Ohio | Department of Medicaid

OhioRISE | Resilience through Integrated Systems and Excellence

OhioRISE Advisory Council Meeting

February 9, 2021

9:00-11:00 AM

The Meeting Will Begin at 9:00 AM

Housekeeping

- All participants will have control of their own mics and cameras.
  - » Should you be muted by the organizer, you will have to unmute yourself to speak again. If you joined by phone, dial *6
- This meeting is intended for dialogue among Advisory Council members and is open to the public.
  - » Interested Parties can submit questions using the chat feature, raise hand, or unmute yourself. Some questions may be addressed today, others may be addressed at a later date.
- The slides from this webinar will be available following the meeting on the OhioRISE Website.
- Note about OhioRISE procurement

Agenda

- Welcome & Introductions
- Overview of System of Care
- Engaging our Communities:
  - » Additional Children, Families, Young Adults with Lived Experience
  - » Other Community Partners
- Workgroup Updates
- Next Steps

Purpose of the Advisory Council

Stakeholder Input Through Program Phases

CURRENT PHASE

Provide Feedback to inform the OhioRISE Program

Provide Expertise for Development of New and Enhanced OhioRISE Services

Collaborate on Readiness, Transition and Implementation

Actively Participate in Population Health, Quality Improvement Activities

Communicate with individuals we serve and our shared community partners

Provide ongoing feedback to OhioRISE Governance

Network, collaborate, and learn across systems

OhioRISE Advisory Council & Workgroups – Membership and Purpose

Purposes of the OhioRISE Advisory Council & Workgroups

- Offer specific advice, expert opinions and suggestions to Directors and staff regarding the OhioRISE program
- Provide clinical and programmatic input on key components of new and enhanced services
- Review rule development and changes
- Provide critical technical feedback regarding initial implementation activities and OhioRISE operations

MEMBERS SELECTED FOR THE ADVISORY COUNCIL REPRESENT:

- Diverse range of expertise and experience
- Local system partners
- Associations and providers of services
- Youth and Families with lived experience
- Ohio's geography

Workgroups

Near-Term Areas of Focus

Provide feedback on new and enhanced OhioRISE services, eligibility

- ✓ Services
  - Service Specifications
  - Provider Qualifications
- ✓ Requirements for Eligibility
  - Assessment tool development, implementation, and training
- ✓ Care Coordination Model
  - Care Management Entities (CMEs)
  - Intensive and Moderate Care Coordination service development
- ✓ Provider Workforce Considerations
  - Recommendations for initial focus for OhioRISE
  - Recommendations for support needed for new or enhanced services

Longer-Term Areas of Focus

Prepare for and Implement OhioRISE Plan and Services

- ✓ Operational considerations
- ✓ Child/youth and family communication, education
- ✓ Provider education, training
- ✓ Preparations for Go-Live
- ✓ Feedback post-implementation

Overview of System of Care

Systems of Care for Children and Youth with Behavioral Health Conditions and Their Families

Sheila A. Pires
Managing Partner, Human Service Collaborative
Senior Consultant, Center for Health Care Strategies, Inc.

OhioRISE Advisory Council
January 11, 2021

Human Service Collaborative

How Many Children and Youth Experience Behavioral Health Challenges?

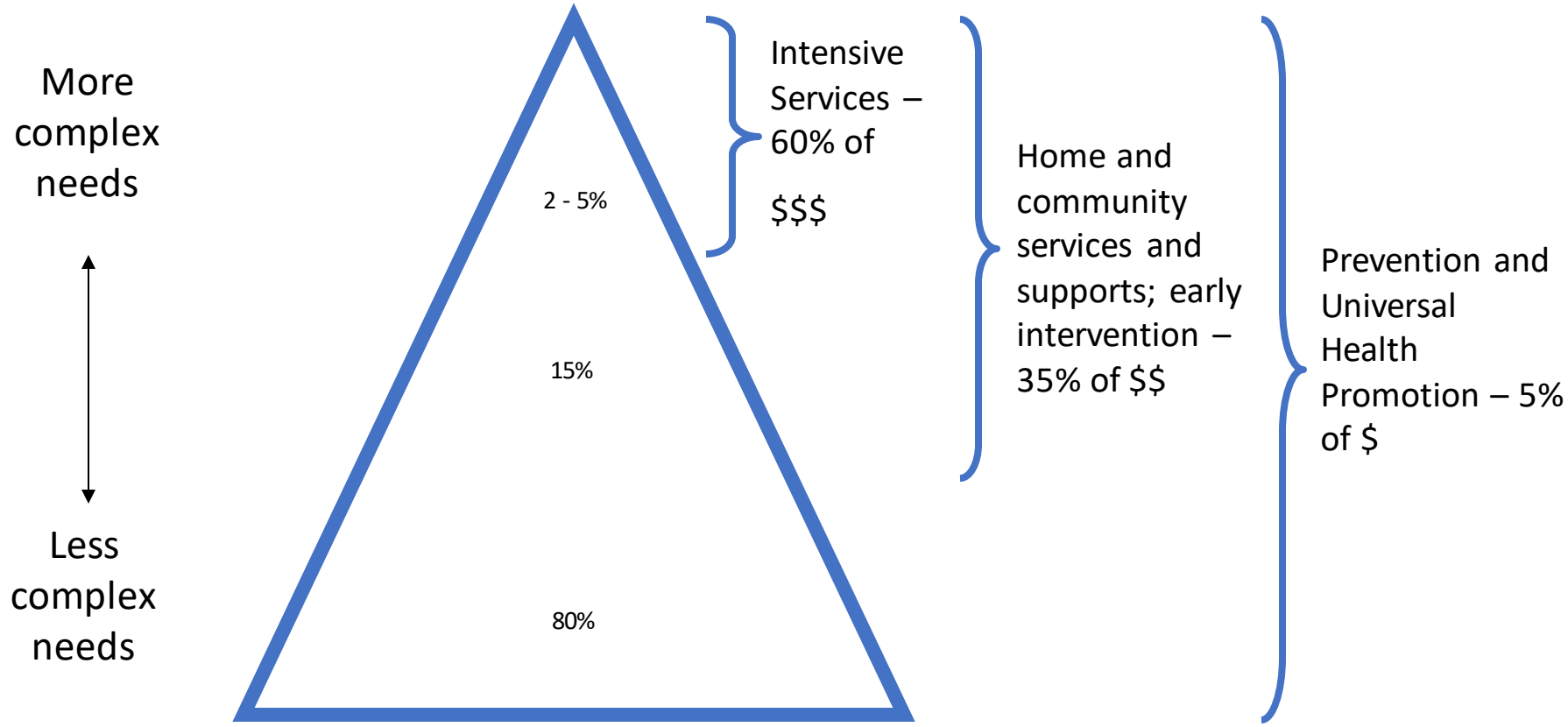
- "An estimated 13-20% of children in the US (up to 1 out of 5 children) experience a mental disorder in a given year…"
- Centers for Disease Control and Prevention. Mental health surveillance among children – United States 2005-2011. MMWR 2013;62 (Suppl; May 16, 2013):1-35. The report is available at www.cdc.gov/mmwr

- About one out of every ten youth is estimated to meet the SAMHSA criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally
- Costello, EJ, Egger, H, Angold, A. 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: 1. Methods and public health burden. J Am Acad Child Adolescent Psychiatry. 2005. Oct; 44 (10): 972-86

- In 2017, approximately 4% of the American adolescent population age 12 to 17 suffered from a substance use disorder; in 2017, an estimated 20.7 million people age 12 and older needed treatment for a substance use disorder. Only 4 million people received treatment, or about 19% of those who needed it
- Substance Abuse and Mental Health Services Administration. (2018). Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health.

- Approximately 13% of children under 18 in the US have a developmental disorder (CDC, 2012). Reliable population-based estimates are not yet available to clarify the proportion who also have mental health disorders. Studies have documented that 30-50% of children and adolescents with Intellectual Disability (IDD) have co-occurring mental health disorders or challenging behavior. Very high rates of co-occurring emotional disorders are found among children with Autism Spectrum Disorders (41-70%) National Association of State Mental Health Program Directors. September 15, 2015

Prevalence and Utilization



Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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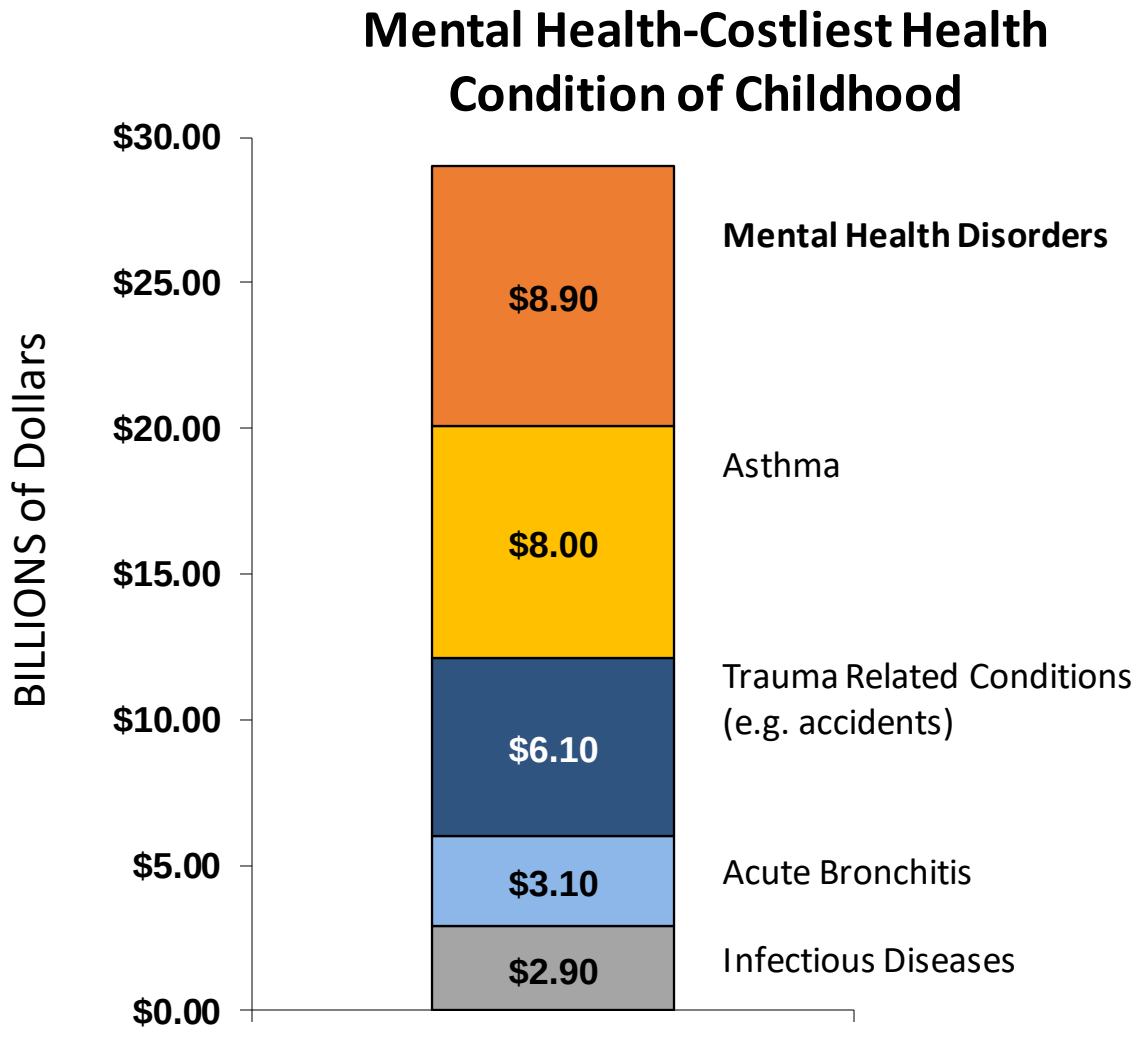
Costs



Soni, 2009 (AHRQ Research Brief #242)

Children in Medicaid Who Use Behavioral Health Care Are Expensive Population

- 11% of children in Medicaid use behavioral health care
- Account for 36% of all Medicaid child expenditures
- Mean expense at $10,259 is 4x higher than for children who do not use behavioral health services
- Mean expense for children in foster care at $12,130 is 5x higher
- Mean expense for children on SSI at $15,159 is over 6x higher
- Mean expense for children on TANF at $5,082 is over twice as high

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures; 2005-2011.* Center for Health Care Strategies: Hamilton, NJ. Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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Children Using Behavioral Health Care in Medicaid with Top 10% Highest Expenditures

- Have mean expenditures of $46,959
  - BH expense: $36,646
  - PH expense: $10,314

Expense is driven by use of behavioral health, not physical health care

- Major cost drivers
  - Residential treatment and therapeutic group homes
  - Psychotropic medications

Pires, S., Gilmer, T., McLean, J. and Allen, K. 2018. *Faces of Medicaid Series: Examining Children's Behavioral Health Service Use and Expenditures:, 20052011.* Center for Health Care Strategies: Hamilton, NJ. Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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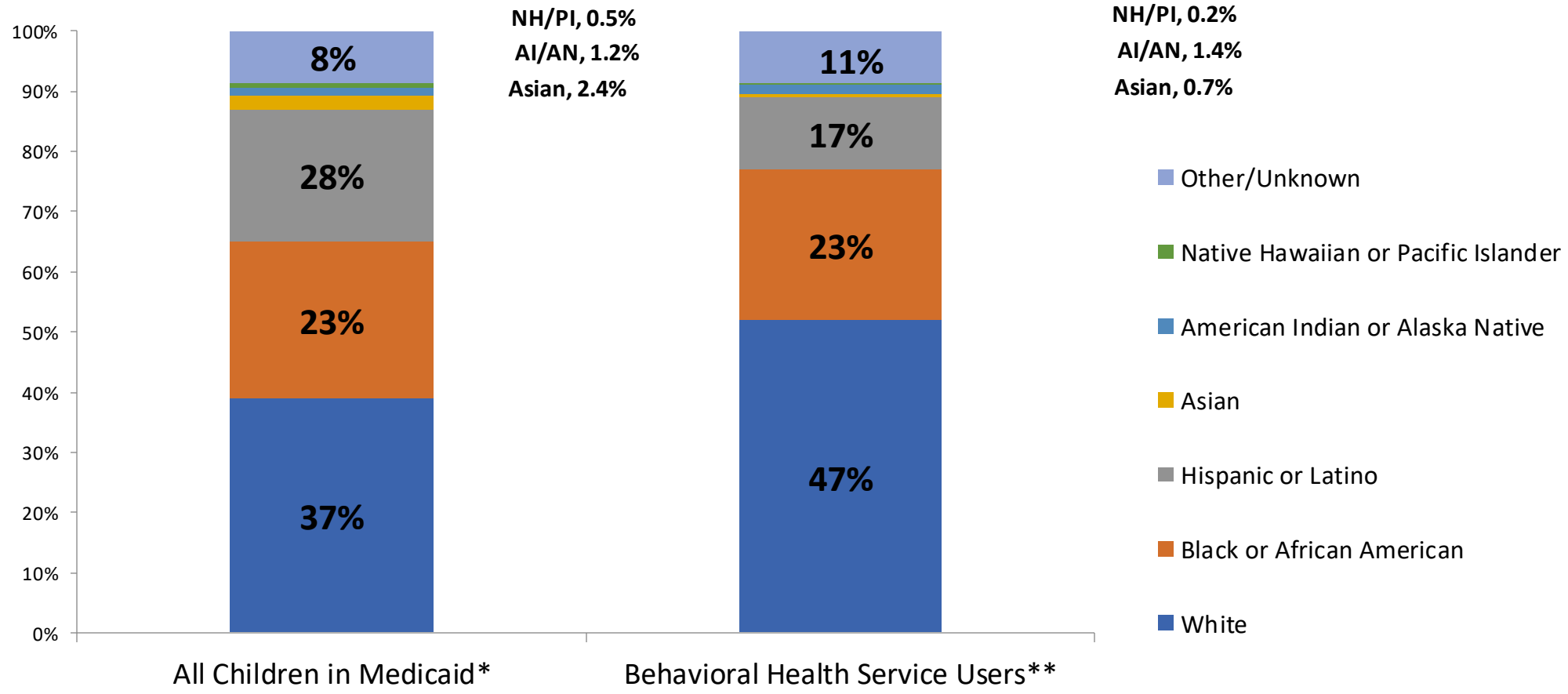
Racial and Ethnic Disparities in Behavioral Health Use



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Available at: https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/

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Children and Youth with Serious Behavioral Health Conditions Are A Distinct Population from Adults with Serious and Persistent Mental Illness

Do not have the same high rates of co-morbid physical health conditions.

Have different mental health diagnoses (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults), and diagnoses change often.

Are multi-system involved – two-thirds typically are involved with CW and/or JJ systems and 60% may be in special education – systems governed by legal mandates.

Coordination with other children's systems (CW, JJ, schools) and among behavioral health providers, as well as family issues, consumes most of care coordinator's time, not coordination with primary care, though primary care coordination also important.

To improve cost and quality of care, focus must be on child and family/caregiver(s) – takes time – implies lower care coordination ratios and higher rates.

Human Service Collaborative

Pires, S. March 2013 *Customizing Health Homes for Children with Serious Behavioral Health Challenges.* Human Service Collaborative. Washington, D.C.

What is a System of Care?

A broad, flexible array of evidence-informed services and supports for defined populations, which:

- ✓ Is organized into a coordinated network;
- ✓ Integrates care planning and care management across multiple levels;
- ✓ Is culturally and linguistically competent;
- ✓ Builds meaningful partnerships with families and with youth at service delivery, management, and policy levels;
- ✓ Has supportive and collaborative management and policy infrastructure;
- ✓ Is data-driven; and
- ✓ Is coordinated across child-serving systems

Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

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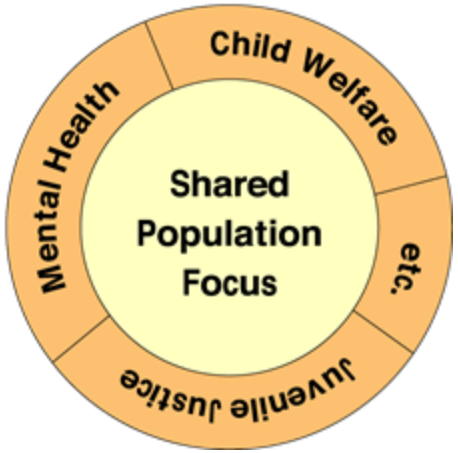
System of care is, first and foremost,

a set of values and principles *that provides an organizing framework for systems reform on behalf of defined populations of children, youth and families.*

- Family-driven and youth-guided
- Home and community based
- Strengths-based and individualized
- Trauma-informed
- Commitment to health equity through cultural and linguistic competency
- Connected to natural helping networks
- Resiliency-and recovery-oriented
- Data-driven, quality and outcomes oriented
- Coordinated across providers and systems
- Takes a population focus across child-serving systems

Categorical System Reforms

Non-Categorical Reforms



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Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Washington, D.C.: Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health.

Core System of Care Component:

Comprehensive In-Home and Community-Based Service Array

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Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration May 2013 Joint Information Bulletin

- Intensive Care Coordination: Wraparound Approach
- Parent and Youth Peer Support Services
- Intensive In-Home Services
- Respite
- Mobile Crisis Response and Stabilization
- Flex Funds
- Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma

Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions

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Mobile Crisis Response and Stabilization

➢ Newer generation MRSS models

- Child, Youth and Family Focus
- Crisis defined by family
- Mobile teams – can work with youth/family over 30-45-day stabilization period
- MRSS can go to homes, school, group homes, Eds, etc.

- New Jersey has MRSS capacity for children statewide; 95% of children who use MRSS remain at home or in current community-based placement
- Connecticut MRSS saved $4m in one year in inpatient and ED expenditures
- Milwaukee County, WI MRSS reduced placement disruption rates in child welfare by 35%
- Seattle/King County WA MRSS diverted over 90% of psychiatric hospitalizations, saving $7.5m in inpatient and $2.8m in out of home expenditures in Medicaid

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Family and Youth Partnerships

Policy	Meaningful representation and strong voice on governing bodies; as members of system design workgroups and advisory boards; leaders in raising public awareness
Management	As administrators; part of quality improvement processes; as evaluators of system performance; as trainers; as advisors in selecting personnel; full time youth coordinators; as members of teams to write/review request for proposals and contracts
Service Level	As members of team for own children/youth; service delivery providers, such as family support providers, care managers, peer support providers, youth group development, system navigators

Core System of Care Component:

Structuring Care Coordination

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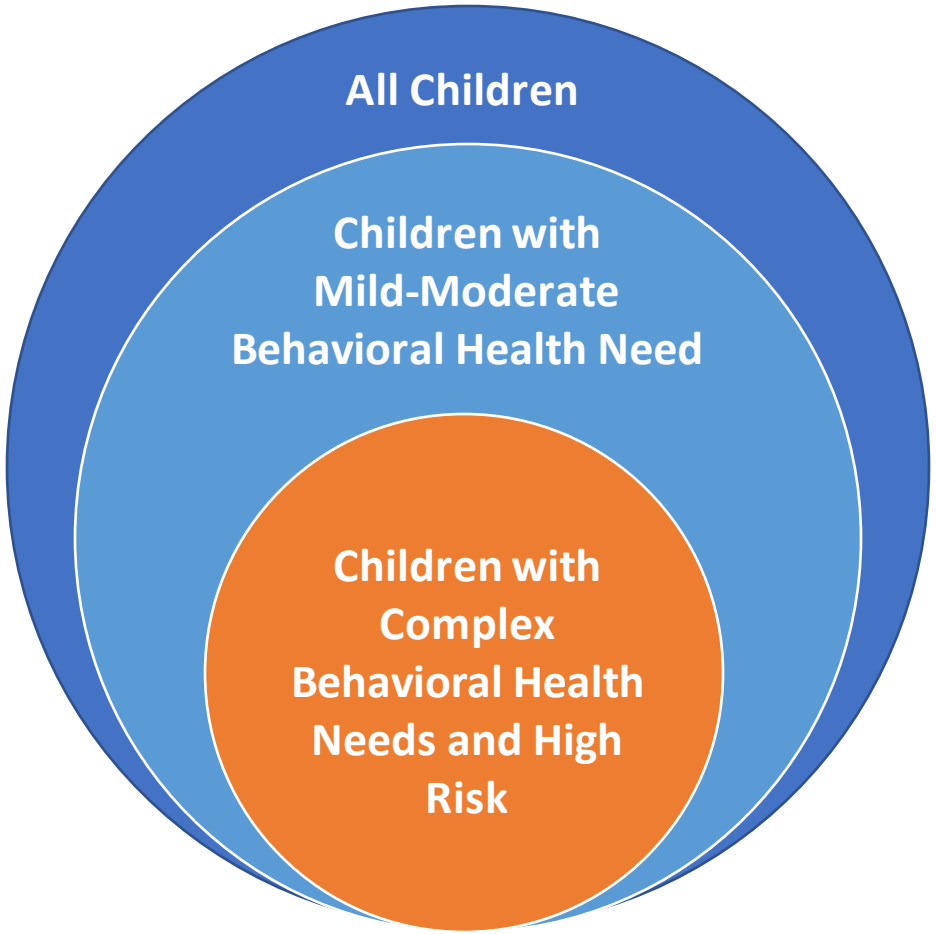
Care Coordination Continuum – What Belongs Where?



Screening, Information and Referral on an as Needed Basis/ During Well Child Visits

Service Coordination and System Navigation To Support Effective Response to Identified Need

Intensive Customized Care Coordination To Provide Extended Support and Address Multi-System Needs

Unmet need for care coordination is high for children and youth with mental health conditions

American Academy of Pediatrics (Brown, N. et. al. 2013)

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Care Coordination: Especially High Unmet Need for Children with Significant Behavioral Health Challenges

Not Met by Usual Approaches

Neither traditional case management, MCO care coordination, nor health home approaches for adults are sufficient for children and youth with significant behavioral health needs

Need:

- Lower case ratios (*MO health home care coordination ratio is 1:250*; Wraparound is 1:10)*
- Approach based on evidence of effectiveness, i.e. fidelity Wraparound
- Intensity of approach that is largely face-to-face, not telephonic
- Intensity of involvement with family, schools, other systems like child welfare

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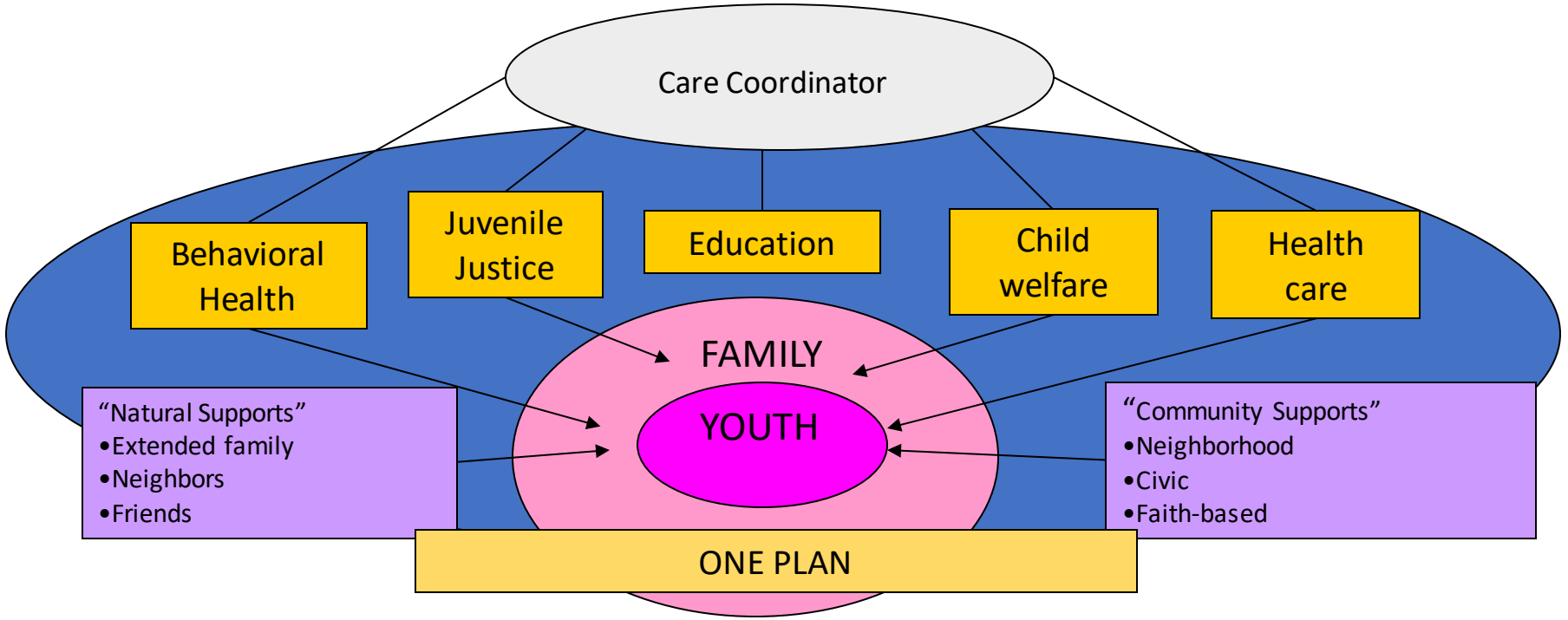
*L. Alexander, B. Druss, and J. Parks. "A (Health) Home Run: Operationalizing Behavioral Health Homes." Webinar, Center for Integrated Health Solutions, U.S. Substance Abuse and Mental Health Services Administration, January 2013.

Intensive Care Coordination Using Fidelity Wraparound

Wraparound is an evidence-based, defined, team-based service planning and coordination process. The goal is to improve outcomes, per capita costs of care, and family and youth experience. In Wraparound, a dedicated care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan.



Adapted from Laura Burger Lucas, ohana coaching, 2009

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Outcomes and Return on Investment with Intensive Care Coordination Using Fidelity Wraparound

9 States	Cost Savings
Evaluation of Medicaid PRTF Waiver Demonstration – 9 States	• Waiver expenditures cost 32% of services provided in PRTFs (home- and community- based services with wraparound process) • Average savings of 68% • Average per child savings of between $35,000 and $40,000 • Improved clinical and functional outcomes • Improved family and youth experience
Community	**Cost Savings**
California: Los Angeles – Child Welfare Population	• 56% of youth graduating from SOC approach with Wraparound had subsequent out-of-home placements vs. 91% of youth graduating from services in a residential treatment setting • Average post-graduation costs nearly 60% less for Wraparound group than comparison group ($10,737 versus $27,383) • Placement costs for residential treatment group were 2.5 times greater than the cost for Wraparound group
Massachusetts Mental Health Services Program for Youth (MHSPY)	• Total per-child per-month Medicaid claims expense Wraparound group less than half of that of comparison group (both physical and behavioral health) • Claims 31% lower for ER, 73% lower for inpatient • Clinical/functional improvement; high family/youth satisfaction

Wraparound Outcomes Depend on Implementation - Fidelity is Critical

- Research shows
  - Provider staff whose families experience better outcomes score higher on fidelity tools (Bruns, Rast et al., 2006)
  - Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)
- Wraparound implementation that is in name only
  - No investment in workforce development such as training and coaching to accreditation
  - Does not follow the research-based practice model
  - Does not monitor fidelity and outcomes and use the data for CQI
  - Does not have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)

Core System of Care Component:

Standardized Screening and Assessment

- ✓ Massachusetts (Rosie D.) requires that PCPs conduct behavioral health screens using standardized screening tools

- ✓ Many states use the Child and Adolescent Needs and
  - Strengths (CANS) tools for assessment and determination of
  - intensity of need – NJ, MA, IL, OH, KY, LA, OH moving to CANS

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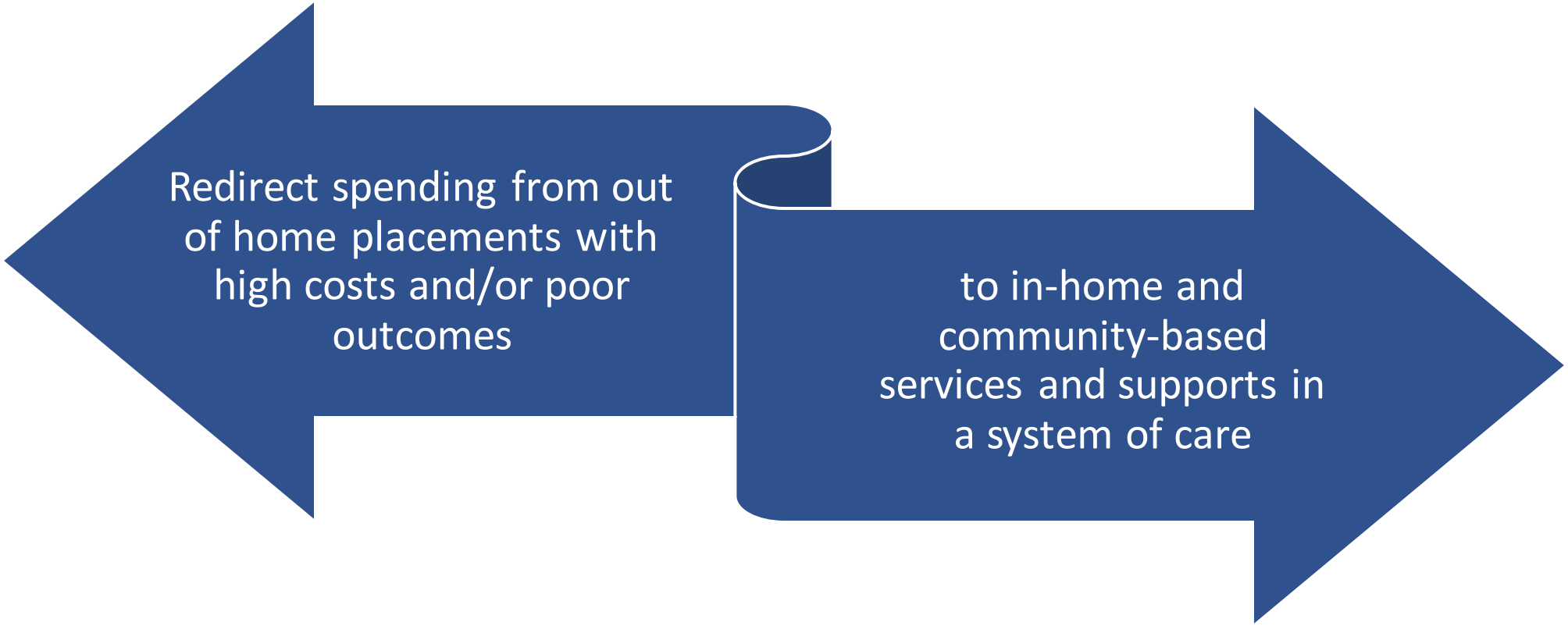
Fundamental Concept in Systems of Care



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Core System of Care Component:

Residential Treatment Best Practice - *Building Bridges Initiative*

- Movement away from "placement" orientation and long lengths of stay
- Residential as part of an integrated continuum, connected to community
- Shared decision making with families/youth and other providers and agencies
- Family and youth engagement and provision of aftercare
- Individualized treatment approaches through a child and family team process
- Trauma-informed care

Building Bridges Initiative: www.buildingbridges4youth.org

➢ **Family First Prevention Services Act –** focus on home and community- based services, reduction of use of residential care, and quality standards

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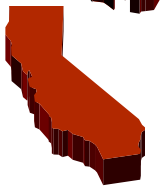
Core System of Care Component:

Workforce Development: State/Local Centers of Excellence Supporting Systems Reform

Maryland Institute on Innovation and Implementation- University of Maryland



California Institute of Mental Health

Georgia Center of Excellence in Child and Adolescent Behavioral Health - Georgia State University

Illinois – Statewide TA Resource, University of Illinois

New Jersey Centers of Excellence – Rutgers University, Boggs Center (IDD), Autism NJ

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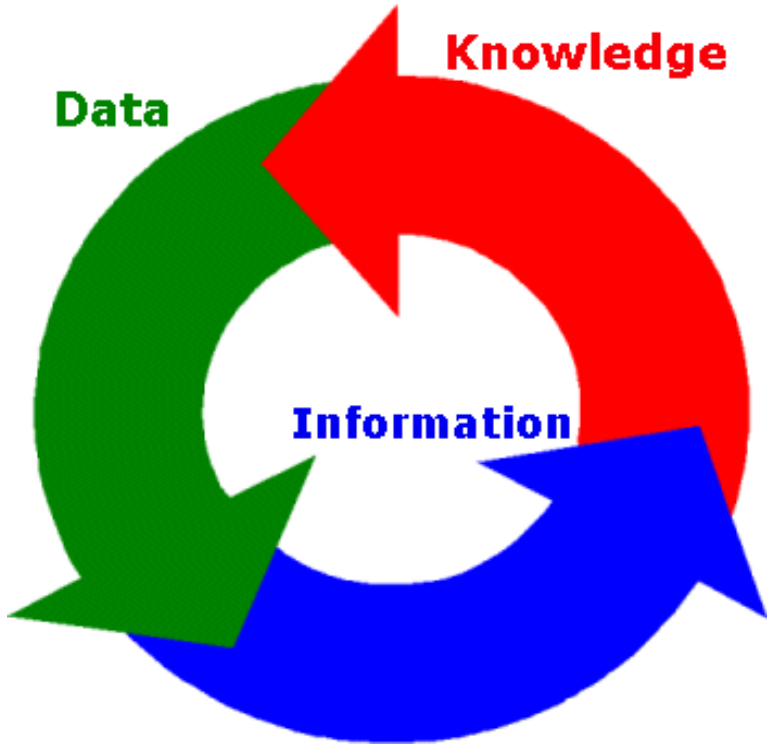
Core System of Care Component:

Data and Continuous Quality Improvement

"If we have data, let's look at data.
If all we have are opinions,
let's go with mine."

Jim Barksdale, former CEO, Netscape



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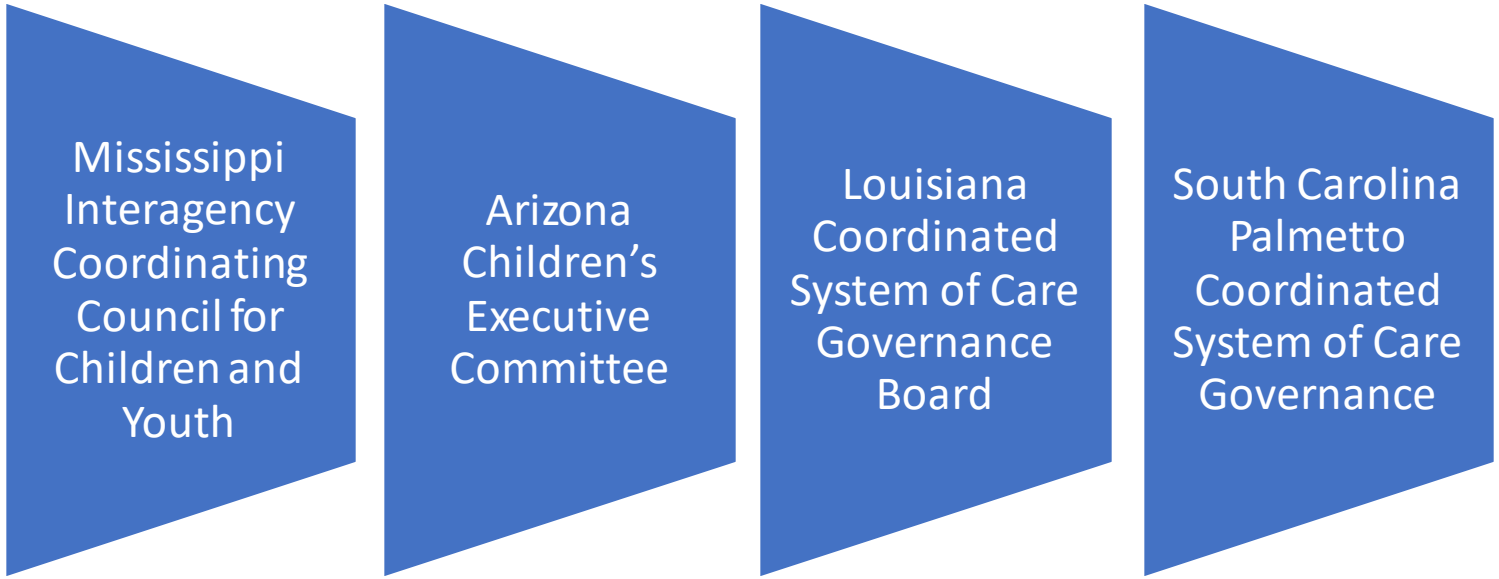
Core System of Care Component:

State & Local-Level Leadership for Systems of Care

- Multiple state and local agencies are responsible for children and youth with behavioral health challenges.
- When everyone is responsible, it is too easy for no one to be responsible.
- States and localities create cross-agency governance bodies for systems of care.

State Level Examples

All use subcommittee structures to bring in additional perspectives – e.g. families, youth, providers, schools, advocates, county reps



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New Jersey (1115)

BH, CW, MA $$ - Single Payor

Department of Children and Families
Division of Children's System of Care (CSOC)

Dept. of Human Services Division of Medical Assistance and Health Services (Medicaid)

➢Use CANS

Partners Council

COE: Rutgers, Boggs Center, Autism NJ

Contracted Systems Administrator-
PerformCare – ASO for child BH carve out

- 1-800 number
- Screening
- Utilization management
- Outcomes tracking

Broad Provider Network

Mobile Response & Stabilization Services

Medicaid and DCF-certified providers

Family Support Organizations

***Care Management Entities- CMOs**

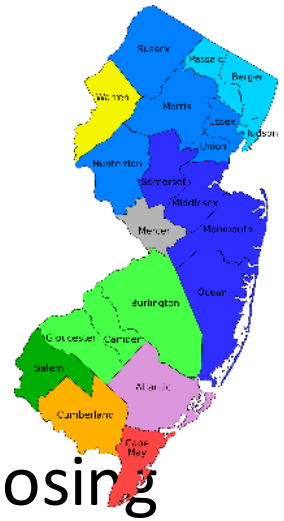
Local SOC Committees

Family peer support, education and advocacy
Youth movement

Lead non-profit agencies providing tiered care coordination for children with serious challenges, multisystem involvement, fidelity Wraparound

Adapted from State of New Jersey 2010

New Jersey Outcomes



- Increase in Access to Care
- Decrease in over-reliance in out of home treatment
- Decrease in over-reliance on detention with 9 centers closing
- Decrease by 70% the population of youth who are on Probation
- The only state hospital has closed; in one three-year period, $30m savings in inpatient psych use
- Have brought all children with behavioral health challenges home to NJ
- Decrease in use of restraint, seclusion and coercion in all out of home treatment interventions.

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OhioRISE Ecosystem

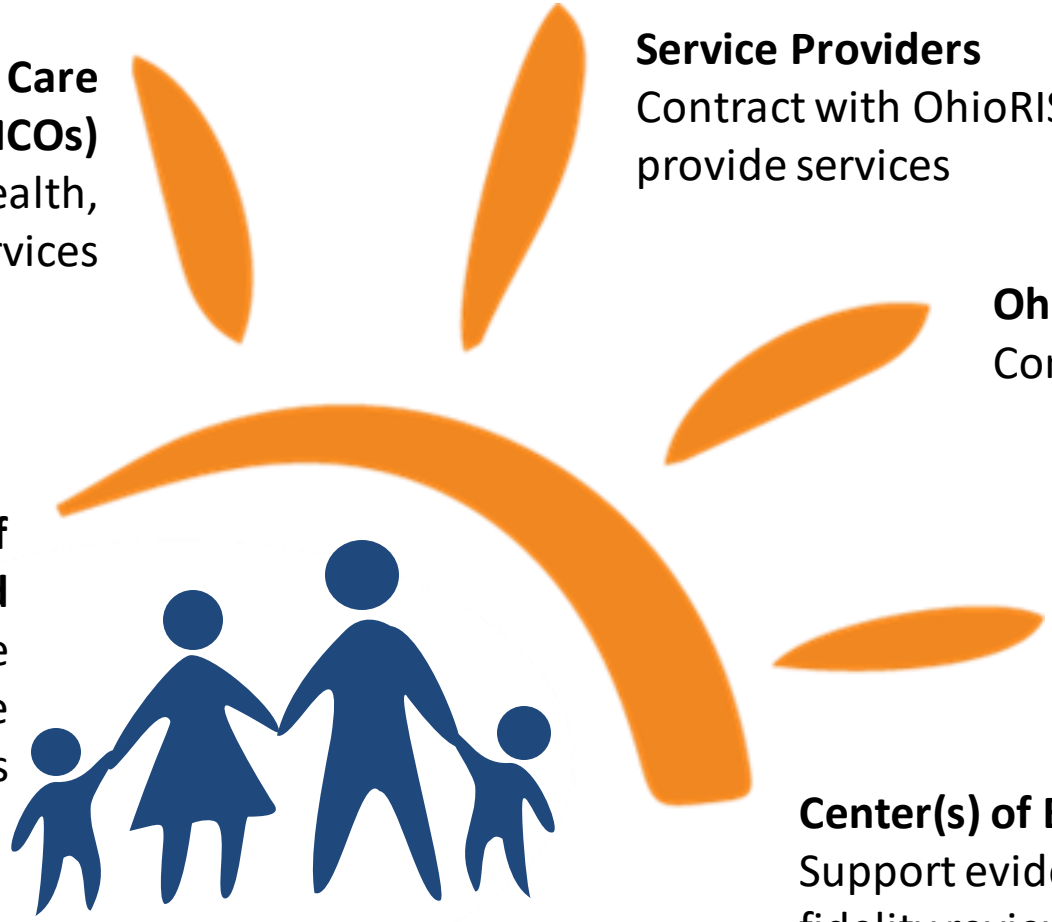
Family and Children First Cabinet Council:
Governor's Office of Children's Initiatives, Office of Family & Children First MHAS, ODJFS, DODD, ODM, DYS, DRC, ODH, ODE,
Federal and State funds | Governance and Oversight

Medicaid Managed Care Organizations (MCOs)
Physical health, limited BH services

Service Providers
Contract with OhioRISE & MCOs to provide services

OhioRISE Plan
Contract with CMEs, providers

Department of Medicaid
Contract, provide oversight of the OhioRISE and MCOs



Network of Care Management Entities (CMEs)
Provide Intensive Care Coordination using High Fidelity Wraparound

Center(s) of Excellence (COEs)
Support evidence-based practices, training, fidelity reviews, workforce development

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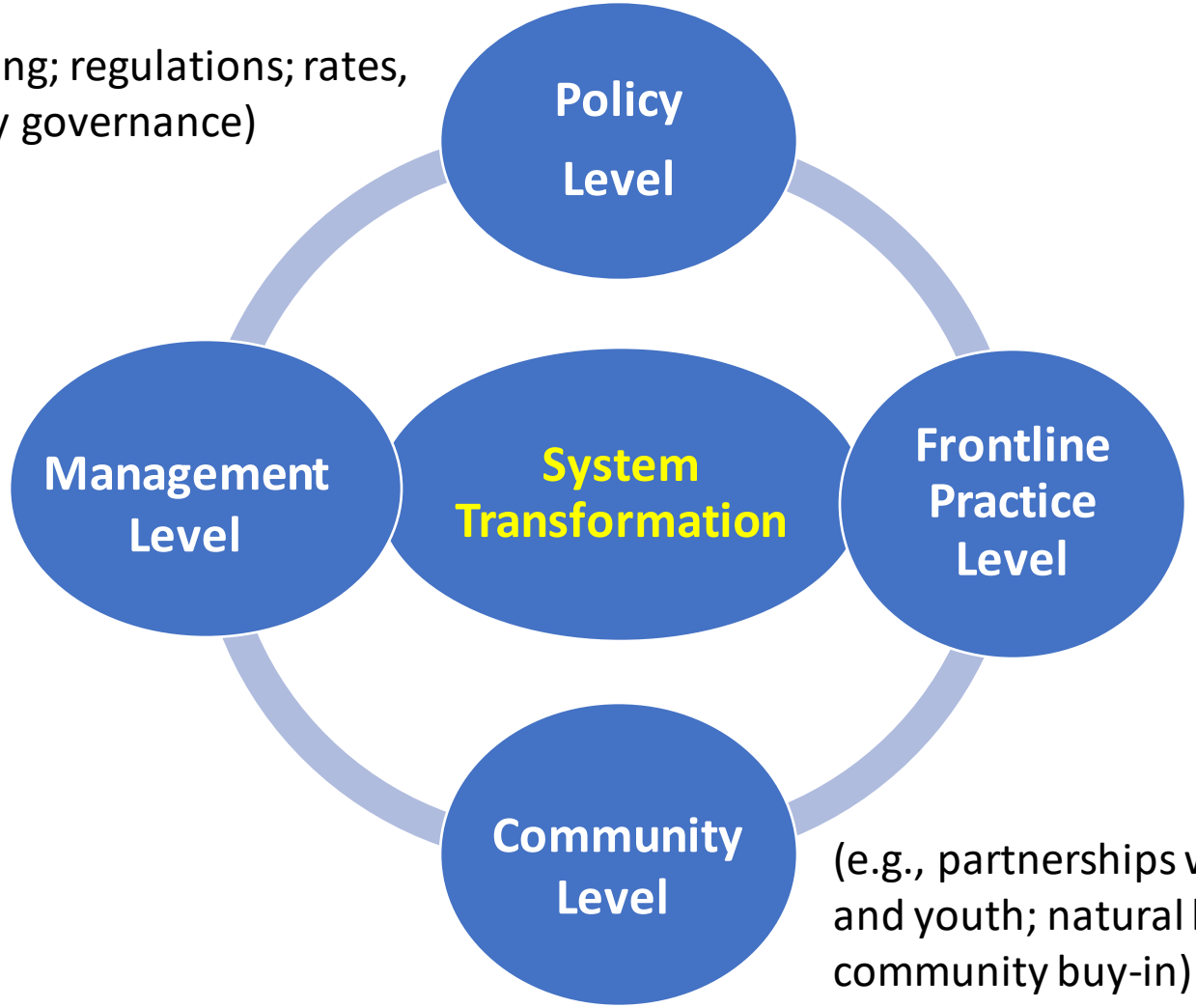
Building Systems of Care = Transforming Systems

(e.g., financing; regulations; rates, cross-agency governance)



(e.g., data; quality improvement; human resource development; system organization)

(e.g., assessment; service planning; care coordination; services/ supports provision)

(e.g., partnerships with families and youth; natural helpers; community buy-in)

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Pires, S. (2002). *Building systems of care: A primer.* Washington, D.C.: Human Service Collaborative.

Discussion

Which aspects of Systems of Care:

- Resonate most with you?
- Are best suited for the OhioRISE Advisory Council focus?
- Do you want to learn more about?

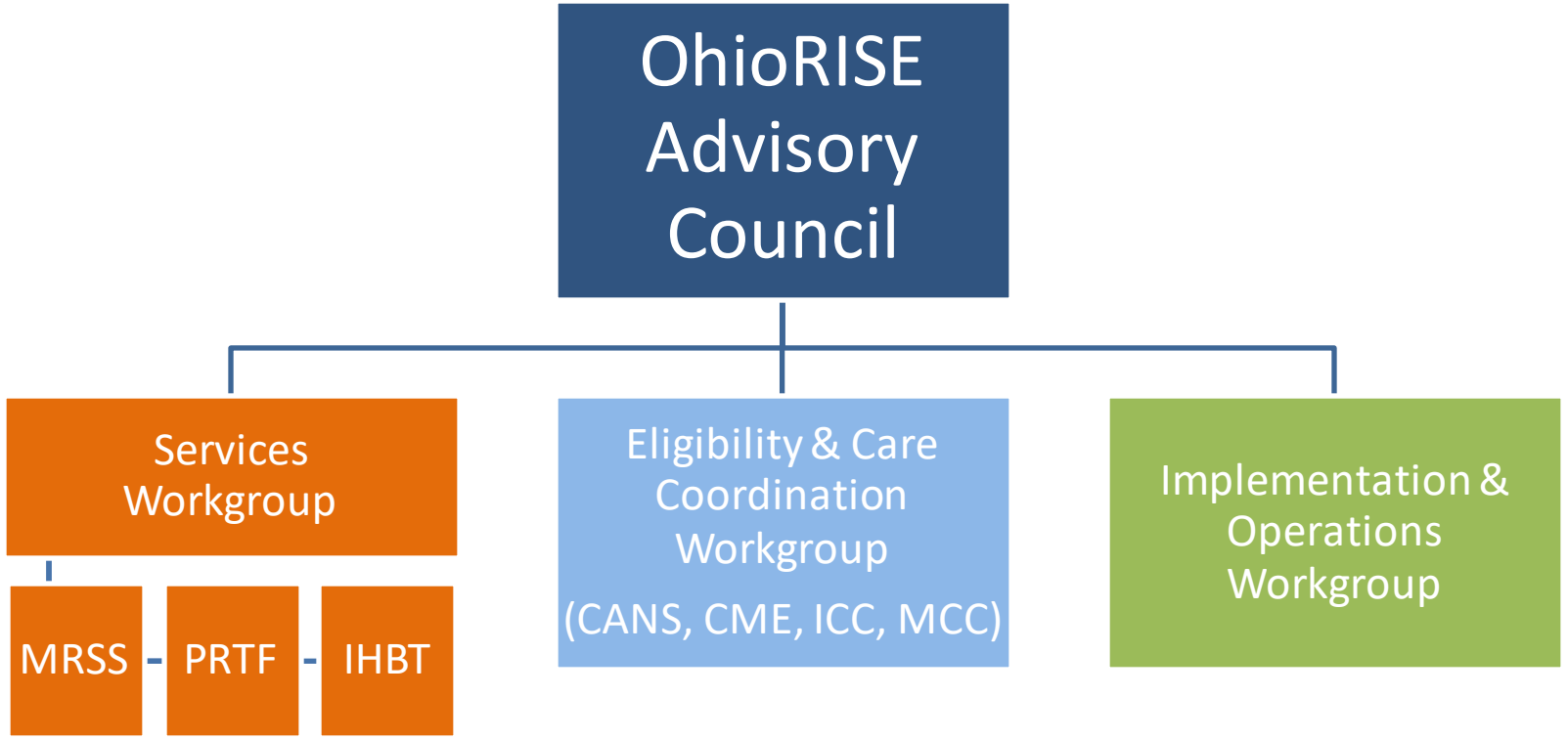
Engaging our Communities

Engaging our Communities

- Additional Children, Families, Young Adults with Lived Experience
  - » How can we leverage the Advisory Council and members' expertise, geography, connections, etc. to include more people with lived experience?
  - » What do those opportunities look like?
- Other Community Partners
  - » What would be helpful as you talk with local community partners?
    - Example: One-pagers on overview of OhioRISE, services, eligibility

Workgroup Updates

OhioRISE Advisory Committee & Workgroup Structure



Services, Eligibility & Care Coordination Workgroups

Input on services and models to inform regulatory processes	Mobile Response and Stabilization Services
	Intensive Home-Based Treatment
	Psychiatric Residential Treatment Facilities
	Child and Adolescent Needs and Strengths (CANS) Tool
	Care Management Entities, Care Coordination Services
Discussion and feedback on critical components of each model and service	Service Definitions
	Target Population(s) for Services
	Service Activities
	Provider Qualifications and Competencies (Organizational & Staff)
	Reporting Requirements

Workgroup Update
Mobile Response and Stabilization Services (MRSS)

- Topics Covered at the Jan. 22 Meeting:
  - » Crisis Continuum Vision and Infrastructure
  - » MRSS History in Ohio
    - Definition
    - Best Practices
    - Who it serves
    - Activities
- Next Meeting: Tuesday, February 9
  - » Topic: regulatory concepts

Key Areas for Stakeholder Engagement

- ✓ **Inform service based on experience with ENGAGE 2.0 MRSS**
- ✓ **Staff credentials and requirements**

Workgroup Update
Child and Adolescent Needs and Strengths (CANS) and Care Coordination

- Topics Covered at the Jan. 28 Meeting:
  - » OhioRISE Eligibility and Enrollment Draft Rule 5160-59-02
  - » Things to know about the CANS
  - » High Fidelity Wraparound Principles
  - » Began CME discussion
- Next meeting: Thursday, February 11
  - » Topic: Deeper dive into the CANS

Key Areas for Stakeholder Engagement

- ✓ **Review of the Ohio CANS tool**
- ✓ **Decision-support algorithm feedback**
- ✓ **Care coordination model and requirements**

Process of Workgroups

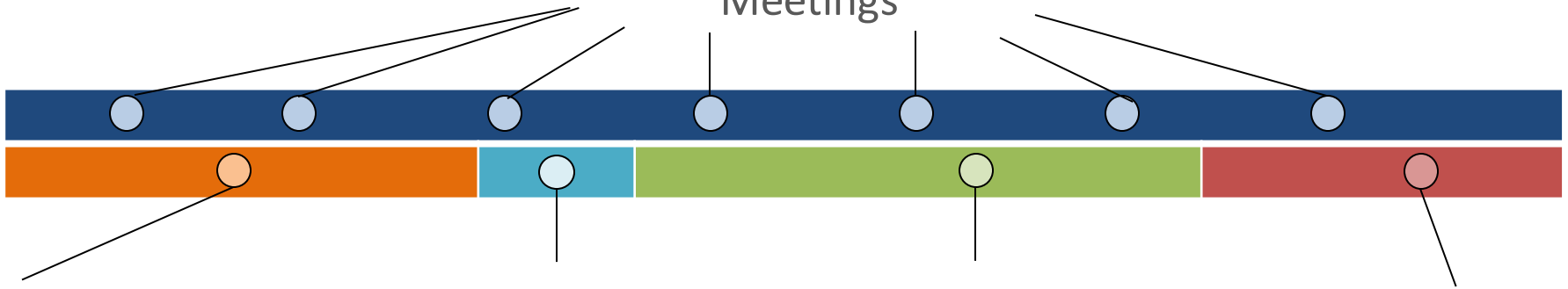
- Next Steps for Services Workgroups
- Draft Rule Considerations
  - » Each Services Workgroup will provide initial feedback on regulatory concepts
  - » Draft rules will be shared with a timeframe to provide feedback
  - » Updates on draft will be rules shared with Advisory Council
  - » Proceed with rule filing process

Future Schedule and Meetings

OhioRISE Stakeholder Timeline

JANUARY 2021 - TBD 2022

OhioRISE Advisory Council Meetings



JANUARY – MARCH 2021

Services & Care Coordination / Eligibility Workgroups

SPRING 2021

Initial Rule Filings

APRIL 2021 & BEYOND

Operations and Implementation Workgroup

FALL 2021

Final Rule Filings

Upcoming Meetings

February 9-11, 2021

Services Stakeholder Workgroups:

- ✓ *2nd MRSS Workgroup this afternoon*
- ✓ *2nd CANS and Care Coordination Workgroup Feb. 11 from 12 – 2:00PM*

February 19, 2021

First IHBT Stakeholder Workgroup Meeting from 2:30 – 4:30PM

Late February 2021

Continuing Services Stakeholder Meetings

- ✓ *Topics: Begin rule discussions in workgroups*
- ✓ *Share draft rules for consideration*

OhioRISE Website

On the OhioRISE website we are posting

1. Dates and times of future meetings
2. Links to join meetings (pre-registration is no longer required)
3. Presentation materials from all meetings

Upcoming Meetings

Meeting Name (Link to Materials)	Date	Time	Registration Link
OhioRISE Advisory Council Meeting	1/11/2021	12:00 – 1:30 PM EST	Registration Has Closed
MRSS Workgroup	01/22/2021	12:00 – 1:30 PM EST	Registration Has Closed
CANS & Care Coordination Workgroup	01/28/2021	12:00 – 2:00 PM EST	Registration Has Closed
Advisory Council Meeting	02/09/2021	9:00 – 11:00 AM EST	Click here to join the meeting - Registration not required
MRSS Workgroup	02/09/2021	1:30 - 3:30 PM EST	Click here to join the meeting - Registration not required
CANS and Care Coordination Workgroup	02/22/2021	12:00 - 2:00 PM EST	Click here to join the meeting - Registration not required
Advisory Council Meeting	03/09/2021	9:00 – 11:00 AM EST	To be Updated