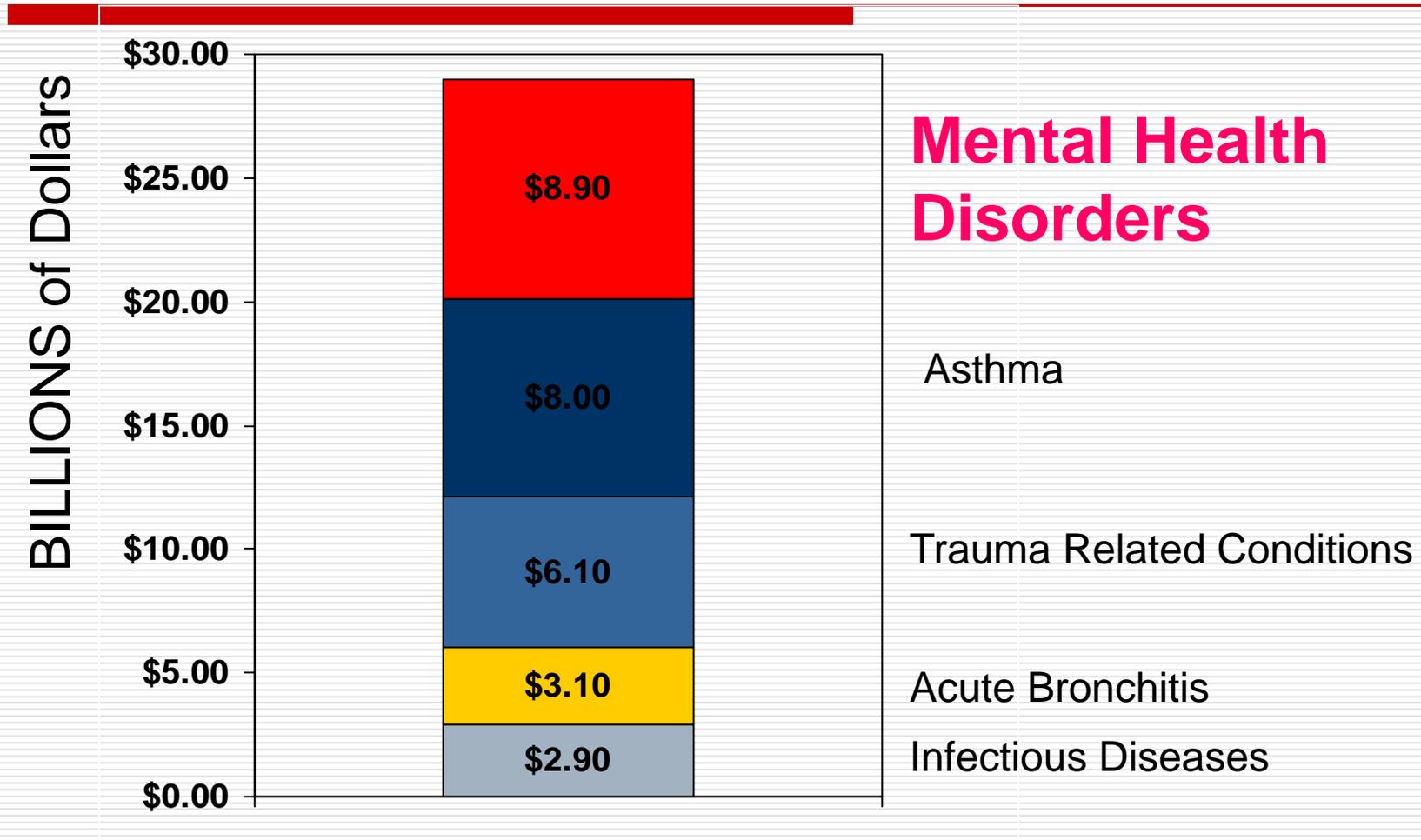


Child and Adolescent Mental Health and Wraparound

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Mental Health is the Costliest Health Condition of Childhood



Soni, 2009 (AHRQ Research Brief #242)

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Children in Medicaid Who Use Behavioral Health Care Are an Expensive Population

- *Estimate:* 9.6% of children in Medicaid who used behavioral health care in 2005 accounted for 38% of all spending for children in Medicaid
 - Based on: 1.2M children with FFS expenditure data

Caveats:

- FFS expenditure data applied to children in capitated managed care arrangements
- Expenditures might be less in managed care

Mean Health Expenditures for Children in Medicaid Using Behavioral Health Care*, 2005

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI /Disabled **	Top 10% Most Expensive Children Using Behavioral Health Care***
Physical Health Services	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
Behavioral Health Services	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
Total Health Services	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790

* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201

** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)

***Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323

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

- ✓ Children with SED do not have the same high rates of co-morbid physical health conditions as adults with SPMI
- ✓ Children, for the most part, have different mental health diagnoses from adults with SPMI (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults)
- ✓ Among children with serious behavioral health challenges, two-thirds are also involved with child welfare and/or juvenile justice systems and 60% may be in special education – governed by legal mandates
- ✓ Coordination with other children's systems – child welfare, juvenile justice, schools – and among behavioral health providers consumes most of care coordinator's time, not coordination with primary care
- ✓ To improve cost and quality of care, focus must be on child and family/caregiver(s)

Why are Outcomes so Poor and Costs so High?

- Child and family needs are complex
 - Youths with serious EBD typically have multiple and overlapping problem areas that need attention
 - Families often have unmet basic needs
 - Traditional services don't attend to health, mental health, substance abuse, and basic needs holistically
 - Or even know how to prioritize what to work on



Behavioral Health Expenditures by Service Type

Top Three Highest Expenditure Services

- **Residential treatment and therapeutic group homes** account for largest percentage of total expenditures – 19.2% of all expenditures for 3.6% of children using behavioral health services
- Outpatient treatment second highest – 16.5% of all expenditures for 53.1% of children using behavioral health services
- **Psychotropic medications** third highest – 13.5% of all expenditures for 43.8% of children using behavioral health services
 - *Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was **\$1.6b**, with **42% of expense represented by anti-psychotic use***

Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. 2013. (in press) *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies: Hamilton, NJ

Why are Outcomes so Poor and Costs so High?

- Families are rarely fully engaged in services
 - They don't feel that the system is working for them
 - Leads to treatment dropouts and missed opportunities



Outcomes are poor and costs high for youths with complex needs and multiple system involvement

- ❑ Systems are in “silos”
- ❑ Systems don't work together well for individual families unless there is a way to bring them together
 - Youth get passed from one system to another as problems get worse
 - Families relinquish custody to get help
 - Children are placed out of home



The Wraparound Process

- ❑ Wraparound is a defined, team-based service planning and coordination process
 - ❑ The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
 - ❑ Wraparound is not a service per se, it is a structured approach to service planning and care coordination
 - ❑ The ultimate goal is both to improve outcomes and per capita costs of care
-

What's Different in Wraparound?

- High quality Teamwork
 - Collaborative activity
 - Brainstorming options
 - Goal setting and progress monitoring
 - The plan and the team process is driven by and "owned" by the family and youth
 - Taking a strengths based approach
 - The plan focuses on the priority needs as identified by the youth and family
 - A whole youth and family focus
 - A focus on developing optimism and self-efficacy
 - A focus on developing enduring social supports
-

Core Components of the Wraparound Theory of Change

- Services and supports ***work better***:
 - Focusing on priority needs as identified by the youth and family
 - Creating an integrated plan
 - Greater engagement and motivation to participate on the part of the youth and family

 - The process ***builds family capacities***:
 - Increasing self-efficacy (i.e., confidence and optimism that they can make a difference in their own lives)
 - Increasing social support
-

Coordination with Primary Care in a Wraparound Approach

For children with complex behavioral health challenges enrolled in Health Home, Care Management Entity or Wraparound Team of Health Care Professionals --

- ✓ Ensures child has an identified primary care provider (PCP)
- ✓ Tracks whether child receives EPSDT screens on schedule
- ✓ Ensures child has an annual well-child visit (more frequent if on psychotropic medications or chronic health condition identified)
- ✓ Communicates with PCP opportunity to participate in child and family team and ensures PCP has child's plan of care and is informed of changes
- ✓ Ensures PCP has information about child's psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

Does Wraparound Work?

Evidence from Nine Published Controlled Studies is Positive

Study	Target population	Control Group Design	N
1. Hyde et al. (1996)*	Mental health	Non-equivalent comparison	69
2. Clark et al. (1998)*	Child welfare	Randomized control	132
3. Evans et al. (1998)*	Mental health	Randomized control	42
4. Bickman et al. (2003)*	Mental health	Non-equivalent comparison	111
5. Carney et al. (2003)*	Juvenile justice	Randomized control	141
6. Pullman et al. (2006)*	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)*	Child welfare	Matched comparison	67
8. Rauso et al. (2009)	Child welfare	Matched comparison	210
9. Mears et al. (2009)	MH/Child welfare	Matched comparison	121

*Included in 2009 meta-analysis (Suter & Bruns, 2009)

Outcomes of Wraparound

(9 controlled, published studies to date; Bruns & Suter, 2010)

- ❑ Better functioning and mental health outcomes
- ❑ Reduced recidivism and better juvenile justice outcomes
- ❑ Increased rate of case closure for child welfare involved youths
- ❑ Reduction in costs associated with residential placements



Costs and Residential Outcomes Are Robust

- Wraparound Milwaukee reduced psychiatric hospitalization from 5000 to less than 200 days annually
 - Also reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008).

 - Controlled study in Massachusetts found 32% lower emergency room expenses and 74% lower inpatient expenses than propensity score matched youths in "usual care".
 - Intervention youth spent 88% of days at home and showed improved clinical functioning on standard measures.
-

Costs and Residential Outcomes Are Robust

- New Jersey saved over \$30 million in inpatient psychiatric expenditures over the last three years (Hancock, 2012).
 - State of Maine reduced net Medicaid spending by 30%, even as use of home and community services increased
 - 43% reduction in inpatient and 29% in residential treatment expenses (Yoe, Bruns, & Ryan, 2011)
 - Los Angeles County DSS found 12 month placement costs were \$10,800 for Wraparound-discharged youths compared to \$27,400 for matched group of RTC youths
-

“Full 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)
 - Much of wraparound implementation is in name only
 - Don't invest in workforce development such as training and coaching to accreditation
 - Don't follow the research-based practice model
 - Don't monitor fidelity and outcomes and use the data for CQI
 - Don't have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)
-

Statewide Children's Wraparound Initiative

Phase 1

- children in the custody of DHS child welfare for more than one year
- and who have had at least 4 placements,
- or children who have behavioral, emotional and/or mental health conditions severe enough to warrant direct entry into the service system at a high level of care.

Three Sites

- Washington County Wraparound
- Mid-Valley WRAP: Marion, Linn, Polk, Tillamook and Yamhill counties
- Rogue Valley Wraparound Collaborative: Jackson and Josephine counties

CY 2011-2012 served over 500 children

What Happens at the Community and Case Level

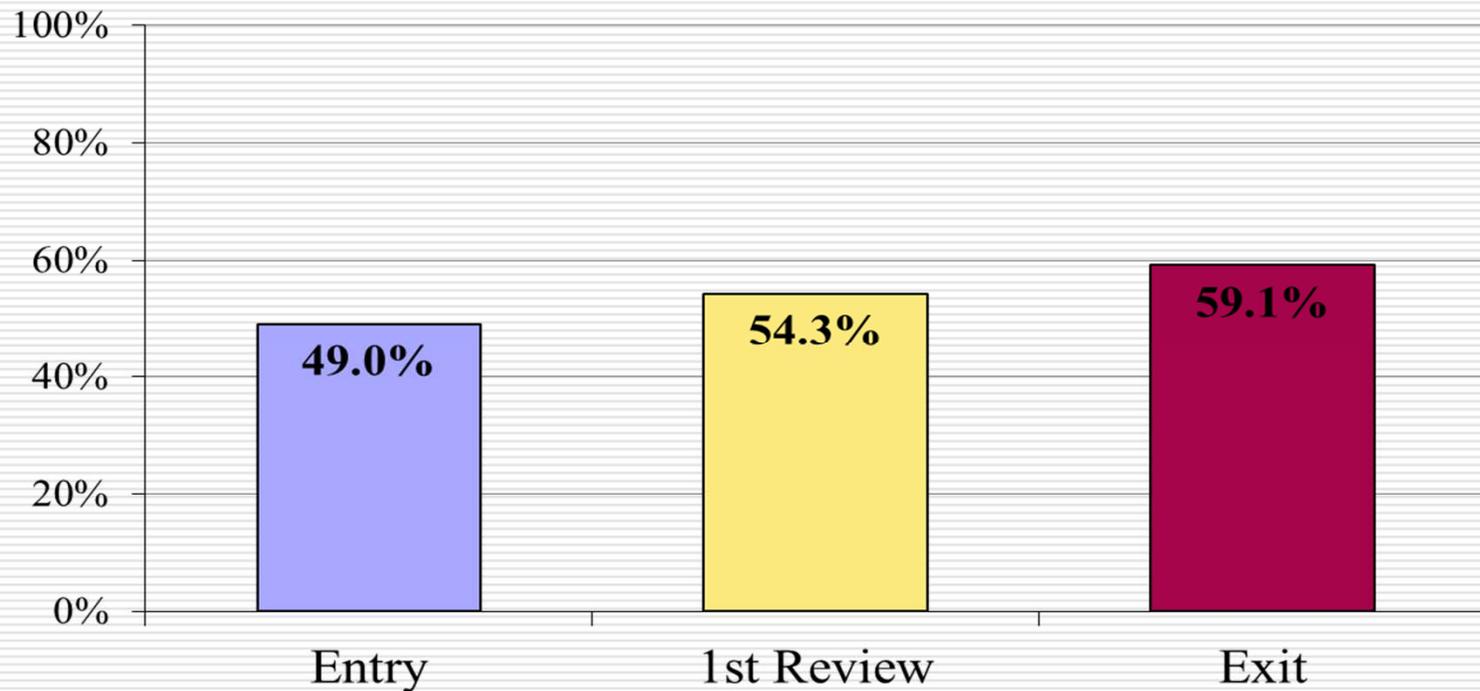
- ❑ A single accountable entity in each community
 - ❑ Uniform referral and determination process
 - ❑ Care coordinator
 - ❑ Family navigator
 - ❑ Child and Family Team
 - ❑ Individualized Services and Supports Plan
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Why Use System of Care and Wraparound?

- National and State experiences demonstrate
 - Better Health
 - Better Care
 - Lower Cost
-

Better Health

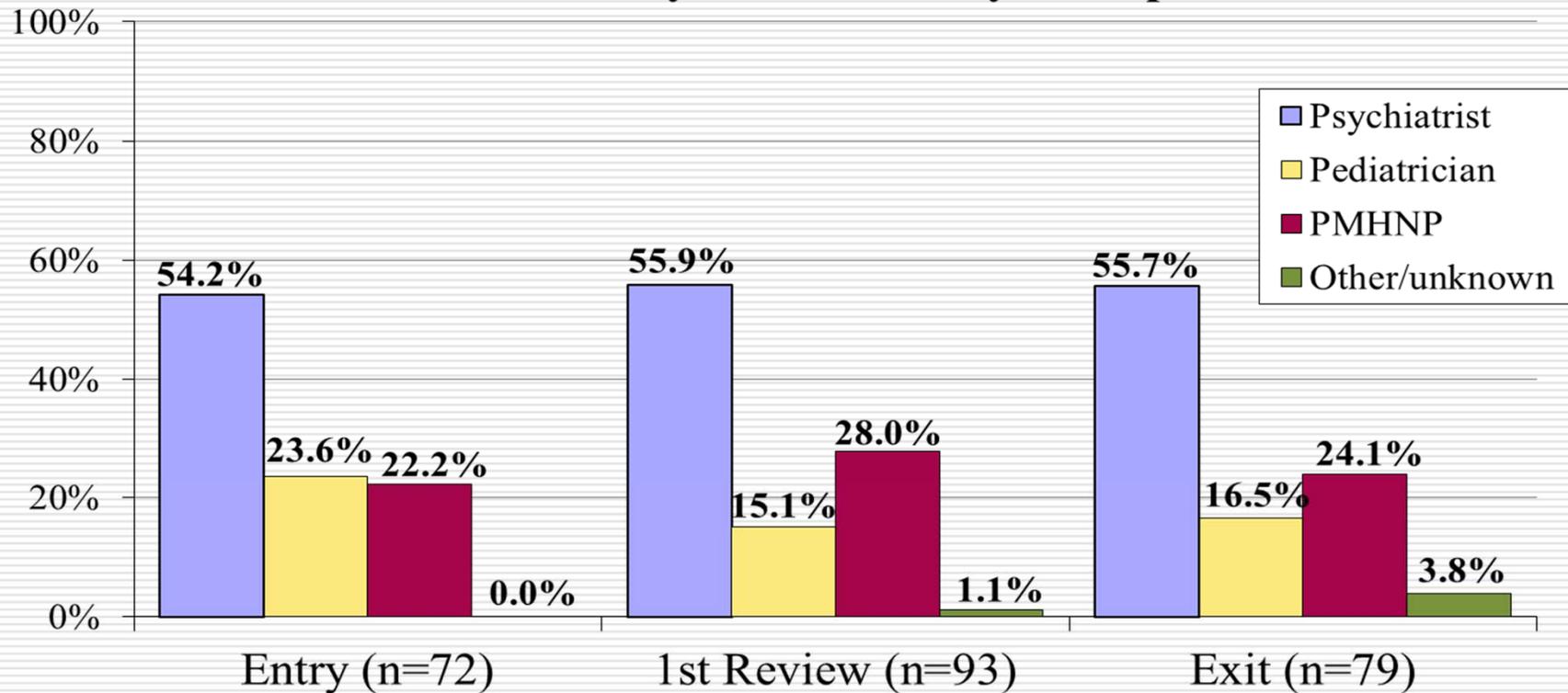
Figure 3b: Children Who Are NOT Currently Prescribed Psychotropic Medications



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

Better Health

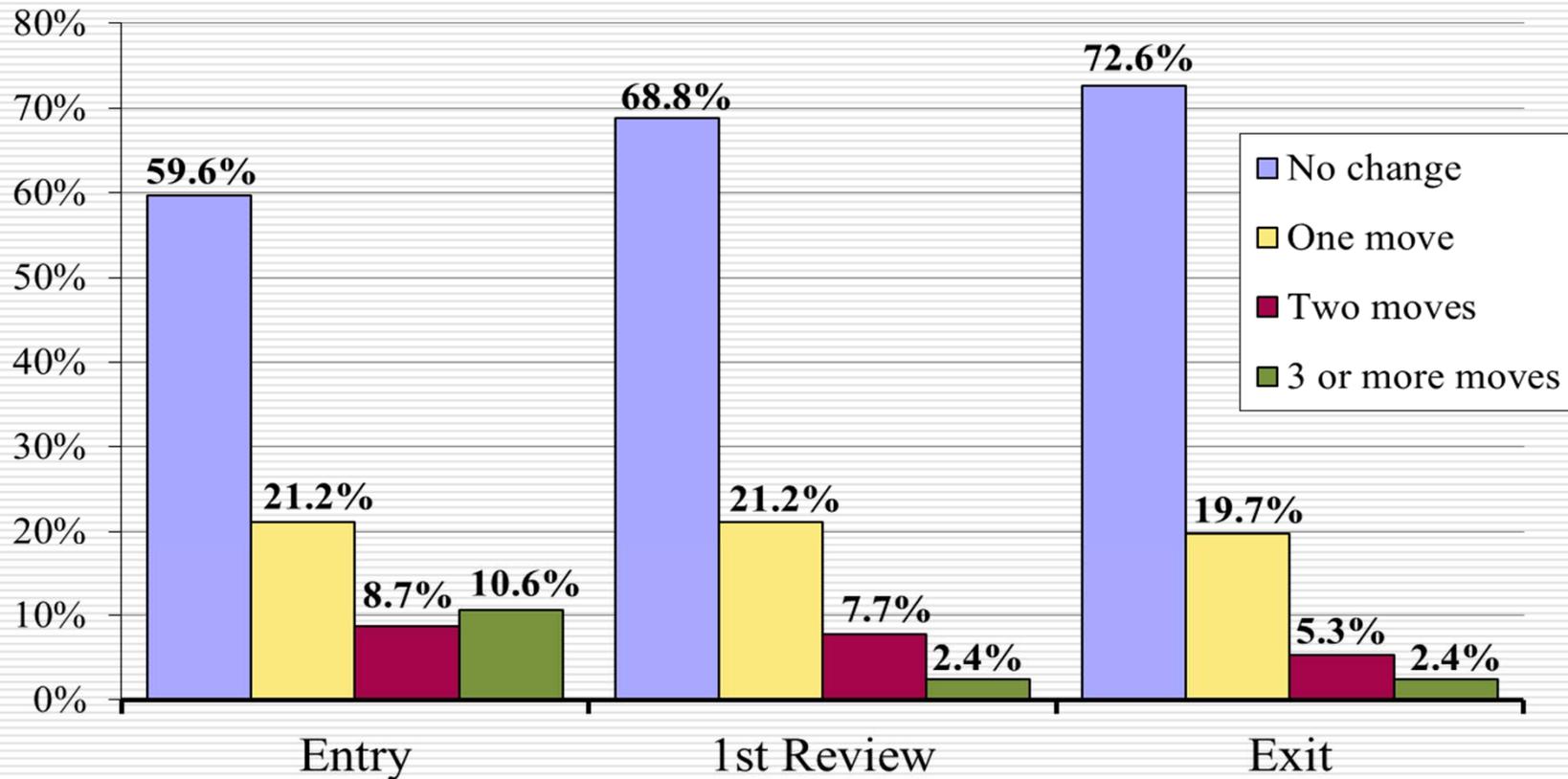
Figure 3c: Type of Provider for Children Currently Prescribed Psychotropic Medications



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

Better Care

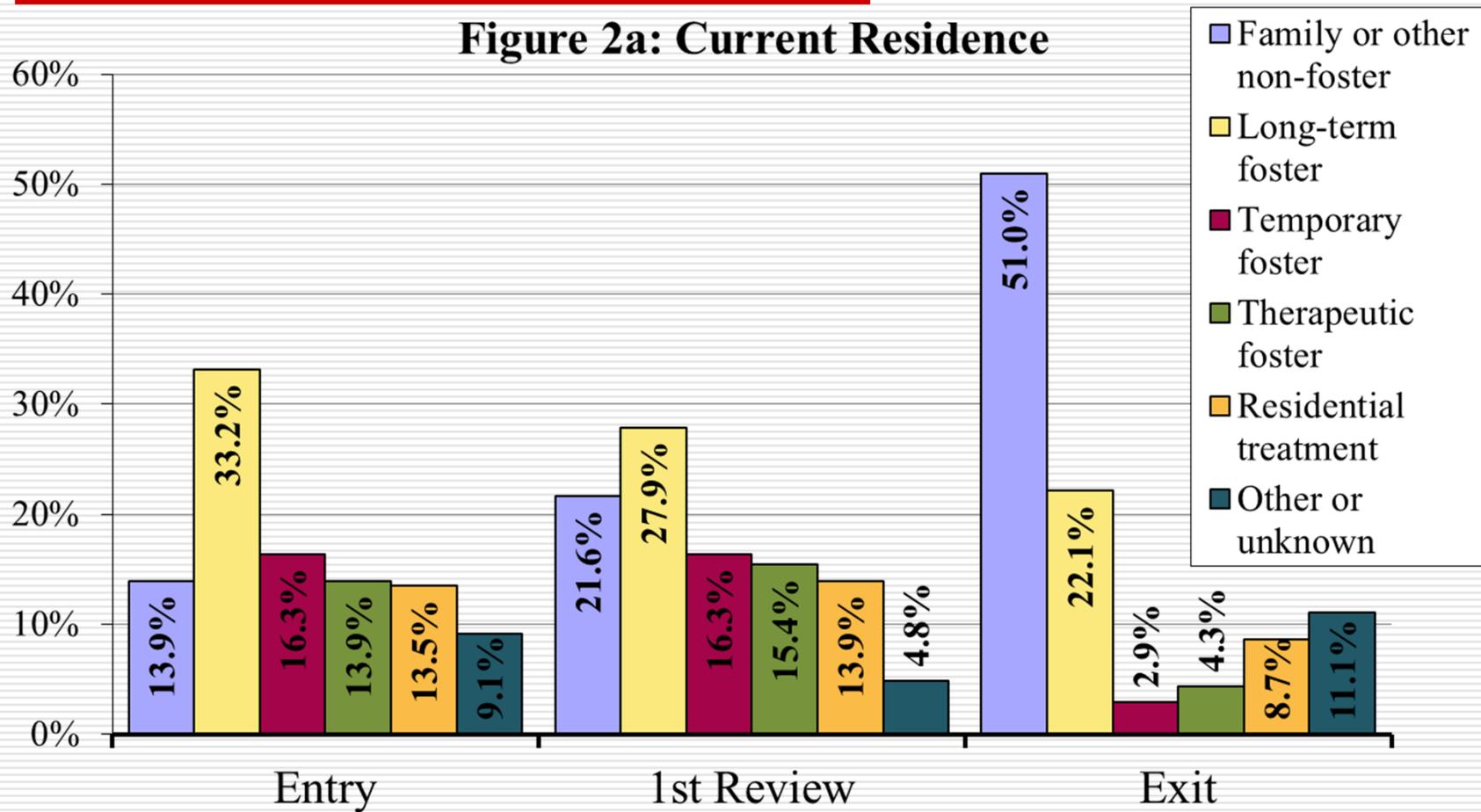
Figure 2b: Residence Changes in Prior 90 Days



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

Better Care

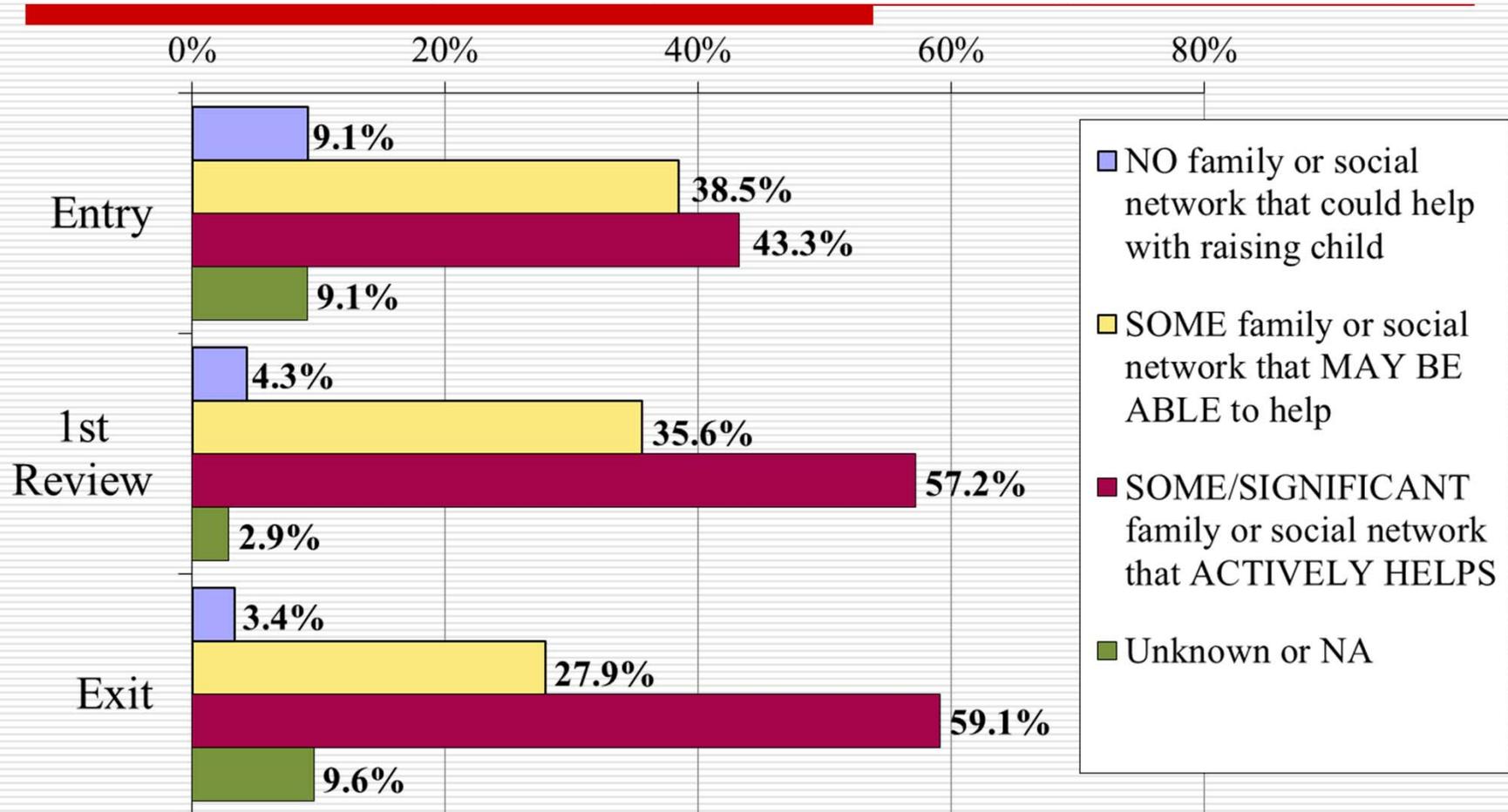
Figure 2a: Current Residence



Results for 208 children with assessment at Entry, first Progress Review, and at Exit.

Better Care

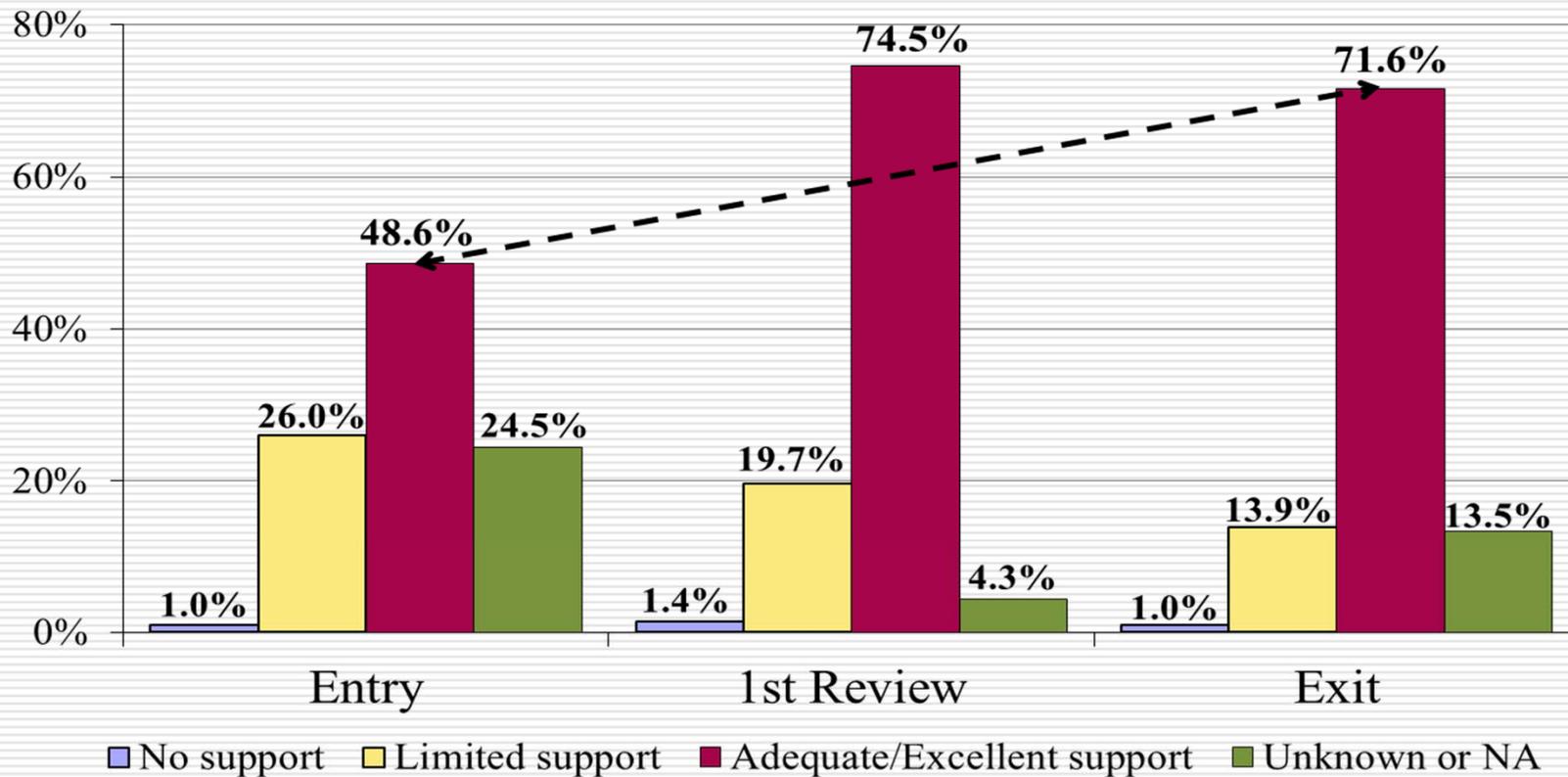
Figure 6a: Caregiver Family/Social Network Support Past 30 Days



Results for parents/caregivers of 208 children with assessment at Entry, first Progress Review, and at Exit

Better Care

Figure 6b: Caregiver Support to Address Problematic Behaviors

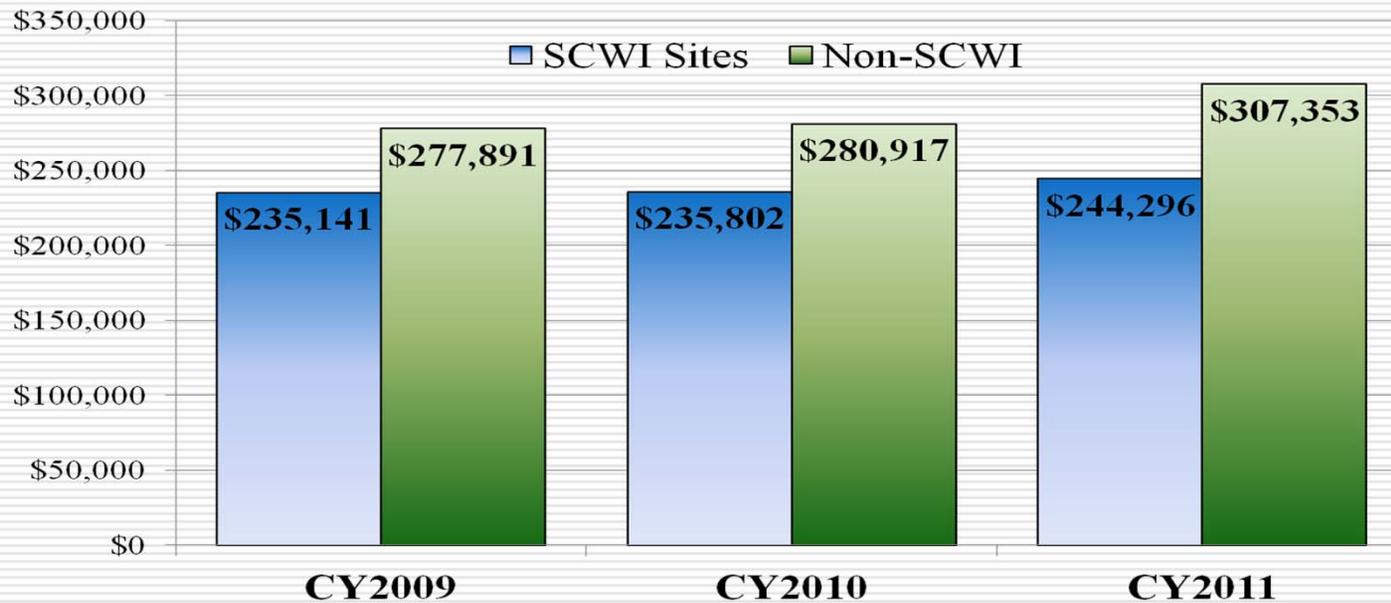


Results for parents/caregivers of 208 children with assessment at Entry, first Progress Review, and at Exit

Lower Cost

All levels of service

Total Billed per 1,000 Members age 0-17
Calendar Years 2009-2011



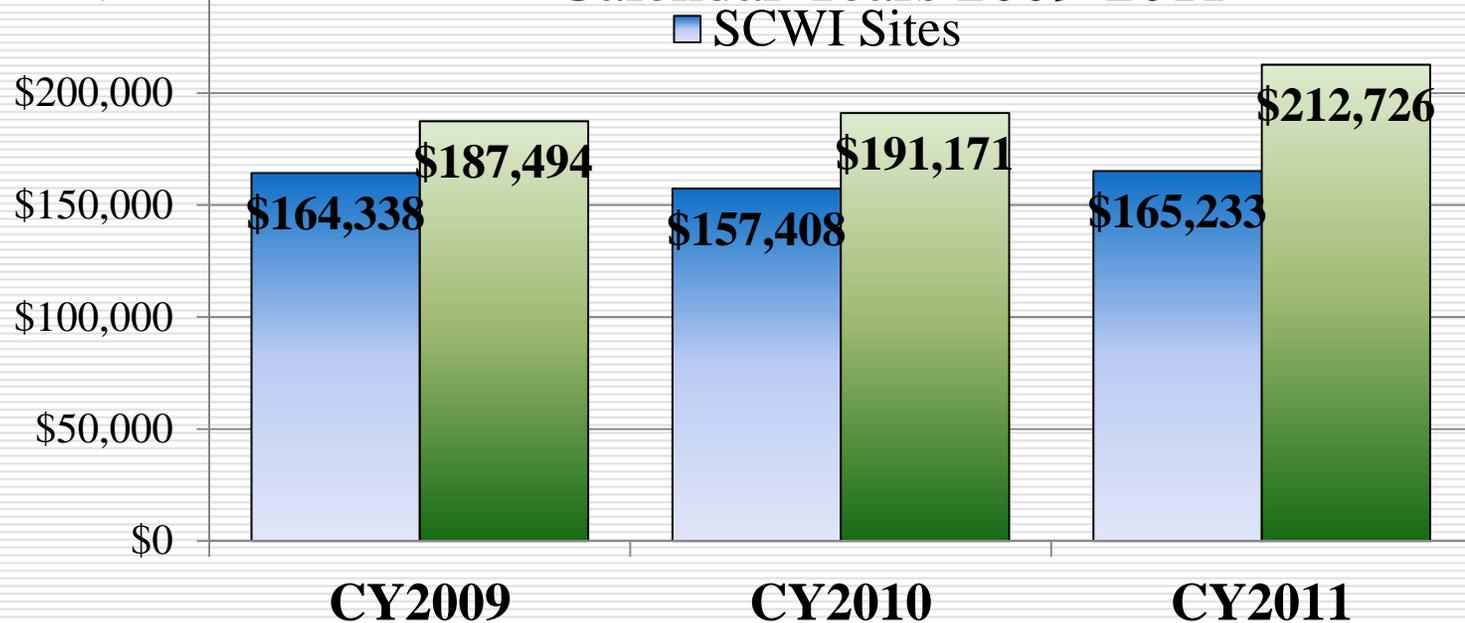
Source: Medicaid Management Information System (MMIS); data pulled on 10/18/2012

Lower Costs

Outpatient Services

Total Billed per 1,000 Members age 0-17

Calendar Years 2009-2011



Source: Medicaid Management Information System (MMIS); data pulled on 10/18/20

CCO Contract Examples

- ❑ Physical Health and Behavioral Health Integration
 - ❑ Children's Mental Health Section: Integrated Service Array is based on Wraparound principles and processes
 - ❑ Children's Wraparound Demonstration Projects
 - ❑ Medication Management
-

CCO Contract Examples

- Intensive Case Management
 - Member and Member Representative Engagement and Activation
 - Integration and Coordination:
 - Implementation of a system of care approach, incorporating models such as...Wraparound for children with behavioral health disorders
-

CCO Contract Examples

- Access to Care
 - Patient Centered Primary Care
 - Care Coordination
 - Care Integration
-

CCO Contract Examples

- ❑ Intensive Care Coordination for Special Health Members
 - ❑ State and Local Government Agencies and Community Social and Support Services Organizations
 - ❑ Health Equity
-

CCO Contract Examples

- Performance Improvement Projects
 - Transformation Plan
 - Learning Collaborative
 - Members with Special Health Care Needs
-

The Goal: Children are at home, in school, out of trouble and with friends

- Fully developed local and statewide Systems of Care in Oregon are necessary to maximize the efforts of child serving agencies and support their activities on behalf of children and families.
 - It is essential to integrate and coordinate efforts through evidence-based practices like Wraparound to ensure positive clinical outcomes for Oregon's children and their families.
 - Family and Youth voice must inform all levels of the system. Families with shared experience can support each other in being active participants in the planning for their children.
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