

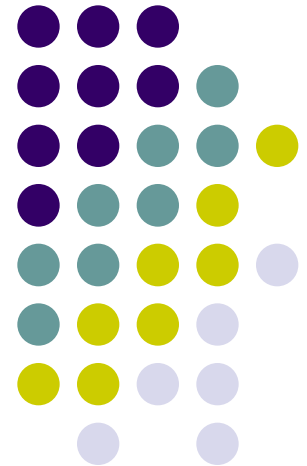
# How to Build a Statewide System of Care – Massachusetts Experience

Expanding Access to  
Children's Behavioral Healthcare

Conference of Local Mental Hygiene

Directors, Inc.

October 8, 2014

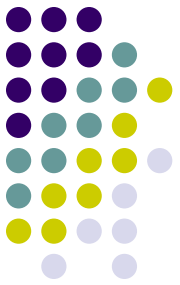


# Agenda



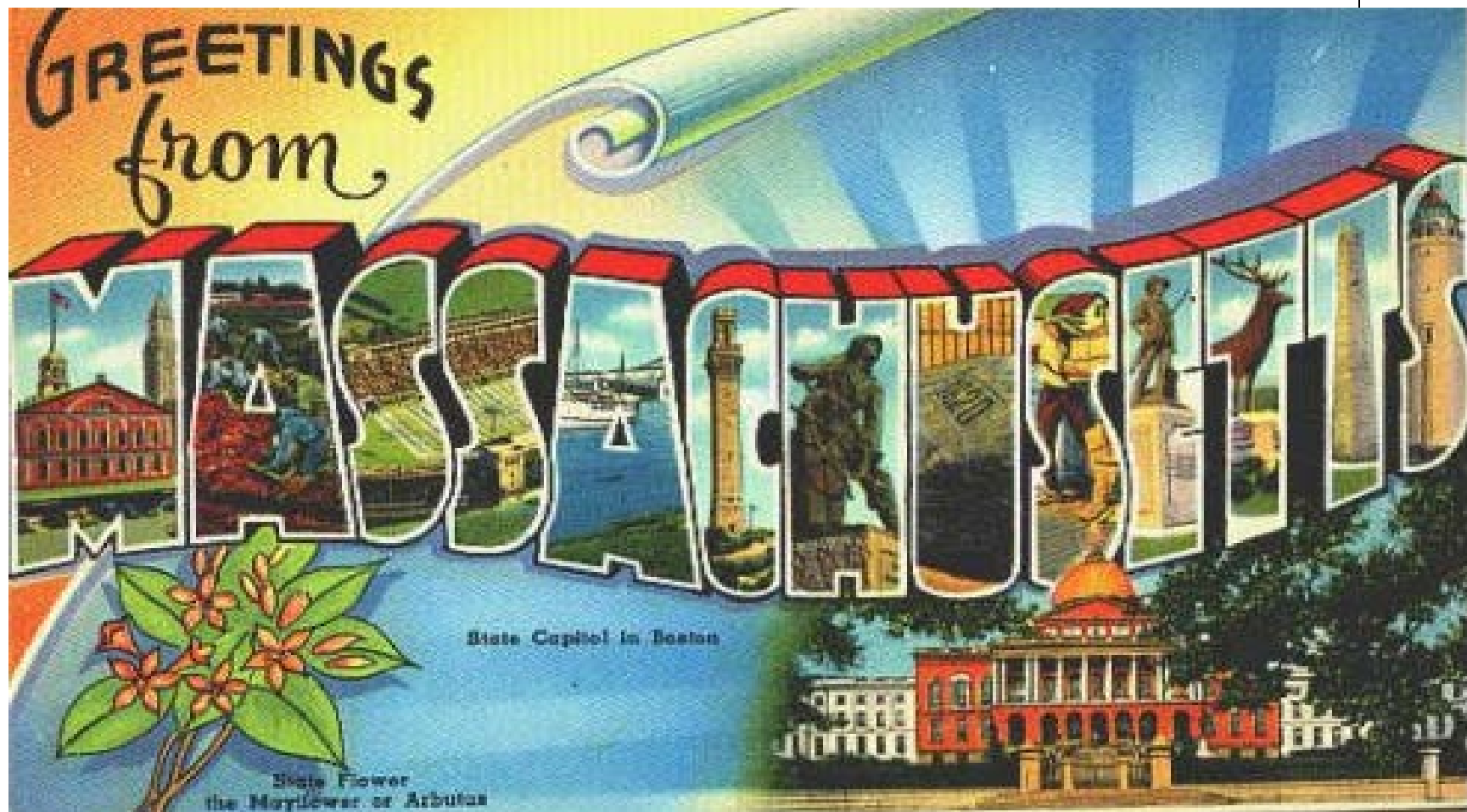
- I. Overview
- II. Designing the New Service Delivery System
- III. Service Implementation
- IV. SOC Development: Policy and Practice Levels
- V. Measuring System Performance
- VI. Working in the Context of Litigation

# I. Overview



- A. Introduction to Massachusetts
- B. Massachusetts' system of care – 30 years in the making
- c. Litigation context

## B. Introduction to Massachusetts



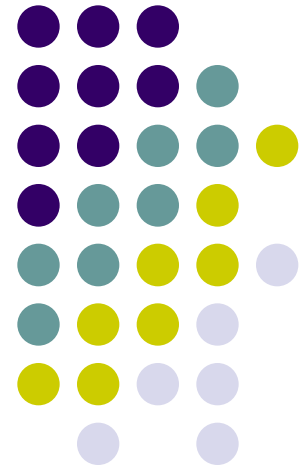
# Some relevant facts....

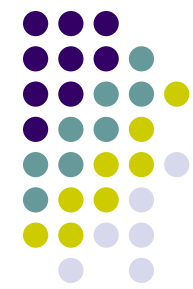


- 6.6 million people
- 1.6 million receive MassHealth (Medicaid)(600,000 under 21)
- Multi-ethnic white, African-American; immigrants from the Caribbean, Brazil, the Azores, Cape Verde, Africa, Southeast Asia, China, Russia; small Native American communities
- Two economies: “Knowledge economy”: highly paid, highly educated workforce; “Service economy”: low-wage work
- Services delivered through statewide systems with state agencies, and statewide managed care entities who contract with local provider organizations
- Greatest concentration of teaching hospitals in U.S.

# C. Massachusetts' system of care – 30 years in the making

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# Our story starts in the 1980s and 90s...

Federal CASSP Grants (1980s)

State Dept. of Mental Health introduces salaried Family Support Specialists with lived experience

Child Welfare agency adopts Family Group Conferencing, strengths-based planning and emphasis on community-based and natural supports (2000s)

1991: Parent/Professional Advocacy League starts. PPAL is the state organization of the Federation of Families for Children's Mental Health

Managed Care expands with expanded covered behavioral health services 2003

MHSPY and WCC expanded to five cities as Coordinated-Family Focused Care (CFFC) through Medicaid Waiver (2003)

Many providers use grants to experiment with more strengths-based family-centered, ecological approaches

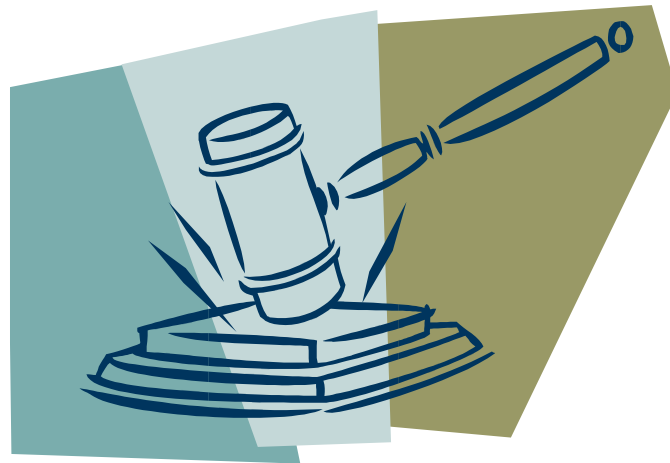
SAMHSA System of Care Grants to Worcester Communities of Care (WCC, 1999)

Juvenile Justice agency adopts Positive Youth Development approaches

# The Big Catalyst: The “Rosie D” Class Action Lawsuit....



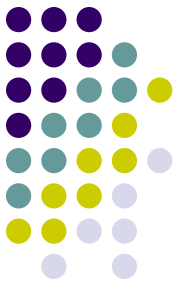
- Filed in 2001 on behalf of children and youth with serious emotional disturbance; final Judgment issued July, 2007
- MassHealth, found to be out of compliance with “**reasonable promptness**” and “**Early Periodic Screening Diagnosis and Treatment**” (EPSDT) provisions of federal Medicaid law







# The “Rosie D.” lawsuit remedy included:

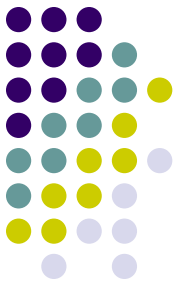


- New home- and community-based behavioral health (BH) services, including Wraparound
- Standardized BH screening in primary care
- Standardized scope of BH assessment, using the Child and Adolescent Needs and Strengths (CANS) tool

# Children's Behavioral Health Initiative (CBHI) Mission

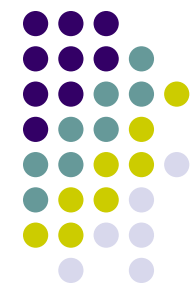


To strengthen, expand and integrate Massachusetts services into a comprehensive system of community-based, culturally competent behavioral health and complementary services for all children with serious emotional disturbance and other emotional and behavioral health needs, along with their families.

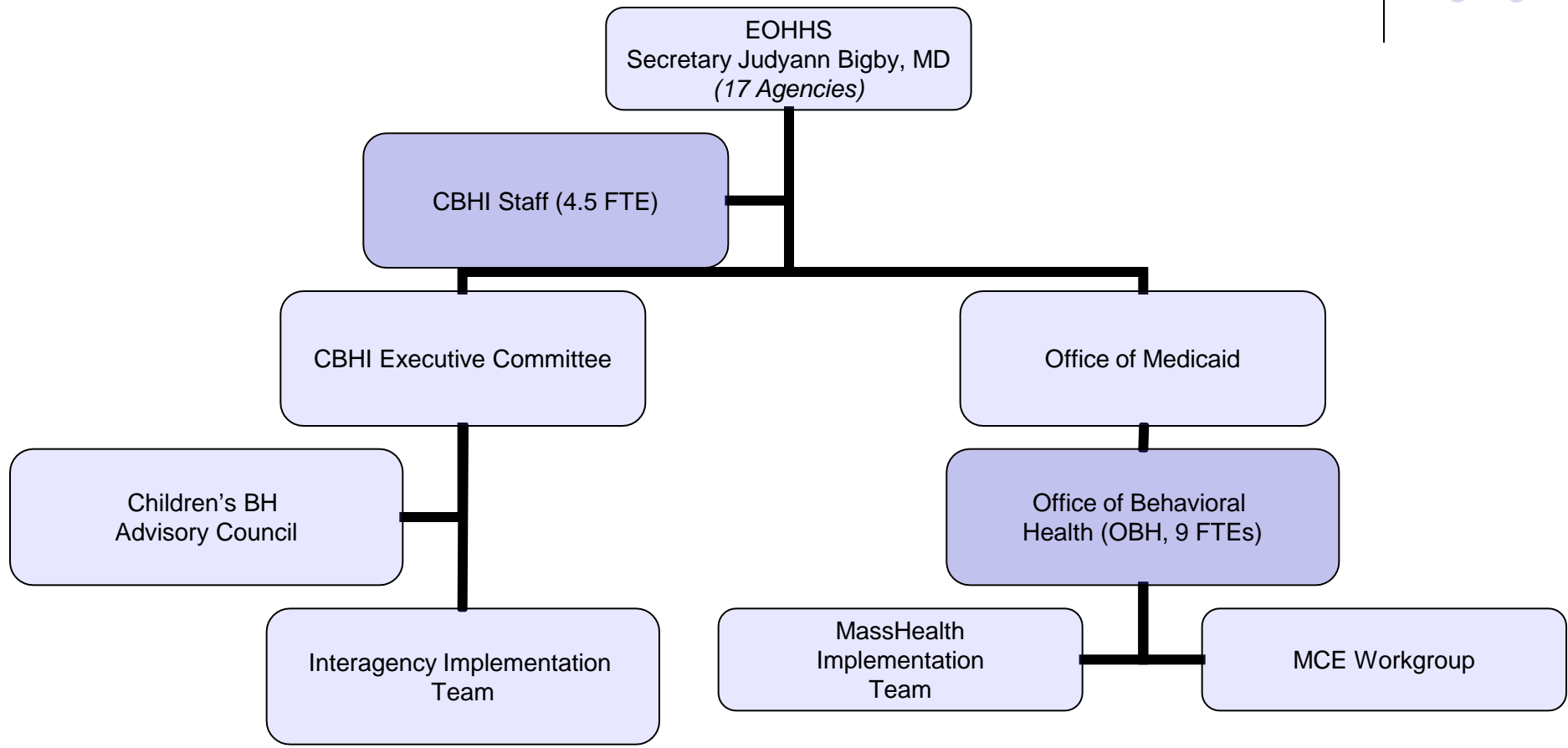


# CBHI Values

- Child-Centered & Family-Driven
- Strengths-Based
- Culturally Responsive
- Collaborative and Integrated
- Continuously Improving



# CBHI Governance





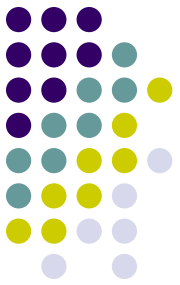
# OBH Staff Responsibilities



- Manage MassHealth's BH services & contracts
- Led design process for new services
- Lead the seven Managed Care Entities (MCEs) to collaboratively develop & manage the new provider networks
- Manage communications with MCEs and providers
- Develop payment methodologies
- Support litigation activities



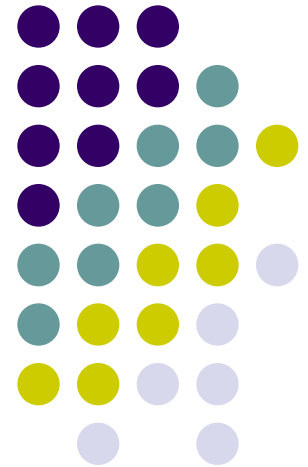
# CBHI Staff Responsibilities:



- CBHI Director is lawsuit “Compliance Coordinator”
- Oversee BH screening implementation and quality improvement (QI)
- Manage the CANS implementation, infrastructure development and QI

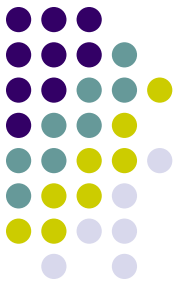
# C. Litigation context

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# Litigation presents opportunities...

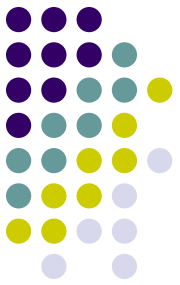


- Federal Court Order requires the State to pay for new services (\$200M+)
- Court-ordered timelines must be met



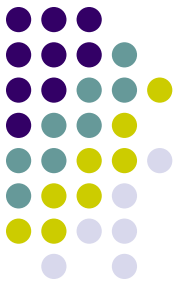


# ...and challenges



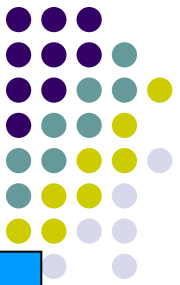
- Reduced budgetary discretion
- The primary “customer” is the Court, not other system builders
- Process is adversarial
- Contrasting with what is needed to build a SOC: collaboration & transparency

# **II. Designing the New Service Delivery System**



- A. Overview
- B. Home- and community-based services

# Overview: Phases of Work



## Screening



## CANS



## Services



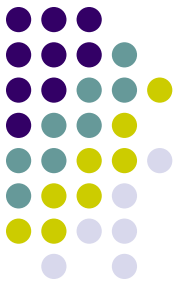
**Fall 2006**   **July 2007**   **Dec. 2007**   **July 2008**   **Nov. 2008**   **June 2009**   **Sept. 2009**   **Oct. 2009**

Final Judgment Issued

ICC, FS&T, MCI Start June 30, 2009  
 IHBS, TM Start Sept. 1, 2009  
 IHT Starts Oct. 1, 2009



# Overview: a complex stakeholder world



- Executive Branch Agencies
- Courts, Legislature, Local Government
- Federal Government Agencies
- Managed Care Entities (MCE's)
- Advocates
- Provider community

*Stakeholders have their own internal and external constituencies!*



# Overview: Internal resources to mirror external complexity

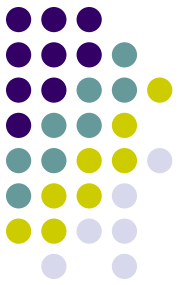


- A diverse internal team
- OBH and CBHI staff have experience in:
  - Clinical and Wraparound practice
  - Managed care
  - Medicaid administration
  - State agency operations and administration
  - Legislative/political processes

# Core strategies



- Champion: endorsement from EOHHS Secretary
- Articulate SOC Vision & Values to all stakeholders
- Achieve internal consistency on message
- Develop individualized strategies for ongoing stakeholder engagement
  - Staged and prioritized
  - Clear assignments among EHS staff for stakeholder relationships
  - Be transparent about what is open to change - Listen !

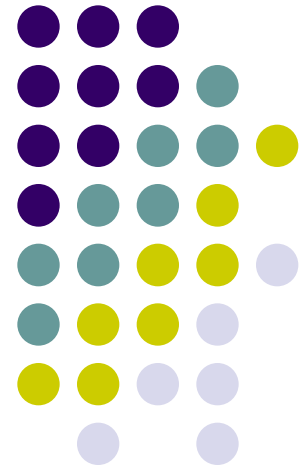


# Avenues for Information and Education

- Website [www.mass.gov/masshealth/cbhi](http://www.mass.gov/masshealth/cbhi)
- E-Newsletter
- Behavioral Health Advisory Council
- Statewide & regional conference calls and presentations
- Training and tailored materials for state agency, school, court and probation staff

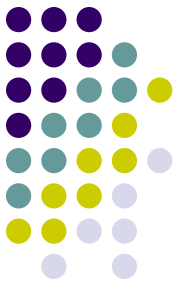
# Home- and community-based services

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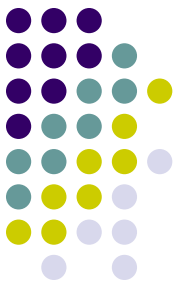




# The “Rosie D” Remedy Services



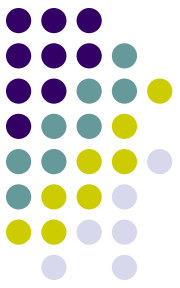
- Intensive Care Coordination (ICC)(Wraparound)
- Family Support & Training (FS&T)(Family Partners)
- In-Home Therapy (IHT)
- In-Home Behavioral Services (IHBS)
- Therapeutic Mentoring (TM)
- Mobile Crisis Intervention (MCI)



# Designing the services

## Internal, interagency process:

- EOHHS formed an Interagency Network Development Workgroup in 2007
- Became the CBHI Interagency Implementation Team in early 2008
- Recommendations finalized by CBHI Executive Committee



## Designing the services (2)

### State's work informed by system builders:

- Children's Behavioral Health Advisory Council – established by CBHI Executive Committee in 2008; reconfigured in 2009 pursuant to new law\*
- Solicited feedback on preliminary plans through Request for Information (80 responses)
- Meetings and Stakeholder Forums (15+)

\* Ch. 321 of the Acts of 2008

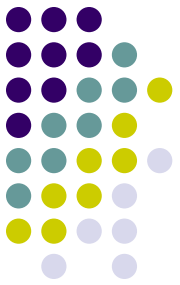


# Designing the Services (3)

## Key intervention by Court Monitor

Ms. Snyder used funds from her budget to hire consultants - approved by both parties. Led by John O'Brien, they included Mary Brogan, Bruce Kamradt, Patrick Kanary, Marty Knisely, Michael Lancaster, Kappy Maddenwald and Sheila Pires

# At the Center: Care Coordination



Three  
Service  
“HUBS”:

1

## Intensive Care Coordination (Wraparound)

- Clinical Assessment inc. CANS
- SED determination for eligibility
- Medical Necessity determination
- Care coordination

2

## In-Home Therapy

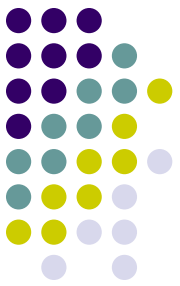
- Clinical Assessment inc. CANS
- Medical necessity determination
- Care coordination available

3

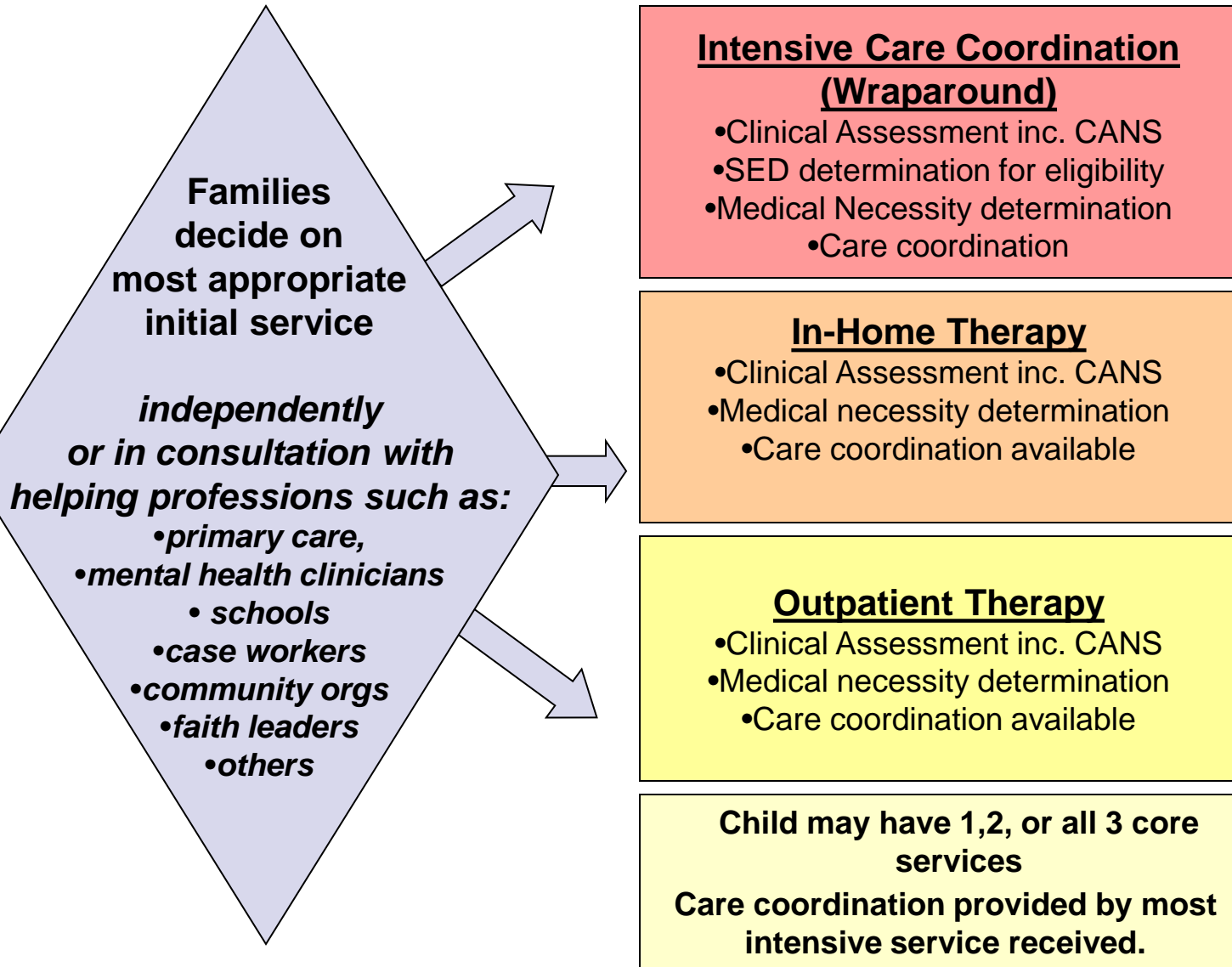
## Outpatient Therapy

- Clinical Assessment inc. CANS
- Medical necessity determination
- Care coordination available

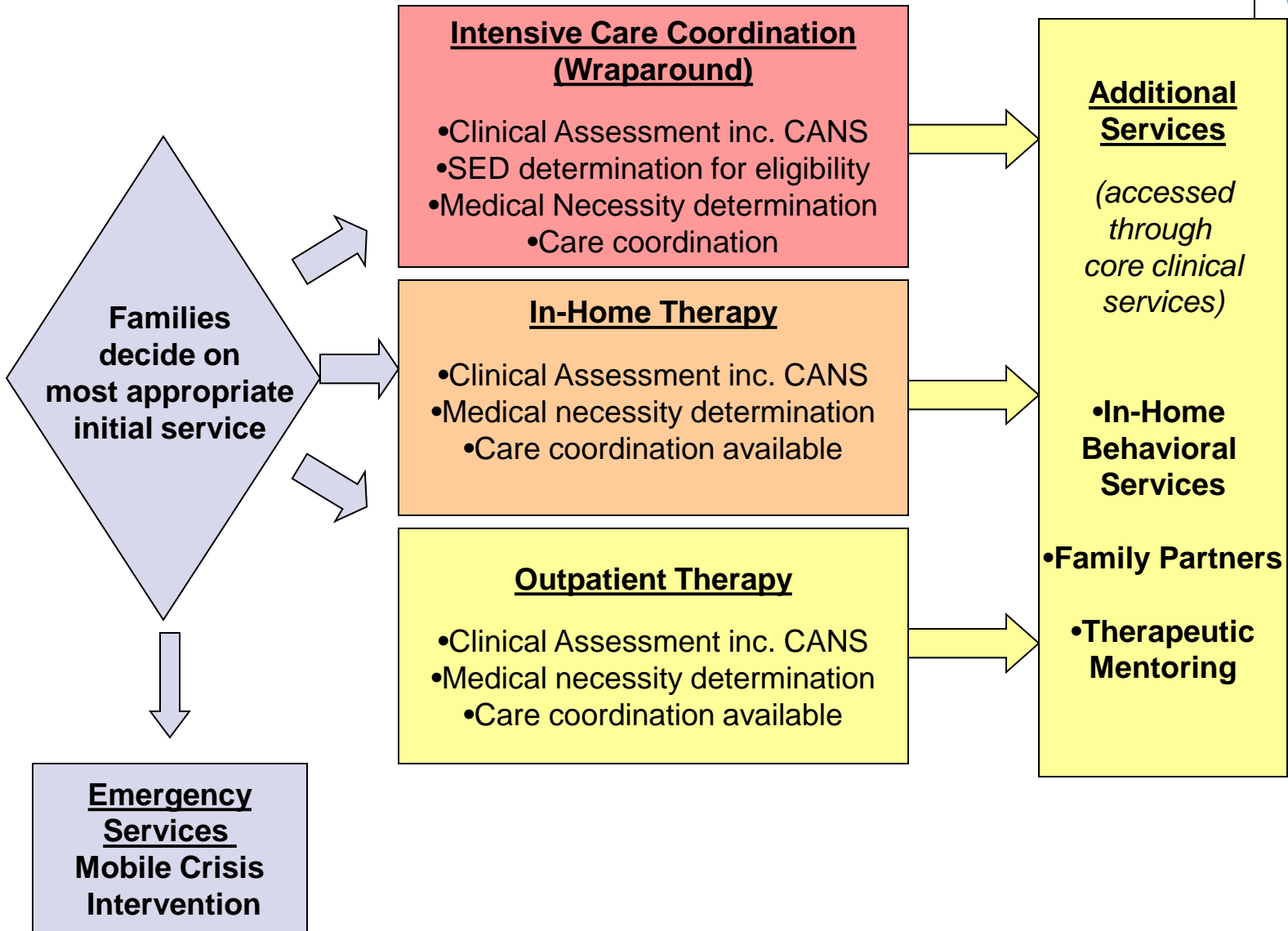
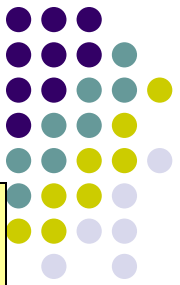
Child may have 1,2, or all 3 services  
Care coordination provided by most  
intensive service received.



# Accessing Service Hubs:



# Accessing Additional Services



# III. Service Implementation

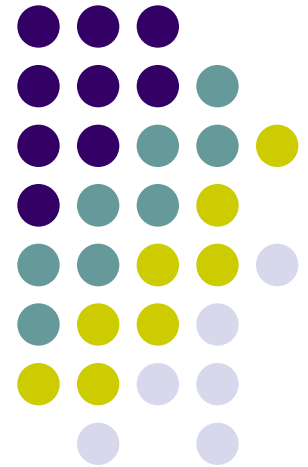


- A. Role of managed care entities (MCEs)
- B. Engagement of providers
- C. Development of rates and payment methodologies



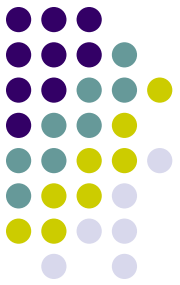
# **A. Role of Managed Care Entities (MCEs)**

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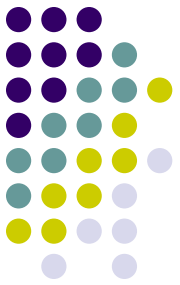


# Building a system of care within a managed care framework:



- OBH AND MCE'S:
  - Ensured oversight of providers
  - Ensured services delivered according to specifications
  - Provides technical assistance, quality management, and a systematic data feedback loop to providers to promote continuous quality improvement and management of outliers

# Quality Management

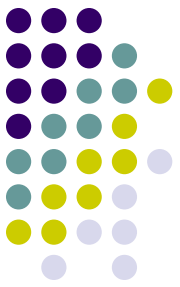


Key approaches:

- MCEs provide technical assistance (TA) to provider agencies
- MCEs convene joint meetings and trainings for all service providers
- State and MCEs contract with consultants, trainers and coaches



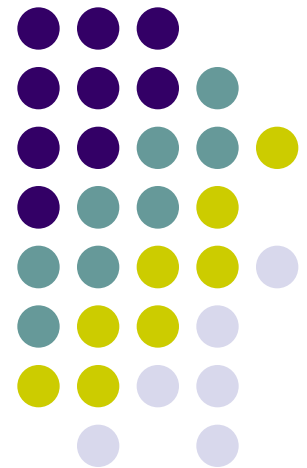
# External consultants, trainers and coaches:

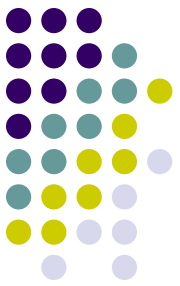


- Three-year contract with Vroon VanDenBerg (VVDB) for Wraparound training and coaching to ICC providers
- Basic training on Wraparound provided to MCE and state agency staff
- Three-year contract with Kappy Maddenwald, MSW, for coaching and technical assistance to MCI providers, and other providers re: “Risk Management/Safety Plans”

# B. Engaging providers

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# Importance of provider engagement

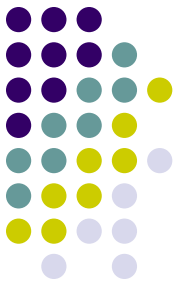
- Ensure compliance with complex new services and requirements
- Motivate performance that goes *beyond* compliance, to best practices
- Elicit provider contributions to the process
- Maintain provider engagement during ongoing changes
- Sustain and extend gains by internalizing the values of the initiative



# Challenges



- Heterogeneity of workforce
- Tradition of professional autonomy & local clinical traditions
- Concurrent stresses on provider organizations
- Technology challenges for clinicians and organizations
- Multiple levels between the policy level and clinicians in provider organizations == loose coupling



# Approach to stakeholders

- Transparency re the lawsuit and the process
- Seize opportunities for stakeholder input when possible
- Support mandates with training and coaching
- Have experienced implementers on staff
- Engage Providers in sustainability planning





# Major foci of training/coaching/TA



- Intensive Care Coordination & Family Partners in newly formed Community Service Agencies (CSAs)
- Mobile Crisis Intervention: an enhancement of existing Emergency Service Providers
- CANS training, certification, and practice improvement

# Example: High Fidelity Wraparound

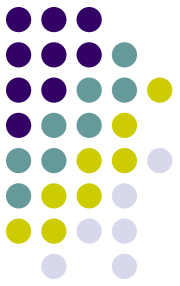


## Challenges:

- Speed of implementation / workforce development
- Complexity of design / new entities to manage Wraparound Care Coordination
- How to go beyond initial training to ongoing, sustainable practice improvement?



# Training and coaching strategies: High Fidelity Wraparound



- Build on existing expertise
- Invest in training, coaching & fidelity measurement
- Provide opportunities for agencies to share accomplishments
- Train Family Partners with Care Coordinators



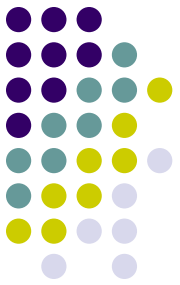
# Training implementation: High Fidelity Wraparound



- Selected large training company that could manage needed scale
- First year -- large trainings for line staff and supervisors
- Some startup funding to CSAs for lost productivity
- Trainings for wraparound stakeholders, too
- Second and third years, more seminar-style coaching of supervisors; CSAs training own staff



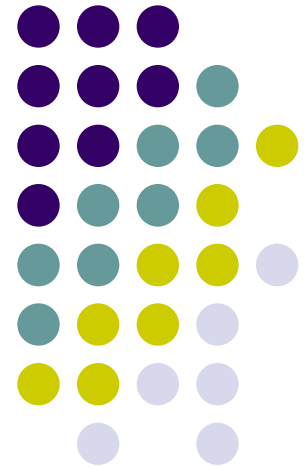
# Impact of training / coaching: High Fidelity Wraparound



- Fidelity scores higher than national average in years 1 and 2
- Continued improvement in year 3 on Community Supports
- Providers strongly committed to Wraparound values, fidelity,
- More work is needed to help Wraparound team members from other systems
- Sustainably through coaching offered from Subject Matter Experts within existing workforce to other CSA's.

# IV. Tracking and Measurement

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# Types and sources of data:



<u>Measure</u>	<u>Source</u>
cost and utilization	claims data
access	provider reports
performance measures	provider reports
Wraparound fidelity	Wraparound Fidelity Index



# New Services – Numbers Served



Serving approximately 25,000 youth per year:

- 4000 a month receive ICC
- 3200 a month have Family Partners
- 6200 a month receive IHT
- 4000 a month receive TM
- 600 a month receive IHBS
- 1500 a month use MCI

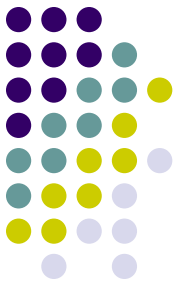


# Use of other services by youth receiving ICC:



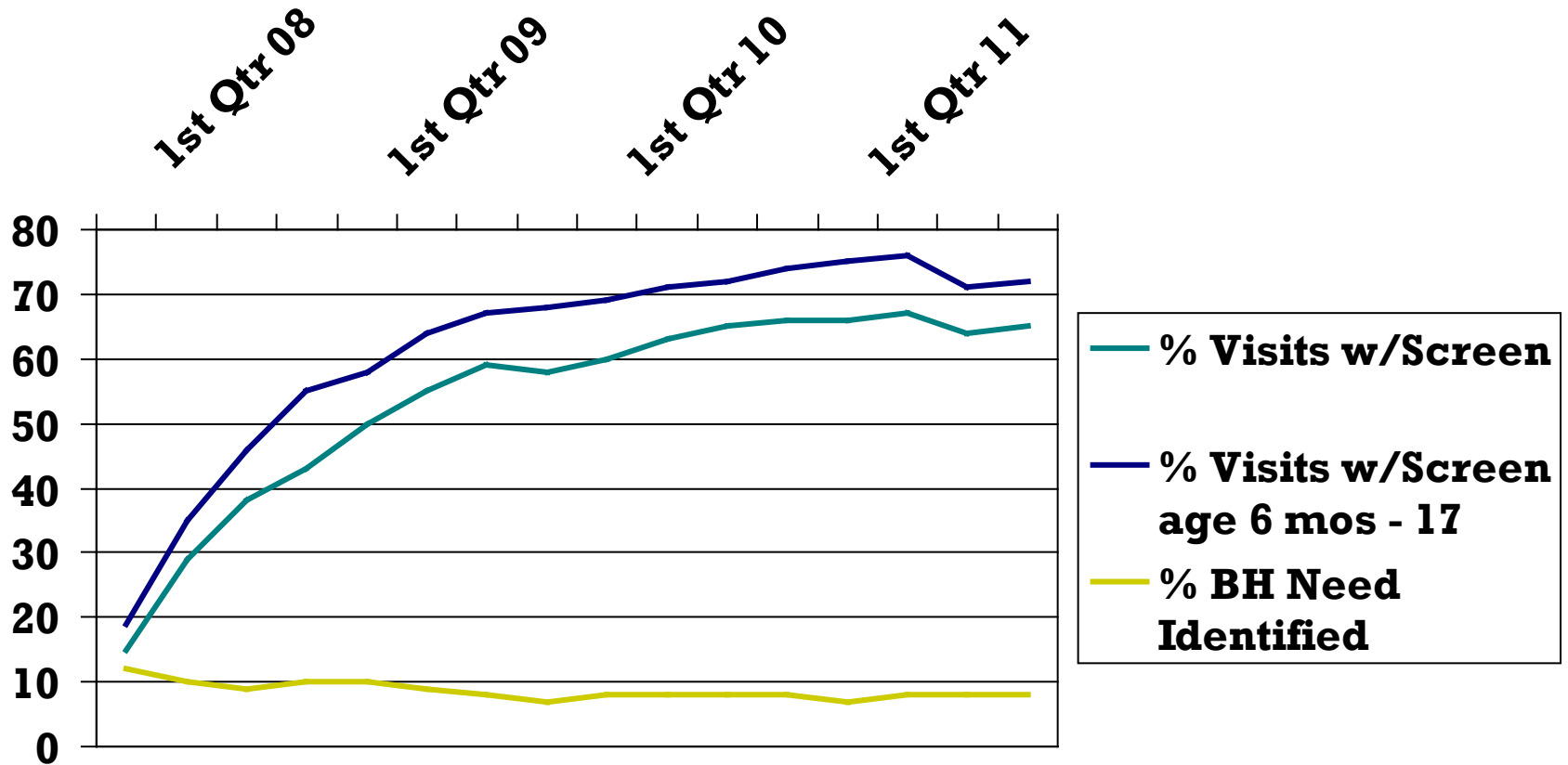
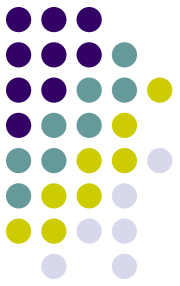
- 77% have a Family Partner
- 60% receive outpatient therapy
- 36% receive TM
- 31% receive IHT
- 16.5% receive IHBS
- 6% use inpatient care
- 2% use 24 hour diversionary care

# Expenditures

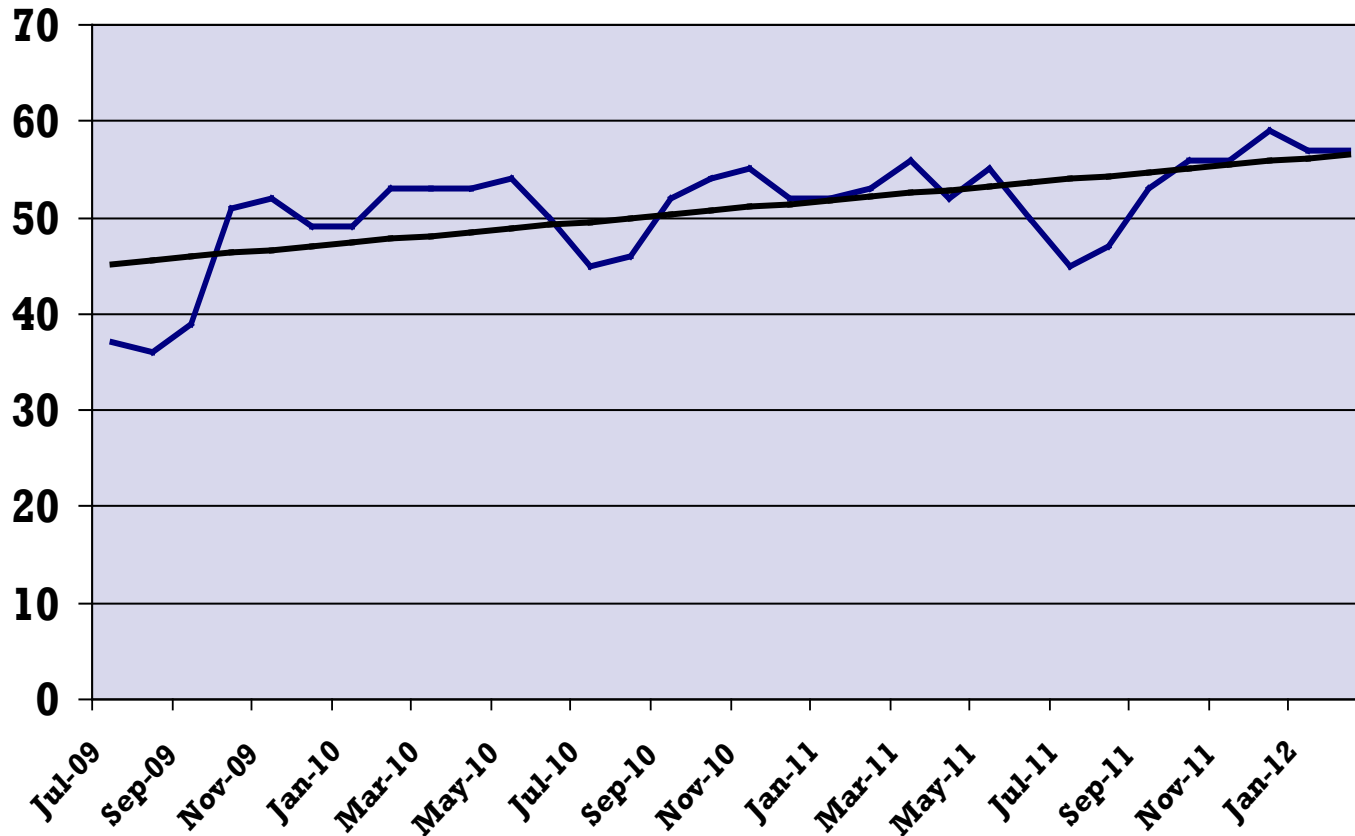


<b>Service</b>	<b>FY2008</b>	<b>FY2009</b>	<b>FY2010</b>	<b>FY2011</b>
BH Screens	\$1,577,571	\$5,101,376	\$4,121,349	\$4,752,917
<b>CANS</b>	\$0	\$1,210,474	\$3,869,246	\$4,373,053
<b>ICC</b>	\$0	\$0	\$17,626,866	\$30,618,606
<b>FS&amp;T</b>	\$0	\$0	\$7,935,469	\$13,678,147
<b>IHT</b>	\$0	\$0	\$29,966,743	\$60,477,904
<b>IHBS</b>	\$0	\$0	\$698,923	\$4,214,459
<b>TM</b>	\$0	\$0	\$5,697,556	\$18,702,714
<b>MCI</b>	\$0	\$0	\$9,175,465	\$11,688,111
<b>Total</b>	\$1,577,571	\$6,311,850	\$79,091,617	\$148,505,911

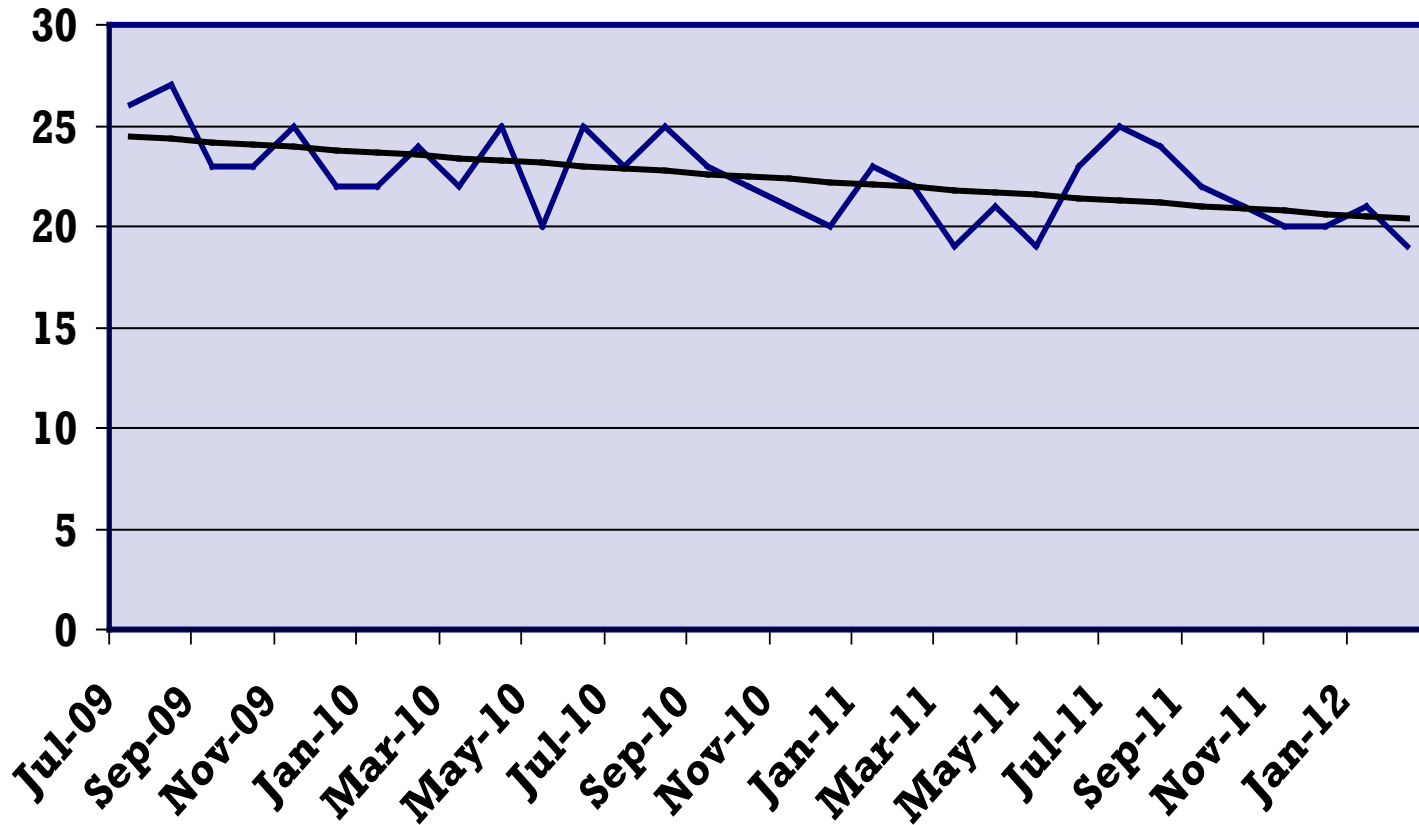
# Behavioral Health Screening



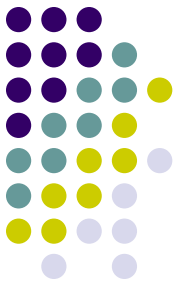
# % of MCI Encounters in Community Location



# % of MCI Encounters Resulting in Inpatient Admissions

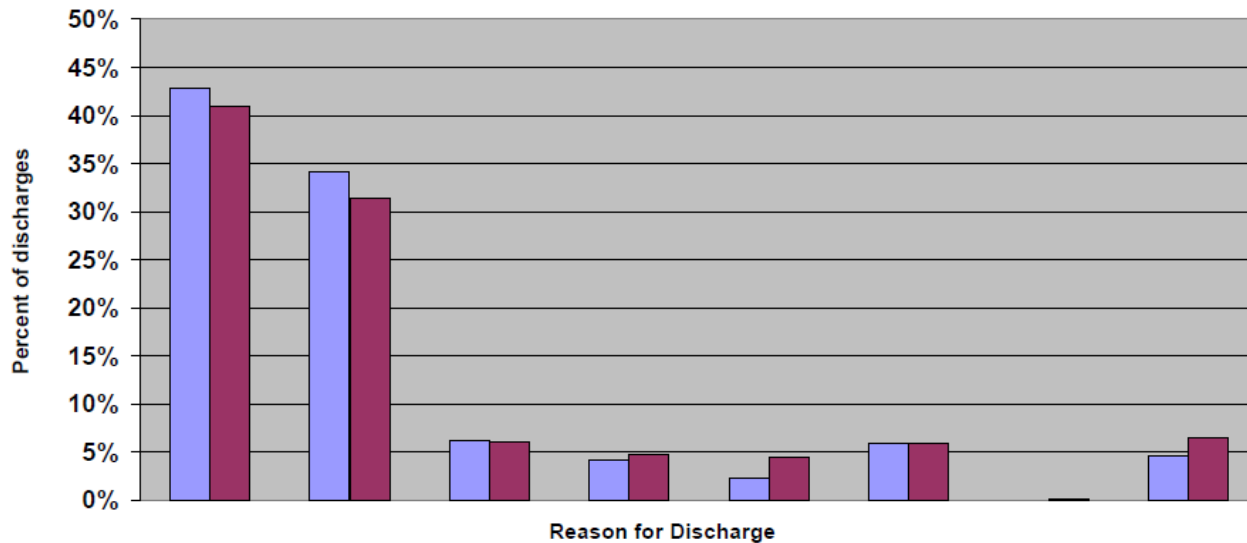


# Disposition from ICC



## CSA Monthly Report for November 2011, Report 9

### Discharge Reasons for Current Month and Fiscal Year 2012



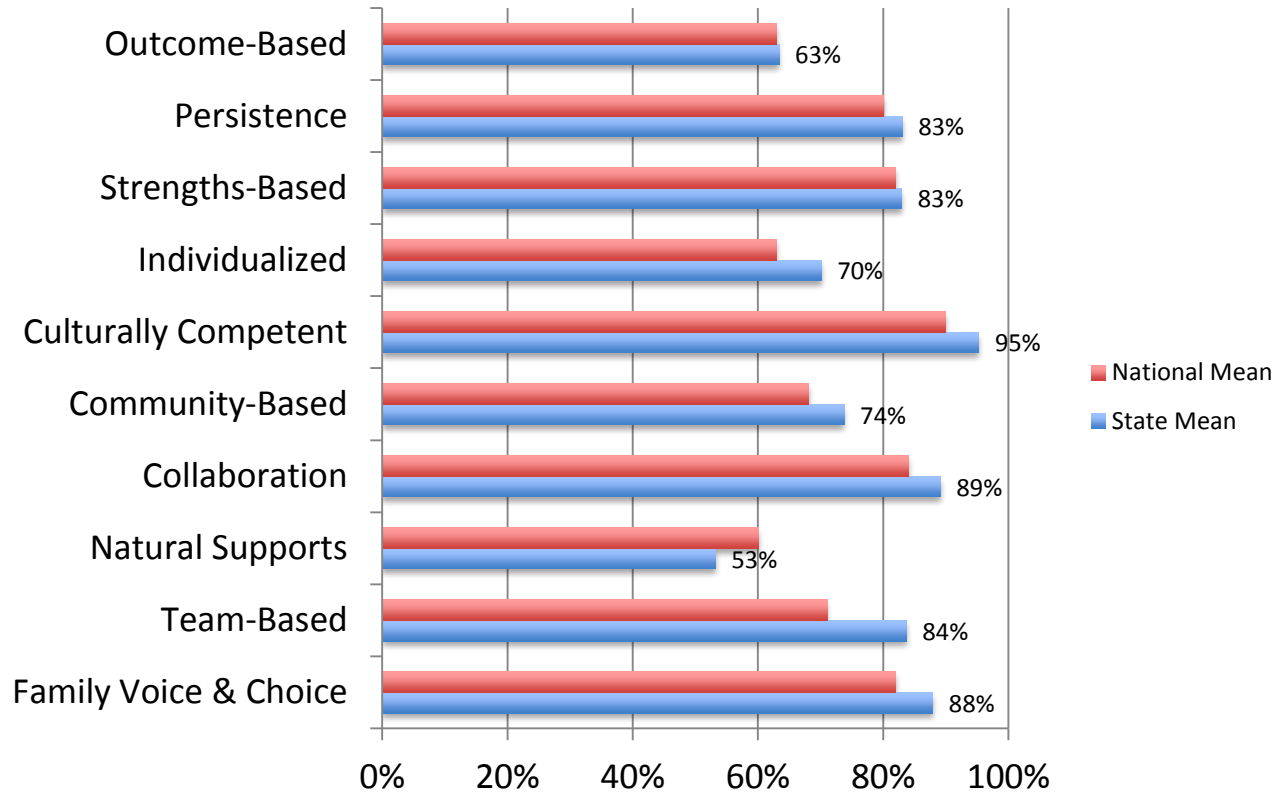
	Goals Met	Consent Withdrawn	Not SED	Family Moved	Disenrolled MH	Out of Home	Youth 21	Other	Total
Nov-11 (%)	43%	34%	6%	4%	2%	6%	0%	5%	
YTD (%)	41%	31%	6%	5%	4%	6%	0%	6%	
Youth	132	105	19	13	7	18	0	14	308
YTD (N)	799	612	118	94	86	115	1	126	1951

Prepared by the Massachusetts Behavioral Health Partnership on 12/27/2011.



# Wraparound Fidelity Scores, Year I

## WFI-4 Fidelity by Principle



Slide from Mass. Behavioral Health Partnership, Melissa King

# Reduced Use of Inpatient Care

