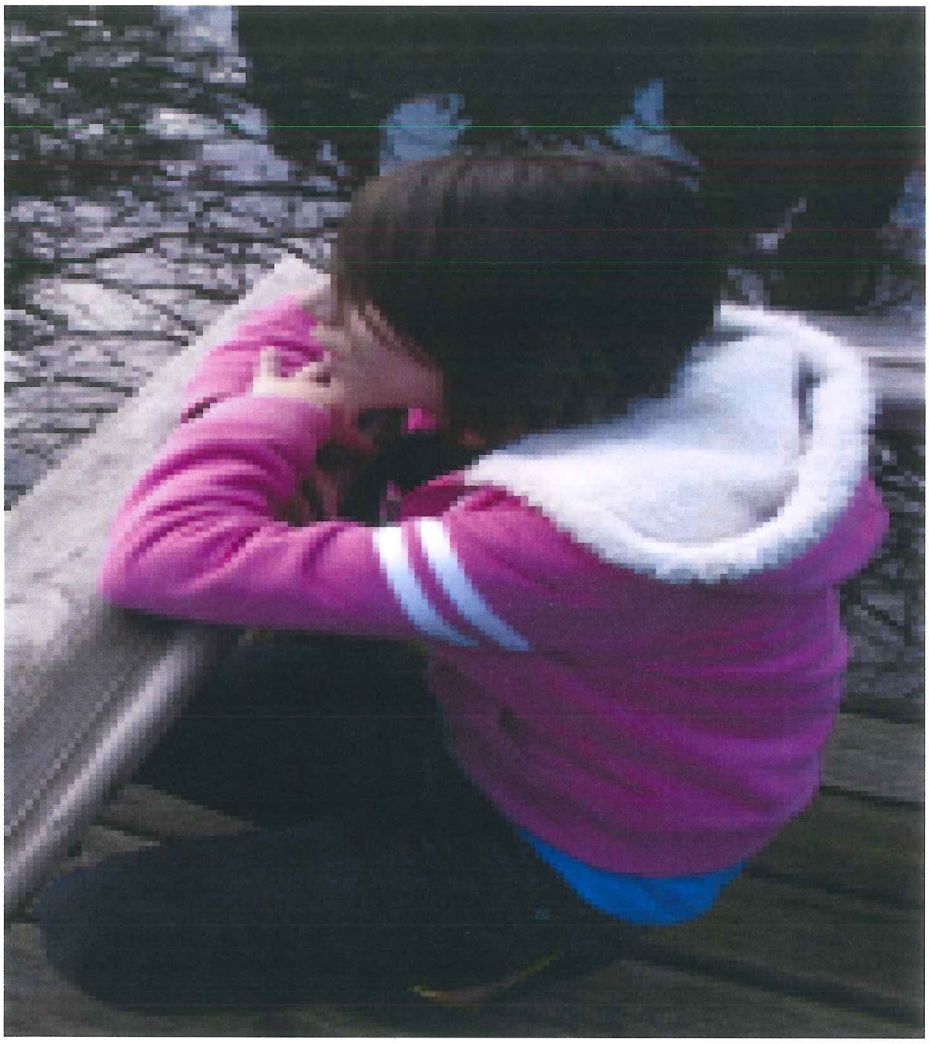
Commonwealth of Massachusetts
Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL



Annual Report 2013

MAMH

Massachusetts Association for Mental Health

James T. Brett
President
Thaleia Tsongas Schlesinger
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Executive Director

October 1, 2013

Hon. Deval L. Patrick, Governor of the Commonwealth
Thomas Weber, Acting Commissioner, Department of Early Education and Care
Mitchell D. Chester, Commissioner, Department of Elementary and Secondary Education
Hon. Gail Garinger, The Child Advocate
Hon. Joan Lovely, 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 Barrett, 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. James Welch, 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. Brain S. Dempsey, Chair, House Committee on Ways and Means

On behalf of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, I am pleased to transmit its 2013 Annual Report.

A listing of the Council's membership is attached as ***Appendix A***.

Much of our activity the past year involved research, discussion and the development of a range of recommendations to the Behavioral Health Integration Task Force (Task Force) on the issues identified in Section 275 of Chapter 224 of the Acts of 2012 as they affect behavioral health care for children. The Council submitted a report, which responded to each of the six questions posed in Section 275. The Council was pleased the Task Force accepted the Council's recommendations and included the entirety of our report as an appendix to its own Report to the Legislature and the Health Policy Commission.

Because we believe the Report of the Task Force and subsequent follow-up will be critically important, we have made the Council's report to the Task Force our Annual Report for 2013.

Chapter 224 of the Acts and Resolves of 2012 is a comprehensive law, which at its core is designed to contain health care costs. The Council believes health care cost containment is best achieved through the development of integrated delivery of health care systems, with attention to preventative care.

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience "significant impairment" and 5 percent experience "extreme functional impairment."
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.

Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults. Thus, while children are not "cost drivers" our failure to intervene or engage in preventative measures result in bringing them to adulthood, where their medical needs and costs become significantly higher.

We know we can improve outcomes, lower long term costs and do better by our children and adolescents with behavioral disorders and their families. This Annual Report provides a blue print and a series of recommendations, which we believe are clinically effective, cost efficient and will contribute to the well-being of all our children.

Sincerely,

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

cc: John Polanowicz, Secretary, Executive Office of Health and Human Services
Marcia Fowler, Commissioner, Department of Mental Health

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.

With the enactment of Chapter 224 of the Acts of 2012, Massachusetts appropriately signaled the importance of health care cost containment and the integration of primary and behavioral health care. Section 275 of that act established a Behavioral Health

Integration Task Force and charged it with providing recommendation on a number of important questions. The Council was asked to provide its recommendations with respect to behavioral health care for children and adolescents. **The remainder of this Annual Report is the Executive Summary of the Council's Report.**

Children's Behavioral Health Advisory Council
Recommendations to the Behavioral Health Integration Task Force
Executive Summary

The Children's Behavioral Health Advisory Council has provided a range of recommendations to the Behavioral Health Integration Task Force on the issues identified in Section 275 of Chapter 224 as they affect behavioral health care for children. Our full report responds to each of the six questions posed by the Legislature in Section 275. This executive summary organizes our recommendations at the service delivery, organizational and systems levels.

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It would be easy, but a mistake, to overlook the needs of children in the context of the healthcare reform efforts required by Chapter 224. Children are not "cost drivers" when compared to some groups of adults, e.g. adults eligible for both Medicaid and Medicare.

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience "significant impairment" and 5 percent experience "extreme functional impairment."[i]
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.[ii]
- Approximately 36% of youth with any lifetime mental health disorder received services, and only half of these youth who were severely impaired by their condition received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime.[iii]

Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults.[iv] Moreover, the Adverse Childhood Events literature underscores the impact that the untreated consequences of childhood toxic stress can have on adult physical health care morbidity, mortality and costs.[v]

I. SERVICE DELIVERY STRATEGIES

Strategies to improve what and how services are provided, beginning with access and engagement, and extending to how providers work together with and on behalf of children and their families.

Ensure behavioral health screening for all children.

1. Require all payers to reimburse primary care providers (PCP) for administration, scoring, and interpretation of behavioral health screening at every well child visit for children up to age 21.
2. Require all payers to reimburse pediatric primary care providers for administration, scoring, and interpretation of post partum screening at well child visits for children ages 0 to 6 months.
3. Educate primary care providers in the adult system who care for young adults (18 to 21) about their obligation to provide behavioral health screening.
4. Allow reimbursement for both a mental health screening and a substance abuse screening in a single visit when the Primary Care Provider deems necessary for a youth's health.

Behavioral health consultation should be readily accessible to primary care providers.

A range of arrangements supporting strong working relationships should be allowed, including co-location to facilitate access and ongoing collaboration.

Peer supports, including family partners and youth mentors, should be a standard service that is readily available and reimbursed.

Peer supports are critical to initial and on-going engagement for families and youth who might be reluctant to or lack knowledge about/skills for engaging in behavioral health care.

Care coordination should be a standard of care and reimbursed for all children receiving both primary and behavioral health care.

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Ensure all reimbursement policies support integrated delivery of primary care and behavioral health care. [vi] [vii]

1. Eliminate any restrictions on same-day billing between behavioral health and primary care providers. Allow both primary care and behavioral health providers to bill for overlapping time.
2. Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day. Allow for brief intervention services to be billed before a full assessment is completed.
3. Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
4. Set rates for consultation time to a PCP commensurate with rate for direct care provision.
5. Pay primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without their child present when the focus of the visit is the child's healthcare needs.

Ensure full and appropriate funding for MCPAP
The Massachusetts Child Psychiatry Access Program (MCPAP) provides broad access to child psychiatry consultation to any PCP regardless of a child's insurance source. Over half all consults provided were for children covered by commercial insurance (FY2009).[viii] To date, DMH has been the sole source of funding. Commercial insurers should be required to pay commensurate with their PCPs' use of MCPAP.

Fully enforce state and federal parity laws.
Clear guidance for both providers and consumers and enforcement regarding parity will remain necessary as new health care delivery arrangements are developed. There must be a full array of community-based behavioral health services available regardless of payer. Currently, MassHealth offers a richer array than do private insurers. Rates paid for behavioral health services should be set on par with rates for primary care.

II. ORGANIZATIONAL STRATEGIES

Strategies to strengthen the capacities of healthcare providers, insurers, regulators, and policy-makers manage, monitor, and continuously improve the quality and cost of healthcare.

Ensure family and youth consumer voices are fully represented in healthcare reform conversations at the systems and service delivery levels from the beginning.
ACOs should appoint to their governing structure more than the one consumer representative required by Chapter 224. At least one should represent families whose children receive both primary and behavioral health care and one should represent transition age youth. Healthcare organizations not specifically required to do so should consider including consumers in their governance structure.

Graduate programs and credentialing bodies must take a leadership role in preparing the healthcare workforce.

Training programs to produce skilled behavioral health specialists to work in primary care settings are needed, as are training programs for pediatricians in working with behavioral health specialists. Licensing standards and continuing education requirements must reflect the knowledge and competencies required to be effective in an integrated healthcare system.

Develop performance measures.
Reliable and useable measures must be developed to study the quality and cost effectiveness of integration mechanisms. Key process milestones towards good clinical outcomes (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, patient satisfaction) should also be measured. Payment methods should provide reimbursement for PCPs to collect and use data to improve their performance.

Enhance the service array based on both innovation and research evidence.
Reimbursement methods should support the adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment services. An effective system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care.

Develop protocols that allow information to be shared among care providers while protecting privacy.
Integrated healthcare requires integrated health information. The MA Child Health Quality Coalition's Communication and Confidentiality Task Force has been identifying issues impacting communications and confidentiality as well as resources that can help in addressing those issues.
The Council encourages their continued work to address the tension that exists between promoting communication among all members of a child's care team and ensuring that confidentiality and privacy protections are in place.

III. MULTI-SYSTEMS STRATEGIES

As a multi-disciplinary Council, we take a broad view of children's healthcare to include prevention and wellness. Transforming the children's healthcare system should include connecting it with other systems that impact / contribute to children's health and well-being.

Link pediatric care with care for parents.
Parents of children with a behavioral health condition are often under great stress and /or burdened with their own physical and/or psychological disorders. This impedes their ability to fully care for and manage care for their children. Care coordination for children's health care should be prepared to develop linkages with the parents' medical care, in conjunction with the parent and the child's PCP, as needed. Family Partners could be helpful in making these linkages.

Explore healthcare financing across child-serving systems.
Alternative financing methods across child-serving systems should be explored. Children access behavioral health care services through primary care and schools. However, funding is siloed and healthcare reform doesn't impact some of the financing sources for school-based care. Methods that integrate healthcare financing across these two systems might allow for even more effective healthcare delivery integration and reduced healthcare costs.

Invest in prevention and wellness.
The landmark Adverse Childhood Experiences (ACE) study has demonstrated dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of adult deaths. The Prevention and Wellness Trust Fund, created by Chapter 224, should take a strategically long-term approach by investing, in part, in children's well-being. The Council recognizes that responding to ACEs and childhood trauma is not solely the purview of the healthcare system but also of the broader social services and public health systems. The Prevention and Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations.

In addition, the MA Department of Public Health should explore the feasibility of incorporating the ACE questions in its annual Behavioral Risk Factor Surveillance System (BRFSS) survey, as several other states have done. This data, along with other sources, could then guide the Fund's grant-making.

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[i] Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999
[ii] NIMH, Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.
[iii] NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011
[iv] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251
[v] http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html
[vi] The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O'Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.
[vii] Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251
[viii] The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care

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	Carla Saccone Association for Behavioral Healthcare Representative
Christopher Counihan Office of Medicaid	Barbara Talkov/Erin Bradley 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
Jennifer Tracey Department of Public Health	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter Representative
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/Jack Simons Executive Office of Health and Human Services Children's Behavioral Health Interagency Initiative	Mary McGeown Massachusetts Society for the Prevention of Cruelty to Children

Sarah GordonChiaramida 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	Katherine Flores Young Adult Policy Team
Joel Goldstein, M.D. Cambridge Health Alliance	Alison Hunt Young Adult Policy Team
Amy Carafoli-Pires Boston Medical Center HealthNet Plan	Erin Goodrich Beacon Health Strategies
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.
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