CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE REDESIGN

I. BACKGROUND.

The national "system of care" philosophy holds that services should be community based, child centered, family focused, and culturally and linguistically competent. They should be:

- Comprehensive, including a broad array of services and supports;
- Individualized;
- Provided in the least restrictive, appropriate setting;
- Coordinated at the system and service delivery levels;
- Involve families and youth as full partners; and
- Emphasize early identification and intervention.

As documented by numerous studies over the past two decades, the behavioral health care system for children currently funded by Medicaid is fragmented. Care is often crisis oriented and resources are allocated to the most restrictive settings – residential therapeutic services for children removed from their families. The system is designed around the structure and capabilities of public and private providers rather than the needs of children and their families. As a result, services are limited and expensive, and the lack of common standards across the public and private service systems has frustrated efforts to ensure accountability and measure outcomes of care.

II. CURRENT PLANNING PROCESS

As the single state agency responsible for the administration of the Medicaid Program, the SC Department of Health and Human Services is responsible for purchasing quality behavioral health services for children with severe emotional or behavioral problems who qualify for Medicaid. Each year approximately 4,000 South Carolina children with severe emotional or behavioral problems receive therapeutic out-of-home placement services covered by Medicaid. These children are generally diagnosed with a mental health problem that substantially disrupts their ability to function.

SCDHHS initiated a planning process to improve the system of care. The purpose of this planning process is to ensure an integrated system of care for children with emotional or behavioral problems and related populations, while promoting fiscal and outcomes accountability for key policymakers and advocates. The process was designed to:

- Focus on implementation of those elements long recognized as essential elements of a system of care in South Carolina; and
- Establish a process for development and implementation of additional elements needed for a system of care for Medicaid beneficiaries.

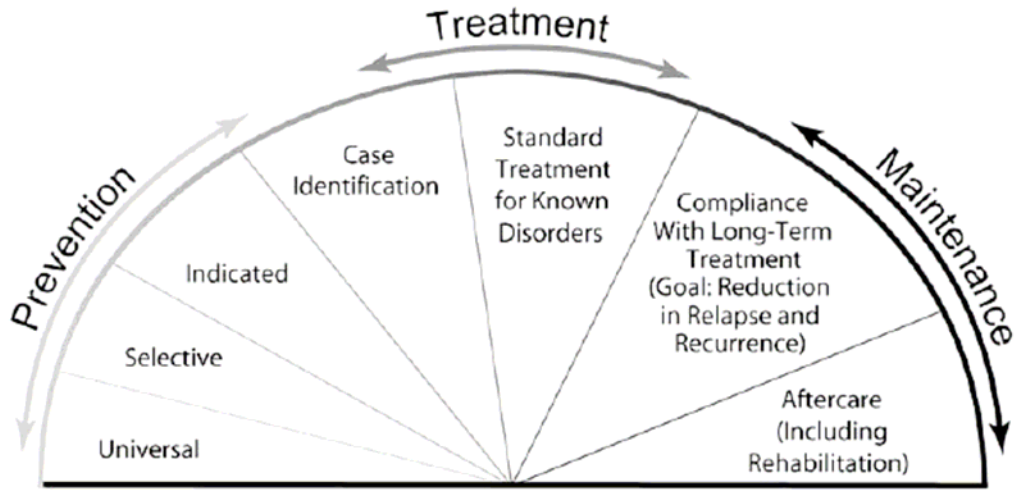
The intent is to build on the following longstanding recommendations that reflect almost two decades of South Carolina studies and findings:

- Emphasize treatment in the "least restrictive" settings by providing services similar in concept to Home and Community based Waiver Services to avoid removal of children with

severe emotional or behavioral problems from their homes and to improve the percent of children who are able to be successful in community placements.

- Develop and implement:
    - A uniform intake process that includes common diagnostic/assessment protocol leading to a joint standard classification system;
    - A standard template for treatment plans, focused on needs identified through the assessment process and measurable outcomes of therapeutic progress;
    - A common (across agencies) system for case management, client tracking, and data collection - this includes not only the technology needed, but also the training and standard policies, procedures, and definitions essential to a common system.
    - A standard method of evaluating the effectiveness of services provided by state agencies as well as private entities.
    - Training, policies, procedures, and technology essential to communication within and among state agencies, as well as with private providers.

The recommended reforms are organized along the continuum of mental health interventions as shown in Figure #1.



Prevention Recommendations

1. The state needs a coordinated, evidence-based, population-based approach to prevention that includes public and private efforts. Prevention programs should focus on:
    a. fostering positive parenting practices; and
    b. providing positive behavioral supports in the school setting.

Case Identification

1. Use of Parent's Evaluation of Developmental Status (PEDS) (age 0-5) and Pediatric Symptoms Checklist (age 6+) by health professionals as part of the EPSDT program, and by parents and staff who work with children.
2. Children (age 0-3) scoring above threshold on PEDS are referred to BabyNet for assessment.

3. Children (age 4-5) scoring above threshold on PEDS are referred for basic assessment.
4. Children scoring above threshold on Pediatric Symptoms Checklist are referred for basic assessment; (at risk) children scoring just below threshold are referred for indicated prevention.
5. Comprehensive basic assessments are conducted by licensed health/behavioral health professional acting within scope of practice and expertise, or someone supervised by such a professional.
    a. Assessment reports must cover all essential elements.
    b. On-line training to assure consistent interpretation of the assessment elements.
    c. Referral for supplemental/specialty assessments (Developmental, Sex Offender, Child Abuse, Substance Abuse, Psycho-Education) based on responses to screening elements of basic assessment.
        i. Conducted by qualified providers (list).
        ii. Comply with required protocol.
    d. Need for case manager/service coordinator will be determined. If the client or the client's third party payer will cover the cost of a case manager, the client will be offered the option of case management. If they so choose, they will select a case manager from the third party payer's approved list, if applicable. If there are no funds for an independent case manager, an entity providing treatment for the client may assign a case manager.
    e. Ability to pay/third party coverage will be determined. Since the basic and supplemental assessments must precede any identification of a "lead" state agency, funds for assessment of Medicaid eligible children will need to be identified.
    f. Based on assessment results and financial status, patient/family will be offered choice of treatment provider(s). By doing the assessment, an otherwise qualified provider is not prohibited from providing treatment or case management if selected from the list by the client.
    g. Unless the client/family prefers otherwise, the assessor will make the initial contact with the treatment and/or case management provider, set up an appointment, and arrange to send them the assessment report and treatment recommendations.

<u>Treatment</u>

1. Treating professional/organization receives comprehensive assessment report; must develop plan of care within 30 days of initial appointment.
2. Use of a web-based "electronic medical/health record", including the ORS case management information system, should be tested.
3. The system will make no distinction between treatment and support/wraparound services – although third party payers might.
4. A uniform level of care standard for residential placement is under development.
5. An independent reassessment of the client/family must be conducted every six months, generating a standard report and treatment recommendations comparable to the initial assessment report. This reassessment must be based on direct contact with the client/family and must reflect client/family assessment of treatment progress.

Follow-up Care/Relapse Prevention

1. Prior to discharging a child from treatment, the treatment provider is responsible for developing a transition/aftercare plan.
2. In general, treatment professionals are not required to do post-discharge follow-up – though third party payers might require this.

Uniform methods for tracking client outcomes and system accountability are under development.

III. BENCHMARKS FOR SUCCESS

As the agency responsible for purchasing quality behavioral health services for children with severe emotional or behavioral problems who qualify for Medicaid, SCDHHS will provide leadership to assure coordinated and integrated children's services so that all children receive needed services.

Progress Toward Systems of Care Reforms

FROM	**TO**
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Multidisciplinary team/blended resources
Limited service availability	Comprehensive service array
Reactive crisis-oriented approach	Prevention/early interventions
Focus on most restrictive settings	Focus on least restrictive settings
Children placed out of home	Children within families
Centralized authority	Community-based ownership
Creation of dependency	Self-help and active participation
Child-only focus	Family focus
Needs/deficits assessments	Strengths-based assessments
Families as problems	Families as partners/therapeutic allies
Cultural blindness	Cultural competence
Highly professionalized	Informal and natural supports
Child and family must fit services	Individualized/wraparound approach
Input focused accountability	Outcomes/results-oriented accountability
Funding tied to programs	Funding tied to populations

Simple, Direct Answers to These Questions

- Is SC meeting both the medical and behavioral health care needs of Medicaid beneficiaries who are emotionally disturbed children?
- Does SC have the Medicaid provider capacity to serve this population?
- What evidence supports SC's values and guiding principles on least restrictive environment for this population?
- Are these beneficiaries, their families and child advocates full participants in the system of care planning process?

- Does the system of care accurately identify the number of children in need of behavioral health services?
- Does the system of care describe an assessment process specifically designed for children and their families and for the purpose of ascertaining what is needed for the child to live in the community?
- Does the system of care discuss treatment planning and offer children and families choices about services?
- Does the system of care provider for transitions throughout childhood and between childhood and adulthood?
- Does the system of care discuss the development and funding of an adequate service array?
- Does the system of care ensure that high quality services will be available?
- Does the system of care provide for quality improvement and data to track the outcomes that are important to children, families, advocates and state policymakers and payers?
- Does the system of care specifically address the challenges of multi-agency involvement in children's and families lives?

IV. MEDICAID 1115 WAIVER DEMONSTRATION PILOT

Eligibility

The demonstration pilot project would include all children (birth through age 18) who are already eligible for Medicaid through existing eligibility categories and all children who would be eligible for Medicaid if they were appropriately placed in a therapeutic residential treatment setting (i.e., met the state's level of care standard for residential placement).

Coverage & Benefits

The demonstration pilot project would be limited to a small geographic area in the state. Demonstration services would include all services currently covered by the state's Medicaid program as well as the following new services:

- Designated preventive services
- Inclusion of the PEDS or Pediatric Symptoms Checklist in EPSDT screenings
- Intensive outpatient treatment and support services for children meeting the state's standard for residential placement
- Respite

Delivery System

The demonstration pilot would expand the number and types of Medicaid behavioral health providers. Assessment and treatment services will be provided by:

- Licensed and certified health or behavioral health professional working within their legal scope of practice, training, and experience. The Medicaid program will establish minimum requirements regarding scope of practice, training, and experience.
- A person supervised by such professional. Supervision must comply with existing Medicaid policies as well as the standards for supervision set by the professional discipline.

Access

Changes in eligibility, benefits, and delivery system should increase access to services.

Quality

System changes will be implemented to eliminate unnecessary variation in: screening, early identification, intake, assessment, diagnosis, treatment planning, treatment, case management, client tracking, and data collection. These changes include standard policies, procedures, and definitions, as well as the training and technology needed to implement such changes. Reduced variability as a result of standardization will allow ongoing evaluation of the effectiveness of services provided by state agencies as well as private entities. The use of a web-based electronic behavioral health record will enhance utilization review and quality assurance. Allowing greater consumer choice of provider will improve quality of care related to those sometime intangible dimensions (i.e., provider attitude, responsiveness) that can be difficult to measure through data collection.

Budget Neutrality

Through the changes in eligibility, services, and delivery system, as well as the adoption of a single reimbursement rate structure for public and private providers, Medicaid costs per eligible child should be reduced. The number of children who are placed in therapeutic residential settings and the length of time a child is in intensive treatment should decrease.

Systems Support

The state has spent a year in identifying the changes in eligibility, services, delivery system, and accountability needed for the pilot. A planning committee has started work to provide the working details needed to accomplish these changes. Areas of focus include:

- Identifying specific prevention programs
- Revising EPSDT screening and referral procedures to include the PEDS and PSC.
- Establishing a uniform standard for residential placement
- Identifying the intensive outpatient services for children who qualify for residential placement
- Establish minimum requirements for providers regarding scope of practice, training, and experience.
- Developing the standard policies, procedures, and definitions, as well as the training and technology needed to implement system changes. One major item is the web based electronic behavioral health record.

Implementation Time Frames

Implementation Step	Date
CMS 1115 Waiver Concept Phase (concept paper)	Feb 2006
Implementation planning	
• Identify pilot counties	Mar 2006
• Identify prevention programs	Mar 2006
• Revise EPSDT procedures to include the PEDS and PSC.	Mar 2006
• Establish a uniform standard for residential placement	Feb 2006
• Identify intensive outpatient services for children who qualify for residential placement	Mar 2006
• Establish minimum requirements for providers regarding scope of practice, training, and experience.	Mar-Apr 2006
• Developing the standard policies, procedures, and definitions, as well as the training and technology needed to implement system changes. One major item is the web based electronic behavioral health record.	Feb – June 2006
• Identify/obtain state financial resources needed to implement the system changes.	Apr – Jun 2006
CMS 1115 Waiver Proposal Review Phase (application)	Feb - June 2006
CMS 1115 Waiver Pre-implementation Phase (waiver approval)	Jul - Sep 2006
CMS 1115 Waiver Operational Phase (implementation)	Oct 2006 – Sep 2009
CMS 1115 Waiver Evaluation Phase (implementation)	Oct 2006 – Sep 2009

Evaluation & Reporting

An evaluation will be designed and conducted by an independent evaluator, subject to SCDHHS and CMS approval. All evaluation and reporting activities will comply with the waiver terms and conditions.