Commonwealth of Massachusetts

Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL

Annual Report
2012

MAMH
Massachusetts Association for Mental Health

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October 1, 2012

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JudyAnn Bigby, M.D., Secretary, Executive Office of Health and Human Services
Sherri Killins, Commissioner, Department of Early Education and Care
Mitchell D. Chester, Commissioner, Department of Elementary and Secondary Education
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Hon. John F. Keenan, Senate Chair, Joint Committee on Mental Health and Substance Abuse
Hon. Elizabeth A. Malia, House Chair, Joint Committee on Mental Health and Substance Abuse
Hon. Michael J. Rodrigues, 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. Steven M. Walsh, House Chair, Joint Committee on Health Care Financing
Hon. Stephen M. Brewer, Chair, Senate Committee on Ways and Means
Hon. Brian S. Dempsey, Chair, House Committee on Ways and Means

I am pleased to submit the fourth annual report of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008. A listing of the Council's membership is attached as ***Appendix A***.

The Council met seven times since October 1, 2011. Attendance by Council members and Committee activity was robust and meaningful. The activities, recommendations and work products of the Committees are noted in the following pages. The Council concluded the year engaging in a process whereby it reassessed its Committee structure, and developed overarching themes and principles and set priorities for work to be accomplished within that framework. This process is underway and it will result in a Council with a more narrow and sharpened focus.

One theme and organizing principle which will guide the work of the Council this year is the integration of children's behavioral healthcare in the wide range of Commonwealth healthcare reform initiatives, including, but not limited to Accountable Care Organizations, Health Homes, Pediatric Patient Centered Medical Homes, Asthma Bundled Payment Programs, and Integrated Primary and Behavioral Healthcare. To this end, a fall briefing on these initiatives is scheduled for the Council.

In addition to the Council's efforts to identify priorities for the upcoming year, its Committees have been active in the past twelve months on a variety of issues. The Council's Child Systems Integration Committee was asked to participate in the deliberations of the Behavioral Health Working Group appointed by the Advisory Committee for Children and Families convened by Secretary Bigby in the summer of 2011. The Committee produced the attached document entitled *Improving Access and Continuity of Care For Mental Health Treatment* ***(Appendix B)***, which was incorporated into the Advisory Committee's Final Report to the Governor in December 2011.

The Council's Workforce Development Committee issued two reports, which are attached to this Annual Report as ***Appendices C and D***. These reports provide a plan and strategy for the Committee to continue its work helping to build a workforce to address the complex behavioral health needs of the Commonwealth's children and adolescents.

The development and collection of data to measure outcomes remains problematic, although some data is available and progress is being made. The Council has recommended in its past two annual reports that a significant investment be made to improve information technology, particularly among the agencies within the Executive Office of Health and Human Services. The Council was pleased that an effort was made by the Administration in its FY 2013 budget proposal to begin to address the issue, but it was not adopted by the legislative branch. The Council's Data and Outcomes Committee, with input from the full Council has developed a logic model ***(Appendix E)*** as the preliminary guide towards the development of proposed outcomes to measure the effectiveness of new mental health services and the model indicates which data is available. The model is a worthy and informative document.

The Council has stated its interest in developing more formal relationships with members of the Legislature and will explore the feasibility of scheduling annual or semi-annual meetings. The Council would like to consider amending the Council membership to include individuals from the Legislature appointed by the President of the Senate or Speaker of the House. Since the Council was created to advise both the Executive and Legislative Branch, it is appropriate to explore ways to more fully engage legislators in the work of the Council.

While the challenges facing the child and adolescent behavioral health system are significant and complex, progress is being made as a result of the energy, dedication and commitment of Council members and many others, who have extended their time and expertise to the work of its standing Committees.

Sincerely,

Timothy O'Leary, Co-Chair
Data, Trends and Outcomes Committee
Children's Behavioral Health Advisory Council

cc: Marcia Fowler, Commissioner, Department of Mental Health
Chair, Children's Behavioral Health Advisory Council

INTRODUCTION AND PRELIMINARY STATEMENT

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 scope and breadth of the Council's advisory role is best evidenced in subparagraph (d) of Section 16Q, which authorizes the Council to make recommendations in the following areas:

(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.

The Council believes it is vital to its mission, and ultimately to the families and children of the Commonwealth, that its members, policy makers and others keep in mind 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. While our policy recommendations may be tempered by fiscal realities, they 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.

Because of the *Rosie D* litigation, considerable attention has been paid to the public delivery of care system and to the creation, and penetration of the new services created as part of the remediation plan under that litigation. While the Council shares that interest

and gives it due attention, we are very much aware that those new services are only available to families and children covered under MassHealth, and, as the enabling provisions of the law that created us make clear, our purview is much broader than the *Rosie D*. case and the Children's Behavioral Health Initiative. ***Accordingly, we need to focus appropriate attention on the families and children who are covered by commercial carriers.***

This is particularly true where the Commonwealth, indeed the nation, is beginning the implementation of health coverage reform. As terms such as integrated care, medical home and accountable care organizations become part of our health care nomenclature, we need to pay attention to and understand their impact on children's mental health. In the upcoming year, the Council intends to sharpen and focus its attention on ensuring and advocating the full integration of children's behavioral healthcare in the wide range of reform initiatives currently underway in the Commonwealth.

The enactment of legislation such as mental health parity and, more recently, Chapter 207 of the Acts of 2010 relative to insurance coverage for autism, prompts us to ask questions about implementation, enforcement and whether or not the intended purposes of these pieces of legislation have been realized. These questions and discussions need not commence or proceed in an adversarial way, but rather in a fashion utilizing the Council's professional diversity, and its common interests in improving the mental health of all the Commonwealth's children. Only through extensive and thoughtful examinations and discussions – those designed to illicit information, understanding and perhaps consensus – as opposed to simply articulating current opinions, biases or practices - can we hope to offer policy makers and others the kind of guidance and recommendations the Council was established to provide. In this connection, we look forward to the results of the survey being conducted by the Division of Insurance, which will provide information and perhaps guidance as to those areas where commercial carriers have been successful, those areas where they have not and those areas where additional attention needs to be directed.

ROSIE D. V. PATRICK (F/K/A ROSIE D. V. ROMNEY)

In 2001, a class action lawsuit, *Rosie D. v. Romney,* was filed in the federal court by **parents on behalf of children with serious emotional disturbance (SED)**. 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 has been appointed to oversee the implementation of the remedy.

The **Commonwealth's Implementation Report**, filed with the Court on May 16, 2012 describes in detail all of the Commonwealth's efforts since 2007 to develop and implement a children's mental health service system built on the *Rosie D.* remedial services. The 112-page report asserts that the Commonwealth has "fully complied" with each requirement under the *Rosie D.* Judgment. The Report describes the work of the Children's Behavioral Health Initiative (CBHI) to implement the key components of that system, including outreach, screening, assessments, service coordination, in-home supports, service utilization, and quality improvement measures. The report highlights quantitative data through the end of 2011 to illustrate the defendants' progress:

- Clinicians screened between 81,000 and 92,000 children and youth during each quarter of the 2011 federal fiscal year (October 2010-September 2011).
- Over 14,000 youth have received Intensive Care Coordination (ICC) since June 30, 2009.
- Since In-Home Support services were first offered in the fall of 2009, 19,766 youth have had In-Home Therapy.
- More than 11,500 have had Therapeutic Mentoring.
- More than 1,850 have received In-Home Behavioral Services.
- Inpatient psychiatric hospitalization of youth also has decreased significantly since the implementation of the *Rosie D.* services.

Moreover, Mobile Crisis Interventions are occurring in the community, although still far less than envisioned by the plaintiffs. In November 2011, 57% of MCI encounters occurred in the community, up from 37% in June of 2009. However, this still means that 43% of all youth who need MCI services are being seen in emergency departments.

In response to the Commonwealth's Report on Implementation, the **Plaintiffs 18th Status Report**, filed June 13, 2012 challenged the Commonwealth's assertions of compliance with the *Rosie D.* Judgment and the Medicaid Act. In the Status Report the plaintiffs identified thirteen areas where they assert that compliance has not been achieved. The Plaintiffs requested the Court instruct the parties to work with the Court Monitor to develop disengagement criteria for each outstanding requirement of the Judgment and federal law.

On the positive side, the plaintiffs acknowledged the Commonwealth's considerable progress over the past five years transforming the children's mental health system. The plaintiffs cited the Commonwealth's impressive array of outreach materials, the high numbers of youth who have had behavioral health screens and mental health assessments, and the increasing number of children who have had and are receiving remedial services. They also acknowledge the defendants' commitment to implementing the Judgment through the CBHI, and singled out Emily Sherwood, the compliance coordinator, for her work.

But, as the plaintiffs emphasize in their report: **progress is not the same as compliance**.

It is not surprising, given the fact the remediation plan is being implemented in the context of litigation, that disagreement exists between plaintiffs and the defendants as to the degree of success or shortcomings in how the plan is being implemented, the penetration rate of the new services as well as how does one (or when does one) begin to assess whether or not the new services are having a positive impact on the children and families they are designed to serve.

It is not the Council's role to resolve these differences, nor frankly is it equipped to do so. There are websites readers of this report can access to view current (sometimes conflicting) information on the implementation of the Commonwealth remediation plan. Two such websites are:

- http://mass.gov/masshealth/cbhi
- http://www.rosied.org

The Council is however, greatly encouraged by the fact the Plaintiffs, while not agreeing with the assertion that the Commonwealth is in full compliance, has acknowledged the considerable progress that has been made over the past five years.

We have indicated in previous Annual Reports the professionalism, dedication, energy and commitment we have observed in those charged with the responsibility of implementing the remediation plan. This is important, complex work being performed under tight guidelines and the unblinking eye of a federal court. While much remains to be done, we believe all who have been involved at every level of the transformation that is occurring should be congratulated for what has been accomplished to date, particularly when one considers it is being done in an economic environment that could have produced failure but for their efforts.

OUTCOMES AND DATA NEEDS

The Judgment, which incorporated a Remedial Plan, sought to ensure that Medicaid-eligible children with SED receive home-based services with the requisite frequency, intensity and duration, as set forth in each child's Individual Care Plan. It also required that the Commonwealth collect data, which demonstrates its compliance with this mandate.

The Commonwealth conceded in its Report on Implementation, its data collection system does not track frequency, intensity and duration of services directly in relation to individual children's Care Plans. However, as reported by the Commonwealth in its May 2012 report to the Court, it is collecting data on a number of system outcomes, including: timely access to services, numbers of youth receiving services, hours per month of services received, fidelity of ICC to the Wraparound model; location of mobile crisis interventions (MCI) encounters, disposition of MCI encounters; utilization of behavioral health services by youth prior to and post MCI encounters; use of inpatient hospitalization by MassHealth members, percentage of children receiving behavioral health screens, outcomes of screens, clinical follow up to screens; numbers and

percentages of youth receiving CANS assessments; percentages of youth receiving CANS who are SED. The Commonwealth continues to consult with national experts and to develop its own expertise and knowledge in how to best use the CANS to track outcomes across numbers of youth.

The plaintiffs assert that the Commonwealth's efforts at data collection are insufficient and are not adequately developed to permit the Court to determine compliance with EPSDT requirements. While there is a legal dispute regarding which data are necessary to demonstrate compliance, the Council agrees with the plaintiffs that the Commonwealth's capacity to collect and assess such critical data and outcomes is inadequate.

The Council cites the above data issue not to criticize the Commonwealth or the good people at EOHHS and elsewhere who are working tirelessly to implement the remediation plan. Rather, we do so to again highlight a recommendation which we have made in our past two Annual reports: - that there is a critical need for the Commonwealth to invest and build a suitable information technology infrastructure for the accumulation and sharing of data between and among the 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.

While improvements have been made, particularly with regard to the CANS instrument, we will not be able to adequately identify racial or ethnic disparities without data more comprehensive than what exists today.

The Council's Data, Trends and Outcomes Committee has developed a "logic model" ***(Appendix E)*** outlining the kinds of outcomes, data collection and indicators we need to look at in the immediate, near and more distant future to make determinations as to whether or not these new services have improved the mental health of the children and families receiving them. We fully appreciate the difficulty of ascribing any change in child functioning to any particular service, but we believe the enormity of time, energy and public resources being expended to comply with the Court's order require that we measure more than fidelity to a model and more than family or customer satisfaction. We need to put in place a mechanism that will allow future researchers and others to determine whether or not children's mental health improved as a result of these efforts and services.

CHILDREN NOT COVERED UNDER ROSIE D V. PATRICK

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.

We believe part of the Council's mission and charge is to ask, among other things:

- 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?

The Council is scheduling a meeting to review the results of a recent survey conducted by the Commonwealth's Division of Insurance. We view this as a starting point from which the Council can begin to address the issues noted above.

Medical Home, Payment Reform, Accountable Care Organizations and Children's Mental Health

As the Commonwealth continues with the implementation of federal health reform, as well as payment reform, the Council should be vigilant that children's mental health – indeed all behavioral health – is at the policy and decision making table. We need to guard against the unintended consequences that often result when mental health is simply "lumped in" as part of primary health. Some quick examples of topics that could occupy the Council's time in the coming year include:

- The opportunities presented in the federal Patient Protection and Affordable Care Act for Pediatric Accountable Care Organizations warrant the Council's examination or discussion as to the potential impact on children's mental health and how such organizations might be structured or organized.
- A Pediatric Medical Home will necessarily look different from the Medical Home envisioned for adult patients; how will resources be allocated and how does children's mental health fit in?
- The real (or perceived) lack of relevant and validated risk adjustment methodologies for pediatrics raises issues about global payment models. If risk cannot be accurately determined, how can resources be allocated fairly?
- To what extent can the authority provided to the Commissioner of DMH under Section 113 of Chapter 58 of the Acts of 2006[1] be used to influence policy development in the area of integration of behavioral and primary health?

[1] "….all managed care organizations contracting or delivering behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI SCHIP, and any MassHealth expansion population served under Section 1115 waivers, and youth in the care and custody of the department of social services or the department of youth services, including any specialty behavioral health managed care organization contracted to

During the past year, the Council's Child Systems Integration Committee was asked to participate in the deliberations of the Behavioral Health Working Group appointed by the Advisory Committee for Children and Families convened by Secretary Bigby in the summer of 2011. The Committee produced the document attached as ***Appendix B,*** which was incorporated into the Advisory Committee's Final Report to the Governor in December 2011.

The Committee also spent some time deliberating on the integration of child, adolescent and family mental health services with physical health services as health care reform takes effect in Massachusetts. The following is a summary of the Committee's recommendations:

There is potential for Accountable Care Organizations (ACOs) to be integrated with child Behavioral Health care. The Council is not aware of many of the plans or policy level discussions on this issue, however, we have several ideas about this and the first is to become more informed about current thinking. As ACOs move ahead, they may be primarily focused on saving money in connection with chronic illness and adult patients. How do we create an organization that pays attention to the needs of children? How do we require them to have the knowledge and skills that are needed to care for children? For example:

i. Developmental appropriateness
ii. Context of child – safety, child protection, community, connection to schools, after-school structure, family, the role of community and state
iii. Important functions
    1. screening
    2. monitoring and follow-up
    3. mandated reporting
    4. continuity over time
iv. Care needs to be individualized, not just according to a protocol
v. If CSAs are Health Homes, but would not otherwise stay involved with a child over time, do CSA's meet the expectations of continuity of care and monitoring of child well being?
vi. For the pediatric Medical Home, who is needed? The role of Family Partner here is very important and not being considered.

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administer said behavioral health services, shall obtain the approval of the commissioner of mental health for all of the behavioral health benefits, including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. For purposes of this section, "specialty behavioral health managed care organization" shall mean a managed care organization whose primary line of business is the management of mental health and substance abuse services." (Emphasis added)

vii. What is the role of the EMR in follow up and monitoring

viii. Screening and referral need to be followed by treatment and return Children's Behavioral Health needs a "seat at the planning and policy making table."

INTERACTING WITH LEGISLATIVE LEADERSHIP

The Council is interested in developing more formal interactions with members of the Legislature and will explore the feasibility of scheduling annual or semi-annual meetings. The Council would like to consider amending Council membership to include individuals from the Legislature appointed by the President of the Senate and the Speaker of the House. Since the Council was created to advise both the Executive and Legislative Branch, it is appropriate to explore ways to more fully engage legislators in the work of the Council.

CONCLUSION

We are grateful for the assistance and support we received from Barbara Leadholm, while Commissioner of the Department of Mental Health, Marcia Fowler, current DMH Commissioner, EOHHS Secretary JudyAnn Bigby, M.D., Chris Counihan, Director of Behavioral Health/MassHealth, Emily Sherwood, Director of Children's Behavioral Health Interagency Initiatives, and the other wonderful people at EOHHS, DMH and the child serving agencies within EOHHS. Special thanks to Joan Mikula, Lester Blumberg and 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

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:

Marcia Fowler, Chair Commissioner Department of Mental Health	Gail Garinger The Child Advocate Office of the Child Advocate
Jan Nisenbaum Department of Children and Families	David Matteodo 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 of Mass Representative
Anita Moeller Department of Early Education and Care	Peter Metz, M.D. New England Council of Child and Adolescent Psychiatry Representative
Nancy Schwartz Division of Insurance	Barry Sarvet, M..D. Massachusetts Psychiatric Society Representative
Marcia Mittnacht Department of Elementary and Secondary Education	Michael Yogman, M.D. Mass Chapter of the American Academy of Pediatrics Representative
Robert Turillo Department of Youth Services	Eugene D'Angelo, Ph.D. Massachusetts Psychological Association Representative
Michael Botticelli Department of Public Health	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter
William R. Beardslee, M.D. Massachusetts Hospital Association Representative	Dalene Basden Parent/Professional Advocacy League Representative
Timothy O'Leary Massachusetts Association for Mental Health Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Emily Sherwood Director Executive Office of Health and Human Services Children's Behavioral Health Interagency Initiative	Marylou Sudders Massachusetts Society for the Prevention of Cruelty to Children

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

Children's Behavioral Health Advisory Council Committees

Peter Metz, Co-Chair Barry Sarvet, Co-Chair	Culturally-informed, Best/Promising Practices Committee
Toni Irsfeld, Co-Chair	Legislative and Regulatory Committee
Joseph Leavey, Co-Chair John Sargent, Co-Chair	Child Systems Integration Committee
Karen Darcy, Co-Chair Marylou Sudders, Co-Chair	Insurance Committee
Robin Vann Ricca, Co-Chair Yolanda Coentro, Co-Chair	Healthcare Disparities Reduction and Elimination Committee
Timothy O'Leary, Co-Chair Karen Hacker, Co-Chair	Data, Trends and Outcomes Committee
Mary Ann Gapinski, Co-Chair Carol Trust, Co-Chair	Workforce Development Committee

Working Group Template

The purpose of the Working Group template is to provide all Advisory Committee Working Groups with a consistent framework to develop and synthesize inputs and recommendations for strengthening Children, Youth, and Family services.

Behavioral Health Working Group

Working Group Roles			
Chair	John Sargent 617-636-8768	**Co-Chair**	Joe Leavey 617 267-1031
State Support	Jack Simons 617-573-1791	**Facilitator**	
Scribe		**Recorder**	

1) Working Group Overview

Overall Charter

This Group would be asked to make recommendations about improving access and continuity of care mental health issues.

Problem Statement

Summary

Many members feel that the state is making progress in providing continuity and integration for families of children with BH needs, with Wraparound and a broad array of services in CBHI, including Family Partners, and with the plans for the joint DCF/DMH residential treatment reprocurement, including Family Partners. But there was agreement that we still have far to go: that there is still too much confusion about options and access, too much dependence on finding the right door. Youth and Families still get bounced from one door to another, and still end up feeling that they are not listened to. Service coordination with public school is a haphazard phenomenon. Substance abuse assessment and treatment often are split off from mental health assessment and treatment. At the state level we still do not use information about how youth and families cross our agency boundaries, and we still design, implement and evaluate services within agency silos.

Root Causes

A changing model of care that is family centered, youth guided, culturally informed and truly integrated is within our view but we need more investment in workforce development and training, programming and reimbursement that supports integration and continuity at the youth and family level, and at the level of system level processes and infrastructure.

Working Group Charge

Services

Services are effective, collaborative, accessible and coordinated. Care is available over time, appropriate and timely.

Systems

Our goal is to "enhance the integration of children's behavioral health services among all systems that children touch, ensuring longitudinal care, continuity of care and appropriate care at the appropriate time."

Systems promote the availability of appropriate and longitudinal services while also monitoring effectiveness and family endorsement.

Key Indicators of Success

Families report that behavioral health services are accessible, effective, comprehensive and respectful.

Families report that agencies and professionals are partners in recovery over time.

Families and youth report better understanding of available services and supports, and feeling assisted in knowing what they need and how to get it.

Families report they feel listened to by providers.

The state has a way to track youth across agencies and to evaluate the impact and cost of services for youth and families across agencies.

No youth or family falls through the cracks due to diffusion of responsibility.

Guiding Principles

Family is the expert on their child; youth is expert on self

Peer supports (Family Partners and Youth Peer Supports) have a profound impact on youth / families ability to be empowered and use the system effectively.

Build on what is working now.

Helpers need to demonstrate sense of "ownership" in that helper will stay engaged as long as needed for the family to be in the right place. The group did not reach consensus on whether the state should designate a single "behavioral health home" for each family (e.g. patient-centered medical home, BH provider or state agency) or whether the "home" should be a network of community based resources sharing a strong commitment to stick with families that

come to the door.

Prevention is integral to helping youth and families succeed, as are supports for families of young children who have not yet been diagnosed and inducted into the formal BH system.

Providers / helpers make integration happen for families at the community level when they are given support to do so. Support includes investment in collaboration across agencies, in collaboration at the local level across all kinds of supports (not just the state agencies), and in training staff in a family-centered collaborative model of care.

Mental health and substance abuse services need to live in the same world.

CBHI shows lots of promise -- we should work to make this kind of support available across payers including state agencies and commercial healthcare plans. Public and private insurance systems should provide funding for similar behavioral health services, depending on clinical need.

Working group was not sure that reorganizing departments would move us toward our goals; but also not sure the idea should be rejected. Most members were wary of "moving the boxes around" as a solution, but open to new evidence. Any reorganization should be based on careful research of outcomes in other states and a clear consensus plan on methods, expected outcomes, and a way of evaluating outcomes. With or without complete consolidation of agencies, having consistent regional boundaries across agencies would help.

Maintain awareness of payment reform and PCMH initiatives that have the potential to improve care, or to set back the progress we have made. Since adults cost the medical system more than kids, we are concerned that new healthcare initiatives will organize around adult models that are not appropriate for children and families.

NOTE: in making recommendations, below, our working group emphasized just six major recommendations, all of which we consider to be HIGH priority. None can be safely neglected. Within these essential six areas, EHS may assign higher or lower levels of priority to specific options. Some options are already partly in place, while others require attention to principles rather than large investments of resources.

2) Recommendations for Improvement

#	Recommendation Description	System or Services	Break out Group	Anticipated Benefits / Outcomes	Key Implementation Challenges / Risks	Priority *(H/M/L)*
1	Peer supports for parents (Family Partners) and for youth (Youth Peer Supports). Peer Supports should be available to youth and families as long as needed.	FPs exist in MassHealth (CBHI) and DMH / DCF will build on this platform. Youth Peer Support is supported by DMH but needs to be system wide. Key is to allow supports to follow family across agencies / payers.		Powerful impact for youth / families to be better informed, more empowered, and to experience more continuity. Very cost-effective way to produce dramatic impact. Peer supports can also help to provide care that is more culturally informed.	Risk of putting supports in silos instead of across agencies / sectors. Need to support with training / certification. Stakeholders need to be trained, too, to understand the roles of these new helpers. Peer supports need excellent training, supervision (by peer supports) and organizational support.	High (see NOTE, p. 3 above)
2	Data sharing at the youth / family level	All agencies including non-EHS (esp schools). Wraparound in ICC shows how this could work, but is limited to MassHealth. Some members felt the system should build shared assessment tools and		Better understanding of needs / priorities and better collaboration around implementation of care. Better continuity for care for kids, for example when returning to school from being hospitalized.	Not to share is "default position" when agencies are uncertain. Accenture work in NY shows data sharing takes lot of commitment and effort over time. MA may be more averse to data	High

		children and families (e.g. modified CANS) and should share one Master Treatment Plan with all providers and agencies.			sharing than other states. Will require sustained effort and EHS leadership, along with investment in provider training. Requires working across secretariats esp with DESE. EHS should use DESE Behavioral Health Taskforce Recommendations as roadmap for collaboration.	
3	Availability of resources to address family and youth needs of all kinds -- including basic needs -- is central to making the system of care effective. There must be "no wrong door" for information, referral and support for families. Education for families and communities	All EHS agencies plus collaboration with provider community, schools, and other natural sources of information and support for families. Examples include 211 lines, Family Resource Centers, Centers for Ageing and Disability, web-based resource directories, Autism Support Centers, Childcare R&Rs and other resource		Low-cost way to build on infrastructure we have. Sector-specific Resource &Referral services often do not address all the needs of a family; linking them together and cross training staff would increase ability to address all needs.	We love our silos. State tends to think only of state-funded services; efforts should go further to include the many channels and sources that families go to for information. Need to go beyond EHS. Schools are especially important partners. Ask DESE to partner with EHS around DESE Behavioral Health Taskforce Recommendations recently	High

	concerning behavioral health problems and treatments is essential.	centers all be linked and mutually informed. Information should be available about all agency, CBHI and behavioral health services. Don't limit this effort to directly state-funded centers, but include local nodes of all kinds in the information net.			released.	
4	System-level planning, implementation and evaluation across agencies, including rationalizing agency geographic areas	All EHS agencies: joint visioning, planning, procurement, contract management, and evaluation of process and outcomes, including cost.		Better ability to allocate resources to long-term priorities. More efficient / effective procurement and contract management. Ability to track child outcomes and costs across agencies longitudinally. Capacity to evaluate service models and refine	Integrated planning and implementation are useless if we do not also have integrated data across agencies, and the capacity to understand it. Accomplishing this may be the strongest argument for reorganization; in any case, it will require high-level leadership and investment in analytic resources.	High

				services to improve outcome and reduce costs.		
5	Support for workforce development. We are changing the model and we need everyone providing services to understand the collaborative, family driven, youth guided and culturally informed approach.	Across EHS and broader system, including education, early ed. Ensure that MH and SA training are not siloed. Common training elements should be used throughout including understanding impact of SA on families; also need common training on trauma-informed care. We also need to build diversity in all levels of the workforce to help address disparities.		This is essential to make all the recommendations above happen. People working with youth and families need good training and coaching to be effective. Failing to do this wastes service money because we pay for services that are not as effective as they should be.	Training and certification for new roles in peer support is currently emerging. Lack of funding for training. (But newly announced CMS initiatives may offer some options and need to be vigorously investigated.) Difficult to get out of training silos. This will require high level EHS leadership. Again, schools are key partners. Need for an ongoing dialog with DEEC, DESE about common goals and how to collaborate to reach them. Use ESE Behavioral Health Task Force recommendations as guidance.	high
6	Vigilant attention to	EHS / MassHealth, keeping		Reforms should build and	We are concerned that payment	High

promises and risks of payment reform.	larger service vision in mind.		support integrated collaborative care connecting services and systems and should reinforce and sustain progress we are already making. Creation of patient centered pediatric medical home is promising and can aligned with other EHS efforts to build community-based services that provide a long-term "home" for individual care.	reform may undo gains made by inappropriately applying adult healthcare models, by inappropriately shifting family support to a medical model, and by losing awareness of family-driven, youth guided care in favor of professionally driven care.	

APPENDIX C

Workforce Development Committee	**Unlicensed Healthcare Providers** Elevate the quality of the CBHI workforce by strengthening and integrating the system's capacity (including providers, State agencies and higher education) to train, develop and retain the workforce. Particular attention should be paid to removing systemic barriers linguistically and racially diverse workers. As an initial step, the Council shall partner with the newly forming DMH Research and Training Center to spearhead an online training initiative that supports and enhances provider training efforts on key competencies (to be defined), and provides college credits or CEUs to employees through the Commonwealth's higher education system. Content might initially be developed for the Family Partner workforce, but should be adapted for use with clinicians and behavioral health workers across the system. (Table: Analysis of training requirements by service)	**Nursing Workforce Development** Increase the number of Family Psychiatric Mental Health Nurse Practitioners (FPMHNP) 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 clinical nurse specialists who 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 FPMHNP, thereby increasing the workforce of Nurse Practitioners specializing in the assessment and treatment of children's behavioral 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 • 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. 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.

CBHI Training

		(CSA)	(IHT)	(TM)
1	*Systems of Care* philosophy	X	X	X
2	The four phases of *Wraparound* and the 10 principles of *Wraparound*	X		X
3	Family systems	X	X	
4	Peer support	X		
5	Partnering with parents/caregivers/guardians	X		
6	Psychotropic medications and possible side effects	X	X	X
7	Child and adolescent development including Sexuality		X	X
8	Related core clinical issues/topics	X		
9	Overview of the clinical and psychosocial needs of the target population	X	X	X
10	Available community mental health and substance-specific services	X		
11	Intro to child-serving systems and processes (DCF, DYS, DMH, DESE, etc)	X	X	X
12	Individual Care Plans	X		
13	Risk management/safety plans	X	X	X
14	Crisis Management	X	X	X
15	Ethnic, cultural, and linguistic considerations of the community	X	X	X
16	Community resources and services	X	X	X
17	Family-centered practice	X	X	X
18	Behavior management coaching	X	X	X
19	Mandated reporting	X		
20	Social skills training	X	X	X
21	Basic IEP and special education information	X	X	X
22	CANS	X		
23	CHINS		X	
24	Managed Care Entities performance & Medical Necc. Criteria		X	X
25	Child and adolescent development	X		
26	Conflict Resolution		X	X
27	Role within a CPT		X	X
28	Principles of rehab and recovery		X	
	TOTALS:	22	19	17

APPENDIX D

Revised Report

Private and Independently Licensed Practitioners Subgroup

CSA are finding it difficult to both hire experienced, licensed clinicians, and to have a sufficient referral base of experienced, licensed clinicians on MassHealth panels to fulfill the needs of their CBHI programs. Our subcommittee was tasked with the very specific goal of identifying barriers and recommending strategies for overcoming the barriers to recruiting and retaining independently licensed practitioners.

The subcommittee identified several barriers and made specific recommendations to address each. The next step is in identifying when, how, who will implement the accepted recommendations and action items.

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

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

A. 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	Explore uniform credentialing process with MassHealth Managed Care Entities and MBHP Taskforce develop & propose a template credentialing process

3. Reduce post-licensure work experience & volume (% of practice working with children) requirements for empanelment	Explore revising and developing reduced **post-licensure work experience & volume (% of practice working with children)** requirements with MassHealth Managed Care Entities and MBHP Taskforce develop & propose template for **post-licensure work experience & volume (% of practice working with children)**
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. Develop of CEU programs on CBHI to help educate practitioners regarding the systemic changes in Massachusetts
5. Develop benefits message re value of working with CBHI for licensed practitioners	**Possible benefits:** 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.
B. RECOMMENDATIONS TO RECRUIT & RETAIN INDEPENDENTLY LICENSED PROVIDERS TO AGENCIES THAT PROVIDE CBHI PROGRAMS AND SERVICES	**Action Items**
1. Provide Differential payment rates for independently licensed practitioners with more years of experience	Propose a draft, uniform, differential rate structure based on experience
2. Provide Differential payment for independently licensed practitioners with language capacity	Propose a draft, rate structure for clinicians with additional language(s) capacity

3. Support Loan forgiveness programs for human service practitioners working in home-based services	Explore draft legislation for loan forgiveness for clinicians working in CBHI programs
4. Identify strategies to promote use of independently licensed private practitioners to support agencies needing licensed practitioners for supervision	Develop criteria for CBHI clinical supervisors Draft/explore templates for using 'contract supervision/outside supervision.'
5. Expand Internship and training opportunities	a. Long-term strategy: Influence NCQA requirements that present barriers to funding internship training

APPENDIX E
CBHI LOGIC MODEL

CONTEXT (Problems)	INPUTS & ACTIVITIES	PROCESS MEASURES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES	IMPACT	AS MEASURED BY
Rosie D. Lawsuit Inconsistent community treatment Inconsistent identification of problems at early stage Limited outcome measurement Adverse childhood events/ mental health/substance abuse Uncoordinated system of care Health disparities	ICC Vocational support/housing In home Treatment Service Models Pediatric BH screening 0-21 CANs implementation Emergency care in community setting MCPAP Outpatient Treatment School Sx; Ed and BH health Early Intervention	Number of children using ICC √ Number of children using in home treatment √ Number of eligible children screening in primary care√ Number of children receiving CANS√ Number of families satisfied with services received ICC fidelity√ Staff turnover in ICC (family partners and care coordinators)√ Number of children using CBHI services√ Number of children using in home therapy√ School health services	Changes in CANS scores over time√ Strengths and deficit scores Changes in stuck kids list√ Readmissions (7 and 30 days) √ ED utilization√ Psych hospitalization √ (number and duration) Increased numbers of children with positive screens who receive care (before or after) All outcomes by race/ethnicity/language/ gender Increased number of children served in community√ School attendance	Improve symptoms and functioning as measured by CANS Decrease emergency psych utilization Decrease inpatient child psych utilization Decrease disparities in access to care Decreased use of residential placement Increased number of youth living in pre independent program 766 educational outcomes Therapy response and utilization for Substance Abuse	Improve children's mental health • Decreased child abuse and neglect • Increased community tenure • Decreased children in juvenile justice system • Maximized independent living • Increase school graduation rates • Decreased successive psychopharm use • Family hopefulness	• Number of reported child abuse cases annually • • Consumer expectations about psychopharmacology • Housing stability • Decreased frequency and duration of children in out of community care** • Number of children in residential DYS facilities annually with mental health issues • CHINs data • Employment rates of CBHI children >18, % of CBHI recipients on Transitional Assistance • Higher education enrollment of CBHI children and HS graduation rates • Use of antipsychotics <7 years of age, use of > one medication in same class at same time, Use of > 3 psychotropics at same time

Data Sources
Mass Health Claims, ICC reports, CANS, DFS, DOE, DOJ, DMH, school health services -DPH

√ Data is available
** out of community defined as: residential, hospital, subacute (Residential CBAT (ART) Inpatient, TCU, Continuing care, IRTP, BIRT)

[28]