Collaboration In Action:
Sharing Goals, Risks and Outcomes

Massachusetts
MHSPY
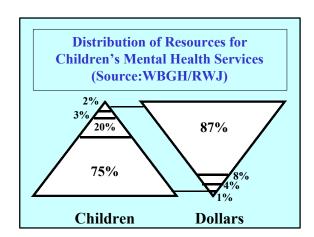Mental Health Services Program for Youth

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March 1, 2004

Need

- 20% child population in U.S. have diagnosable psychiatric disorders
- 9-13% of all children meet criteria for "serious emotional disturbance"
- Only one in five of these children get mental health services
- Massachusetts data indicates 115,000 kids with mental health needs (public and private)

Costs

- Average out of home placement $120,000 annually, not including medication, specialty services or family treatment
- Fragmented care contributes to "polypharmacy", many children on 4-6 medications with no consistent provider, increased cost and increased risk
- Lack of coordination and access barriers drive increased reliance on ER, increased cost and decreased quality

Distribution of Resources for Children's Mental Health Services (Source:WBGH/RWJ)

2%
3%
20%
75%

87%
8%
4%
1%

Children   **Dollars**

Mission

The **M**ental **H**ealth **S**ervices **P**rogram for **Y**outh is a private/public collaboration to redesign health care delivery for high-risk children and families, using a *strength-based*, *integrated* system-of-care.

Our goal is to use the resulting improvements in clinical outcomes and lowered costs toward *increasing access* to care and *earlier intervention* for a broader range of children in need.

Brief History

- 1982, Jane Knitzer, Unclaimed Children
- 1984, Child and Adolescent Service System Program (CASSP)
- 1988, Robert Wood Johnson Foundation created 22 Mental Health Services Programs for Youth (MHSPY) sites across the country
- 1992 CMHS "system of care" grants, large wraparound dollar amounts with steep match requirements
- 1997, RWJ/WBGH, "MHSPY- replication" one year planning grants to 12 states, including MA

MA-MHSPY Pilot

- National demonstration project for *coordinated* services and *integrated* medical care delivered in a *managed* care setting
- Uses blended funding from five categorically distinct state agencies; Mental Health, Child Welfare, Education, Juvenile Justice, and Massachusetts Medicaid
- Implementation and referrals began in March 1998, following two years of stakeholder consensus building

MHSPY Spectrum of Services

- Standard Medicaid physical health benefit: medical, surgical, pharmacy, etc.
- Standard Medicaid mental health and substance abuse benefit: inpatient and outpatient treatment, medications, acute residential treatment
- Non-traditional services: care management, Parent Partners, therapeutic after-school, respite, etc.
- Wraparound: transportation, basketball camp, pizza, talent show, etc.

Pilot Eligibility Criteria

- Medicaid members 3-18 years of age
- 1997 - Cambridge and Somerville residents
- 2002 - Malden, Everett, Medford
- Referred by another state agency (i.e.Child Welfare, MH, Juvenile Justice, Special Education) also serving the child
- Functional impairment (CAFAS)
- Risk of out of home placement
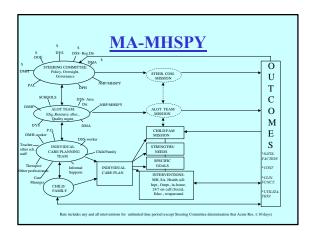- Parental or guardian consent

Outcome Domains

- Level of functioning
- Service utilization
- Cost
- Satisfaction

Continuity of Intent

- VISION: Leadership/support at a state-wide level for an integrated system of care
- COLLABORATION: community level partnerships involving clinicians, agencies and informal supports to build resources
- IMPLEMENTATION: Strength-based, family-driven, individualized care management, via Care Planning Team, provides clinical intervention for child

Vision

- Sustainable, outcome driven, systems change
- Taking root at the community level
- Supported by collaborative processes (family/professionals, formal/informal supports, clinical/social, medical/mental health, evaluation/operations)
- Defined by local needs
- Inclusively managed to respect family strengths, central budget limits, and clinical quality measurement principles

MA-MHSPY

Rate includes any and all interventions for unlimited time period (except Steering Committee determination that Acute Res. ≤ 30 days)

Collaboration

- State departments of Education, Mental Health, Juvenile Justice and Social Services agreed to share governance and blend funds via Medicaid to purchase expanded health and mental health benefit from HPHC (now NHP)
- State Level Steering Committee defines scope, creates policy, sets rates, etc.
- Area Level Operations Team manages shared intervention processes and prioritizes referrals
- Individualized family-based teams

Implementation

- Medical, mental health, substance abuse care for each child, as well as social supports and non-traditional services, are all authorized and monitored via a MHSPY Care Manager
- Each member has a Care Planning Team which brings family members and providers together to identify goals and interventions
- Clinical functioning, service utilization, satisfaction and cost are all tracked individually and in aggregate

Care Planning Team

- Dedicated group of individuals identified by the family
- Includes family and Care Manager
- Care Managers are salaried, Master's level clinicians with caseloads of up to 8 enrollees
- Professionals and non-professionals (i.e. relatives, friends, teachers, agency representatives, parent partner)
- Primary care, mental health and substance abuse clinicians

Three Phase Process

- *Initiation*: Identifying the process and the participants. Establishing terms of contract within the team.
- *Engagement*: Active partnership toward shared goals.
- *Resolution*: Clarification of goals achieved and work remaining; definition of strengths and needs for transition from MHSPY.

Phase I: Initiation

- *Orientation:*
Mission introduction, team composition decisions, transition from previous team and past expectations
- *Working Agreement*:
Defining relationships, embarking on challenges, "what is really the work?"

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Initial Team Tasks

- Setting the Tone
- Strengths/Needs Identification
- Life Domains
- Mission
- Crisis/Safety Plan
- Comprehensive Assessment
- Goals and Interventions

Phase II: Engagement

- *Developmental Surging*: Mission defined, goals introduced, work, success/crisis, clarification
- *Constructive Cycles of Involvement*:
  Re-contracting as needed, goals refined, work, success/crisis, growth

Roles of the Care Manager

Direct Care - supportive, therapeutic relationship to child and family via "wraparound" process, which combines traditional and non-traditional services.

Roles of the Care Manager

Care Coordination - leadership and facilitation of collaboration among agencies, families, community supports, to create a community-based system of care.

Roles of the Care Manager

Case Administration - Documentation and execution of decisions made within the Care Planning Team regarding family needs and identified goals.

Role of Parent Partner

- *Facilitate* - the process of increasing parent voice, access, and ownership in the care planning process
- *Collaborate* - with the other team members and Care Manager; work directly with family to achieve their mission for the child
- *Participate* - as designated parent support on the Care Planning Team

Phase III: Resolution

- *Transition Planning:* Begins at enrollment, "what will it look like?"; community links sought throughout process; as goals are met, clarification of remaining work to achieve mission
- *Graduation/Disenrollment and Beyond:* Not all terminations are planned, not all dis-enrollments are graduations, but impact of strength based care planning always felt. Emphasis on sustainability of resources and hope.
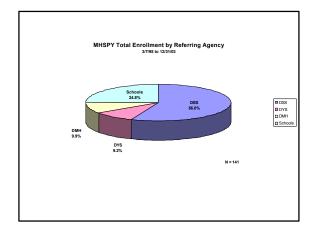
"Wave" Theory of Change

- The three care planning phases are not mutually exclusive
- Overlapping, with continuity across phases
- Momentum builds from one phase to the next
- Not binary "success" or "failure", but forward movement in understanding
- MHSPY offers a resource for change so that strengths/capacities can better match needs
- Planned end to MHSPY involvement encourages family growth; improved ways to meet needs
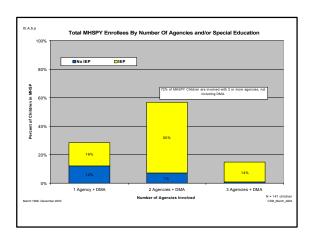
Enrollees

- Five years in Site 1 (two cities)
- 1 year in Site 2 (three cities)
- Average time in program: 20 mbr. mos.
- Initially older, mostly male, social service and court involved youth of color
- Overall shift to younger, more school referred, more white and more girls, especially in new communities

Enrollees: Agency Involvement

- 100% of MHSPY children are Medicaid recipients
- 72% of all MHSPY children are involved with two or more state agencies, in addition to Medicaid
- 80% of total enrollees are in Special Education

MHSPY Total Enrollment by Referring Agency
3/7/98 to 12/31/03

Schools 24.8%
DSS 56.0%
DMH 9.9%
DYS 9.2%
N = 141

III.A.5.a

Total MHSPY Enrollees By Number Of Agencies and/or Special Education

72% of MHSPY Children are involved with 2 or more agencies, not including DMA.

1 Agency + DMA: 16% IEP, 12% No IEP
2 Agencies + DMA: 50% IEP, 7% No IEP
3 Agencies + DMA: 14% IEP

March 1998- December 2003
N = 141 children
CSM_March_2004

III.A.5.b
Total MHSPY Enrollee Distribution By State Agency and Special Education Involvement

Note: 100% of enrolled children were also covered by Medicaid.
March 1998 - December 2003
N=141
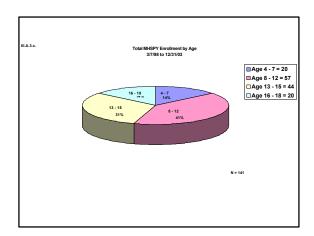CSM_March_2004

Enrollees: Age and Gender by Site
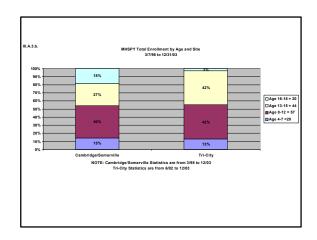
- Age:
  - 39% of enrollees in both Sites are between ages 8-12
  - The percent of enrollees ages 16-18 is higher in Site 1 (18%) than in Site 2 (3%).
  - The percent of 13-15 year olds is much higher in Site 2 (42%) than in Site 1 (27%).
- Gender:
  - The majority of all enrollees are still male (69%), although this is a down from the program's onset
  - The majority of MHSPY members at both sites are male, 70% in Site 1 and 66% in the Site 2 site.

*Total enrollees for the period March 1998 through December 2003

III.A.3.c.
Total MHSPY Enrollment by Age
3/7/98 to 12/31/03

- Age 4 - 7 = 20
- Age 8 - 12 = 57
- Age 13 - 15 = 44
- Age 16 - 18 = 20

N = 141

III.A.3.b.
MHSPY Total Enrollment by Age and Site
3/7/98 to 12/31/03

- Age 16-18 = 20
- Age 13-15 = 44
- Age 8-12 = 57
- Age 4-7 =20

NOTE: Cambridge/Somerville Statistics are from 3/98 to 12/03
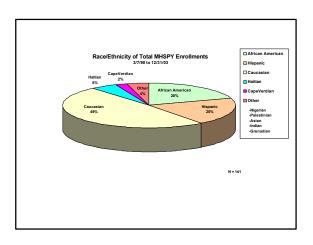Tri-City Statistics are from 6/02 to 12/03

Enrollees: Race/Ethnicity by Site

- Site 1 reports a significantly higher percentage of children of color than does Site 2 (62% vs. 22%), consistent with the differing racial and ethnic make-up within the two sites
- 23% of enrolled children in Site 1 are identified as African-American, while Site 2 had 11 % African-American enrollees
- 25% of Site 1 children were listed as Hispanic, only 5% of the Site 2 children were identified as Hispanic.

*Total enrollees for the period March 1998 through December 2003

Race/Ethnicity of Total MHSPY Enrollments
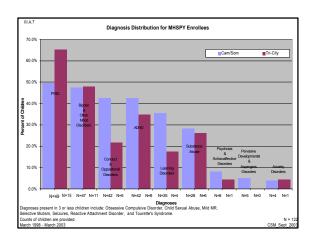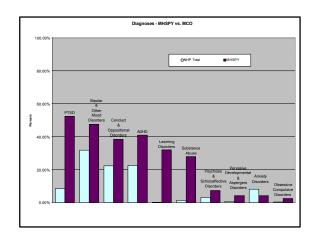**3/7/98 to 12/31/03**

- African American
- Hispanic
- Caucasian
- Haitian
- CapeVerdian
- Other
  - -Nigerian
  - -Palestinian
  - -Asian
  - -Indian
  - -Grenadian

N = 141

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Race/Ethnicity of Total MHSPY Enrollment by Site 3/7/98 to 12/31/03

Diagnoses of MHSPY Enrollees by Site

- The leading diagnosis for both MHSPY sites is *PTSD:* (65%) in Site 1 and (50%) in Site 2
- *Bi-Polar/Mood Disorders* are diagnosed at equal rates in both sites (48%)
- *Conduct Disorders* appear almost twice as likely to be diagnosed in Site 1 (42%) as in Site 2 (22%)
- *ADHD* is slightly more prevalent in Site 1 (43% vs. 35%)
- The next three most prominent diagnoses for both MHSPY sites are: *Learning Disorders*, *Substance Abuse*, and *Psychosis*
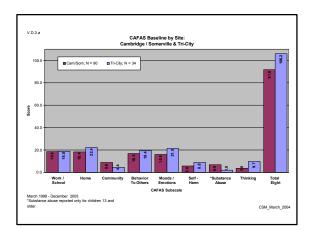
*For the period March 1998 through March 2003

Diagnosis Distribution for MHSPY Enrollees

Diagnoses - MHSPY vs. MCO

Diagnosis	Commercial	RC1	RC2	NHP Total	MHSPY
PTSD	3.39%	8.98%	8.23%	8.57%	52%
Bipolar & Other Mood Disorders	39.38%	32.09%	25.36%	31.78%	48%
Conduct & Oppositional Disorders	17.47%	24.07%	12.88%	22.43%	39%
ADHD	18.60%	20.96%	36.84%	22.58%	41%
Learning Disorders	0.02%	0.21%	0.15%	0.19%	32%
Substance Abuse	1.26%	1.27%	1.56%	1.30%	28%
Psychosis & Schizoaffective Disorders	8.27%	2.23%	6.35%	3.05%	7%
Pervasive Developmental & Aspergers Disorders	0.81%	0.52%	1.07%	0.60%	4%
Anxiety Disorders	9.01%	8.35%	6.54%	8.19%	4%
Obsessive Compulsive Disorders	0.13%	0.34%	0.56%	0.35%	2%

Level of Functioning

- CGAS, CAFAS, CBCL and PAT indicate consistent improvements across all areas from baseline to eighteen months
- CAFAS scores improved 39 % overall
- Self-Harm improved by 53%
- Substance Abuse improved by 78 %
- Behavior to Others improved by 42%

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V.D.3.a

CAFAS Baseline by Site:
Cambridge / Somerville & Tri-City

March 1998 - December 2003
*Substance abuse reported only for children 13 and older.

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V.D.3.b

CAFAS - Improvement - Baseline to 18 Months:
Cambridge / Somerville

March 1998 - December 2003
*Substance abuse reported only for children 13 and older.
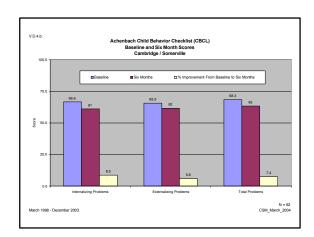
N= 29 CSM_March_2004

V.D.1.b

MHSPY Child Global Assessment Scores
Baseline to Two Years: Cambridge/Somerville

March 1998 - December 2003

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V.D.4.b.

Achenbach Child Behavior Checklist (CBCL)
Baseline and Six Month Scores
Cambridge / Somerville

March 1998 - December 2003

N = 62
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V.D.2.b

Improvement in PAT Scores
Baseline to Eighteen Months: Cambridge/Somerville

March 1998 - December 2003
*Substance Abuse and Duration of Abstinence are for children 13 and over, only.

N=54
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V.E.1.a.

MHSPY Level of Restrictivenes
Percentage of Days At Home for the Overall Program
March 1998 - Dec 2003

Note: *Other includes foster care, residential, group home, detention/DYS facility, jail, pre-independent living, assesment, secure treatment, and bootcamp.
      **Percentage of children within Other in Foster Care identified in parentheses ( ).

N=141
CSM_March_2004

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V.E.2

Location of Children After Disenrollment
March 1998 - March 2003

Home 67%, Residential - School 10%, College 8%, DYS Facility 7%, Foster Care 2%, Incarcerated 2%, DMH Facility 2%, Non-Family Home 2%

N=61 CSM_Sept_2003

Cost

- Annual cost to DSS, DMH or DOE per child less than 10% of usual placement cost
- Integrated system of care, with access to consistent clinical management, reduced high cost areas such as pharmacy and ER use
- Improved school functioning impacts cost
- Children leave MHSPY for home, not higher levels of care

IV.D.4

Total Pharmacy Cost PMPM

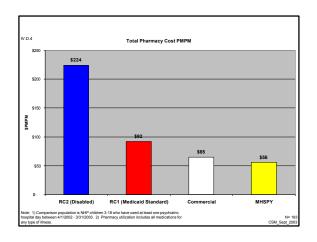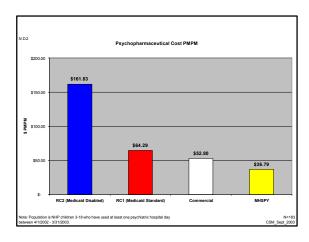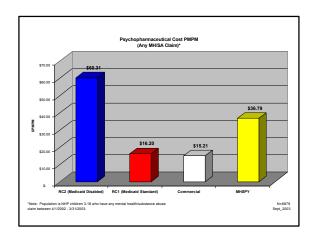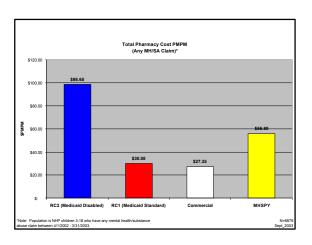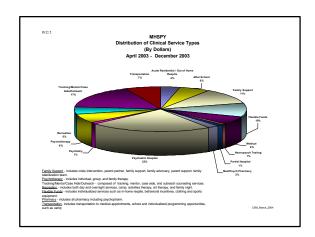|	$PMPM
RC2 (Disabled)	$224
RC1 (Medicaid Standard)	$92
Commercial	$65
MHSPY	$56

Note: 1) Comparison population is NHP children 3-18 who have used at least one psychiatric hospital day between 4/1/2002 - 3/31/2003. 2) Pharmacy utilization includes all medications for any type of illness.

N= 183
CSM_Sept_2003

IV.D.2

Psychopharmaceutical Cost PMPM

	$ PMPM
RC2 (Medicaid Disabled)	$161.83
RC1 (Medicaid Standard)	$64.29
Commercial	$52.80
MHSPY	$36.79

Note: Population is NHP children 3-18 who have used at least one psychiatric hospital day between 4/1/2002 - 3/31/2003.

N=183
CSM_Sept_2003

Psychopharmaceutical Cost PMPM
(Any MH/SA Claim)*

	$PMPM
RC2 (Medicaid Disabled)	$60.31
RC1 (Medicaid Standard)	$16.20
Commercial	$15.21
MHSPY	$36.79

*Note: Population is NHP children 3-18 who have any mental health/substance abuse claim between 4/1/2002 - 3/31/2003.

N=8879
Sept_2003

Total Pharmacy Cost PMPM
(Any MH/SA Claim)*

	$PMPM
RC2 (Medicaid Disabled)	$98.65
RC1 (Medicaid Standard)	$30.08
Commercial	$27.35
MHSPY	$55.80

*Note: Population is NHP children 3-18 who have any mental health/substance abuse claim between 4/1/2002 - 3/31/2003.
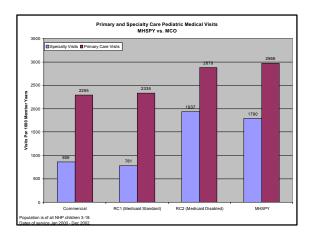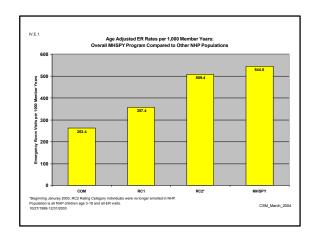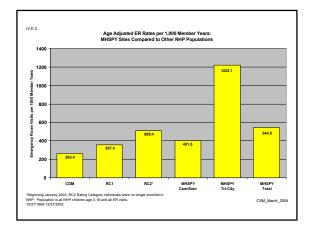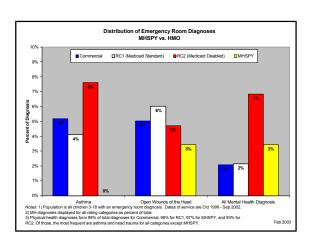
N=8879
Sept_2003

Utilization

- Outpatient Pedi visits higher than AFDC
- Inpatient utilization lower than AFDC
- 53% of medical and mental health claims dollars were spent on non-traditional and/or "wraparound" services
- Medication use is 39 % less than rate for commercially insured, 45 % less than AFDC Medicaid and 49 % less than Medicaid Disabled
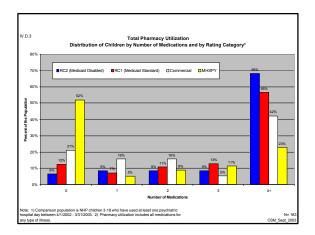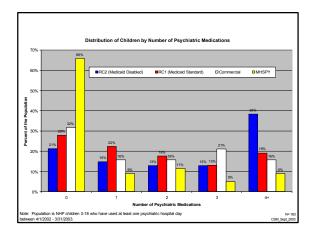- 89% days spent in least restrictive setting

IV.C.1.

MHSPY
Distribution of Clinical Service Types
(By Dollars)
April 2003 - December 2003

Family Support - includes crisis intervention, parent partner, family support, family advocacy, parent support, family stabilization team.
Psychotherapy - includes individual, group, and family therapy.
Tracking/Mentor/Case Aide/Outreach - composed of tracking, mentor, case aide, and outreach counseling services.
Recreation - includes both day and overnight services, camp, activities therapy, art therapy, and family night.
Flexible Funds - includes individualized services such as in-home respite, behavioral incentives, clothing and sports equipment.
Pharmacy - includes all pharmacy including psychopharm.
Transportation - includes transportation to medical appointments, school and individualized programming opportunities, such as camp

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Primary and Specialty Care Pediatric Medical Visits
MHSPY vs. MCO

Population is of all NHP children 3-18.
Dates of service Jan 2000 - Dec 2002

IV.E.1.

Age Adjusted ER Rates per 1,000 Member Years:
Overall MHSPY Program Compared to Other NHP Populations

*Beginning Januray 2003, RC2 Rating Category individuals were no longer enrolled in NHP.
Population is all NHP children age 3-18 and all ER visits.
10/27/1999-12/31/2003

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IV.E.2

Age Adjusted ER Rates per 1,000 Member Years:
MHSPY Sites Compared to Other NHP Populations

*Beginning Januray 2003, RC2 Rating Category individuals were no longer enrolled in NHP. Population is all NHP children age 3-18 and all ER visits.
10/27/1999-12/31/2003

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Distribution of Emergency Room Diagnoses
MHSPY vs. HMO

Notes: 1) Population is all children 3-18 with an emergency room diagnosis. Dates of service are Oct 1999 - Sep 2002.
2) MH diagnoses displayed for all rating categories as percent of total.
3) Physical health diagnoses form 98% of total diagnoses for Commercial, 98% for RC1, 97% for MHSPY, and 93% for RC2. Of those, the most frequent are asthma and head trauma for all categories except MHSPY.
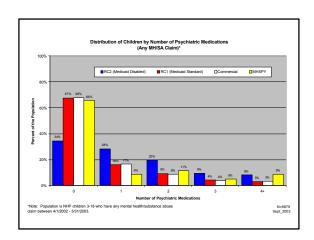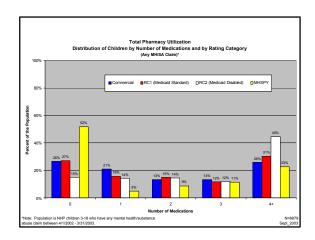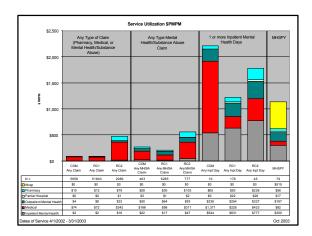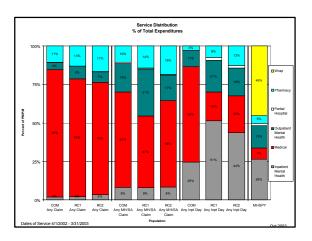
Feb 2003

Satisfaction

- MHSPY families complete the program at a 97% rate
- 87% of families report being satisfied or very satisfied
- Growing source of referrals is other families
- Families and youth seeking ways to participate in program development (Family Leadership Council, Youth Advisory Board)

Conclusions/Lessons Learned

- Process is "organic"; principles can be followed but implementation must be responsive to environment
- Crucial to establish authentic connections; but still need some "role" protections to avoid burnout
- Successful transitions require strong community support; a "real" system of care based on local concern and responsibility

Conclusions/Lessons Learned

- Categorical mandates divide ownership and contribute to fragmentation of care for families (i.e.mutually exclusive eligibilities)
- Shared governance increases transparency and accountability for all parties: insurers, agencies, providers
- Inclusive process, with family voice, contributes to community based, sustainable system

Conclusions/Lessons Learned

- "Wraparound" dollars alone insufficient
- "Systems of Care" need to be managed to outcomes (measure improvement in areas of concern to stakeholders)
- Neither " in-home" providers nor "flexible funds" guarantee clinical quality
- Shared governance, including consumers, maintains system integrity
- High-level support and transparent implementation allow for CQI

Conclusions/Lessons Learned

- "Economies of scale" necessary to create change (i.e. "size matters" when driving creation of new service types)
- Linking of public data currently collected by state necessary for full evaluation of change efforts (i.e. "compared to what"?)
- Sustainability and next level benefits cannot be achieved if opportunities denied (i.e. second-generation of "ownership") by site turnover

Recommendations

- Public-private collaboration can create purchasing volume for necessary new services, such as respite
- Commercial "buy-in" upstream diminishes movement of high-risk children into public sector (Medicaid, DSS, CHINS)
- Executive or legislative branch leadership can provide mandate for interagency collaboration

Recommendations

- Authorized, funded collaboration among agencies, if managed to outcomes, can lead to increased efficiency
- Linked research and evaluation initiatives can contribute to a coherent state database
- Real time use of research/evaluation results offers providers the chance to improve care
- Better outcomes allow transfer of resources "upstream", enhancing health of population