospital; reducing the cost of emergency psychiatric services and favorable perception by consumers.
- Public payers are required by the *Rosie D* remedy to increasingly invest in mobile crisis intervention services and diversion strategies to keep children and youth out of the ED whenever possible. The Committee survey found that the public payers are providing mobile crisis services.
- Private payers primarily rely on EDs for children in crisis. Harvard Pilgrim Health Care/ United Behavioral Health contract with Emergency Service Providers, however, their utilization is noted to be "very low".

Recommendation: The Commissioner of Mental Health shall convene appropriate stakeholders to discuss and determine the best policy to serve children and families experiencing a mental health crisis in their own communities regardless of insurance status.

Continuity of Care

- Regarding compliance with law, the Committee concluded that all payers have policies in place to provide continuity of care for children currently in treatment when there is a change in insurance.
- There continue to be areas of concern regarding continuity of care for children with mental health disorders ranging from availability of child psychiatrists to adequacy of reimbursement.

Recommendation: No recommendation at this time.

Mental Health Parity

- Recent revisions to the state parity law (Chapter 256 of the Acts of 2008) expanded the number of biologically-based categories that require coverage for diagnosis and treatment to include the following: PTSD, eating disorders, substance abuse and autism.
- The law does not apply to Medicaid or self insurer (ERISA) plans
- All of the private payers in our survey indicated that they have expanded coverage for these diagnostic categories.
- We believe the principal purpose and intent of the Mental Health Parity law was to require insurers to elevate mental health disorders to the same level as physical health disorders. That means diagnosis and treatment are covered the same as other medical problems (diseases, chronic conditions, etc.), and based on the course of treatment

recommended by their health care provider. To clarify this, the Division of Insurance and the Department of Mental Health issued a bulletin (2009-04), March 4, 2009, on the *Changes to State and Federal Mental Health Parity* laws, released Marcy 4, 2009 which states: "Nondiscriminatory basis" means that co-payments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums *are not greater for mental disorders than those required for physical conditions,* and office visit co-payments are not greater than those required for primary care visits.

Recommendations: 1. Require the Division of Insurance to issue an annual report to the public on behavioral health data as it applies to children and adolescents, based upon information that is submitted by commercial insurers on an annual basis.

2. Require the Department of Public Health and the Office of Patient Protection to study and to report to the Council the number and frequency of denials/successful appeals of denials for behavioral health services for children as compared to medical services.

B. Recommendation relative to Data Collection and Information Technology

Legislators should be aware that there is a critical need for the Commonwealth and in particular, the Executive Office of Health and Human Services to build a suitable information technology infrastructure for the accumulation and sharing of data between and among the Executive Office of Health and Human Services (EOHHS) child serving agencies. We will never know how the children of the Commonwealth with behavioral health needs are doing until we can see accurate and unduplicated data. We will not be able to adequately identify racial or ethnic disparities without data. ***Two of the Council's Committees (Data, Trends and Outcomes; and the Racial and Ethnic Disparities Reduction and Elimination Committee) have cited the need for better data collection and analysis***.

We note EOHHS and its child serving agencies share this priority and collective efforts have been made and are underway to identify resources, barriers and strategies to create the system we need. To be sure, it is more than the purchase of equipment and information technology. There are laws relative to confidentiality and other matters that need to be examined, perhaps modernized, amended or, frankly repealed. We know from experience and our own common sense that children and adolescents with behavioral health needs often present to multiple state agencies, including the juvenile justice system, schools, health clinics, shelters and the streets. We need a system to help the Commonwealth provide services that are needed and wanted, to measure the effectiveness of those services, and in a manner that protects legitimate privacy considerations.

Unfortunately, subjects as unglamorous as information technology, data collection, indicators and outcome measurements often take a back seat to programs specifically addressing human conditions. This is particularly true during difficult economic times. Yet, if we do not pay attention to data collection issues and information technology, and make a collaborative commitment to developing the infrastructure and information technology we need, we may never know if the programs addressing those human conditions are working or if we are dong the very best by our children.

Action Plan: The Council will work with the Administration and others in an effort to identify potential resources as well as the policy and statutory changes necessary to improve the Commonwealth's capacity for data collection and analysis.

C. Recommendations relative to Workforce Development

The full report of the Council's Workforce Development Workgroup is attached as part of Appendix B. The Workgroup's comprehensive report, including attachments sets forth "action steps" for most of its recommendations.

We urge legislators and others interested in workforce development to pay close attention to the report because it provides the beginnings of a blueprint to address one of the most serious issues facing human services, in general, and the children's behavioral health delivery of care system in particular.

The recommendations of the Workgroup were targeted at specific topic areas or goals within workforce development.

Topic area: Expand and diversify the workforce to reflect the populations served and meet the linguistic needs of families on MassHealth and for those interested in community-based, family-centered practice.

Recommendations:

- Remove barriers to field placements at CBHI provider agencies as a way of developing and training a workforce interested in community-based practice.
- Actively promote field placements that can help improve workforce diversity.
- Enhance provider efforts to expand the number and diversity of Family Partners.
- Remove barriers for individuals with relevant personal life and community experience, but without degrees, to serve in "paraprofessional" positions.

Topic area: Nursing

Recommendations:

- Increase the number of advanced practice psychiatric nurses (APRNS/ CNS) with an expertise in the assessment and treatment of child/adolescent mental health
- Increase expertise of school nurses to provide both prevention and treatment-based services, using a public health approach as well as individually-based services

Topic area: Recruit and Retain Outpatient Providers in Private Practice to MassHealth

Recommendations:

- Address perception of MassHealth/MCE panels are closed
- Managed Care Entities (MCEs) should create uniform credentialing procedures
- Reduce post-licensure work experience & volume requirements for empanelment

- Provide trainings about CBHI & wrap-around/home based services
- Develop benefits message

Topic area: Recruit & Retain Independently Licensed Providers to Agencies that provide CBHI services

Recommendations:

- Differential rates for independently licensed practitioners with more years of experience or additional credentials as a mechanism for retaining qualified staff
- Differential rates for independently licensed practitioners with language capacity
- Loan forgiveness programs for human service practitioners working in home-based services
- Identify strategies to promote use of independently licensed in private practitioners to support agencies needing licensed practitioners for supervision
- Expand Internship and training opportunities

Action Plan: Some of the foregoing recommendations require legislation, others would require the work, collaboration and commitment of stakeholder (some with diverse or at least competing interests) to participate in a process designed to review current practices such as credentialing, licensure requirements, and others. We hope this Council and its committees, legislators, state officials and others can become the impetus for such a process.

D. Recommendations relative to the Department of Mental Health (DMH) and Department of Children and Families (DCF) Joint Procurement for Residential Treatment (RTC)

The full report of the Council's Child System Integration Committee is attached as part of Appendix B.

The Committee was asked for recommendations relative to the joint procurement by DMH and DCF for Residential Services (RTC).

Recommendation: The procurement Document should include provisions relative to the following:

- A focus on preserving and encouraging long term relationships among staff, families and youth throughout RTC involvement.
- Ready linkages between RTCs and CBHI services so that movement among programs is seamless and collaboration is fostered
- A primary goal of RTC placement is strengthening families and building parenting competency, including working toward parental mental health and substance abuse recovery.
- Opportunities for RTC staff to continue involvement with youth and families after physical discharge of the youth.
- Each child and family should have one master treatment plan across all settings, which should include attention to issues raised in the CANS assessment.

- RTCs should include attention to the impact of trauma upon children and adolescents in their care.
- Treatment plans should be based on family voice and choice and also include essential DCF safety concerns and DYS legal concerns if those agencies are involved with the family in a mandated fashion.
- Community tenure is a goal to be achieved as frequently as possible
- Transitions should be managed with care and planning.
- Specialty populations such as children with eating disorders and children with autistic spectrum disorders will need specialty programming.
- For some youth the goal of Residential Care may be independent living and there should be opportunity to work toward that goal.
- Involvement of Peer specialists in Residential Treatment Center staffing
- RTC planning will need to be able to meet the needs of DYS involved youth including attention to trauma informed care and the capacity to deal with troubling youth behaviors.
- Measurement of important outcomes including child and family functioning over both short and long term should be included.

E. Recommendations Relative to Racial and Ethnic Disparities Reduction and Elimination

The Full Report of the Racial and Ethnic Disparities Reduction and Elimination Committee is attached as part of Appendix B

The Committee's report clearly notes the need for resources for data collection and analysis. This committee, as well as the Data, Trends and Outcomes Committee will be working with the Administration and others to identify potential resources, statutory and policy changes, and other actions necessary to improve the Commonwealth's capacity for data collection and analysis. Among the report's conclusions and recommendations were:

- Data analysis on access, utilization and outcomes of CBHI services by race, ethnicity and language is essential for monitoring increases or decreases in disparities.

- There are significant barriers to establishing a disparities baseline and then tracking in disparities within CBHI. The Committee identified the following specific barriers to producing data reports to identify health disparities.
    - The need for common race, ethnicity language data elements across EOHHS state agencies and in CANS.
    - The need for additional analytic capacity to merge and analyze available data and produce reports on disparities.
    - The challenges (legal and technical) of integrating data across EOHHS state agencies and with Department of Elementary and Secondary Education to examine disparities.

Recommendations:

- Significant new resources should be identified to provide EOHHS and its agencies the capacity for interagency data analysis to ensure its effectiveness and continuous quality improvement in the overall behavioral health system, and to reduce behavioral health disparities. (See note above)
- Encourage best practices and remove system barriers to serving racially and ethnically diverse families in new CBHI services
- The MassHealth Managed Care Entities (MCEs) should collaborate with the Council/ Committee to hold a "Community Service Agency (CSA) Director Peer Learning Dialogue on Reducing Disparities in Intensive Care Coordination. The Peer Learning Dialogue would take place as part of the regularly scheduled series of Statewide CSA Director meetings convened by the MCEs.
- Improve the CANS instrument and training to encourage the culturally appropriate exploration of the needs and strengths of racially and ethnically diverse populations, informed by research.

Action Plan: The Council will work with the Administration and others in an effort to identify potential resources as well as the policy and statutory changes necessary to improve the Commonwealth's capacity for data collection and analysis.

PART III: THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM, IMPLEMENTATION OF THE REMEDIATION PLAN AND THE ACTIVITIES OF THE COUNCIL

A. Children's Behavioral Health Advisory Council

Section 1 of Chapter 321 of the Acts of 2008 amended Chapter 6A of the Massachusetts General Laws, by inserting Section 16Q and established the Children's Behavioral Health Advisory Council (Council) and placed the Council, "within but not subject to control of, the executive office of health and human services." Additionally, the language of section 16Q (a) states the Council is to, "advise the governor, the general court and the secretary of health and human services."

As was stated in the Council's first annual report, filed October 1, 2009:

" …[W]e think it vital to our mission, and ultimately to the families and children of the Commonwealth, that everyone understand that the Council was established as an independent advisor to both the Executive and Legislative branches. Our credibility as an advisory body depends upon our independence and ongoing commitment to advocate for legislation, policies, practices and procedures that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. Our policy recommendations should not depend upon who is governor, who is the EOHHS Secretary or which political party represents the majority in the Legislature. Our recommendations should be guided by our expertise, experience, and our commitment to the families and children of the Commonwealth. To do anything less would be a disservice to both branches, as well as to those children and families."

A review of the subject areas in which the enabling legislation authorizes the Council to make recommendations provides a clear indication of the breadth of the Council's advisory role and its subject jurisdiction.

Subparagraph (d) of Section 16Q provides, The Council shall make legislative and regulatory recommendations related to:

- (i) best and promising practices for behavioral health care of children and their families, including practices that promote wellness and the prevention of behavioral health problems and that support the development of evidence-based interventions with children and their parents;
- (ii) implementation of interagency children's behavioral health initiatives with the goal of promoting a comprehensive, coordinated , high-quality, safe, effective, timely, efficient, equitable, family-centered, culturally-competent and a linguistically and clinically appropriate continuum of behavioral health services for children;
- (iii) the extent to which children with behavioral health needs are involved with the juvenile justice and child welfare systems;
- (iv) licensing standards relevant to the provision of behavioral health services for programs serving children, including those licensed by entities outside of the executive office of health and human services;
- (v) continuity of care for children and families across payers, including private insurance; and
- (vi) racial and ethnic disparities in the provision of behavioral health care to children.

Readers will note this report devotes considerable space to a review of the progress that has been made in the implementation of the remediation plan in the *Rosie D* case. We did so because the Court's decision and the remediation plan have changed and are still changing the landscape for the public behavioral health service delivery system for children, adolescents and their families in Massachusetts. We also hope to provide readers with an accurate overview of the system, and a better understanding as to the Council's role *vis* à *vis* the Children's Behavioral Health Initiative (CBHI), which includes but goes beyond the Commonwealth's remediation plan for the *Rosie D*. case.

We remain mindful, however, as the enabling provisions of the law that created us make clear, the Council's purview is much broader than both the *Rosie D.* case and the Children's Behavioral Health Initiative.

B. Rosie D. v. Patrick (f/k/a Rosie D. v. Romney)

In 2002, a class action lawsuit, *Rosie D. v. Romney,* was filed in the federal court by **parents on behalf of children with serious psychiatric disorders**. In January 2006, the Court ruled the Commonwealth was in violation of the federal Medicaid law by failing to provide home-based services to an estimated 15,000 children with serious emotional disturbances. The Commonwealth was also found to be lacking in the provision of services specifically required by Medicaid – early and periodic screening, diagnostic and treatment services (EPSDT).

To its credit, the Patrick Administration decided not to appeal the decision, which would have delayed change for years. Instead, it set about the task of fashioning a remediation plan to comply with the Court's decision. In February 2007, the Court approved a modified version of the Commonwealth's plan, and incorporated it into a final judgment with strict timetables. A court monitor was appointed to oversee the implementation of the remedy. **Some highlights of the Plan and progress to date, include**

- **Mental health screening** by primary care clinicians began in November 30, 2007.
  - The Court Order required that as of December 31, 2007, require primary care providers to offer standardized behavioral health screenings at well child visits for all youth under the age of 21 enrolled in MassHealth Standard or CommonHealth.
  - The most recent screening data (first quarter of calendar year (CY) 2010, January 1 through March 31. Data is available for all providers serving MassHealth members under age 21: those under contract with one of MassHealth's health plans, those who participate in the Primary Care Clinician (PCC) Plan and those who bill MassHealth on a Fee For Service (FFS) basis.

Screening rates vary by age:

Age Group	Oct. 1- Dec. 31, 2009	Jan. 1 – Mar. 31, 2010
< 6 months	33.46%	35.39%
6 months through 2 years	62.79%	65.12%
3 through 6 years	67.77%	70.22%
7 through 12 years	70.12%	73.05%
13 through 17 years	64.07%	66.98%
18 through 20 years	28.76%	28.09%

The above rates of screening correlate with anecdotal reports from Primary Care Clinicians that they are not satisfied with the current instruments available for screening children under six months of age. Moreover, some speculate that clinicians serving members 18 and over may not be thinking of these members as subject to the EPSDT periodicity schedule for screening. MassHealth is in the process of developing quality improvement activities to address variations in screening rates.

- Use of the **Massachusetts CANS (Child and Adolescent Needs and Strengths)**, a standardized decision support tool used as part of the assessment process, began November 30, 2008.

  - The number of organizations entering CANS records rose steadily, from 225 at the end of November 2009 to 260 in May 2010.
  - The number of trained and certified CANS assessors had topped 9,300 as of the June 1, 2010 Implementation report filed with the Federal Court, and continues to grow.

  - The Department of Mental Health (DMH) the Department Of Children and Families (f/k/a Department of Social Services) and the Department of Youth Services all use the CANS. This is the first time ever all the large child-serving state agencies are using the same basic assessment tool.
  - The number of CANS records in the system is approaching 70,000.
  - A CANS Newsletter providing updates and refreshers about the CANS requirement, good practice using the CANS, among other items was created and the first issue released in January 2010.

- In the spring 2009, the Massachusetts Behavioral Health Partnership (MBHP) in conjunction with the MassHealth managed care entities, selected provider agencies to serve as **Community Service Agencies (CSAs)** providing **Intensive Care Coordination (ICC) and Family Support and Training**, based on the wraparound model ordered in the case. These services began June 30, 2009.

  - There is a CSA for each of the 29 geographic Areas of the Department of Children and Families (DCF) as well as three CSAs, not limited to a single DCF area, who were chosen for their expertise in serving specific linguistic and cultural communities (African-American, Latino, Deaf and hard of hearing).

- Additional **new Medicaid services** were phased in:

  - **In-Home Behavioral Services and Therapeutic Mentoring** began October 1, 2009
  - **In-Home Therapy** began November 1, 2009.

  - **Crisis Stabilization** was scheduled to start in December, 2009, but the federal Centers for Medicare and Medicaid Services (CMS) rejected MassHealth's proposed state plan amendment for Crisis Stabilization because it included a room and board component, a fundamental feature of the service.[1]

<u>Utilization of new Medicaid (CBHI) Services</u>

Reporting Period is July 1, 2009 through April 30, 2010

The Council, through its Data, Trends and Outcomes Committee, reviewed the available data on the utilization of the above services. It is outlined with detail in the Committee's August 2, 2010 report, attached to this Report as part of Appendix B.

It should be noted that while the numbers within a particular CBHI service are unduplicated, there may well be duplication among all the services since individuals or families may have

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[1] Crisis Stabilization services is one of the seven services the judgment required MassHealth to implement, if approved as a Medicaid State plan service by CMS. CMS did approve the other six: Intensive Care Coordination, Family Support & Training, In-Home Therapy, In-Home Behavioral Services, Therapeutic Mentoring, and Youth Mobile Crisis Intervention.

received more than one of the listed services.[2] Moreover, Family Support and Training is not a "stand alone" service, but rather is provided as needed in conjunction with Intensive Care Coordination.

Intensive Care Coordination	5,721
Family Support & Training	4,613
In-Home Therapy	6,120
Therapeutic Mentoring	2,125
In-Home Behavioral Services	165
Youth Mobile Crisis Intervention	8,241

Wraparound Fidelity Index

MassHealth is using national best-practice assessment tools to measure whether Intensive Care Coordination is being delivered with fidelity to the Wraparound model.

- During the first six months of 2009, over 600 parents or caregivers of youth receiving ICC were interviewed over the phone, using the Wraparound Fidelity Index. In addition, supervisors observed Care Coordinators conducting Wraparound team meetings and rated them using the Team Observation Measure.
- Data from both instruments was sent to the researcher who developed these tools, Eric Bruns, PhD, who analyzed the data.
- On nine out of ten Wraparound Principles, Massachusetts scored slightly higher than the national mean, leading Dr. Bruns to state that Massachusetts' implementation has been the fastest in the history of Wraparound.

The work that is underway implementing the Remediation Plan, planning and implementing the CBHI is enormous and significant. While much of the data we have reviewed is early and in some cases dated, it is clear that important and positive work has been done. Clinicians have been trained in the use of assessment instrument, children and adolescents are being assessed, CBHI services have been rolled out on time, and there is increasing utilization of these services.

While much remains to be done, we think all who have been involved at any level of the transformation that is occurring should feel very good about and should be congratulated for what has been accomplished to date in an economic environment that would have produced failure but for their efforts.

We also intend to report and comment on other ongoing initiatives to evaluate or improve the children's behavioral health care system, as they are brought to our attention.

C. Challenges to the Council

It is important for legislators, Council members and readers of this Report to remember that the policy changes and transformation of the children's mental health system we are witnessing and

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[2] The numbers reported here are more recent than those reported in the attached Data, Trends and Outcomes Committee Report, which stated the utilization figures as of December 31, 2010.

engaged in are occurring in the context of court litigation and during a period of economic decline and decreasing revenues. While the interests and legislative mandate of the Council are broader than that of the Court in *Rosie D.*, the time demands and constraints presented by the litigation, coupled with declining state resources have had and will continue to have an impact on the Council, particularly in areas such as data collection and outcome measurements. Two quick examples:

- The remediation plan approved by the Court requires adherence to strict timeframes as well as to goals or outcomes that are more directed at compliance to and utilization of treatment models, services, an assessment tool and other aspects of the Plan than at whether or not children's mental health has actually improved. Even a cursory review of the Implementation Report filed on June 1, 2010, reveals the enormity of the tasks required in the Plan and the magnitude of the data collection work needed to demonstrate compliance and to avoid sanctions.[3] Obviously, this is not to say the Court and the Commonwealth are not interested in whether or not children's mental health is actually improving, but rather to state when significant policy change is being developed and implemented under a Court order, the initial priority and focus tends to be on compliance with the order – number of clinicians trained in the assessment tool, the roll out dates of new services, and the numbers of children and adolescents being screened and served, fidelity to the wraparound service model – rather than on ultimate outcomes such as improvement of mental health. And while it is too early in the implementation of the Court order process to be looking for these kind of outcomes, it is not too early to be developing appropriate indicators and determining what data needs to be collected to make an informed judgment as to whether or not the result of *Rosie D.* has been improvement of children's mental health.

- Although established as an independent advisory council, no funds were appropriated to support the Council and its activities. This is understandable, given the current economic climate. However, the consequence is that the Council must rely on a state work force already reduced by budget cuts and dealing with the increased workloads caused by staff reductions, as well as the requirements of the aforesaid remediation plan. When, for example, a committee of the Council wants to review or asks about the availability of certain data, we often learn that the data that is available has been compiled in connection with the *Rosie D.* case and, as noted above, is targeted at compliance with the court decree or subjects different from (although not inconsistent with) the interests of the Council.

It is important to acknowledge that outcomes more directed at the improvement to the mental health of the children and adolescents covered under the Rosie D. case will be receiving a more increased focus and attention from the Court and its monitor.

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[3] The Implementation Report and other court documents are available at: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2&b=terminalcontent&f=masshealth_researcher_court_docs_child-bh-hlth-intiative&csid=Eeohhs2

- In the Implementation Report filed with the Court on June 1, 2010 it is stated that the Commonwealth, "will use CANS data and data on Member utilization of Mobile Crisis Intervention services and Inpatient care to measure member-level outcomes for children and youth receiving Intensive Care Coordination." (June 1, 2010 Implementation Report, Page 52, cited in footnote 1 of this Report)

- The Implementation Report further states that MBHP is conducting a survey on a sample of 20 ICC members per CSA as part of the effort to measure outcomes. A report on this survey is expected in early Fall 2010. (June 1, 2010 Implementation Report, page 54.)

- The final paragraph of the 54 page Implementation Report states, " During the Winter of 2010-2011, the …[Commonwealth]… plan to conduct member satisfaction surveys of members who have had some experience with the services covered under the Judgment."

- MassHealth is beginning to analyze CANS data on entry to the Intensive Care Coordination Service (ICC) showing the level of acuity of the youth in ICC. By the end of 2010 it is expected that the first analysis of clinical change for youth enrolled in ICC and In-Home Therapy will have been completed, by looking at the scores on entry and exit.

The Council looks forward to reviewing the Report, the results of the surveys, and the CANS analysis. It remains to be seen if they are directed at outcomes concerning the improvement of mental health, satisfaction with the services or both.

PART IV: FINAL COMMENTS

Much has been said or written about the *Rosie D.* case and the new Medicaid services offered as part of the remediation plan. The Council needs to pay due attention to both because (1) they are transforming the public mental health system for children, adolescents and their families; and (2) they are potentially creating the blueprint for improving the system for all of the children and adolescents of the Commonwealth.

However, what should not be forgotten is that these services are only being offered to those children and adolescents covered by MassHealth. We know there are a large number of children and adolescents whose mental health care is not part of a remediation plan being monitored by a federal judge, a court appointed monitor or by a team of attorneys representing their interests.

The prevalence estimates (based on the 2006 state census) included as part of the Commonwealth's Mental Health Plan estimates there are 50,210 children and adolescents ages 9-18 with Severe Emotional Disturbance (SED) with extreme dysfunction, 83,233 ages 9-18 with SED with substantial functional impairment and 19,311 children ages 0-8 with SED and in need of mental health services, for a total of 152,754 children and adolescents.[4]

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[4] Commonwealth of Massachusetts Mental Health Plan State Fiscal Years 2009-2011 (OMB document 0930-0168, Page 183 http://www.mass.gov/Eeohhs2/docs/dmh/state_mental_health_plan_09.pdf

While the data made available to the Council was early and only through March 31, 2010, the number of children and adolescents enrolled in Intensive Care Coordination (ICC) was 5,721. Moreover, based upon studies conducted in other states and information provided by consultants to the Commonwealth in developing and implementing the remediation plan, it is expected that the number of youth who may need ICC ranges from 7,800 to 19,600. We have been advised the lower number is a fair estimate based on historical data on children and youth receiving services through MassHealth, DCF and DMH. Research tells us that the majority of youth with diagnosable behavioral health conditions do not receive services. In addition, we know there is disparity among different racial, ethnic and language groups in accessing behavioral health services.

It is clear that notwithstanding the extraordinary work that has been done in getting the new Medicaid services in place, the trainings and assessments that have been taking place across the Commonwealth, and the roll out of new Medicaid services, there are large numbers of children and adolescents with behavioral health needs who will not receive these new services.

We believe part of the Council's mission and charge is to ask:

- How are those children and adolescents not covered by Rosie D. doing?
- What can be done to improve the children's behavioral health system for *all* children in the Commonwealth with emotional disorders and behavioral health needs?

Legislators, state officials, advocates and others must keep thinking about those children and families outside the remediation plan and what the Commonwealth can do to help them. The Council's policy and legislative recommendations set forth in PART II of this Report were made with a focus on these children and families, as well as those covered under the remediation plan. We believe they are responsive to the Council's charge, and we hope they will receive serious consideration and support from legislators, state officials, advocates and others.

We are grateful for the assistance and support we have received from Barbara Leadholm, Commissioner of the Department of Mental Health and EOHHS Secretary JudyAnn Bigby, Emily Sherwood, Director of Children's Behavioral Health Interagency Initiatives, Jackie Gelb and the other wonderful people at EOHHS, DMH and the child serving agencies within EOHHS. Special thanks to Carol Gyurina and Jennifer Maniates (MassHealth), Joan Mikula, Lester Blumberg, Stephen Cidlevich from DMH, for their professionalism, patience and graciousness in helping the Council and for all they do for the children and families of the Commonwealth.

LIST OF APPENDICES

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APPENDIX B **Reports of Council Standing Committees and Work Group**
- **Insurance Committee**
- **Data, Trends and Outcomes Committee**
- **Culturally Informed, Best and Promising Practices Committee**
- **Child Systems Integration Committee**
- **Healthcare Disparities Reduction and Elimination Committee**
- **Workforce Development Committee**

Appendix A

The Children's Behavioral Health Advisory Council (the Council) was established under the provisions of Chapter 321 of the Acts of 2008. The Council is a unique public-private partnership representing child-serving agencies, parents and professionals with expertise in the issues of children's mental health. The membership of the Commission is as follows:

Barbara A. Leadholm, Chair *Commissioner* Department of Mental Health	Gail Garinger *The Child Advocate* Office of the Child Advocate
Jan Nisenbaum Department of Children and Families	Joseph Gold, MD *Board Certified Child Psychiatrist* Massachusetts Association of Behavioral Health Systems Representative
Janet George Department of Developmental Services	Vicker DiGravio III Association for Behavioral Healthcare Representative
Christopher Counihan Office of Medicaid	Barbara Talkov Children's League Representative
Anita Moeller Department of Early Education and Care	Barry Sarvet, MD *Board Certified Child Psychiatrist* Massachusetts Psychiatric Society Representative/ New England Council of Child and Adolescent Psychiatry Representative
Nancy Schwartz Division of Insurance	Michael Yogman, MD *Board Certified Pediatrician* Mass Chapter of the American Academy of Pediatrics Representative
Marcia Mittnacht *State Director of Special Education* Department of Elementary and Secondary Education	Eugene D'Angelo, Ph.D. *Licensed Psychologist* Massachusetts Psychological Association Representative
Robert Turillo Department of Youth Services	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter
Michael Botticelli Department of Public Health	Dalene Basden Parent/Professional Advocacy League Representative
William R. Beardslee, MD *Board Certified Child and Adult Psychiatrist* Massachusetts Hospital Association Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Timothy O'Leary Massachusetts Association for Mental Health Representative	Marylou Sudders Massachusetts Society for the Prevention of Cruelty to Children

Sarah Gordon Massachusetts Association of Health Plans	Jeffrey Simmons, MD Blue Cross Blue Shields of Massachusetts Representative
Kermit Crawford, Ph.D. *Professional in human services workforce development* Boston Medical Center	John Straus, MD Massachusetts Behavioral Health Partnership Representative
Holly Oh, MD *Pediatrician from a Community Health Center* The Dimock Center	Stephanie Morrill Young Adult Policy Team
Emily Sherwood *Director* Executive Office of Health and Human Services Children's Behavioral Health Interagency Initiative	Emily Russell Young Adult Policy Team
Amy Carafoli Boston Medical Center HealthNet Plan	Lauren Falls Network Health
Joel Goldstein, MD Cambridge Health Alliance	Jill Lack Neighborhood Health Plan
John Sargent, MD	Karen Hacker, MD
Margarita Alegria	Midge Williams
Roxana Llerena-Quinn, Ph.D.	Gisela Morales-Barreto, Ed.D.
Paul Shaw	Booker Lester
Sara Trillo Adams	Kathleen Regan
Gail Gall	Mary Ann Gapinski
Toni DuBrino	

Children's Behavioral Health Advisory Council Committees and Work Group

Peter Metz, Co-Chair Barry Sarvet, Co-Chair	Culturally-informed, Best/Promising Practices Committee
Nina Rosenberg, Co-Chair Toni DuBrino, Co-Chair	Legislative and Regulatory Committee
Joe Leavey, Co-Chair John Sargent, Co-Chair	Child Systems Integration Committee
Karen Darcy, Co-Chair Marylou Sudders, Co-Chair	Insurance Committee
Sara Trillo Adams, Co-Chair Roxana Llerena-Quinn, Co-Chair	Healthcare Disparities Reduction and Elimination Committee
Timothy O'Leary, Co-Chair Karen Hacker, Co-Chair	Data, Trends and Outcomes Committee
Kermit Crawford, Co-Chair	Workforce Development Work Group

APPENDIX B

Insurance Committee Report
Children's Behavioral Health Advisory Council
August 3, 2010

I. Background

Chapter 321 of the Acts of 2008: "An Act Relative to Children's Mental Health" called for the establishment of "a children's behavioral health advisory council … [whom] shall advise the governor, the general court and the secretary of health and human services [and] shall make legislative and regulatory recommendations related to continuity of care for children and families across payers, including private insurance."

The Insurance Committee members met five times and collectively decided to assess coverage by insurers in five key areas: case management, care coordination, continuity of care, mobile crisis and mental health parity. These five areas were deemed to be most critical to helping children and families have the most successful outcome of their treatment. Case management and mental health parity are required by regulation ((211 CMR 52.13(3) (a)) and Chapter 256 of the Acts of 2008 respectively.

Senior leadership/managers at eight public and private insurers were interviewed by the Insurance Committee co-chairs and a summary of the results of the survey is provided below. A chart describing the results of the interviews with more detail is attached.

Recommendations related to these five issue areas were considered across legislative, regulatory and policy avenues and are based on what is considered to be the most important and effective steps to take at this time. The Committee reserves the right to make additional stronger recommendations if the goals are not achieved through these means. These report recommendations were not endorsed by all members of this committee.

II. Findings of the Survey and Recommendations

A. Case Management

Case management services are designed to help children and families coordinate services and identify resources to optimize health outcomes. Case management is defined in the Massachusetts Managed Care Regulations: 211 CMR 52.03 as a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Public payors, in general, pro-actively provide case management services and inform their members of case management services that are available to them. For private payors, however, case management programs include those that focus only on transition from inpatient stays or more restrictive levels to other programs that are primarily triggered by certain diagnostic categories or admissions to Emergency Departments (EDs) and inpatient units. Of important note, the private payor case management services, while sometimes available are not well publicized or easily accessed by plan members and are designed to assist providers rather than subscribers.

Recommendations:

1. DOI and DMH jointly shall issue a bulletin clarifying the existing regulation that pursuant to 211 CMR 52.13 (3) (a) insurers must include a clear, concise and complete statement of case management services in the evidence of coverage as case management constitutes "any other benefit to which the insured is entitled on a non-discriminatory basis" (211 CMR 52.13(3)(a)). The statement should include both a definition of case management services and a description of how the benefit is accessed by members and publicized by the plan

2. The Committee will revisit this issue in one year from issuance of the bulletin to assess compliance by private insurers.

B. Care Coordination

For children's behavioral health, care coordination includes the necessary communication between children, families, health care providers and specialists in different settings and schools and the community, state agencies, etc. Recent research supports the benefits of professional care coordination in clinical and process improvements and in reducing hospital admissions, emergency room utilization, health care costs and improving family satisfaction. Strong scientific evidence shows that poor communication, and lack of care coordination, *reduces patient safety and quality of care*.

Our survey of insurers found care coordination to be provided and reimbursed by all the public payors. None of the private payors, with the exception of Neighborhood Health Plan, reimburse for care coordination.

Recommendation:
Passage of the Coordination of Care bill. The bill would require that all payors reimburse mental health professionals for the coordination of care or collateral services.

C. Continuity of Care

Regarding compliance with statute: All payors have policies in place to provide continuity of care for children currently in treatment when there is a change in insurance. However, there continues to be areas of concern regarding continuity of care for children with mental health disorders ranging from availability of child psychiatrists to adequacy of reimbursement.

Recommendation:
No specific recommendation on statutory compliance is recommended. The committee will monitor for continued compliance.
Refer to the Future Issues section at the end of this report for further inquiry.

D. Mobile Crisis

Mobile crisis services are community-based interventions for children and families during a mental health crisis. Mobile crisis services are designed to optimally assist children and families through a crisis situation without a visit to the Emergency Department (ED) or hospitalization (if that is not necessary).

Long a priority of the public mental health and Medicaid systems, public payors are required by the Rosie D. v. Patrick remedy to increasingly invest in mobile crisis intervention services and diversion strategies to keep children and youth out of the ED when possible. Our survey found that the public payors are providing mobile crisis services.

Another finding was that private payors primarily rely on EDs for children in crisis. HPHC/ UBH contract with Emergency Service Providers (ESP), however, their utilization is noted to be "very low".

A brief review of recent medical literature points to the effectiveness of mobile crisis services in reducing inpatient hospitalization; reducing re-admittance to the hospital; reducing the cost of emergency psychiatric services and favorable perception by consumers.

Recommendation:
The Commissioner of Mental Health shall convene appropriate stakeholders to discuss and determine the best policy to serve children and families experiencing a mental health crisis in their own communities regardless of insurance status.

E. Parity

Revisions to the state parity law (now known as Chapter 256 of the Acts of 2008: "An Act Relative to Mental Health Parity") expanded the number of biologically-based categories that require coverage for diagnosis and treatment to include the following: PTSD, eating disorders, substance abuse and autism. All of the private payors in our survey indicated that they have expanded coverage for these diagnostic categories. Note: the law does not apply to Medicaid or ERISA plans

The purpose of the Mental Health Parity law and the implied intent is to require insurers to elevate mental health disorders to the same level as physical health disorders. That means diagnosis and treatment are covered the same as other medical problems (diseases, chronic conditions, etc.), and based on the course of treatment recommended by their health care provider. To clarify this, the Division of Insurance and the Department of Mental Health issued a bulletin (2009-04), March 4, 2009, on the *Changes to State and Federal Mental Health Parity* laws, released Marcy 4, 2009 which states: "Nondiscriminatory basis" means that co-payments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums *are not greater for mental disorders than those required for physical conditions,* and office visit co-payments are not greater than those required for primary care visits.

It has come to our attention that some insurers are seeking to continue to put strict limits on mental health treatment services by comparing mental health therapy with other temporary therapy services [or sub-specialty therapies] like occupational therapy, speech therapy, etc. and not other medical disorders. This emerging policy debate highlights different perspectives on mental health parity and coverage from the intent of the law (Bulletin 2009-4, cited above).

Recommendations:

1. Require the Division of Insurance to issue an annual report to the public on behavioral health data as it applies to children and adolescents, based upon information that is submitted by commercial insurers on an annual basis.

2. Require the Department of Public Health and the Office of Patient Protection to study and to report to the CBHAC regarding the number and frequency of denials/successful appeals of denials for behavioral health services for children as compared to medical services.

III. For the future the Committee intends to examine the following issues:

a. The relationship between public schools and mobile psychiatric crisis;
b. Continuity of care for Medicaid MCO enrollees if the enrollee switches plans;
c. Self reporting practice of mental health providers for credentialing;
d. With Workforce Committee: Ensure that there is an adequate supply of child/adolescent mental health providers;
e. Continuity of care issues.

IV. Definitions

a. Case management

Definition from the Managed Care Regulations: 211 CMR 52.03

Case management is a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

b. Care coordination

Definition from a Commonwealth MCE

Care coordination is “collateral contacts” or “case consultations”, which can be a telephonic or in-person meeting(s) between an outpatient behavioral health provider and another treater for the same member, such as a hospital, a PCP, a school, a state agency, another outpatient provider.

c. Continuity of care

Definition derived from MH Parity Law 1 M.G.L. Ch 175: Section 47B(c) and Managed Care Regulation: 211 CMR 52.13

Continuity of care: In summary, if a youth is in ongoing behavioral health treatment and his/her insurance changes, the new insurer provides or helps arrange for the payment of those services throughout the course of treatment.

d. **Mobile crisis services**

Definition from CBHI

Mobile crisis service intervention: provides a short-term service that is a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. This service is provided 24 hours a day, 7 days a week.

IV. Attachments

- Survey chart-in the insurers own words
- List of members of the Insurance Committee

To: **CBHAC**
From: **Marylou Sudders, Karen Darcy and the Insurance Committee**
Date: **August 2, 2010**
Re: **Insurance survey report- in their own words**

	Commercial				**Public and commercial**	**Public**		
Insurers →	**Blue Cross and Blue Shield of MA (BCBS)**	**Harvard Pilgrim Health Plan/ United Behavioral Health manages the Mental Health benefit (HPHC/UBH)**	**Tufts**	**Fallon Community Health Plan/Beacon manages the Mental Health benefit (Fallon/Beacon)**	**Neighborhood Health Plan/Beacon manages the Mental Health benefit (NHP/Beacon)**	**Primary Care Clinician Plan/MA Behavioral Health Partnership (PCC/MBHP)**	**Boston Medical Center Health Net/Fallon/Beacon manages the Mental Health benefit for both (BMC/Health Net/Beacon)**	**Network Health**
Issue areas								
↓								
Compliance with required Mental Health Parity changes	broad interpretation of the law, expanded diagnostic categories	No change in practice- Additional diagnostic categories included.	No change in practice- additional diagnostic categories included.	Not much has changed-increase in diagnostic categories	No change in practice	Feel that medical necessity drives services	No change in practice-continue to evolve—public payor focus	No change in practice
Prior auth requirements	Automatic 12 sessions-no activity required by the provider or member. Beyond 12 sessions submission of Treatment Review form required	Automatic 8-10 visits; then require weekly 1:1 for additional visits "Outpatient care requests require prior authorization. When members call, they are given an open authorization to see a network practitioner, subject to medical necessity review."	The 10 visits are paid outright, with no pre-authorization, so long as Tufts is notified of the start of treatment.	Automatic 8 without prior auth	Automatic 8 visits without prior auth	Authorize without prior auth, 12 visits in 6 months. If more visits are needed, the provider completes a web based request for extension form. Telephonic review of those forms is generally only required for outlier providers based on frequency of asking for extension	MassHealth automatic 12 before treatment plan review	Expanded outpt benefit-26/yr without authorization

Insurers ⟶	**BCBS**	**HPHC/UBH**	**Tufts**	**Fallon/Beacon**		**NHP/Beacon**		**PCC/MBHP**	**BMC Health Net/Fallon/Beacon**	**Network Health**
Intermediate levels of care	Sees parity as the catalyst for the DOI look at Intermediate levels of care and provide guidance to insurers	"UBH provides"	Network not developed for all levels of care-bed approved if it exists	"Used at Fallon—concerns about kids falling between the cracks when they transfer"		"more expansive with commercials in this category" when medically necessary-have same providers for commercial and MassHealth members		covered	"Beacon covers intermediate levels of care for all product lines". Services may be accessed as a step-down from a higher level of care (i.e., inpatient) or directly accessed based on the member's acuity/need.	NH has a "full range of inpatient, diversion, and outpatient services and all are determined by medical necessity".
321 changes	None	none	none	none		Carve out notifications as required in C321		none	none	

Insurers ⟶	BCBS	HPHP/ UBH	Tufts	Fallon/Beacon		NHP/Beacon		PCC/MBHP	BMC Health Net/Fallon/Beacon	Network Health

Case management
🟥 1= services not provided or very limited
🟨 2=services provided when asked or triggered
🟩 3=services well advertised and provided
	3 ☐ 🟨 ☐
	• Case management (CM) services available
	• Triggered in 3 ways
	  • all hospital admissions-systems review and trigger
	  • repeat ER visits
	  • providers referrals
	• most providers know about CM services-part of all quality contracts
	• Families are not always aware---but if so can request CM
	• BCBS has 24 hr nurse hot line where families can access information on CM, etc
	• BCBS has 10 part time psychiatrists and 3 part time neuropsychologists who do the UM
		2 ☐ 🟨 ☐
		UBH-
		• offered when triggered by admission or discharge-provide family dependent outreach - coordination with pediatrician, residential services-intent to get kids and family ready for transition from acute care
		• youth with Eating Disorders-#1 disease for ICM
		• youth with complex bipolar disorders (pharmacy data used to trigger this service)
		• members get CM services if they request them
		• " HPHC-UBH offers 24/7 call-center availability for requests for urgent care"
		• psych call service available for pediatricians at HPHC-low utilization
			1 🟥 ☐ ☐
			• "not a robust program at the moment" in process of setting up a department and making a commitment
			• Currently being expanded with focus on support for transition to home
			• "no dedicated program for children with complex MH disorders"
			• Working on ways to identify children at risk-specifically the Eating Disorder population
				1 🟥 ☐ ☐
				• "no behavioral CM for children with Behavioral health disorders"
				• Families call the 1-800 # to learn about the CM program
						3 ☐ ☐ 🟩
						• Began in 2004-expertise of Beacon is built into teams at NHP
						• Beacon is co-located and very involved at NHP
						• 3 tiers of CM
						• Families informed
						• Using claims data (behavioral, medical, and pharmacy) to proactively identify individuals for CM-demonstrated + health outcomes using systematic approaches
						• Members with medical/MH co-morbidities identified
						• Use pharmacy data mining and admission as triggers for referral
								3 ☐ ☐ 🟩
								• Initiated by referral from provider or at request of member
								• Targeted outreach to one of 3 types of care management services
								• Provided by in house Masters level or purchased community services
								• Well publicized to members and providers
								• Metrics available for #s serviced- all exceeded the target
									3 ☐ ☐ 🟩
									• "CM makes an impact"
									• Goal is to keep clients in the community
									• Models-"Beacon has staff co-located at NHP and BMC-increasing support to Fallon"
									• 3 levels of CM
									• Using claims data (behavioral, medical, and pharmacy) to proactively identify individuals for CM-demonstrated + health outcomes using systematic approaches
									• Members with medical/MH co-morbidities identified
									• Use pharmacy data mining and admission as triggers for referral
									Promotion:
									• Open referral process
									• Members get informed through newsletters
									• PCP referrals
										3 ☐ ☐ 🟩
										• Recent restructure to department
										• Moving to integration of medical and social case management—master's level clinicians doing in-home outreach and CM
										• Different levels of CM-these include
										  ○ Social CM-intervening in behavioral non-medial situation
										  ○ Intensive CM (ICM) specific to behavioral health
										• Triggers for CM services include:
										  ○ 3 hosp/yr
										  ○ Clinical/provider judgment
										  ○ Multiple family members
										• Claims data also informs the CM decision

Insurers ⟶	BCBS	HPHC/UBH	Tufts	Fallon/Beacon	NHP/Beacon	PCC/MBHP	BMC Health Net/Fallon/Beacon	Network Health
Care coordination 🟥1=not reimbursed as a separate benefit 🟨2=provided and reimbursed 🟩3=well advertised for families, provided and reimbursed	1 🟥☐☐ Collateral services not reimbursed separately; BCBS considers "coordination of care" an expectation of providers	1 🟥☐☐ HPHC-"very proud of the coordination of care provided by HPHC…taken reasonable public policy approaches.. expect of the carve out (UBH) a high degree of coordination" "expect weekly coordination of care rounds with care managers for youth with ED, co-morbid disorders" "HPHC cited by NCQA for medical behavioral consultation"	1 🟥☐☐ "Assume cost included in rate-professional expectation that it is included in care" "Expect this is the standard of care for all affected professional providers".	1 🟥☐☐ "Not on outpatient services" "Medication monitoring"	3 ☐☐🟩 Benefit for both commercial and MassHealth members	3 ☐☐🟩 MBHP reimburses providers for collateral contacts and case consultations	3 ☐☐🟩 benefit	3 ☐☐🟩 Reimbursed no auth required-no max per year

Insurers ⟶	BCBS	HPHC/UBH	Tufts	Fallon/Beacon		NHP/Beacon		PCC/MBHP	BMC Health Net/Fallon/Beacon	Network Health
Continuity of care 🟥 1=not provided 🟨 2=provided with restrictions based on clearly defined criteria 🟩 3=clear policy with provisions for extension based on individual need	3 ☐☐🟩 BCBS has policy where members are entitled to 90 days of treatment. In practice, if child has long standing relationship with provider they work out an agreement where the provider can continue if he/she agrees to accept the BCBS rates	3 ☐☐🟩 90 day transition policy from the time one enters the plan For routine care transition expected-have a subset where it is necessary to extend out as far as one year or based on plan renewal	3 ☐☐🟩 4-6 transitional visits for members new to Plan unless there is medical necessity for more—"more flexible about authorizing care with non-contracting providers when this comes to children This tends to be high volume with people changing plans with frequency	3 ☐☐🟩 "Beacon's outpatient department manages the transitional care visits for both commercial and MassHealth members." look to see if the provider may be interested in joining their network.		3 ☐☐🟩 Beacon honors continuity of treatment for members who join one of their health plans and are in active treatment relationships. Beacon's outpatient department manages the transitional care visits for both commercial and MassHealth members" Looks to see that the provider may be interested in joining their network.		3 ☐☐🟩 Yes—decisions based on medical necessity and case by case basis—out of network provider requests a single case agreement-based on clinical information provided and medical necessity criteria met, an agreement is made with the provider for coverage of negotiated length of treatment	3 ☐☐🟩 Beacon honors continuity of treatment for members who join one of their health plans and are in active treatment relationships. Beacon's outpatient department manages the transitional care visits for both commercial and MassHealth members. Look to see that the provider may be interested in joining their network-particularly if the provider offers a clinical, cultural or linguistic specialty	3 ☐☐🟩 "Policies around continuity of care applied equally to all members. Factors that determine whether or not an out of network provider may provide care include whether or not the member has a pre-existing relationships (with provider), any cultural, ethnic and/or language needs as well as access. Work closely with providers to ensure transition"

Insurers ⟶	BCBS	HPHC/UBH	Tufts	Fallon/Beacon		NHP/Beacon		MBHP	BMC Health Net/Fallon/Beacon	Network Health
Mobile crisis 🟥1=no mobile crisis services offered 🟨2=some access to ESPs 🟩3=contracts will all ESPs	2 ☐🟨☐ Pay for Family Stabilization when recommended by providers (see FST as mobile crisis) Don't use Mobile Crisis teams—"if there is a safety issue child should be evaluated in the ED" Almost no diversion services	3 ☐☐🟩 Contract with all ESPs-Utilization is low Emergency at home services access-call the 1-800# on health card, verify eligibility, and talk with clinician…"	2 ☐🟨☐ Emergency crisis teams: "members are referred to ERs in a crisis. A given hospital may use the service of one of these independent crisis (ESP) teams, in which case the contractual agreement is invisible to Tufts, residing between the crisis team and the hospital. In Western MA Tufts has a few direct contracts with some crisis teams "When a team is called to a member's home, or police department, etc., we are most likely to pay as a 90801, as we do not have codes fully implemented for this service for many of these providers. So, "it depends." It depends on which provider is used, what product the member has, etc.	2 ☐🟨☐ A 24X7 hotline is available for emergencies Fallon has "purchased FST" Dedicated PS ED at U Mass Not a mandated benefit for commercial members-		3 ☐☐🟩 Beacon contracts with ESPs for both products		3 ☐☐🟩 Contracts with ESPs statewide	3 ☐☐🟩 Compliance with regulations on access to emergency services "Diversionary services are those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support a member in returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community."	2 ☐🟨☐ NH members may access all ER and ESP service but Youth Mobile Crisis is not currently a covered benefit for non-MassHealth members All ESP providers are contracted for and expected to do mobile or community based interventions and assessments FST covered benefit

Insurers ⟶	BCBS	HPHC/UBH	Tufts	Fallon/Beacon	NHP/Beacon	MBHP	BMC Health Net/Fallon/Beacon	Network Health
Challenges and opportunities	How providers in networks define their expertise Autism spectrum disorders Substance abuse as epidemic-significant increase in the # of claims Medical co-morbidities-youth with eating disorders, long haul in treatment and significant resources-see great opportunities here See above as forcing cost control discussions	Substance abuse services for teens Evidence Based care and off label meds prescribed Kids not being seen often enough-phone f/up-believe kids do better with more visits face to face"	• Shortage of child psychiatrists and Psychopharm providers • Lack of intermediate services for adolescents esp. in Western MA • Substance abuse credentialed providers • Constraints on reimbursement strategies • Need for family systems approaches for ED	• pharmacy use-multiple prescribers • youth with Eating Disorders-want to see more family systems approaches to care • concerns about chemical addiction services—the linear nature of the treatment	Most challenging group is • youth with PDD—medically complex, require significant family support • youth with ED-NHP currently leveraging community partners in central MA to respond to need and limited services • youth with SA is less problematic-they use the same providers for full range of service needs • bottom line "NHP responsible even though Beacon is the MH partner-close oversight by NHP-knows what is going on—Beacon co-located	• kids with PDD • autistic children with significant developmental delay without state supports-no DDS services for anyone less than 22 yrs • kids with co-morbid medical conditions • work with schools	• "better than most on the substance abuse side" • Exploring how to work more effectively with PCPs • Would like to see transparency in state data sets, particularly in ESP and substance abuse data.	• Intermediate levels of care and family access • Concerned about how funding ESP services; funding cuts for schools and towns • Sees need for social supports like transportation and housing • More transparency for families and their consumer rights

Insurers ⟶	BCBS	HPHC/UBH	Tufts	Fallon/Beacon	NHP/Beacon	MBHP	BMC Health Net/Fallon/Beacon	Network Health
#s	2.94 M. members	1.5 M members (~100K behavioral health clients-22% children)	757,356 members	164,000 commercial members	140,000 Medicaid and 40,000 CommCare	~350,000	BMC: 170,000 Medicaid and 60,000 Comm Care Fallon: 12,000 Medicaid and 10,000 Comm Care	102,000 MassHealth members 60,000 CommCare
Next frontier	• Outcomes data from CBHI will help inform • Field of "health coaching" may influence innovation-may not require Master's level-may end up creating new profession • Autism spectrum disorders-difficult to know what works-controversy around ABA services that BCBS sees as still investigational; therefore, not covered. • Eating disorders • Medical co-morbidities • Co-morbidities • Response to increase in claims for substance	UBH- • Home based behavioral health services • Some interest in the CBHI experience • Noted in meetings with ESP providers their concerns about state budget appropriation to support their services • Would like to see more of a continuum in the commercial sector such as the public sector-concerned about the disparities (JS)	• Committed to keeping mental health management in-house • All levels of care throughout the state	• Integration of medical with behavioral • Pharmacy controls • Disease management	• The Health Equity leverages practical experience along with available race, ethnicity, and language data to achieve health equity in the diverse population and communities we serve. • More delivery of community based services-more like MA Health • EBPs for members • Broaden partnerships wit • How CBHI services can be used by commercial population • Pharmacy data monitoring	community • Like to see more utilization for case consultation • Improved communication between/among providers-outpatient to outpatient providers-CBHI services are challenged by building linkages • Making systems more seamless for families • Finishing implementation of CBHI • How the CBHI work dictates/shapes what comes next for the commercial payors • Improved use of community support • Determine ways to track effectiveness of this group Addictions • Assessment and	• mandate for autism services-gearing up for that-exploring ABA staff and expansion of services • access to continuum of care • better utilization of data • better identification of what is happening in the disparate system of care. Major focus of Beacon's work is clinical knowledge and expertise—review of data sets, etc • better identification of pharmacological trends • build on the input from their expert advisory panel	• "rethink how we are using services in general" • Would like to see a pre-notification process for addiction services • Would like to see more transparency between systems-sees opportunity to leverage data"

	• Need for more robust systems of care							• Improved SA screening by MH clinicians • Improved school based services for youth with addictions-such as recovery high schools Use of EBPs at all levels		

Children's Behavioral Health Advisory Council
Data, Trends and Outcomes Committee
August 2, 2010

I. Introduction & Overview:

The August 2, 2010 meeting of the Children's Behavioral Health Advisory Council is the last regularly scheduled meeting before the October 1, 2010 filing date for the Council's 2010 Annual Report. Accordingly, the Data, Trends and Outcomes Committee (Committee) thought it appropriate to file this report outlining the Committee's activities since October 1, 2009, its plans for the remaining months of 2010, and its goals for the year ahead.

We also thought it appropriate to partially reiterate the legislative charge to the Council and the sometimes competing (although not inconsistent) priorities of the Council, its individual members, and those charged with the principal responsibilities for the oversight and implementation of the remediation plan approved by the Court in *Rosie D v. Patrick* (f/k/a *Rosie D v. Romney*).

Section 1 of Chapter 321 of the Acts of 2008 established the Children's Behavioral Health Advisory Council and placed the Council, "within but not subject to control of, the executive office of health and human services." Additionally, the language of the specific section states the Council is to, "advise the governor, the general court and the secretary of health and human services."

As was stated in the Council's first annual report, filed October 1, 2009:

> " … [W]e think it vital to our mission, and ultimately to the families and children of the Commonwealth, that everyone understands that the Council was established as an independent advisor to both the Executive and Legislative branches. Our credibility as an advisory body depends upon our independence and ongoing commitment to advocate for legislation, policies, practices and procedures that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. Our policy recommendations should not depend upon who is governor, who is the EOHHS Secretary or which political party represents the majority in the Legislature. Our recommendations should be guided by our expertise, experience, and our commitment to the families and children of the Commonwealth. To do anything less would be a disservice to both branches, as well as to those children and families."

It is important for legislators, Council members (and our Committee members) to remember that the policy changes and transformation of the children's mental health system we are witnessing and engaged in are occurring in the context of court litigation and during a period of economic decline and decreasing revenues. Two quick notes of illustration:

- The remediation plan approved by the Court requires adherence to strict timeframes as well as to goals or outcomes more directed at compliance to a treatment model, an assessment tool and other aspects of the Plan than at whether or not children's mental health has actually improved. Even a cursory review of the Implementation Report filed on June 1, 2010 reveals the enormity of the tasks required in the Plan and the magnitude of the data collection work needed to demonstrate compliance and avoid sanctions.[5]

- Although established as an independent advisory council, no funds were appropriated to support the Council and its activities, and we have had to rely on a state work force already reduced by budget cuts and dealing with the increased workloads caused by staff reductions.

From its initial meeting, this Committee has been mindful of the competing (not inconsistent) priorities of the remediation plan and the overall charge of the CBH Advisory Council. While the assistance and cooperation we have received from Emily Sherwood, Carol Gyurina, Jennifer Maniates and other staff from EOHHS, MassHealth and DMH has been significant, we can only review the data that is actually collected. We have attempted to limit and simplify our data requests because of the severely limited resources of the data collection team at MassHealth and EOHHS.

For at least this current period of economic decline we have informally adopted a policy that if in the judgment of the Committee certain data, which is not collected, is necessary in order for the Council to perform its statutory mandate, we will recommend to the full council that it request an appropriate appropriation to EOHHS or one of its agencies to allow it to collect the data and to transmit it to the Council. Thus far, we have not made any such request because we are early in the process and by necessity the data being reviewed is targeted more at reviewing current conditions, as opposed to measuring outcomes related not to compliance with a treatment model, but rather the effectiveness of the treatment and whether or not children's mental health has improved.

II. Committee Activities and Findings

For the first year of its existence, the focus of the Data, Trends and Outcomes Committee has been:

- to analyze the data that is available;
- to determine what data that is not currently being collected should be accumulated to better measure the effectiveness of the children's mental health system as a whole, and the remediation plan in particular; and
- What outcomes should be considered (and their indicators) in order to effectively measure the effectiveness of both the remediation plan and the Children's Behavioral Health Initiative, understanding, of course, that effective outcome measurements may be as much as five years away.

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[5] The Implementation Report and other court documents are available at: http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Special+Commissions+and+Initiatives&L3=Children's+Behavioral+Health+Initiative&sid=Eeohhs2&b=terminalcontent&f=masshealth_researcher_court_docs_child-bh-hlth-intiative&csid=Eeohhs2

The Committee received data in large, often confusing, doses. This is not a criticism, but rather a statement of the consequence of the fact all of this is new, the data collectors and analyzers are few in number and are focused on what is required under the remediation plan, as opposed to what the Committee might need or desire.

Over the months, the data sent to the Committee became more focused, and manageable. While it is too early to see beyond "initial trends", we wanted to inform the Council as to initial findings:

<u>Screening for mental health in primary care</u>

- We are improving as time goes for all ages and as a whole with the percentage of EPSDT visits with associated screens rising to 62% in Jul-Sept 09. The goal is 100% and the Committee will assess progress towards that goal.
- The screening rates for children under 6 months are quite low (although they have improved somewhat over time). This can be explained by the fact that most primary care providers do not believe there are adequate tools available for this age group. There are several groups working to make a postpartum screen for a new mother an approved tool, which might help improve this percentage.
- The Committee would like to be able to compare the percentage of behavioral health needs identified in MA with other states if possible. We recognize that most prevalence reports are taken from children seen for mental health services and that these are rates for children seen in primary care.
- It is noteworthy that the age group with the highest percentage of behavioral health needs was the 7-12 year olds, which is consistent with national trends and studies.
- The Committee would like to get information on children insured by private payers who are seen and screened, but this is not currently available.
- We need to improve the percentage of screens with a modifier (which connotes whether or not a behavioral health need was identified) or we may be missing children with needs that were identified but we are unable to track.
- The Committee would like to understand mental health service utilization that is related to these screens. As such we would like to have data that provides information on those with identified behavioral health needs 6 months before and 6 months after the screen was provided. The committee understands there are not sufficient resources to accomplish this task. There will be additional committee discussion, including exploring possible collaborations and/or funding sources to collect this data. If, however, we are unsuccessful and remain firm in our conviction this data is critical to future outcome determinations, we may recommend to the Council that it support a request to the Legislature to appropriate additional funds for the collection of this data.
- The issues on screening for the Committee are not centered on whether children are being screened, but rather: what does the screening lead to? Are children getting services? Are the services changing anything?

Child and Adolescent Needs and Strengths (CANS)

- The percentage of eligible children who received the CANS in the outpatient setting increased in the first several months post initiation. However, it appears to have leveled off at 51% from 3/09-9/09. There were and remain issues around the user friendliness of the instrument, problems for providers to enter the CANS into the state database and the fact change often comes slowly.

- The Committee has had extensive discussions on the value of CANS and we are interested in continuing to review it.

    - Members voiced some of the concerns that have been expressed to them by providers: the document is burdensome and difficult to navigate; staff get frustrated with the amount of time spent inputting data.

    - The Committee has been advised improvements are being made and technological advice is being provided to help with respect to the virtual gateway and the CANS. Moreover, the experience in other states indicate that generally provider acceptance of and appreciation of the instrument does not come until it has been used for a year or so.

- The Committee appreciates the fact the CANS is a critical component of the remediation plan approved by the Court, and, thus, will remain the assessment instrument. However, unless providers use it properly, its value as an overall indicator as to whether or not the system has improved will be diminished. The Committee looks forward to the time when we can use this data to assess progress particularly for the children with major mental health issues.

- It should be reiterated that the Committee's interest in the utilization rates of CANS is not connected to monitoring compliance with the Remediation Plan, but to determining what benefit is coming to children. If close to half of the clinicians continue to resist using the CANS, then we should ask is it the correct instrument and is it making things better for children with emotional disturbances?

Children Awaiting Resolution of Disposition (CARD)

- The Committee has reviewed the CARD data and we will continue to see this and follow the trend. The numbers have been decreasing for the last four years.
- We cannot yet determine if the CBHI has any additional impact on the numbers.
- We would also like to follow the DCF population (CHINS and Voluntary) and obtain a table that shows the trends for this population.
- The Committee has some interest in data relative to patients waiting for hospitalization. We have been advised MBHP does report on this and efforts are underway to obtain this.

- The Committee would like information on total length of stay in hospital for children from ICC as soon as that is available and will monitor those trends over time.
- Lastly, we would like to get information on out of home placement for DYS, DMH, and DCF. We may need to request that individually of each Department, as there is currently no ability to share across departments.

Utilization of CBHI Services

Reporting Period is July 1, 2009 through December 31, 2009

The Committee reviewed data based managed care cost and utilization data of members who received any CBHI service. While, as with the other data, it too early to talk in terms other than "initial or early trends," we wanted to share the information with the Council.

Please note that while the numbers within a particular CBHI service are unduplicated, there may well be duplication among all the services since individuals or families may have received more than one of the listed services. Moreover, these numbers do not account for individuals or families moving between MassHealth managed care entities, which would cause a slight decrease in the numbers presented.

Intensive Care Coordination (6 months reported)……………………………4,135

- There has been a steady increase each month from a low of 938 in July to 2,558 in December, and with the exception of a slight drop in November the hours per utilizer have been consistent (about 7.4)
- In general members ages 19-20 utilize the most hours of ICC per utilizer, even though they are the smallest group
- The number of utilizers ages 0-12 and 13-18 have increased dramatically as ICC has ramped up

Family Support & Training (6 months reported).……………………………3,206

- The number of utilizers has increased since July (616) to December (1906) and the hours per utilizer have been relatively consistent (6)
- The number of utilizers ages 0-12 and 13-18 have increased significantly, while the number of utilizers ages 19-20 has remained small

In-home Therapy (2 months reported)…………………………………………4,029

- There was a slight increase in the number of utilizers (1429 to 1646) in the first two months of service
- Ages 13-18 utilized the most hours of service, per utilizer

In-home Behavioral Services (3 months reported)……..………………………….. 64

- There was an increase in the number of utilizers in the first three months of service (7 to 23 to 36)
- There was an increase each month in the hours per utilizer (7.1 to 10.4 to 13.9)

Therapeutic Mentoring (3 months reported)…………………………….........1,176

- There was an increase of utilizers (150 to 503 to 761) and in the hours per utilizer (7.4 to 12.9 to 11.2) during the first three months of the service
- The number of utilizers ages 0-12 (80 to 240 to 378) and 13-18 (68 to 260 to 375) increased significantly over the first three months, while the number of utilizers ages 19-20 has remained small (2 to 3 to 8)

Youth Mobile Crisis Intervention (6 months reported)………………………….5,504

- There were increases in utilizers July through October (725 to 766 to 1070 to 1226) and then slight decreases in November (1093) and December (1081)
- The hours per utilizer has remained constant for all age groups
- The number of utilizers ages 13-18 has increased the most (418 to 612) while the number of utilizers ages 19-20 has remained flat (118 to 124) and those ages 0-12 have trended upward (189 to 347)

Lastly, we note with respect to the above utilization data that it cannot really be put into proper perspective until we can state what the intended target populations were for these services.

III. Next Steps:

At our next meeting, the Committee intends to begin the discussion of what would be appropriate indicators to measure outcomes – not in terms of fidelity to a service model or plan – but has the mental health of our children and adolescents improved. From these indicators, we will determine the data that needs to be collected, and perhaps suggest data collection tools.

We will also continue to review data on CARD and the other subjects noted, because to properly develop a sound outcome measurement system, you need to know what is occurring now and what trends, if any, have been established.

IV. Conclusion:

The work that is underway implementing the Remediation Plan, planning and implementing the CBHI and the work and oversight of the Council is enormous and significant. While the data we have reviewed is early and in many cases already dated, it is clear that important and positive work has been done. CBHI services have been rolled out on time, and there appears (initially at least) to have been significant penetration of those services.

While much remains to be done, we think those who are involved at any level of the transformation that is occurring should feel very good at what has been accomplished to date in an economic environment that would have produced failure but for their efforts.

Respectfully submitted,

Karen Hacker, M.D. Co-Chair	Tim O'Leary Co-Char

Children's Behavioral Health Advisory Council
Culturally Informed, Best and Promising Practices Committee Report
Elements of Culturally Informed Best and Promising Practices: Characteristics and Implementation
September 1, 2010

Introduction

The elements of culturally informed best and promising practices summarized in this document are divided into two sections: About the Practice and About the Implementation Plan. They are intended to serve as a guide for all practices that may be introduced as part of the Child Behavioral Health Initiative, in favor of endorsement of any specific practices. The elements are all firmly based on System of Care Values and Principles, which are attached as Appendix 1 to this document. This Elements document was created by the Children's Behavioral Health Advisory Council Culturally Informed, Best and Promising Practices Committee, co chaired by Barry Sarvet, MD and Peter Metz, MD.

I: About the Practice

A: Practice Model Description

- Practice is thoroughly documented in systematic and usable format such that fidelity can be measured
- Documentation should address direct practice, supervision, program administration, and systems collaboration
- Application of practice to clearly defined goals and needs

B: Support for Therapeutic Model

- Documented evidence of effectiveness of therapeutic model in relation to defined goals, ideally on the basis of randomized controlled clinical trials (RCTs). Recognizing the limitations in the feasibility and availability of RCTs for psychotherapy, other sources of evidence of effectiveness will also be considered.
- Documented evidence of professional and clinical consensus regarding efficacy and applicability of therapeutic models.
- Therapeutic model may be an adaptation of a practice for which there is documented evidence of efficacy, and/or a practice which combines components of more than one evidence-based practice. For such practices, ongoing outcome evaluation is critically important.
- Documented evidence of fidelity/reproducibility of practice
- Applicability to culture(s) within the population in which the practice is proposed

C: Relevance to Documented Needs within Population

- Practice is applicable to clearly defined and documented needs within the population in which the practice is proposed.

- Addresses known public health priorities including mental health problems associated with significant morbidity and mortality, and/or psychosocial needs associated with significant impact on childhood development and health.

II: About the Implementation Plan

A: Cultural Awareness, Sensitivity and Responsiveness

- Program has a defined set of values that includes cultural sensitivity and responsiveness
- Program provides training in diversity/cultural awareness, sensitivity and responsiveness
- Adaptation of practice model to culture(s) within population in which practice is proposed, supporting flexibility regarding community/culture-specific implementation
- Program describes how it will recruit a workforce that reflects the diversity of the population served at all levels of the organization
- Advisory group reflects diversity of the population served, including consumers, youth, as well as formal and natural community stakeholders
- Program describes how it will provide translation for service delivery and linguistic accessibility of program materials

B: Family-Driven and Youth-Guided

- Goals/needs are identified and prioritized by the family, including youth voice
- The parenting or caregiving experience is understood within each family’s unique culture and community
- Provider describes function, responsibilities and authority in the working relationship and discusses parent and youth function, responsibility and authority
- Provider discloses full range of options for intervention that are available, including risks and benefits of each
- Parents participate in all meetings in which decisions impacting the youth and family are made and have the final word regarding decisions (except when legal custody of the child resides with DCF)
- A regular mechanism for mutual review of the functioning of the partnership with the family is built into the provider process-Flexible engagement of consumers:
    - Programs have required protocols to facilitate engagement or reengagement of consumers who miss appointments or do not readily respond to interventions
    - Consumers are not penalized when they attempt to re-engage after disengaging from service
- Provider describes how youth voice is supported and specific program supports for transition-age youth/young adults

C: Strength and Resilience Based

- Youth and family strengths are emphasized throughout application of the practice
- Assessment process assists youth and family in discovery of their strengths and the identification of formal and natural supports in the community that promote resiliency

- Prevention and early intervention strategies should be prioritized to maximize positive outcomes
- Outcome measures, including family satisfaction tools, include youth and family strengths

D: Outcome-Focused, Data-Driven Continuous Quality Improvement

- Individual youth and family outcomes monitored using validated instruments whenever possible
- Quality measures for the program are clearly defined, measured, and reviewed by program administration and advisory group
- Quality measures include effectiveness, fidelity, and satisfaction of family and youth
- The care delivery process has a regular, documented review mechanism through which the persons served and the providers evaluate whether there has been change toward the desired outcomes and whether this change can be expected to be sustained
- Results of CQI effectiveness, fidelity, and family satisfaction measures are used systematically to inform training and coaching activities to improve the quality of services provided

E: Practice Collaboration

- Practice is coordinated with the efforts of the full spectrum of natural and formal resources that the persons served receive, aiming towards the goal of integration of all service plans
- Mechanisms for addressing needs identified and prioritized by the youth and family that extend beyond the scope of the practice are described
- Coordination of resources for support to the child with Parent-Informed care
    - Needs as well as strengths of parents are assessed and considered as appropriate focus of intervention in support of the youth's development (When parents do better, children do better. When children do better, parents do better)
    - Services and supports are available to address the emotional and physical health conditions of parents in relation to their children's development
- Impact of trauma on the youth and family is considered and supports and services are trauma-informed

TRAINING 2010 INSTITUTES

JULY 14–18, 2010 • WASHINGTON, DC • GAYLORD NATIONAL RESORT & CONVENTION CENTER

System of Care Concept and Philosophy Updated

DEFINITION

A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.

Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Children’s Behavioral Health Advisory Council
Child Systems Integration Committee
August 2, 2010

Mission	To facilitate systems integration for children and families health and behavioral health locally, regionally, and statewide.
FY 2010 Priorities	1. The committee will review current collaborations among all secretariats and state agencies with child serving responsibility* to ensure the most efficient and effective approach to enhancing children’s behavioral health across the state. 2. The committee will review funding mechanisms, operations and relationships among state agencies and providers and private agencies to identify barriers to effective function and to develop solutions which improve behavioral health outcomes for children and families. 3. The committee will review the operation and funding process of the CBHI as a model of the transformation of the children’s behavioral health system toward greater integration and collaboration. During this review issues that will need resolution will be identified and potential solutions will be suggested. 4. Regional differences in operation and collaboration will be reviewed and specific solutions to enhance integration locally and regionally will be identified and reported to the Advisory Council. 5. Legal barriers to seamless system responses to specific child and family problems will be identified and reported for potential statutory remedy. *This includes but is not limited to DMH, the Department of Public Health (DPH) including the Bureau of Substance Abuse Services (BSAS), Department of Children and Families, Department of Youth Services, Department of Elementary and Secondary Education, Department of Early Education and Care, Department of Developmental Services and the Office of the Child Advocate.

The Committee has met monthly through the past 12 months and discussed a number of issues from the perspective of ensuring the best possible integration of child and adolescent behavioral health services.

I. Katharine Thomas of the Institute for Health and Recovery led an effort to learn the perspectives of families by holding a series of 3 focus groups with homeless families to learn about families' experiences with CBHI. (Focus Groups questions are attached to this report) Primary findings included:

- Homeless families reported that their children, even those with already diagnosed behavioral heath issues, were not screened for behavioral health problems during well child visits.
- Homeless families, all of them on MassHealth, universally reported that they had received no notification of new services available to them or their children through MassHealth.
- Homeless families reported numerous behavioral health concerns with their children, including hyperactivity, difficulty with concentration, depression, and experiences of trauma following foster care placement,
- The majority of homeless families who attended the focus groups felt that doctors and other social service professionals did not respect them and felt that they were stigmatized due to being homeless, or in the case of one program, due to being in drug/alcohol treatment.

II. Our committee has supported the efforts of members of the Transformation Center to collaborate with DMH to survey youth in residential care to learn their impressions of their Residential Care experience. This project is ongoing and the Committee will review the results when they are available. Instructions for the youth focus groups and the youth survey are attached to this report. (Information about the survey is attached to this report.)

III. Kate Roper of DPH reported regularly to our Committee on the developments and planning associated with the 2 Early Childhood Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored projects in Boston

Pediatric Medical Home with enhanced Early Childhood Mental Health (ECMH) supports:

- Teams of ECMH clinician and family partner at 7 sites including 5 Community Health Centers, Boston Medical Center, and Health Care for the Homeless
- Behavioral health and Family risk screening (including maternal depression) in well child visits
- Early ID and linkage to effective services for all children regardless of insurance coverage
- Spectrum of family support: home visits, parenting education
- Mental Health Consultation to child care, homeless shelters, etc.

Medical Home Learning Collaborative

- Led by the LAUNCH/MYCHILD PIs
- Demo site teams of four staff, plus Boston Public Schools reps

- Three 2-day learning sessions, plus work and conference calls in between
- Medical Home Learning Collaborative will develop tool kit of best practices

Policy and Sustainability

- Learning Collaborative tool kit will support replication to other sites
- Billing strategies to support care coordination, maternal depression screening and linkages to services, mental health consultation
- Developmentally appropriate billing coding for ECMH (informed by *Diagnostic Classification for Early Childhood* (DC 0-3 R))
- Evaluation of outcomes for continuous improvement, and identification of the return on investment of early intervention and treatment

Workforce Development

- Cross-training of early childhood, pediatric, and family support workforces to recognize and respond to Early Childhood Mental Health (ECMH) issues using evidence-based, developmentally appropriate, relationship-based tools and practices.
- Cross systems training, coaching and demo sites in Center for the Social Emotional Foundations of Early Learning (CSEFEL) Pyramid model of positive behavior support
- Clinical Level training: DC 0-3 R, CANS B-4, Parent Child Psychotherapy

IV. The Committee has regularly reviewed the progress of the Commonwealth's Children's Behavioral Health Initiative. We are monitoring the CBHI implementation to monitor the integration with other child and adolescent behavioral health services and systems.

V. We raised concerns about the CANS which were shared with Emily Sherwood and Jack Simons. These had largely to do with the need to repeat the CANS frequently and with the inability to use the same form among different clinicians. There continues to be 2 CANS forms in use: the DCF form and the DMH form. This leads to a duplication of effort that can mitigate against the integration of assessment and service delivery between DCF and CBHI systems of care. Work is continuing to make the CANS process more user friendly and more available for data sharing and for communicating among treaters.

VI. During the year we were asked by Joan Mikula and Bob Wentworth to discuss the DMH/DCF Joint Procurement for Residential Treatment (RTCs) to be put out at the end of this year. We have also reviewed the Request for Information written jointly by DMH and DCF.

We recommend that the Procurement include the following provisions:

1) A focus on preserving and encouraging long term relationships among staff, families and youth throughout RTC involvement.
2) Ready linkages between RTCs and CBHI services so that movement among programs is seamless and collaboration is fostered

3) A primary goal of RTC placement is strengthening families and building parenting competency, including working toward parental mental health and substance abuse recovery.
4) Opportunities for RTC staff to continue involvement with youth and families after physical discharge of the youth.
5) Each child and family should have one master treatment plan across all settings which should include attention to issues raised in the CANS assessment.
6) RTCs should include attention to the impact of trauma upon children and adolescents in their care.
7) Treatment plans should be based on family voice and choice and also include essential DCF safety concerns and DYS legal concerns if those agencies are involved with the family in a mandated fashion.
8) Community tenure is a goal to be achieved as frequently as possible.
9) Transitions should be managed with care and planning.
10) Specialty populations such as children with eating disorders and children with autistic spectrum disorders will need specialty programming.
11) For some youth the goal of Residential Care may be independent living and there should be opportunity to work toward that goal.
12) Involvement of Peer specialists in Residential Treatment Center staffing
13) RTC planning will need to be able to meet the needs of DYS involved youth including attention to trauma informed care and the capacity to deal with troubling youth behaviors.
14) Measurement of important outcomes including child and family functioning over both short and long term should be included.

The Child Systems Integration Committee recognizes that negotiation of the final terms of the Joint DMH/DCF RTC Procurement is an ongoing process and will continue to monitor the process and provide input to DMH and DCF as the process proceeds.

Young Adult Residential Voice Project

Focus Groups: Essential Points for Introduction

- We are here from The Transformation Center – a peer run training center. Everyone in this room is a <u>peer with lived experience</u>.

  Meaning, we have all been diagnosed with a behavioral problem or mental illness and have used a variety of treatments and programs. More importantly, we are all discovering and recovering how to live well, fulfill our dreams, and be satisfied.

  Introduce TC workers – 2 min planned recovery snippets from 2-3 peers.

- We were invited by <u>DMH to lead 8-10 focus groups</u> around the state about residential programs for youth. We are <u>not here to evaluate</u> this specific program or the staff.

- Now that you have heard a little from us, we want to learn from your experiences so that we can <u>pass it on to the people at DMH and DCF</u> who are redesigning the entire Childs and Adolescent residential system.

- <u>No one outside of the Transformation Center</u> – none of the staff here or at DMH - will see our notes from today. We are keeping track of what you say, but not your name, staff names or program names. We will <u>write a report</u> for DMH and DCF based on ALL the focus groups and we will give this program a copy. We will be very careful to take out or change any information that could <u>identify you or the program</u> in our report.

For example:
If ______ says, *"I want to be able to cook. I could make the bacon and chocolate chip cookies that my aunt in Philadelphia sends me every Halloween."*

And cooking turns out to be a theme in 5 of the focus groups, we might put this quote in the final report:
"I want to be able to cook. I could make the [unusual] cookies that my family sends me every year."

If participants seem concerned or confused, 2nd example:
If ______ says, *"The house meeting is boring. Every Thurs night it is the same - Trudy, the evening supervisor, tells us to do our chores.*

And house meetings or chores are an overall theme, the final report might include:
"The house meeting is boring. Every week it is the same – one of the staff tells us to do our chores.

- We will not be able to help you solve any individual or program problems today. If <u>problems come up</u>, we will encourage you to get support and find a way to resolve conflicts or misunderstandings – individually or as a group. If we hear about something that is downright abusive or an immediate threat to someone's life or wellbeing, we will support you to tell someone who is in a position to respond - or we will talk to someone else ourselves.

- We ask that everyone here respect the privacy of anyone who shares personal information and keep it confidential, in this room only.

- The focus group questions are basically asking about two things:

    1. ***What is your experience with residential programs?*** *Please focus on your recent experiences - from the past year.*
    2. ***In your opinion, how could re-designed residential programs help youth get the supports, resources and skills they need to move on with their lives?***

    Many great topics will come up - we may ask you to connect what you are saying to the topic of residential programs.

- In addition to the group discussion, we hope you will fill out a written survey – If you have any trouble filling it out, you can get help from us or ask a friend that is here. The survey does not ask your name and it is voluntary. It gives you a chance to rate different things about residential programs so that DMH will have numbers and "hard data" to report. It also gives us an idea of the age range, culture and experience of everyone here. It's ok to answer "Don't Know or Does not Apply".

- The meeting and survey will take about 2 hours and we'll check in with you about whether to take a break. The discussion and survey are entirely voluntary and optional! It is not part of the program or on anyone's treatment plan. Feel free to leave now or at any time if you are not comfortable staying. If you would like to stay after for some refreshments, we will be here for a little while.

- We will give a $10 gift certificate to you when you hand in the survey as a "thank you" for your time.

Family Focus Group Questions for CBHI, 11/2009	
Awareness	• If you have a question or concern about your child’s behavior, who do you typically ask? • What kinds of behavior have you seen in your children that you think you may need help with? • Did anyone suggest to you that your child may need help from a behavioral health professional, such as a social worker, case manager, or psychologist? • Are you familiar with the assessment tool “CANS”? • Have you noticed any changes in the availability of behavioral healthcare services for children during the past 6 months? • SED definitions: do you think any of your kids meets this definition?
Connection with help	• Did you get the help you needed? o Or did you ever get help you didn’t need or didn’t want? • When you received services, were you treated with respect? • Is getting help a team effort? Are you part of the team? • Is the help tailored to your needs and your child’s needs? • How involved were you with behavioral health decisions regarding your child? • If you received help, were your children active/willing participants? • Have you noticed any changes in the nature of the help your child received during the past 6 months? • Has your child willingly participated with the help you received, or did your child resist the help? • Was the help you received tailored to your needs? • Are your kids up to date on immunizations, well child visits?
Termination and future	• If your child used behavioral health services, how did they end? Who decided to stop the services, and what were the reasons? o Would you have liked to see the services end differently? • Are there services you think would have been helpful that you didn’t get? • What do you think should be different about the services you receive? • What do you think should be different about behavioral healthcare for children and youth?

Children’s Behavioral Health Advisory Council
Healthcare Disparities Reduction and Elimination Committee
August 2, 2010

Chapter 321 of the Acts of 2008 establishes this Children’s Behavioral Health Advisory Council and states that Council shall make legislative and regulatory recommendations related to racial and ethnic disparities in the provision of behavioral health care to children. To fulfill this charge, the Healthcare Disparities Reduction and Elimination Committee (Committee) has three current priorities:

1. Analyze CBHI data for racial and ethnic disparities

2. Identify best practices and system barriers to serving racially and ethnically diverse families with the new CBHI services, as a roadmap for further action.

3. Improve the CANS instrument and training to encourage the culturally appropriate exploration of the needs and strengths of racially and ethnically diverse populations, informed by research.

I. Analyze CBHI data for racial and ethnic disparities

The Committee has noted the possibility that new CBHI services could actually INCREASE rather than decrease disparities in behavioral health services, depending on who is receiving services and what services they receive. Data analysis on access, utilization and outcomes of CBHI services by race, ethnicity and language is essential for monitoring increases or decreases in disparities.

There are significant barriers to establishing a disparities baseline and then tracking in disparities within CBHI. In the context of the overall resources challenge around data, the Committee, in discussion with EOHHS, identified the following specific barriers to producing data reports to identify health disparities.

1. The need for common race, ethnicity language data elements across EOHHS state agencies and in CANS.
2. The need for additional analytic capacity to merge and analyze available data and produce reports on disparities.
3. The challenges (legal and technical) of integrating data across EOHHS state agencies and with Department of Elementary and Secondary Education to examine disparities.

With the Committee's encouragement, EOHHS took the following modest steps in the first year of CBHI implementation to move forward on this challenge:

a. **Adopt common race, ethnicity and language (REL) data elements across state agencies:** CBHI Executive Committee designated an interagency committee to adopt common data elements. In January 2010, the interagency committee drafted common REL elements. These REL data elements were incorporated in the CANS in February 2010, allowing the CANS to become a source of REL demographic data. Technically, the CANS and MassHealth data can be matched through the MassHealth Member ID (resources allowing), which will create a basis for using MassHealth and CANS data together to look at disparities. In addition, each state agency on the CBHI Executive Committee (DCF, DYS, DMH, MassHealth, DPH) is in the process of assessing the steps and costs associated with adopting the common REL data elements. Our Committee is anticipating a status report on this work in the coming period.

b. **Using CANS, produce a report on who received ICC services for 6 months from February-July, 2010** (after the CANS demographic fields were updated to incorporate the proposed REL data elements). The initial report will be generated in August, with guidance from disparities researchers within our Committee. It will be reviewed by members of the Committee, and reported to the Council, probably in October. It will be shared with the Data, Trends and Outcomes Committee.

c. **Seek targeted resources to monitor and reduce disparities in the new CBHI services.** Dr. Maggie Alegria and the Center for Multicultural Mental Health Research worked with EOHHS to respond to an NIH RFP on building a CBHI data infrastructure, which the committee considers an essential first step for identifying and reducing disparities. The proposal was not funded. Alternative resources are needed to move this work forward.

Recommendation for Council Approval: The Council urges significant new resources be identified to provide CBHI the needed capacity for interagency data analysis to ensure its effectiveness and continuous quality improvement in the overall behavioral health system, and to reduce behavioral health disparities.

II. Encourage best practices and remove system barriers to serving racially and ethnically diverse families in new CBHI services

The Best Practices Subcommittee was established to pursue this work. It mapped out a plan to convene CBHI providers who specialize in reaching and serving racially and ethnically diverse populations. The goals are to highlight and disseminate best practices and identify and remove systems barriers to reaching and serving racially and ethnically diverse families. The Subcommittee's timeline is as follows:

Timeline	Encourage Best Practice and Remove System Barriers in ICC
May 17, 2010	"Specialized CSA" Panel Presentation and Discussion
August 2, 2010	Written Summary of Specialized CSA Panel Presentation
Summer, 2010	Follow-up Interviews with Specialized CSA on targeted questions
October 4, 2010	Recommendations on systems barriers for culturally responsive practice.
December 2010/ January 2011	CSA Director Peer Learning Dialogue on Reducing Disparities in ICC

Update: The Specialized CSA Panel Presentation was held on May 17, 2010. Attached is a report highlighting the key issues raised by the presenters. Follow-up interviews are currently underway. Recommendations will be developed for presentation to the Advisory Council on October 4, 2010.

Recommendation for Council Approval: The Council urges the MassHealth Managed Care Entities to collaborate with this Committee to hold a "CSA Director Peer Learning Dialogue on Reducing Disparities in ICC" in December 2010 or January 2011. The Peer Learning Dialogue would take place as part of the regularly scheduled series of Statewide CSA Director meetings convened by the MCEs. The program would be developed jointly by the subcommittee and MCE individuals responsible for the statewide CSA director meetings Specialized CSAs and other CSAs would be encouraged to share their experiences as part of the program.

The Subcommittee has tentatively planned to convene discussions on other CBHI services.

Timeline	Encourage Best Practice and Remove Barriers in Other Services
Nov 2010	In-Home Therapy Panel Presentation and Discussion, featuring provider organizations and program directors who specialize in reaching and serving communities of color
February 2011	Therapeutic Mentoring Panel Presentation and Discussion, featuring provider organizations and program directors who specialize in reaching and serving communities of color

III. Improve the CANS instrument and training to encourage the culturally appropriate exploration of the needs and strengths of racially and ethnically diverse populations, informed by research.

A CANS Subcommittee is working over summer. Recommendations will be presented to the Children's Behavioral Health Advisory Council on October 4, 2010.

Appendix

Children's Behavioral Health Advisory Council
Healthcare Disparities Reduction and Elimination Committee

CBHI Specialized Community Service Agencies Panel Presentation on Delivering Intensive Care Coordination in the Black and Latino Communities, Year 1

May 17, 2010

CBHI Specialized Community Service Agencies
Panel Presentation Summary
May 17, 2010

Overview

On May 17, 2010, the Healthcare Disparities Reduction and Elimination Committee of the Children's Behavioral Health Advisory Council convened a panel presentation of these two Specialized CSAs to hear the lessons learned in the first years of delivering Intensive Care Coordination. The presenters were asked to identify systems barriers to effectively serving the Black and Latino communities and to highlight best practices to increase access and reduce disparities in the delivery of ICC that could be shared with all CSAs.

- ⇒ **The Children's Services of Roxbury** is a specialized CSA serving the Black community in Boston and Greater Boston. Edna Laurent-Tellus, Director of Behavioral Health and Salesia Hughes, CSA Director, participated in the panel.

- ⇒ **The Gándara Center** is a specialized CSA serving the Latino community in Springfield and Holyoke. Henry East-Trou, Executive Director, participated in the panel.

This report summarizes the key issues raised by the presenters. Members of the Healthcare Disparities Reduction and Elimination Committee are in the process conducting follow-up interviews to clarify select issues raised in the report.
The Committee will draw on this information to develop recommendations, which will be presented at the October 2010 CBH Advisory Council meeting.

Gándara Center (Gándara):

Mr. East-Trou began by describing the community roots of the Gándara Center as a center of community activism and advocacy within the Hispanic community. He referenced the high proportion of Hispanics in Holyoke (30% Hispanic population, 70% school population) and Springfield (27% population, 40% school population), and offered some quick demographics on the community, including a very high drop-out rate, average income a little over $8000, single heads of households with many phantom fathers (i.e., fathers who may be around but due to services being received, cannot officially show up in the household.) He briefly summarized the agency's evolution in providing residential, substance abuse, mental health and prevention services through contracts DCF, DYS and others, and most recently the development of an outpatient clinic. He described their advocacy and support for the shift to wraparound within DCF when Harry Spence was Commissioner. In response to the question of why the Gándara Center decided to become a CSA, Henry explained that it was "a logical evolution" and an obvious next step.

Children's Services of Roxbury (CSR):
Ms. Edna Laurent-Tellus also began by describing the community activist roots of the Children's Services of Roxbury, tracing their history in organizing within the Black community to establish an agency that finds Black adoptive and foster care families for Black children. She briefly described the wide array of services CSR provides today, including Parent Mentors and recent addition of children's behavioral health services. CSA Director Ms. Hughes explained that the largest proportion of families the agency serves are a wide diversity of Black families including African American, Haitian, Cape Verdean, Jamaican, and from several African countries. This is followed by a smaller but significant number of Latino families. Responding to the question of why they applied to become a CSA, Ms. Laurent-Tellus explained that children's behavioral health services is a recent addition to the agency's array of services, allowing for more and better preventive work. The agency works to help families access services so they don't have to file a CHINS or go to DYS to find services.

How well does ICC fit the needs of the community?

Both agencies described ICC as "a great fit". Both remarked that the main sentiment from many community members is "Where were you years ago, when I needed you?" This service is very much needed and long overdue.

Both agencies specifically identified the important new resource that ICC provides in building bridges between families and schools. Mr. East-Trou described how the families he works with are very intimidated by schools and professionals. Their voices are very meek and they're used to having the finger pointed at them, so they tend to shy away. He described his own past efforts with schools to increase parent involvement, and the difficulties. Both agencies commented about impact of the Family Partner and Care Coordinator helping the family to work with the school. Both also mentioned the role of the System of Care Committee in building sustained relationships with the schools.

Mr. East-Trou also described how the System of Care Committee opened communication between families and the police. He told of a parent speaking directly to the police at the committee meeting, saying "We don't trust you", and the resulting conversations about how to increase trust and find better ways for the police and community to work together.

Mr. East-Trou remarked that ICC is really helping to change the system of how kids are served. "This is pushing outpatient clinics and schools and the police to do something different, so families have a voice. We are breaking molds doing this."

Q: What practices have you found to be effective or "lessons learned" that might be shared with geographic CSAs as they serve Black and Latino families?

Q: What system barriers get in your way? What do you wish could be different? What would allow you to serve families better?

<u>Practices</u>

As documented below, both agencies described different practices that they use to deliver culturally relevant services to families in their community. Four major areas of practice emerged during the discussion, and within each one, several specific issues were identified.

1. Engagement Strategies
2. Hiring Staff Who "Know the Community"
3. Delivering a Comprehensive, Quality Assessment
4. Collaborative Planning and Training for Community-Oriented Staff

<u>System Barriers</u>

Both agencies identified the biggest system barrier trying to take the grassroots wraparound concept and make it fit into the medical model, especially the fee-for-service payment structure. They described how, in order to "do the right thing" for the families they serve, they had to disregard the financial incentives built into the current fee-for-service model. They expressed concern that these financial disincentives can drive practice "in the wrong direction". They attributed their agency's commitment to do right by families to their agency's roots in community activism. They voiced concern about whether they could sustain the best practices over time, and they expressed concern about the impact of these financial disincentives on practice across the CSA network.

1. Engagement Strategies

Children's Services of Roxbury described the intensive upfront investment of time by their Family Partners to bring families into ICC services (prior to enrollment in ICC), and the challenges involved in meeting families "where they are at" within the constraints of the current MCE guidelines. Ms. Laurent-Tellus remarked that there is a "difference in the Black community, in how they receive services, in how families want to be served" and that "they warm up differently."

The need for families to "warm up" shaped CSR's overall approach to engagement, their extensive upfront use of Family Partners, the amount of time invested to engage a family, the concrete crisis-oriented supports that staff provided prior to enrollment in ICC, and the overall number of days required to enroll the family.

They spoke of the barriers to gaining consent including trust, hospitalizations, parents' schedules, families feeling overwhelmed, chaotic households, telephone number by referral source is disconnected, waiting for DCF to give consent, and families' need for longer times to get comfortable with the services. Strategies for getting consent involve a lot of time and persistence, as well as creative ways to communicate with families: flexible hours, early morning, evening, weekend appointments, driving to the address and leaving notes for parents, writing letters.

This need for intensive engagement with families also informed CSR practice in working with families on the wait list. They described the importance of the trust that CSR had built with families and within the community over many years. As a result, many families refused to be referred to another agency and insisted on waiting until CSR had staff to serve them. At the same time, many of these families were in crisis and needed immediate supports.

To address this need, CSR rapidly ramped up their pool of Family Partners on a per diem basis to do this upfront work, shifting the Family Partner to a full-time employee when they had enough families enrolled to support an ICC caseload.

They also described how they utilized many additional staff beyond those who could bill (i.e., beyond the one family partner and one care coordinator), in order to help the family get to the point where they were actually in ICC. This additional staff time was donated by the organization.

CSR identified the following barriers to their practice of intensive upfront engagement:

⇒ The ICC guidelines say that "telephone contact" should be provided for families in the wait list. But if a family is facing a crisis, they need face-to-face contact. They need support while they're on the wait list.

⇒ Because they invest a tremendous amount of Family Partner time to engage families prior to their enrollment in ICC, they use up Family Partner units at a much higher rate than Care Coordinator units. They then have to invest time to make the case for additional units. Ms. Laurent-Tellus explained, "Yes, we can go for additional units, but it's harder. We need to justify them. The message is that we need to be careful. It encourages us to watch it. My point is to give us more units so that we can get the work done properly."

⇒ They also had to spend time in "trying to justify keeping someone on the list" beyond the allowable number of days. Ms. Laurent-Tellus commented that "the MCE's were very flexible. The policy was initially 28 days, and they changed it to 42 days so we could do the outreach" [without having to remove families from the Wait List while we were still working to engage them fully].

CSR Recommendations:

- ⇒ Ms. Laurent-Tellus urged more units upfront to allow CSR to do the needed engagement work.

- ⇒ Ms. Hughes commented that there are a significant number of families that only need a Family Partner and do not need the intensive service provided by ICC. She urged allowing the Family Partner service to be used separate from ICC, commenting that they had no trouble finding enough Family Partners to do both.

Note: A team within our committee is conducting follow-up interviews with the CSA presenters and their staff to more fully and accurately capture the nuances of the issues and barriers described here and to identify specific recommendations. A follow-up report with recommendations will be submitted in October 2010.

Gándara Center commented that "the trust issue is so huge in the community….so the timetables are different for engagement. And sometimes it's impossible."

"Given the barriers, my fear was that we would get to the start of ICC and not have one referral, so we started marketing early. We did a lot of [internal] training ahead of time so our staff could identify families we work with who are in need of the service."

Mr. East-Trou described how the challenges of trust and cultural stigma inform their approach to helping the family identify natural supports. He described how "in a small community, everybody knows everybody and they don't want their 'dirty laundry' out there. You don't want your church to know. You don't trust other family members because you don't want them to know. Pulling in natural supports is really challenging." He referenced a process that the Gándara Center has adopted which was developed in Texas to engage the family. He described their very concrete way to help families think about their possible natural supports, with a visual map of key institutions in the community. Henry added "We also ask them: Who are the people that you have helped? We turn it around so they can see it."

2. Hiring Staff Who "Know the Community"

Gándara Center described the challenges of finding bilingual clinical staff and their lessons learned in finding the most effective staff for ICC.

- ⇒ **CSA Director:** Henry described their tremendous difficulty in finding someone bilingual who understood the community to be the CSA Director. In the end they hired someone "who is not bilingual who has excellent [clinical] administrative experience, and whose Italian character fits well with the Latino culture."

- ⇒ **Care coordinators:** Henry explained "Initially I spent an enormous amount of time recruiting [bilingual Masters-level] clinicians…. We went twice to Puerto Rico to recruit and will probably go a third time. I have a colleague that used to work at Gándara who is in charge of doctoral level psychologists at the university in Puerto Rico. He puts all the ads in, and I sit for hours and interview people. It's been incredibly successful in terms of identifying qualified clinicians. In Puerto Rico, we recruited 5 Masters-level clinicians….

What we learned, doing this, is that clinicians have the hardest time adjusting to this sort of work because their mindset is different. It's deficiency-based. We brought case studies [from the CBHI Wraparound 101 trainings] to the interviews…. The strengths were in the stories but they couldn't see them. Clinicians had the hardest time finding strengths. They were ready to call DCF right away....

Most of our clinically trained staff has moved on. Some of them moved to our In-Home Therapy program which is closer to what they're trained to do…. The clinical people were accustomed to looking at one person, not at an ecological perspective. The field is changing to include things that we clinicians were not trained to do....

We started looking for care coordinators who aren't clinical social workers, but who understand community relations, case management, and social service. The ones that understand this best are bachelors-level human service workers that we recruited in Springfield, not in Puerto Rico. They're best adapted. They've had the least amount of challenges adapting. It's easier to teach people who haven't been molded. We recruit people who work in hospitals, human services who do case management and get it more easily....

It takes a certain kind of person. As we learned from Wraparound 101, you hire the person and you train the skill. You are really looking for a special person who is engaging, is comfortable with different situations, is positive and notices strengths and can pick those things out and sees things that will be missed from a deficiency point of view. That's the training that needs to happen. We all need to work on that."

Children's Services of Roxbury:

"You really need to know your community" explained Ms. Hughes. "You need to hire people who can go out there and really identify with the people you're serving, including the supervisors."

Care Coordinators: Ms. Laurent-Tellus remarked "I'd echo the same thing that Henry said. Trying to get Masters-level to do care coordination and not provide services … it was a challenge. But we need the Masters-level expertise to do a quality assessment-- to really determine what is going on …. We had to invest a lot in training in the beginning and even play a little with the model." [See below.]
Ms. Hughes added "We had trouble recruiting Spanish-speaking care coordinators."

Supervisors: With the fee structure, it was very hard to attract independently licensed clinicians for supervision.

Family Partners: Ms. Hughes remarked that it was easy for CSR to recruit Family Partners. She explained that she runs CSR's Parent Mentor program. 60% of the Parent Mentors qualified as Family Partners. They had to train them about SED, but it was not a problem to find Family Partners.

They elaborated on the challenges of their use of per diem (independently contracted) Family Partners to address the upfront engagement needs of the families they serve. In addition to hiring a small number of full time Care Coordinators and Family Partners, "we hired a lot of independently contracted Family Partners to fill the gap and meet the need [for intensive engagement prior to enrollment in ICC]. It's not attractive for the Family Partner. We can't pay them for travel. As we ramp up, we want people as fulltime employees. It's a programmatic issue because it's hard to have someone do that work if you're not going to pay them for travel. But we didn't have enough money coming in to offset the cost of hiring more full-time Family Partners.

3. Providing A Comprehensive, Quality Assessment

Children's Services of Roxbury: Ms. Laurent-Tellus made the following observations regarding comprehensive, quality assessment in the context of ICC.

"At CSR, we had a lot of discussion about what is a comprehensive assessment? What is staff supposed to produce? We took this very seriously because there are health care disparities, in terms of how people are diagnosed, what kinds of medications kids are on, and medications not being monitored. There are serious side affects to these medications. Diagnosing a kid is not something we take lightly. They can carry that label for the rest of their lives. And you have DCF, DYS, the school system … different systems looking at this kid, and if you're not careful, you can do more damage than good....

A Bachelors-level Care Coordinator, or even a new MA-level care coordinator coming out of school needs training and supervision to do a good assessment. You have people who are not really trained to work with the DSM-IV and you're sending them out there and giving them the CANS, and you need a comprehensive assessment...

From the very beginning, we were very aware of that, and we were trying to be very careful, so yes, we had some Masters-level clinicians. But we couldn't afford to have them being the only one doing the assessment. We had a doctoral intern working with us through the Center for Multicultural Training in Psychology. She helped us to focus on this issue. We did several things.

- ⇒ We labeled some MA-level people as "Assessors." They led the way through the assessment process. We had an experienced MA-level person working with the BA-level person, training them, supervising them.

- ⇒ We also looked at how we could standardize our assessment practice for this grassroots team, so that we're providing the right services [in our care plans]. So that even if someone doesn't have [clinical] expertise, we could standardize our practice so anyone could learn to do the assessment. We chose the Behavioral Assessment System for Children (BASC) *[Note: BASC is a comprehensive set of rating scales and forms including the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP), Student Observation System (SOS), and Structured Developmental History (SDH). Together, they help you understand the behaviors and emotions of children and adolescents.]* This was in addition to the CANS. This was one of the biggest challenges because we were adding to their paperwork. How do you combine all this information to really provide a comprehensive assessment for your child? That is really challenging.

⇒ In addition to our weekly staff meeting, we have a weekly clinical review meeting with a trained psychologist and psychiatrist, even though they weren't going out to do therapy. We have a child psychiatrist on staff. His time for planning, for training….these are non-billable services. He's very involved with our families. He does see each family, but he's a hands-on consultant for us. If you're talking about SED, the youth usually has a diagnosis and meds. We find kids who have been discharged from the hospital with meds that are not being monitored. They may not have been properly diagnosed and the police come and talk to them. The police can misinterpret what's happening. The psychiatrist needs to be part of the team so the meds they are on are being monitored. One of the systems issues our child psychiatrist asked us to raise is the need for an increased role for psychiatrists within the CSAs."

Gándara Center: Mr. East-Trou recommended a new option on the CANS called "Deferred Diagnosis". He commented "Right now, you have to put in a diagnosis. It doesn't make sense to have someone with a BA degree responsible to do the diagnosis. You want to wait until the family is seen by a clinician [which is part of the care planning process]. When you look at the criteria for ICC, IDEA criteria does not require any diagnosis for the service.

[Note: This was added to the CANS after the panel presentation.]

4. Collaborative Planning and Training for Community-Oriented Staff

Gándara:
Mr. East-Trou: "The biggest system barrier? Trying to take the grassroots wraparound concept and make it fit into the medical model. The challenge is working within the medical model, especially the fee-for-service model. Look at the issue of how long you train people. We can't wait a month to train people because we won't have any revenue for that person. So you try to squeeze as much training into the first week, and do some shadowing in the second week, but they have a caseload in the second week and the caseload keeps growing. And it gets worse if you have turnover and the caseload still needs attention. It's been said in the CSA stakeholder meeting that the rate is inadequate. But there's a bigger disconnect between the philosophy of wraparound and the fee structure. The incentives drive practice in the wrong direction....

If you're hiring people with a high school diploma or AA degree and 5 years experience, or with a BA and 1 year experience, or even a new Masters-level, you have to spend a lot of time with staff. The service is very supervisory intensive, but the fee structure doesn't encourage training or supervision for new people or less experienced people. That's the problem with the Massachusetts model….

Then there's a financial disincentive for the Family Partner and the Care Coordinator to communicate frequently or plan together. That's a non-billable activity if we do that. The Care Coordinator can talk to the child's teacher for a lot of time … as long as you need, but if you're planning for a team meeting and the Family Partner is involved, you can't bill for that time. It's almost as if you're not valuing the Family Partner with the community experience to the same degree as you're valuing something else."

CSR:
Ms. Laurent-Tellus: "The planning and training needed to do a comprehensive assessment, to be culturally competent … these are not billable activities. But if the care coordinators were going to connect the family to the right service, we needed to assess correctly to determine what services the family needs....

With the fee-for-service model, there's a disincentive to invest in this level of training, planning, team development. We're hoping that as we're going on, and we're well-trained and our staff people stay with us. That's part of the challenge. We're hoping to make sure people stay and grow with us."

Ms. Hughes: "You need to do cultural training often, so you get educated. For example, we had several Muslim families. We had to do training about how to work with the families in a way that would be respectful of their beliefs, their culture. We had a Jamaican family that wouldn't even speak to the Black Family Partner or Care Coordinators, so we needed training so we could better adapt to those situations. We need to run them [trainings] often to adapt our services to the families."

Gándara:
Mr. East-Trou: "I agree. Voice and choice means asking, not assuming. You want to make sure your practice is culturally competent. Never assume because if everybody you're serving is all white, you cannot assume that there aren't cultural issues. It's really about listening and making sure the services meet their needs. In the Hispanic community, there are different levels of acculturation. You have two generations in one household with different languages and different levels of acculturation …. Within any group there are particular subgroups with different values. All the gold nuggets you have by understanding the ecological picture of the family."

Other Challenges:

Gándara:

Finding needed services for parents, in order to help the child: Mr. East-Trou commented "When we go to homes, we also find that the parents need services. You're doing work for the mom, the dad who needs substance abuse, medical, case coordination for more than just the child because it impacts the child. That's a very important piece of what gets done. The challenge is whether we can find services for mom. Is there a waiting list if mom is "using" or living in an illegal apartment. What is going on with the parent impacts the child."

CSR:

Measuring Outcomes and Tracking Success: "We don't have the resources to conduct formal surveys or gather data. We know we are making a difference through our youth's progress. I get positive feedback from parents, school (e.g., guidance counselors, teachers, dean of schools) therapists, MDs, etc. For example, we had a guidance counselor and Dean of Students who came to our System of Care Committee to testify about the positive impact of the ICC and Family Partner's work on the lives of their students. Another example is a youth who came to us about 9 months ago, who was a trauma-survivor, homeless, unemployed and now has an apartment with Section 8, and is completing his GED and is employed, hopeful, connected to natural supports and outpatient therapy. This is the anecdotal data. But this is something I wanted to bring up in terms of a challenge. That's the real challenge in terms of funding to gather data. It's not billable. Measuring outcomes, gathering data takes time. We don't have a formal way of monitoring our relationship with the school system. We work with a family for 6 months, and then they move on. We don't have a way of seeing if it makes a difference in school over the long term."

Final Comment:

"As imperfect as this is, this is fantastic!"

Henry East-Trou, Gándara Center

Children's Behavioral Health Advisory Council
Workforce Development Work Group Report
June 7, 2010

The Workforce Development Work Group's recommendations are based on two key sources, a recent children's behavioral health workforce study conducted by the Blue Cross Blue Shield of Massachusetts Foundation (available on the Blue Cross Blue Shield of Massachusetts Foundation website) entitled, "Accessing Children's Mental Health Services in Massachusetts: Workforce Capacity Assessment" and a workforce survey of the 32 new Community Service Agencies conducted by our work group (Appendix). Priority workforce needs were informed by these two sources, as well as the extensive knowledge about the field among our work group members.

The Workforce Development Work Group broke into 3 subcommittees to develop workforce recommendations: 1) Pipelines and Pathways Subcommittee, 2) Nursing Subcommittee and 3) Independently Licensed Practitioners Subcommittee.

Thanks to all the members of the Workforce Development Work Group for the substantial time and commitment that they invested in developing these recommendations.

Kermit Crawford, Chair

I. CSA Workforce Survey: Key Findings

Family Partners:

- **Three quarters of CSAs are finding it somewhat difficult or more to hire Family Partners.** A third have significant vacancies now, while 2/3 anticipate the need to hire 4-8 more Family Partners over the next 12 months. In order of magnitude, we're talking about perhaps 100 more Family Partners, suggesting that a small intervention to support recruitment could yield significant support to the CSAs.

- **There appears to be no clearly developed pathways to reach appropriate candidates for this role.** The top barriers to hiring Family Partners are:
  1. Applicants are not parents/caregivers of kids with behavioral health challenges.
  2. Very few applicants.
  3. Applicants who are caregivers don't have the right skills or experience.

- **Close to half CSAs find it difficult to find Family partners from major racial, linguistic, and ethnic communities,** with another 35% finding it somewhat difficult.

- **Most CSAs were aware of PAL's early efforts to identify interested candidates for Family Partner. Roughly half said they were a good match.** A few commented that the referrals were sent before the CSA was ready to receive the referrals.

- **Over 80% of the CSAs said that supervisors of Family Partners need specific skills, training or supports, distinct from general supervisory skills.** Many CSAs provided detailed comments on the additional training needs of these Supervisors to support the professional development of Family Partners.

Care Coordinators:

- **Hiring for Care Coordinators appears less challenging than for Family Partners. Overall, there has not been a high turn-over in the first year of MA-level clinicians.**

- **CSAs seem to be experimenting with various strategies on balancing MA-level with BA-level care coordinators.** More than half of the CSAs have about a 50/50 ratio, while several CSAs have 90-100% MA-level clinicians. Several indicated plans to shift their ratio slightly, but in both directions. Those relying more heavily on MA-level care coordinators indicated concern about the level of staff development, supervision needed for less-experienced, BA-level staff.

- **There is high interest in placing MASW or MA Psych students as interns at the CSA if they could be billed at a bachelor's level rate.** Sixty percent are definitely interested and another 17% are possibly interested. At least 5 CSAs are already moving forward on this. Adequate time for supervision is the biggest concern.

Clarification from MCEs on billing and from colleges that ICC hours would go toward licensure would be most helpful.

- **CSAs are interested in a model for a BSW internship as a pipeline for BA-level clinicians of color.** 30% are definitely interested and 50% are possibly interested.

For more details on survey results, see Appendix.

II. Summary of Recommendations

Pipelines and Pathways Subgroup

Goal: Pro-actively establish pathways and pipelines to:

- **diversify the CBHI workforce** to reflect the populations served and meet the linguistic needs of families on MassHealth
- **expand the CBHI workforce** for those interested in community-based, family-centered practice.

Recommendations	Action Items
1. Remove barriers to field placements at CBHI provider agencies as a way of developing and training a workforce interested in community-based practice.	a. Publicize the business model for field placements b. Encourage the MCE work group to partner with the Workforce Development Work Group to: ▪ Clarify billing policies for interns in writing ▪ Host a training for CBHI providers on integrating interns into program models. ▪ Share information on the field placement supervisory requirements for the relevant programs at various universities and colleges c. Continue work with the CBHI Higher Education Work Group to: ▪ Educate field placement offices ▪ Promote System of Care Curriculum d. Increase resources for supervision and training of workforce at the provider level
2. Actively promote field placements that can help improve workforce diversity.	a. Promote replication of pre and post doctoral internships through the Center for Multicultural Training in Psychology. Specifically: ▪ Share the attached Case Study on Roxbury Children's Services CSA with providers ▪ Invite the Roxbury Children's Services and the Center for Multicultural Training in Psychology to present to other directors about this program at regular meetings of CSA directors and IHT directors. b. Approach Salem State to adapt BSW Public Welfare Scholars project (partnership between DCF and state college BSW programs) for CBHI to create a pipeline of BSW students of color into the field.

Recommendations	Action Items
3. Enhance provider efforts to expand the number and diversity of Family Partners.	a. Foster partnerships between CSAs and grassroots community organizations where candidates for Family Partners from diverse communities can be readily identified. Continue to support PAL's multicultural outreach efforts to strengthen these linkages and explore federal or private funding opportunities for CSAs to strengthen these partnerships. b. Consider utilizing PAL's Family Partner Training to pre-certify parents as potential Family Partners for any CBHI service, not only for ICC but for expansion of this service as a stand-alone service. c. Consider offering specific supervisor training for Family Partners, to increase supervisor capacity to coach and support a wider range of talented community residents to serve in this role.
4. Remove barriers for individuals with relevant personal life and community experience, but without degrees, to serve in "paraprofessional" positions.	a. Continue to ensure that MCEs authorize team-based interventions that integrate community knowledge with clinical expertise. b. Further expedite the waiver process to allow experienced individuals without degrees to work in "paraprofessional' positions in In-home Therapy, In-home Behavioral and Mobile Crisis. ▪ MCEs are urged to partner with the Workforce Development Work Group to develop additional strategies to decrease risk of hiring candidates requiring a waiver. These may include clearer criteria for a waiver, decreased hiring delay by initiating the waiver process simultaneous with the interview process or other strategies. ▪ Develop online certification program in children's behavioral health for experienced human service workers without degrees, especially residential mileau workers, youth workers, substance abuse counselors, and domestic violence counselors. Certification should pre-qualify individuals for waivers. c. Convey our System of Care's respect for life experience by MassHealth and MCEs shifting language from "paraprofessional" to "community mental health worker" as the generic term for non-degreed positions.

Nursing Subgroup

Recommendations	Action Items
1. Increase the number of advanced practice psychiatric nurses (APRNS/ CNS) with an expertise in the assessment and treatment of child/adolescent mental health	a. **Endorse and encourage the development of a Certificate of Advanced Graduate Study to current psychiatric CNSs** who currently specialize in working with adults ▪ A 24-credit program with a psychiatric subspecialty in children, adolescents and families. ▪ Includes a 16-20 hour/week field placement for 10 months with face-to-face patient contact, preferably within the CBHI service array. ▪ Those who complete the program will be eligible for national certification as a psychiatric CNS, thereby increasing the workforce of APRNS specializing in the assessment and treatment of children's behavioral health.
2. Increase expertise of school nurses to provide both prevention and treatment-based services, using a public health approach as well as individually-based services	a. **Endorse and encourage six regional one-day MDPH Introductory Children's Behavioral Health Program for School Nurse**s to develop the skills and knowledge among school nurses to assist them in identifying, assessing, intervening and referring appropriately when encountering behavioral health problems in children and adolescents. b. **Support a partnership with a university to create a graduate level online course in school nurse behavioral health competencies.** This course could serve as an introductory course to a number of graduate degree programs offered in child and adolescent subspecialties in psychiatric nursing or other nursing subspecialties. c. **Support school nurse pursuit of graduate degrees in related fields,** including identification of funding opportunities such as the National Health Service Corps or ARRA-MA-State Loan Repayment Program. d. **Clinical Specialists in Child & Adolescent Psychiatric/Mental Health Nursing as Consultants to School Nurses.** Drawing on the MCPAP model, create a psychiatric nursing consultation service to schools and school nurses.

Private and Independently Licensed Practitioners Subgroup

Goal: Develop strategies to recruit and retain independently licensed practitioners:

- In private practice as outpatient behavioral heath providers for MassHealth including MBHP and the Managed Care Entities
- In agencies providing CBHI services

Recommendations to Recruit and Retain Outpatient Providers in Private Practice to MassHealth	Action Items
1. Address perception of MassHealth/MCE panels are closed	Possible options: a. Adopt any willing provider. b. Open panels to providers at a specific time for a specific interval each year, e.g. January 1- February 15. c. Notify professional associations of current panel needs 2x/year.
2. MCEs create uniform credentialing procedures	
3. Reduce post-licensure work experience & volume requirements for empanelment	
4. Provide trainings about CBHI & wrap-around/home based services	a. Explore a joint CE training among professional associations, perhaps with private insurers sponsorship b. Development of CEU programs on CBHI as a way to help educate practitioners regarding the systemic changes in Massachusetts
5. Develop benefits message	a. Support/resources available – ICC available for collateral work; not isolated in treating these patients- other CBHI staff available. b. Future Payment reform – private practitioners will need to integrate with accountable care organization. c. May provide a steadier payment stream during bad economic times.

Recommendations to Recruit & Retain Independently Licensed Providers to Agencies that Provide CBHI	**Action Items**
1. Differential rates for independently licensed practitioners with more years of experience or additional credentials as a mechanism for retaining qualified staff	
2. Differential rates for independently licensed practitioners with language capacity	
3. Loan forgiveness programs for human service practitioners working in home-based services	
4. Identify strategies to promote use of independently licensed in private practitioners to support agencies needing licensed practitioners for supervision	
5. Expand Internship and training opportunities	a. Long-term strategy: Influence NCQA requirements that present barriers to funding internship training

III. Pipelines and Pathways Subgroup Report

Submitted by: Yolanda Cuentro, Chantell Albert, Karen Shack, Kelly English, Kermit Crawford, Marcia Webster, Cheryl Springer, Samuel Arce, Robin Van Ricca, Jackie Gelb, Margot Tracey

Goal: Pro-actively establish pathways and pipelines to:

- **diversify the CBHI workforce** to reflect the populations served and meet the linguistic needs of families on MassHealth

- **expand the CBHI workforce** for those interested in community-based, family-centered practice.

CBHI services are fundamentally different from more traditional clinical services, requiring the workforce to go into the community, work in a variety of settings, and engage with families as partners. Those interested in office-based clinical practice are not always the best suited to this work, but there is currently no readily identified professional pathways in Massachusetts for those best suited to this community-based, family centered practice.

In addition, CBHI providers are challenged to find bilingual clinicians and clinicians of color, an important strategy for ensuring culturally responsive practice and reducing disparities.

The success of CBHI in meeting the needs of children, adolescents and families is dependent upon increasing the size and diversity of the professional workforce and insuring that this workforce is adequately prepared in systems of care principles and wraparound practice methods.

Recommendation 1: Remove barriers to field placements at CBHI provider agencies as a way of developing and training a workforce interested in community-based practice.

Field placements, especially with graduating seniors, can be one of the most effective ways to create a pipeline for a CBHI workforce, through direct exposure to systems of care practice and wraparound principles early in a person's career.

In the past, providers have demonstrated with other services (such as FST) that there is a viable business model for supporting field placements by placing interns in entry-level, billable roles during year-long field placements of 16+ hours/week. Students are exposed to community-based mental health services, gain an appreciation of the work and build relationships that readily lead to employment after graduation.

Several CBHI providers are beginning to experiment with field placements for the new services. Examples of potential opportunities might include:

- Placing MA level interns as Therapeutic Mentors as part of an ICC team
- Placing BA level interns such as Therapeutic Training and Support positions as part of In-home Therapy team, or in a paraprofessional role with In-home Behavioral service or perhaps Mobile Crisis.

The financial fragility of the system creates a risk-averse environment for providers. Any ambiguity regarding billable service is enough to discourage a CFO from approving innovation with field placements. Conversely, any information that decreases risk will help advance the goal of engaging field placements in CBHI services.

Action Items

a. Promote business model for field placements: Promote the business model for utilizing interns at community based agencies and educate agency directors on the financial incentives of this practice. Also, educate providers on the positive implications for hiring and capacity-building in programs.

b. Encourage the MCE work group to partner with the Workforce Development Work Group to:

- **Clarify billing policies for interns:** clarify whether providers can bill for bachelors-level seniors (especially in degree programs) in positions requiring associates degrees, and can bill for masters-level seniors in field placements serving in paraprofessional roles, and other related questions.

- **Host a training for CBHI providers** on integrating interns into program models. Specifically, invite The Home and other CBHI providers with well-developed field placement models to share their models at an upcoming CSA directors meeting and IHT directors meeting.

- **Share information on the field placement supervisory requirements for the relevant programs at various universities and colleges**. This information is currently being assembled by the Workforce Development Work Group. Although the financial constraints in the new services means that licensed supervision is less readily available, some programs have more flexibility than other. In our CSA Directors Workforce survey, half of the CSAs definitely want to create a field placement program and another quarter indicated they are possibly interested.

c. Work with CBHI Higher Education Work Group to:

- **Educate field placement offices** about potential internship opportunities in community-based settings and also prepare them for requirements of internships so they can better prepare students to enter the field (cars, somewhat flexible hours)

- **Promote System of Care Curriculum**: Encourage colleges and universities to incorporate curriculum including systems of care philosophy, wraparound principles and CBHI.

d. **Increase Resources for Training and Supervision:** Change the rate structure to provide adequate training and supervision for interns and other inexperienced staff. The inadequate rate structure for supervision, peer collaboration and staff training is the biggest barrier to creating a field placement model within CBHI services. Previous services such as FST were more easily suited to field placements because supervision was separately reimbursed. (See attached.)

Recommendation 2: Actively promote field placements that can help improve workforce diversity.
Some Massachusetts CBHI providers are specifically utilizing field placements as a pipeline strategy for a more diverse workforce. These examples, and any others, should be promoted as best practice and supported by EOHHS and the managed care entities.

Action Items

a. **Promote replication of pre and post doctoral internships through the Center for Multicultural Training in Psychology:**

- **Share the attached Case Study on Roxbury Children's Services CSA with providers**

- **Invite the Roxbury Children's Services and the Center for Multicultural Training in Psychology to present** to other directors about this program at regular meetings of CSA directors and IHT directors.

During the CBHI start-up year, the specialized CSA serving Boston's Black community, Children's Services of Roxbury, partnered with the Center of Multicultural Training in Psychology, to host a 40 hour/week pre-doctoral clinician who worked both as a Care Coordinator for ICC and an In-home Therapy provider over the course of the year. The director estimates that even in this start-up year, the intern generated enough income to pay for 80-100% of the $35,000 cost of the internship, and that in Year 2, the internship will certainly pay for itself. Although the intern went on to Yale for her post-doc, she made it clear that if she had been offered a two-year pre and post-doc, she would have stayed. Roxbury Children's Services will continue to accept interns through the Center for Multicultural Training in Psychology, and post-doc options will be explored for the future. Nationally, evidence shows that interns in their last year of study frequently remain at the organization in which they interned. This model offers a cost-neutral strategy for recruiting and retaining clinicians of color to

Massachusetts. A detailed description of the partnership that placed a pre-doc intern of African-American and Ethiopian descent at Children's Services of Roxbury CSA is attached.

b. **Develop a pathway for BSW Students of Color through Internships:** Consider adapting the model developed by Salem State School of Social Work to create a pipeline of BSW students of color into the field of children's behavioral health.

In April 2009, Salem State College School of Social Work partnered with the Massachusetts Child Welfare Institute and the Department of Children and Families to launch the BSW Child Welfare Scholars Project – a project funded by the National Child Welfare Workforce Institute. The Project is designed to identify "the best and the brightest" BSW students (with a focus mainly on ethnic and linguistic diversity), train them in Systems of Care principles and trauma-informed practice, place them in DCF field placements, and create a pathway for young people of color into the field. *BSW Child Welfare Scholars Project* is collaboration among the BSW programs at the three state colleges, Bridgewater, Westfield, and Salem. Within the first two cohorts, 12 BSW students, including eight students of color and four men, were competitively selected to serve in DCF field placements for 16 hours/week for an academic year, with a commitment to accept employment with the Department of Children and Families upon graduation. Grant funding paid stipends for tuition, fees, and associated educational expenses. Salem State College's BSW Program committed to developing curricula specific to integrating systems-of-care principles into child welfare practice education.

Given the limited number of Masters-levels clinicians of color, and given that approximately half of all Care Coordinators have bachelor's degrees, it is important to recognize the BA-level positions as a potential pipeline for bringing more people of color into the field. UMass programs in counseling and nursing and BSW programs at some private colleges like Wheelock may also be helpful access points for attracting students of color at the bachelor's level.

Recommendation 3: Enhance provider efforts to expand the number and diversity of Family Partners

Our subcommittee conducted a CSA Workforce Survey to gather up-to-date information on the successes and challenges of recruiting and retaining Family Partners and Care Coordinators in the first year of ICC (attached). The survey findings highlighted the challenge of creating a steady pipeline of candidates for Family Partners, particularly from diverse communities.

a. **Three quarters of CSAs are finding it somewhat difficult or more to hire Family Partners.** A third have significant vacancies now, while 2/3 anticipate the need to hire 4-8 more Family Partners over the next 12 months. In order of magnitude, we're talking about perhaps 100 more Family Partners, suggesting that a small intervention to support recruitment could yield significant support to the CSAs.

b. **There appears to be no clearly developed pathways to reach appropriate candidates for this role.** The top barriers to hiring Family Partners are:
   - Applicants are not parents/caregivers of kids with behavioral health challenges.
   - Very few applicants
   - Applicants who are caregivers don't have the right skills or experience.

c. **Close to half CSAs find it difficult to find Family partners from major racial, linguistic, and ethnic communities,** with another 35% finding it somewhat difficult.

d. **Most CSAs were aware of PAL's early efforts to identify interested candidates for Family Partner from communities of color. Roughly half said they were a good match.** A few commented that the referrals were sent before the CSA was ready to receive the referrals.

e. **Over 80% of the CSAs said that supervisors of Family Partners need specific skills, training or supports, distinct from general supervisory skills.** Many CSAs provided detailed comments on the additional training needs of these Supervisors to support the professional development of Family Partners.

Action Items

a. **Foster partnerships between CSAs and grassroots community organizations** where candidates for Family Partners from diverse communities can be readily identified. Continue to support PAL's multicultural outreach efforts to strengthen these linkages and explore funding opportunities for CSAs to strengthen these partnerships.

b. **Utilize PAL's Family Partner Training to pre-certify parents as potential Family Partners** for any CBHI service, not only for ICC but for expansion of this service as a stand-alone service.

c. **Offer specific training for Family Partner supervisors**, to increase supervisor capacity to coach and support a wider range of talented community residents to serve in this role.

Recommendation 4: Remove barriers for individuals with personal life experience and community expertise to serve in "paraprofessional" roles.

Our communities are overflowing with talented individuals without degrees, but rich in personal and community experience dealing with child trauma, youth incarceration, family neglect and substance abuse. These individuals do not qualify for the "Family Partner" role, because they may not be a parent of a child with behavioral health needs. Rather the individuals may, themselves, have grown up in foster care, group homes or DYS, and now work as milieu workers in residential programs, as youth workers, as substance abuse counselors, or in similar social service roles. For those who do stints in residential programs, these are typically part-time jobs with no career ladder into children's mental health. Particularly with shrinking employment opportunities in residential programs, this is a workforce that should be actively pursued.

Action Items

a. Continue to insist that MCEs authorize team-based interventions that integrate community knowledge with clinical expertise.

While MCE policy is to authorize team-based interventions, there has been inconsistency in authorizing team-based services. We appreciate recent MCEs clarification that team-based interventions are allowable. From a workforce perspective, it is important to recognize that any pressure toward individual (non-team) interventions moves the system toward Masters-only staffing models. Team--based interventions, in addition to providing more culturally relevant interventions, provides opportunities for on-the-job professional development.

b. Further expedite the waiver process to allow experienced individuals without degrees to work in "paraprofessional' positions in In-home Therapy, In-home Behavioral and Mobile Crisis.

To date, the Managed Care Entities have taken a great first step at streamlining the waiver process by unifying the process across the 5 MCEs. However, the 3-week delay in approval creates a significant barrier, because the agency incurs a risk in waiting for a waiver that may or may not be approved. In the current risk-averse financial environment, this delay is enough to prevent providers from considering candidates that require a waiver.

- The MCE team is urged to partner with the Workforce Development Work Group to develop additional strategies to reduce risk to providers of considering candidates who require a waiver. These may include clearer criteria for a waiver, a way to initiate the waiver process simultaneous with the interview process or other strategies.

- Develop online certification program in children's behavioral health for experienced human service workers without degrees, especially residential mileau workers, youth workers, substance abuse counselors, and domestic violence counselors. Certification should pre-qualify individuals for waivers.

c. Convey our System of Care's respect for life experience by shifting language from "paraprofessional" to "community mental health worker" as the generic term for non-degreed positions.

Case Study
Center for Multicultural Training in Psychology Arranges Pre-Doctoral Internship at Children's Services of Roxbury CSA
2009-2010

Overview

During 2009-2010 (the start-up year for all CBHI services), the Center for Multicultural Training in Psychology placed a pre-doctoral intern of African American/Ethiopian descent at the specialized CSA in Boston's Black community, Roxbury Children's Services. This marked the first collaboration on child/family focused services between Children Services of Roxbury (CSR) and Center for Multicultural Training in Psychology (CMTP).

The Center for Multicultural Training in Psychology (CMTP), at Boston Medical Center and the Boston University School of Medicine, is an APA-accredited clinical internship program. This program formally began at Boston City Hospital (BCH) in 1972 as the Minority Training Program in Clinical and Community Psychology. The program's primary mission has always been and remains focused on training ethnic minority and other cross-culturally oriented interns in the culturally competent practice of professional Psychology. CMTP interns specialize in providing services with cross-cultural knowledge, awareness, and skills in the appropriate language and at the appropriate level of literacy. Over 257 persons have received training within the program, either as pre-doctoral interns or postdoctoral fellows, since its inception. Of these, 85% have been individuals from racial and ethnic minority groups. CMTP is the oldest multicultural internship training program in the nation.

Internship Description

CMTP placed one intern at Children's Services of Roxbury CSA for the full training year (9/2009- 8/2010). She is placed at CSR forty (40) hours per week (FTE). She is a pre-doctoral intern of African-American/Ethiopian descent who completed all requirements for her doctoral degree with exception of the dissertation prior to internship. She had extensive experience working with Black, Latino, poor, medically under-served urban populations prior to internship. In the CSR placement she has been afforded experiences in the provision and development of intensive, family-centered, strengths-based wraparound services for youth and in-home therapy services for families. She provides diagnostic assessments for children and adolescents, clinical consultation to care coordinators and intensive care coordination for predominantly Black and Latino families residing within the Boston metro area. Additionally, she worked with CSR to develop community partnerships aimed towards the provision of child mental health services. This includes outreach and partnerships with local homeless shelters and developing a parenting group for mothers. Her work at CSR also involves interacting and collaborating with a number of service and community-based agencies that the family is involved with. CSR has recently begun providing in-home therapy services and the intern has been assisting with development of best practices model and program and training development for the In-home Therapy Services program. The intern began working directly with families as these services began on March 30, 2010.

The CSA Perspective
(From the Director of Behavioral Health at Children's Services of Roxbury)

Children's Services of Roxbury is very privileged to be affiliated with the Center for Multicultural Training in Psychology (CMTP), a leading institution in providing cultural competent training and services. The affiliation with CMTP has been strategically important in helping our Community Service Agency (CSA) fulfill its mandates as a specialty CSA for the black population.

We are very fortunate to have an intern who is an experienced clinician. She has been willing to think outside the box to understand and integrate the community-based wraparound process into her clinical practice. I encourage critical thinking. Our intern took advantage of that opportunity to provide constructive feedback. She challenged us to further examine our charge of providing high quality cultural competent services for the black community. Her input helped us to take the extra step in assuring that our assessment process is standardized and evidence-based without neglecting the grassroots aspects of wraparound.

Our experience with CMTP has been positive. They take the care necessary to match interns to the right settings. Also evident was the dedication of CMTP staff to ensure that the placement would be a rewarding experience for the intern and CSR. Our intern came with a wealth of knowledge and experience working with the individuals/families that we serve. She also has a keen interest in exploring innovative approaches in delivering psychological services in community settings.

We also benefit from having the expertise of the CMTP's Director, Dr. Crawford, at a macro level. Dr. Crawford has been accessible and very flexible in accommodating the needs of the program. He has also demonstrated great commitment to our mission and success. Dr. Crawford provides weekly consultation which focus on program development. He also provides staff development training. Through CMTP association, we also have at our disposition the expertise another experienced psychologist, Dr. St. Louis. Dr. St. Louis has been instrumental in working with me and our intern to help standardize our clinical practice. She provides ongoing consultation on best clinical practices and hands-on training to staff members on the implementation of the Behavioral Assessment System for Children (BSAC-2).

Our intern accurately described in her comments the challenges we faced with the placement in the beginning. In order to ensure that her assignment would meet her academic obligations, we were compelled to tackle the issues related to the clinical and non-clinical aspect of Children Behavioral Health Initiative (CBHI) services. CMTP and CSR staff, with the full participation of our intern, were able to brainstorm solutions that have strengthened our program and also enriched the experience of our intern.

The $35,000 fee charged by CMTP fades in comparison to the value added to our program. Even in this first, start-up year, we estimate that the intern's billable income covered 80-100% of that cost. Without question, in Year 2, we will cover 100% of the costs of our next pre-doctoral intern. We hope to continue this important affiliation for years to come.

We asked the intern for her reflection on the experience and she provided the following:

Intern's Perspective

I began working with Children's Services of Roxbury (CSR) in September 2009. Since I was the first pre-doctoral intern to work at the site and as the site was still adjusting to the new services it was offering as a Community Service Agency (CSA), my particular roles and responsibilities were not clear. While this was anxiety provoking at times, it also opened up a number of possibilities to envision and shape my training experience. My initial role at CSR was to serve as an Intensive Care Coordinator (ICC). During my first couple of months in this role, the issue of what constitutes "clinical services" was continuously examined by me and my supervisors. Admittedly, although I have previously provided some forms of in-home and community-based services, what was being attempted at CSR through the utilization of the wraparound process and a rebuilding of community in increasing mental health was a challenge to me. The previous training that I had received in providing individual and family services, even with a systems perspective, felt extremely narrow in comparison to this new way of working with families that I was being presented with. A model in which working with the identified youth and their families could utilize a truly collaborative approach inclusive of a number of providers and "team members" (e.g., school personnel, clergy, PCP, therapist, extended family) and driven by the families needs. How do you adjust traditional individual and family therapy approaches to really incorporate "family voice and choice"? Further, working with other clinicians, paraprofessionals and family mentors with differing levels of education and training on mental health issues presented another challenge – specifically, how do we all get together and "speak the same language" in order to provide the best services possible for our clients?

As I delved into my position during the first few months at CSR, I observed the ICC process, reviewed the CBHI mandates, attended ICC and wraparound trainings and reviewed the wraparound literature. During that time, there were several areas in which I saw CSR could become more efficient and effective in ICC services. Edna Laurent, the CSA program director was extremely receptive to feedback that I presented to her including training topics that I believed would be beneficial to other ICCs and Family Partners. This receptivity is but a highlight of the agency's commitment to establishing best practices. One area that I spoke about with Mrs. Laurent and my clinical supervisor, Dr. Gemima St. Louis, was around assessment procedures. Through several talks, we developed a model of having "assessors" serve as the initial contact for families being referred to for ICC services. The assessors would have more experience and knowledge in clinical issues and could assist in the provision of a "comprehensive assessment inclusive of the CANS" that was being required of agencies. In addition, we defined what a "comprehensive assessment" was inclusive of for the agency and, under the direction *of Dr. St. Louis, began utilizing the Behavior Assessment Scale for Children (BASC-2) as a standardized measure that could provide a more comprehensive picture of the youth's presenting concerns (forms are available for the youth, parents, and teachers) and serve as an outcome measure in the future. As an intern, the involvement of program development and organization is something that is not present in most training settings. My feedback and previous experiences in organizational leadership was well-received by Mrs. Laurent and CSR. Additionally, my clinical background enabled me to provide additional support via clinical consultation to other ICCs and Family Partners.*

In March, CSR began providing In Home Therapy (IHT) Services and I was given the opportunity to serve as an IHT therapist. Again, I was able to provide feedback to CSR and my supervisors about ways in which the process could be streamlined, including actively working with CSR in selecting, developing and refining agency documents (i.e., consents, initial assessment guides, and treatment plan forms) and how we could envision our services. One issue that I noted was that, while the CBHI services all utilized wraparound principles, what I felt was lacking was a clear theoretical lens through which we, as an organization, could articulate how we view our work with families. At this point, I began talking with Edna and Dr. St. Louis about adopting a family systems theory (or "lens") and being explicit about this not only in how we described our services to families and referring agencies, but to how we could all easily understand and conceptualize our work. As these services are new, we are still building on these processes and I am eager to watch these services grow.

So far, I have addressed what I have gained from my experience with this organization on the part of organizational development and administration, but I have not discussed my work with families. The criteria for most CSA services are that the identified youth be diagnosed with a "serious emotional disturbance". Most of the youth I have worked with are dealing with trauma-related issues and reside in families that have become taxed and abused by most of the systems that were intended to assist them. This includes parents being blamed for their children's behavioral concerns by school personnel and mental health workers, youth being defined by their mental health diagnoses, and families that feel helpless to a larger "system" that they have no voice in or control of. Add to this the economic issues, limited access to resources and increased disconnection from any sense of "community" and you not only have youth in crisis, but families in crisis, such that they cannot provide the support that the youth needs. What I have seen and been a part of through my training and work at CSR is how to rebuild family hope. How families can re-author the narratives that have been assigned to them by different systems. How families can reconnect to communities and become a part of that community-building process. This is not something that can simply be taught during the "50-minute" hour in the therapists' office. It requires the therapist to bend and grow with their families. It requires the therapist to take her training and apply it as it is needed, but consistently guided by the family as not merely an "active participant", but as the director of treatment. It requires the therapist to equally value all voices of the clinical team regardless of "degree" or "specialization". Prior to working at this site, I had always believed, and had received feedback, that I worked in a very respectful and collaborative manner – but this was different in that it pushed me in how I used my "expertise" and to *what degree I really incorporated different team members. Knowing that our profession is increasingly moving towards integrated healthcare models and the need for out profession to re-envision the places in which psychologists practice – I feel that this experience has given me some truly cutting edge experiences that have prepared me to not only think about different contexts of work, but even in how to start my own practice or clinic! I believe that this was most evidenced during my interviews for postdoctoral positions, where they were so interested in the model that CSR was using in providing services that they wanted to know how I might go about doing the same at their site!*

As a result of my work at CSR, I have:

- *Gained experiences in the provision and development of intensive, family-centered, wraparound services for youth and in-home therapy services for families;*
- *Provided diagnostic assessments for children and adolescents, clinical consultation to care coordinators and intensive care coordination for predominantly Black and Latino families;*
- *Worked with CSR on developing community partnerships aimed towards the provision of mental health services (including outreach and partnerships with local homeless shelters and developing a parenting group for mothers – which I did not mention earlier);*
- *Interacting and collaborating with a number of service and community-based agencies that the family is involved with and;*
- *As CSR is in the process of developing a separate mental health clinic, I have been on the ground floor of the process involved in its development and have received invaluable experiences in the administrative aspects and planning of a community mental health clinic*

I don't think many pre-doctoral interns can claim such a broad range of experiences ☺

Summary from Center for Multicultural Training in Psychology Perspective

This has been a WIN-WIN proposition in that this collaboration has essentially brought a skilled and experienced doctoral level clinician to provide services as part of and resource to the ICC and In-home Therapy Program working teams.

The intern brought, and has gained, a wealth of clinical experience and knowledge, including knowledge of culturally competent practices. She has been an excellent role model and peer. Significant value has been added to the CSR setting and staff along with a substantial resource for evidence based practices, training and collaboration. This has been an excellent experience for the intern. She has accepted a child post-doctoral fellowship, upon completion of her pre-doctoral internship, at Yale University to begin in September, 2010. Her career plans are to work with CBHI population.

CSR has been an outstanding placement as have the staff and leadership. The challenges were minimal, and primarily involved integration into a new setting. An additional benefit has been the expanded collaboration between CMTP and CSR in development and application for mental health license and also recruitment of experienced and credentialed clinical personnel. This collaboration will continue for the 2010-2011 training year. Further, an affiliation agreement was signed between CSR and CMTP (Boston University School of Medicine/Boston Medical Center) which will facilitate long-term collaboration and resource-sharing.

The training and service model that has been developed in this collaboration is exportable. It can be helpful both in enhancing the quality of existing services and developing child clinicians to address projected future shortages in the state. CMTP is exploring the option of developing a two-year pre- to post-doctoral placement in the CSA. This model would not only allow providers the opportunity to train interns in their methods and culture, but would offer them a higher probability of recruiting and retaining licensed doctoral level child clinicians of Color. This model would benefit the trainee by providing a nationally recognized pre-doctoral internship combined with a post doctoral fellowship at the Boston University School of Medicine. A year long pre-doctoral internship is required for completion of the doctoral degree in psychology, and a year-long post-doctoral fellowship (or equivalent) is required for licensure as a psychologist nationally. Since CMTP recruits interns from across the nation, it has the capacity to expand placements to additional CSAs and In-home Therapy programs.

IV: Nursing Workforce Subgroup

Submitted by: Mary Ann Gapinski, MSN, RN, NCSN; Carol Glod, Ph.D., C.S., FAAN

This proposal suggests two major ways for nursing workforce development related to the Massachusetts Child Behavioral Health Initiative. The overall goal is to increase the knowledge and capacity of the nursing workforce to prevent, evaluate, and treat behavioral health problems in children and adolescents.

Proposal One:
Increase the number of advanced practice psychiatric nurses (APRNs, also known as Clinical Nurse Specialists [CNS]) with an expertise in the assessment and treatment of child/adolescent mental health.

Proposal Two:
School nurses have unique opportunities to prevent and address behavioral health problems in the school setting. This proposal would increase expertise of school nurses to provide both prevention and treatment-based services using a public health approach as well as individually-based services.

Background

Definitions and Scope:

"Behavioral health concern" throughout this document includes:

- Behavioral, neurodevelopmental, psychiatric, psychological, emotional, and substance abuse health related concerns.
- Social concerns such as child abuse and neglect, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment, grief and loss accompanying illness or death of family members
- Somatic manifestations of behavioral health issues such as eating disorders and gastrointestinal disorders, headaches, etc.
- Problem behaviors serious enough to disrupt functioning but not serious enough to warrant the diagnoses of a disorder. This excludes behaviors that raise concern but are within the ranges for the age of the children and adolescents.

The need for nurses to become more involved in the delivery of behavioral health services is driven by the following forces:

- The recognition that adverse psychosocial experiences in childhood have lifelong adverse effects on behavioral and physical health.[6]
- The prevalence of behavioral health disorders and substance abuse among children and adolescents and adolescents.
- The prevalence of children and adolescents who do not meet criteria for specific disorders but who have significant mental health problems.
- The prevalence of mental health concerns in pediatric populations.

- The recognition that half of the adults in the United States with mental health disorders have symptoms by the age of 14 years.[7]
- The low percentage of children and adolescents who receive care for their mental health problems.
- The shortage and inaccessibility of specialty behavioral health services, especially for underserved children and adolescents from low-income families who do not fall within the target population of public/ community health services.
- The disproportionate effects of unmet behavioral health needs on minority populations.
- The recognition that unidentified behavioral health issues are often the basis for many somatic complaints.
- The growing realization that behavioral health has become a national priority and in Massachusetts, universal mental health screening is now mandated for at well-child visits for those covered by MassHealth.[8, 9]

Proposal One:
The report, Accessing Children's Mental Health Services in MA, documents the shortage of clinicians, especially psychiatrists and APRNs who have the training, expertise, and licensure/certification to treat this population. Ninety-two percent of CNSs in MA identified lack of training or credentialing as the most important reason for not working with children. Specifically, 40% of those psychiatric CNSs with adult training note that they would expand their practice to pediatric populations with additional training, supervision, and experience. These providers would increase access to behavioral health services, particularly, assessment, and psychopharmacological evaluation and treatment.

We propose:
To offer the Certificate of Advanced Graduate Study (CAGS) to current psychiatric CNSs who specialize in working with adults. The focus of this 24-credit program is the psychiatric subspecialty children, adolescents, and families. Those who complete the program will be eligible for national certification as a psychiatric CNS, thereby increasing the workforce of APRNs specializing in the assessment and treatment of child behavioral health.

Curriculum

PSYCHIATRIC MENTAL HEALTH THEORY COURSES

NRSG 6286 Contemporary Psychotherapies: Theory & Practice 3
NRSG 6281 Dimensions of Clinical Practice 3
NRSG 6282 Clinical Psychopharmacology 3
NRSG 6283 Psychobiological Bases of Mental Disorders 3

PSYCHIATRIC MENTAL HEALTH PRACTICUM COURSES

NRSG 6480 Psychiatric Nursing Practicum (1) 4
NRSG 6481 Psychiatric Nursing Practicum (2) 4
NRSG 6482 Advanced Psychiatric Nursing Practicum (3) 2
Elective 2 (e.g., online Child/Adolescent Psychopharmacology)

Total credits required for CAGS: 24 Semester Hours

Proposal Two:

Introduction:

School nurses have unique opportunities to prevent and address behavioral health problems in the school setting. The proposed competencies meet the requisite for providing mental and behavioral health services in school nurse's offices. Achievement of these competencies is a goal that will require a commitment by the school nurse to pursue educational opportunities suited to her learning needs. These competencies include knowledge and skills for school nursing practice: both prevention and treatment-based using a public health approach as well as individually-based services. Many school nurses are already engaged in behavioral health screening, assessment, referral and treatment. These services are distinguished from those provided by "mental health specialists" in both the school setting and the community. These specialists have specific training and licensing requirements. School nurses are often the "port of entry" for children and adolescents with behavioral health needs in the school setting and require professional development in the following competencies to be able to meet the needs of the children she serves. The competencies required to serve these needs include:

- Awareness of prevention strategies such as building resiliency, promoting healthy lifestyles, preventing or alleviating behavioral health and substance abuse problems, identifying risk factors and emerging mental health problems
- Knowledge of mental health disorders including attention deficit/hyperactivity disorder, anxiety, depression, and substance abuse as well as recognition of psychiatric emergencies
- Ability to establish relationships in order to partner with families, schools, agencies, and behavioral health specialists to assess, plan and care.
- Interpersonal and communication skills (such as motivational interviewing) to overcome barriers (perceived and/or experienced by children and adolescents and their families) including stigma to seek help for behavioral health and substance abuse concerns.

Rationale for Specific Competencies: School Nurse's Distinctive Role:

School nurses have an exceptional role in behavioral health care that differs from other school mental health providers (school counselors, school adjustment counselors, school guidance counselors, school psychologists, etc) and community mental health providers. Children and adolescents who seek help from other school personnel do so because they have recognized a need for mental health or counseling services. Children and adolescents seeking care in the school nurse's office typically do not frame the visit as "mental health" related; they often present with a physical complaint or simply state they "came to visit". School nurses must find ways to recognize the underlying mental health concern and to intervene as appropriate. This requires that the school nurse:

- Know that children and adolescents may be seeking help for a mental health problem when visiting the school nurse's office with a physical complaint.
- Recognize problems that the school nurse can assess and manage or those that need to be referred to appropriate resources both in school and in the community.
- Distinguish among behavioral health situations that require immediate or emergent intervention versus those that may be viewed as routine or in need of continued monitoring.
- Be aware of a child's level of functioning and apply chronic care principles as they would for other children and adolescents with special health care needs.
- Be able to have a positive effect on the behavioral health needs of children and adolescents (increasing feelings of well-being, supporting resiliency, etc) often times without knowing the specific disorder or diagnosis a child may have.
- Collaborate with a variety of school specialists, educators, and community providers.
- Appreciate that (s)he needs to provide these services given while addressing the constraints of a busy school nurse's office, privacy and confidentiality concerns and issues related to role delineation within the school setting.

The National Association of School Nurses (NASN) recognizes "school nurses play a vital role in supporting early assessment, planning, intervention, and follow-up of children in need of mental health services. In addition, school nurses serve as advocates, facilitators and counselors of mental health services both within the school environment and in the community."[10] School nurses have distinct advantages to providing behavioral health services in the school setting that include:

- A long-lasting, trusting relationship with children and adolescents and their families.
- The ability to offer an understanding of common social, emotional and educational problems in the context of a child's development and environment.
- The skills to promote healthy lifestyles, offer guidance related to behavioral health concerns and provide support for developmental issues to children and their families.
- The capability to coordinate services for children and adolescents both in the school setting and community resources.

The American Academy of Pediatrics (AAP) also recognizes the role of the school nurse as the leader and coordinator of the school health services team.[11] The AAP Policy Statement on the Role of the School Nurse in Providing School Health Services states that the school nurse serves in a leadership role for developing school health policies and programs that include mental health protection and intervention. School nurses have the potential to improve the lives and academic achievement of children and adolescents who might otherwise not be identified as needing services or receive care only after problems become more severe. Achieving these competencies will assist the school nurses to provide these needed services for children and adolescents in the school setting.

The Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, also identifies the role of the school nurse in the delivery of mental health services in schools.[12] The role of the school nurse as defined by SAMHSA is to support students and staff by providing information and consultation on the effects of trauma and depression on health outcomes. The school nurse is recognized as a team member with other school counseling staff to assist in the identification of students who are at risk for long-term mental health challenges and for setting the tone for recovery, concern, and support along "with an eye to reducing or eliminating stigma for students who seek additional health and mental health services and care".

Step One: One Day Introductory Program

The goal of this workshop is to develop the necessary skills and knowledge among school nurses to assist them in identifying, assessing and intervening and referring appropriately when encountering behavioral health problems in children and adolescents.

By the completion of a one-day introductory program the school nurse will be able to:

1. Address systems-based issues in the school setting:
    a. Establish collaborative relationships with other behavioral health professionals both in the school setting and community setting and define the role of these professionals in the delivery of services.
    b. Participate as a respected and valued member in multidisciplinary team meetings.
    c. Communicate effectively with other behavioral health professionals in the care of children and adolescents in the school setting.
2. Plan and provide care for children with behavioral health problems in the school setting:
    a. Provide behavioral health resilience by reinforcing the strengths of children and adolescents.

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  b. Provide guidance to children, adolescents, their families and other school staff on behavioral health problems, coping skills, risk factors and crisis interventions.
  c. Conduct history, physical assessment, and observations for the purpose of screening and identifying behavioral health concerns.
  d. Assist students with self-care and stress reduction strategies.
  e. Identify potential behavioral health problems and common mental health comorbidities in children and adolescents and communicate with parents the need for appropriate services.
  f. Plan for the referral and/or management of behavioral health problems.
  g. Develop an individualized healthcare plan for children with mental health problems.
  h. Refer to appropriate behavioral health providers in the school setting and community as appropriate.
  i. Recognize and provide appropriate intervention for behavioral health emergencies.
  j. Develop a plan for monitoring children and adolescent with known mental health conditions, including pharmacologic therapies.
  k. Identify and address barriers preventing a child or adolescent from obtaining needed services.
3. Have an understanding of fundamental mental health problems in children including:
    a. ADD/ADHD
    b. Anxiety
    c. Autism
    d. Depression
    e. Self-Harm
    f. Substance Abuse
4. Communicate effectively both with students and staff concerning behavioral health issues:
    a. Establish trusting relationships that encourage children and adolescents and their families to share concerns.
    b. Establish open communications with children and adolescents using motivational interviewing techniques that are focused and goal-directed
    c. Describe both school and community behavioral health services available
    d. Available to respond to questions from families and school staff concerning behavioral health issues.
5. Understand the limitations of her knowledge and skill in behavioral health care and seek out professional development opportunities to meet additional school nurse competencies.

Audience:

School nurses

Teaching Methods:
This Behavioral Health Competency Development Workshop will consist of learning opportunities using lecture with discussion, small group discussions, case studies, role-playing, etc.

TBD; Six regional conferences; Fall 2010

Step Two: Graduate Level Preparation

Working with Carol Glod, PhD, RN, CS, FAAN, a graduate level online course in school nurse behavioral health competencies would be offered. This course would also serve as an introductory course to a number of graduate degree programs offered at the University in child and adolescent sub-specialties:

- Masters students prepare to become Clinical Nurse Specialists (CNS) in Child and Adolescent Psychiatric/Mental Health Nursing or Family Psychiatric Nurse Practitioners (NP).
- Students with master's preparation in other nursing specialties may earn a Certificate of Advanced Graduate Study (CAGS) in child/adolescent/family sub-specialty roles (CNS, NP).

Step Three: Graduate Level Degree Program

School Nurses who already possess a BSN degree would be eligible to apply for enrollment in the master’s degree preparation programs listed above; those with an MSN would be eligible for the CAGS. Note: funds may be available for this advanced educational level both through National Health Service Corps, and through ARRA-MA-State Loan Repayment Program (MSLRP) for health professionals who have outstanding educational debt.

Step Four: Clinical Specialists in Child and Adolescent Psychiatric/Mental Health Nursing as Consultants to School Nurses

Upon graduation and pending funding for such purposes, nurses who have completed their advanced practice degree as a Clinical Specialist in Child and Adolescent Psychiatric/Mental Health Nursing would serve as clinical consultants to school nurses. The clinical specialists would provide consultation services similar to those already in place for local pediatricians and family practitioners through the Massachusetts Child Psychiatry Access Project (MCPAP). The goal of this program is to make child and adolescent behavioral health consultation services accessible to school nurses for the students and families they serve throughout the Commonwealth.

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V. Independently Licensed Practitioners Subgroup Report

Submitted by: Midge Williams (MaMHCA); Carol Trust (NASW); Marcy Ravech (BCBSMA Foundation); Robin Risso (MMFT); Kelly English (MassHealth)

Overview:
As a result of the CBHI implementation and passage of Chapter 321: *An Act Relative to Children's Mental Health*, demand for behavioral health services is increasing, both for traditional outpatient services as well as for the new CBHI services provided by community-based behavioral health organizations. Consequently, there is increased need for behavioral heath practitioners – for CBHI the need is specifically for providers who can be reimbursed by MassHealth for outpatient services, in-home therapy, and supervision of CBHI services. For the most part, these are licensed behavioral health providers: psychologists, social workers, mental health counselors, and marriage and family therapists. Outpatient services are provided in a number of settings, most often in private practices in the community or through outpatient clinics of community-based behavioral health organizations. In-home therapy, and other CBHI services which require supervision by licensed practitioners, are also provided by the behavioral health organizations. Access to these licensed providers for those with MassHealth is increasingly limited. Organizations in particular have trouble retaining experienced licensed providers at the independent level of licensure. In addition, once they enter private practice, these providers are less likely to be on public sector insurance panels (MassHealth Managed Care Entities and Mass. Health Behavioral Health Partnership).

According to the BCBSMA Foundation 2009 study "Accessing Children's Mental Health Services in Massachusetts: Workforce Capacity Assessment," fewer practitioners working in private practice report serving on public panels than private panels. Only 49% of psychologists and 63% of LICSWs, LMHCs, and LMFTs participate on public sector panels. For those not wishing to join a public sector panel, the most common disincentive cited was low rates of pay. Other disincentives included excessive paperwork, lack of compensation for collateral work, and burdensome application processes. However, 35% of psychologists and 48% of other licensed providers who do not participate did indicate a desire to join a public sector panel. Yet, there are barriers to joining even when there is a desire to do so. There is widespread perception the panels are "closed, and not accepting new providers. The application process is burdensome. Volume requirements for credentialing present a barrier for many providers who practice in multiple locations and have less than the required hours available at any one practice site.

Goal:
Develop strategies to recruit and retain independently licensed practitioners:

- In private practice as outpatient behavioral heath providers for MassHealth including MBHP and the Managed Care Entities
- In agencies providing CBHI services

Recommendations for Target Practitioner Groups:

Recruit & Retain Private Practitioners to MassHealth	**Recruit & retain independently licensed providers in agencies that provide CBHI**	**Both Groups**
1. **Address perception of MassHealth/MCE panels are closed; Possible options:** a. Adopt any willing provider b. Open panels to providers at a specific time for a specific interval each year, e.g. January 1 - February 15 c. Notify professional associations of current panel needs 2x/year	1. **Differential rates** for independently licensed practitioners with more years of experience or additional credentials as a mechanism for retaining qualified staff	√
2. **MCEs Create Uniform Credentialing procedures**	2. **Differential rates** for independently licensed practitioners with language capacity	√
3. **Reduce post-licensure work experience & volume requirements for empanelment**	3. **Loan forgiveness programs** for human service practitioners working in home-based services	
4. **Trainings about CBHI and wrap-around/home based services** a. Explore a joint CE training among professional associations, perhaps with private insurers sponsorship b. Development of CEU programs on CBHI as a way to help educate practitioners regarding the systemic changes in Massachusetts	4. **Identify strategies to promote use of independently licensed in private practitioners to support agencies needing licensed practitioners for supervision**	
5. **Develop benefits message:** a. Support/resources available – ICC available for collateral work; not isolated in treating these patients-other CBHI staff available b. Future Payment reform – private practitioners will need to integrate with accountable care organization; c. May provide a steadier payment stream during bad economic times.	5. **Expand Internship and training opportunities** Long-term strategy: influence NCQA requirements that present barriers to funding internship training	
	6. **Conduct survey of provider organizations regarding retention and turnover of licensed staff.**	

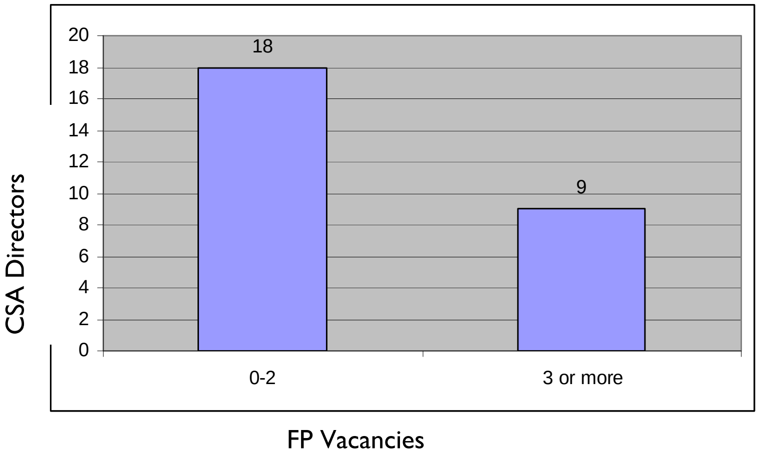
Appendix: CSA Workforce Survey Summary

The Workforce Pipeline group of the CBH Advisory Council Workforce Subcommittee invited all CSA directors to participate in an online survey on the challenges they face in hiring Family Partners and Bachelor's and Master's level Care Coordinators. Twenty-eight out of 29 CSA directors took the survey, though response rates vary by question. The following is a summary of the most relevant survey data.

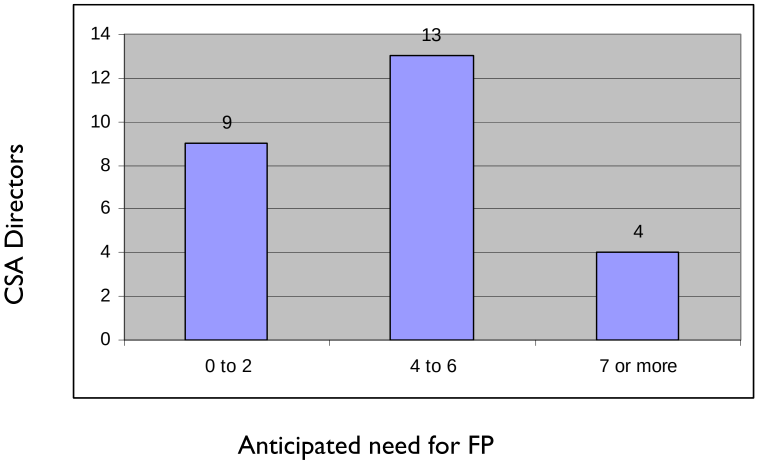
SELECTED FAMILY PARTNER QUESTIONS

On a scale of 1-5, how difficult has it been to find Family Partners for ICC?
25 respondents
44% of respondents answered somewhat difficult and another 36% answered difficult or very difficult

How many Family Partner vacancies do you have at the time?
27 respondents



How many more Family Partners do you anticipate needing over the next 12 months?
26 respondents



Please rank the following barriers to hiring or retaining Family Partners.

24 Respondents

The top 3 barriers to hiring Family Partners

1. Applicants are not parents/caregivers of kids with serious emotional disturbance
2. Very few applicants
3. Applicants who are caregivers don't have the right skills or experience

When asked to describe any additional barriers to hiring Family Partners, CSA directors noted the lower reimbursement rate for services delivered by Family Partners made for an inadequate salary. One director noted many of the resumes received by their CSA come from "outreach workers" who may have some social service experience but often are not even parents/caregivers themselves. Another noted that the job is often not well understood at hire which leads to Family Partners leaving (or being asked to leave). Lastly, a few directors mentioned the challenge of finding bilingual Family Partners to fit the unique language needs of the populations they serve.

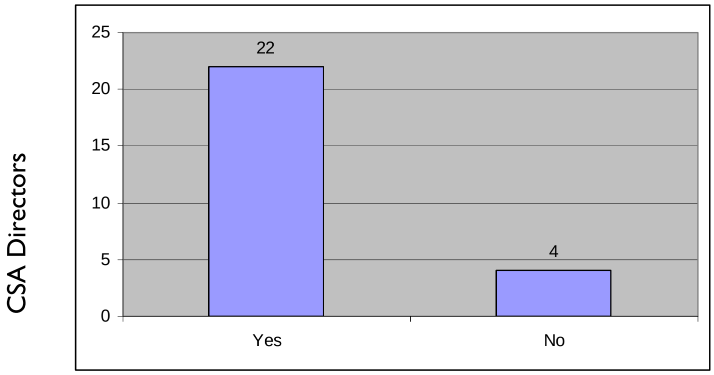
On a scale of 1-5, how difficult is it to find Family Partners from the major racial, linguistic and ethnic communities in your geographic area?

25 Respondents

Roughly 35% of directors answered somewhat difficult and 46% answered difficult or very difficult.

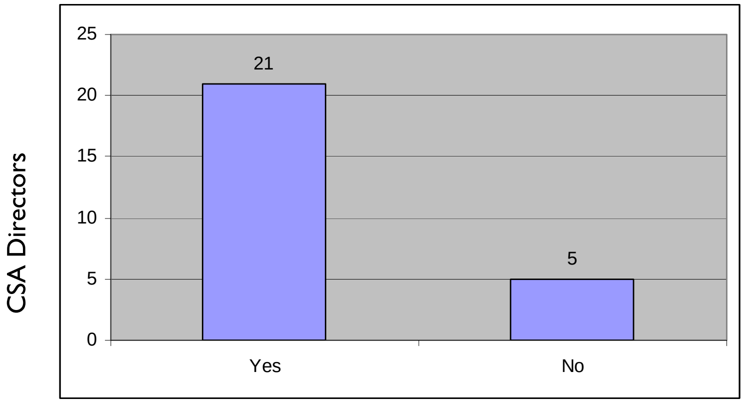
Are you aware of Parent/Professional Advocacy League (PAL) outreach campaign to identify parents in racially and ethnically diverse communities who may be qualified to be Family Partners?

26 Respondents



Of those who were aware of the campaign, roughly half received referrals and of those who received referrals, roughly half said they were a good match. One director commented that the PAL sent a batch of referrals prior to this director's hire. A few responded that candidates did not have appropriate personal or professional experience, i.e. a candidate was not a parent/caregiver or did not meet the cultural/linguistic needs of the area.

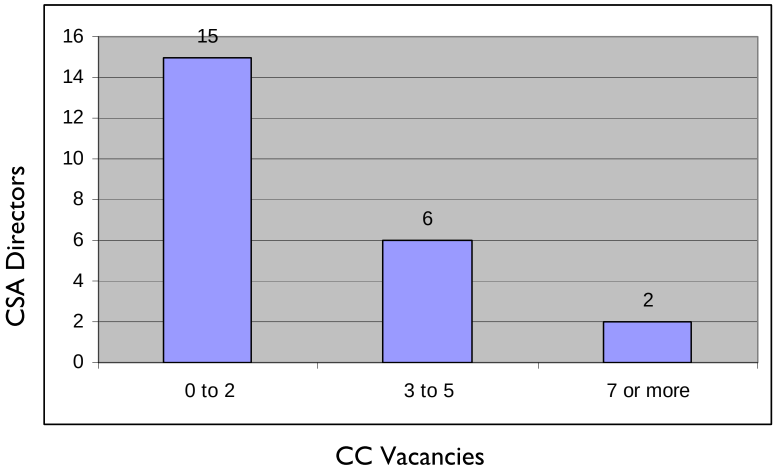
In your experience, do supervisors of Family Partners need specific skills, training or supports that are distinct from general supervisory skills?
26 Respondents



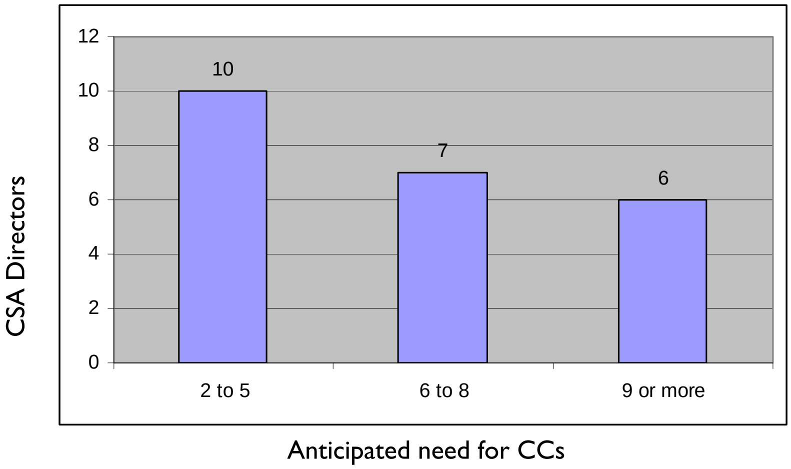
When asked to explain, several directors said that their Family Partners had not worked in the field before and so they required an "*immense amount of coaching and supervision for the basics of how to do the job.*" Many directors discussed the importance of helping Family Partners know how to share their story to help a family. One director noted the difficulty Family Partners have in recognizing "*when telling their story may just be overwhelming for the family and not strategic in terms of using moments to help them see that they can get through it..*" The issue of transference and counter-transference came up in several comments—"*Family Partners are more likely to be triggered by experiences they have in common with families they are supporting.*" Several directors said that Senior Family Partners/Supervisors need to help Family Partners develop appropriate professional boundaries while also supporting them as they deal with the personal issues this job inevitably brings up. As one director put it, supervisors need to help Family Partners *"use [themselves] in their work while maintaining healthy boundaries and consistent self care."* Lastly, a couple directors said that Family Partners needed extra training around the administrative side of the work, such as understanding third party billing and Medical Necessity Criteria.

SELECTED CARE COORDINATOR QUESTIONS

How many Care Coordinator vacancies do you have at this time?
23 Respondents



How many Care Coordinators do you anticipate needing over the next 12 months?
23 Respondents

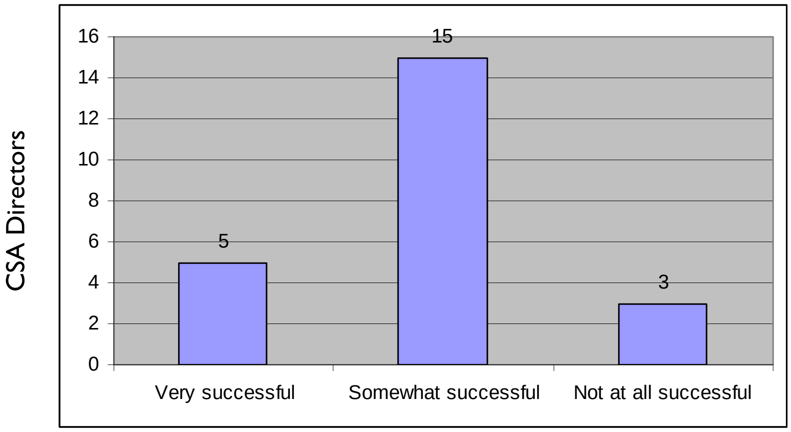


Please rank the following barriers to hiring Master's Level Care Coordinators.
23 Respondents
Top 2 Barriers:

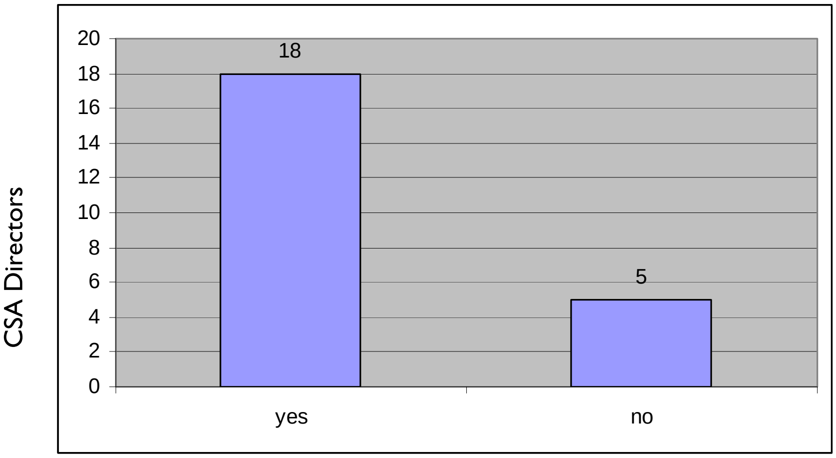
1. Role is not perceived as clinical
2. Applicants lack familiarity with facilitation role

When asked to further describe barriers to hiring MA-level Care Coordinators, most directors cited pay/reimbursement rate as a major challenge to hiring this level clinician. Another director noted that applicants do not want to work the unconventional hours and want to work towards licensure. While it is true that ICC is not a clinical service, this director's concern reflects a commonly held perception that clinicians working ICC cannot count those hours toward licensure. This concern would best be resolved by the social work licensing board. Referring to the position as Clinician rather than an Intensive Care Coordinator posed an obstacle to recruitment for one CSA and the director said that when they changed the language they noticed an improvement in their efforts. Lastly, one director said *"it needs to be acknowledged that much of the work is with families/parents, and not with the children, and few are trained in family work or dealing with adults with serious mental health, SA, DV issues....and that's who we serve."*

How successful has your organization been at hiring Master's level Care Coordinators who reflect the racial and linguistic composition of the communities you serve?
23 Respondents



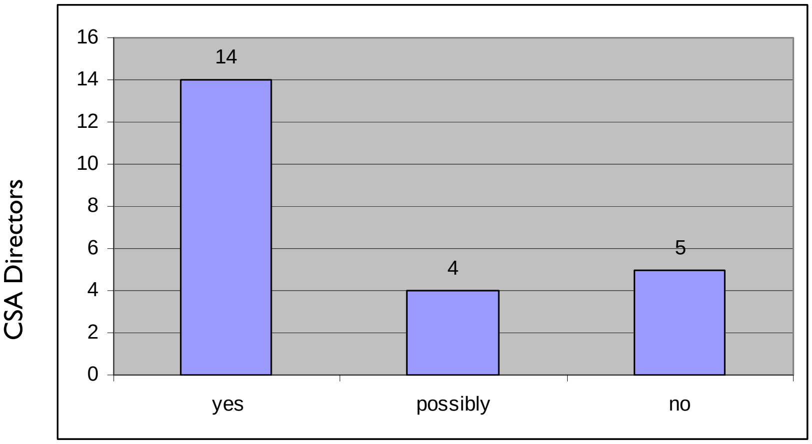
Has your organization or program had Master's student interns in other clinical roles?
23 Respondents



Our organization has clinicians who are licensed to provide supervision for Master's student interns in the following areas (Please select all that apply):

	Yes	**No**	**Resp. Count**
Social Work	100.0% (23)	0.0% (0)	23
Psychology	71.4% (15)	28.6% (6)	21
Marriage and Family Therapy	57.1% (12)	42.9% (9)	21

Would you be interested in a higher education partnership to place MASW or MA Psych students as interns at your CSA next year if they could be billed at the bachelor's level rate?
23 Respondents



When asked what supports would be necessary to support a Master's level intern program, most directors identified adequate supervision as a need. Some specified the need for better reimbursement rates to defray the cost of supervising interns. Others simply stated they needed supervisors. A few directors said they already had the necessary supports in place and either already had interns in place or just needed interns. One director said a minimum commitment of 20 hours/week from the student would be necessary. Another director was concerned about the committing resources to training an intern for the role of Care Coordinator because *"it takes at least 6-9 months to be able to provide high fidelity wraparound and then the staff may leave."* This director also questioned whether an ICC position would count towards Master's level licensure as Wraparound is not a clinical program. This last concern is related to one of the top two barriers for hiring MA level Care Coordinators—that the role itself is not perceived as clinical.

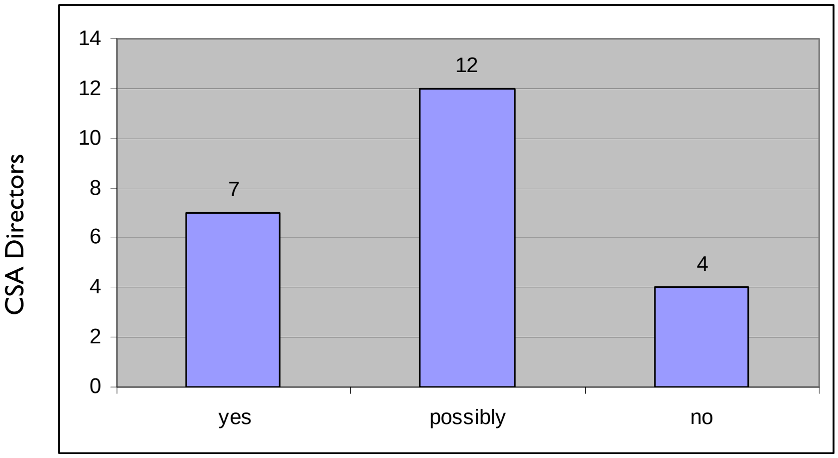
Please rank the most important barriers to hiring Bachelor's level Care Coordinators
21 Respondents
Top 3 Barriers

1. Applicants have inadequate clinical skills to handle the severity or complexity of the caseload
2. Applicants lack familiarity with facilitation role
3. Applicants lack child-related experience or training

When asked to describe additional barriers to hiring Bachelor's level Care Coordinators, some directors said the reimbursement rate for BA level staff did not create an incentive for hiring from this pool. It is interesting to note there was no consensus on this point--in the same follow up question dealing with MA level staff, one director said *"due to the salaries that Master's level candidates are asking for, we cannot financially support them in this role. Even though their reimbursement rate is higher, it is still more cost effective for us to hire Bachelor's level ICCs"*. A couple directors described the extra training and supervision BA level staff require. One noted that *"most of the Bachelor's candidates we've considered have simply not had an opportunity yet to build the skills needed for this complex caseload….we hope to be in a place where less experienced candidates can be hired and adequately trained for readiness in the role, but at this stage of start-up we don't have the time or capacity for that level of prep.*

Several state colleges offer Bachelor of Social Work degrees. Because of their affordability, these programs tend to be more diverse than many other programs. Would you be interested in placing BASW seniors from state colleges as interns at your CSA next year, if they were appropriately trained and their time was billable while they are serving as interns?

23 Respondents



When asked what supports were needed to support BA level interns, a couple said time for adequate supervision while another couple of directors said they had the supports in place to take on BA level interns. One director said they would need a minimum 20 hour/week commitment from the student. One director said that their CSA was working with Salem State to get a BA level intern in the fall.

Please feel free to describe any recommendations that would help your CSA to hire and retain Family Partners and Care Coordinators.

9 Respondents

As would be expected, several directors recommended increasing the reimbursement rate in order to include supervision and training as billable activities as well as to offset lost productivity. One director in particular said they were unable to offer competitive salaries for bi-lingual candidates for Care Coordinators and as a result were losing them to higher paying positions elsewhere. Two directors recommended reimbursing for the time Family Partners spend coordinating with the ICC team in order to ease their productivity pressures. Two recommendations concerned working with higher education: getting master's-level training programs and bachelor's-level to include Wraparound and Systems of Care in the curriculum and educating colleges and universities about ICC and employment opportunities Another suggested sharing CSA contact information with academic programs. Another director recommended state supported advertising and education on these new positions and within CSAs, offering support for family partners re-entering the workforce. One director called for student loan forgiveness. Lastly, one director expressed their "*Wishful thinking: billing could be similar to PACT model. # of families serviced x # of days. It would allow staff to focus on families.*"