

Findings: Promising Managed Care Approaches to Care Management and Clinical Decision-Making

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A System of Care for Children's Mental Health:

Expanding the Research Base

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Health Care Reform Tracking Project

- Tracking publicly financed managed initiatives from 1995 - 2005
- Studying impact on children and adolescents with behavioral health disorders and their families
- Studying impact on the systems of care that serve them



Tracking Project Partners

- Research and Training Center for Children's Mental Health, University of South Florida
- National Technical Assistance Center for Children's Mental Health, Georgetown University
- Human Service Collaborative, Washington, DC



Methodology

- State Surveys (1995, 1997/98, 2000, 2003)
- Impact Analyses (1997, 1999)
- Consensus Conference (2003)
- Study of Promising Approaches (2002-2005)



Study of Promising Approaches Method

- Identify promising approaches through surveys and impact analyses
- Conduct site visits
- Conduct telephone interviews
- Review documentation
- Prepare series of papers to describe promising approaches
- Provide information and guidance to improve managed care systems



Promising Approaches Papers

1. A View from the Child Welfare System
2. Managed Care Design and Financing
3. Making Interagency Initiatives Work for Children and Families in the Child Welfare System
4. Accountability and Quality Assurance in Managed Care Systems
5. Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems
6. Family Involvement in Managed Care Systems



New Promising Approaches Papers

Paper #7:

Clinical Decision Making Guidelines for Child/Adolescent Behavioral Health Care in Public Sector Managed Care Systems

Paper #8:

Care Management in Managed Care Systems



Promising Approaches in Care Management

Overview

- ◆ Description of 3 care management programs
- ◆ Common characteristics
- ◆ Common challenges
- ◆ Recommendations for other managed care care management programs



Coordinated Family Focused Care Massachusetts Behavioral Health Partnership

- **Sites:** 5 communities: Brockton, Lawrence, New Bedford, Springfield, and Worcester
- **Goal:** to support children and adolescents with serious emotional disturbance by building upon child and family strengths and available support systems in order to maintain and improve the child's ability to remain and function productively in the community



Coordinated Family Focused Care

CFFC values

- ◆ developing services that are child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive/least intrusive
- ◆ Families are the most important caregivers
- ◆ All families and children have strengths that must be identified and emphasized
- ◆ Service system professionals have knowledge, skills, and strengths that are helpful to children and families
- ◆ There should be one coordinated plan of care for a child, incorporating all services and supports, including services provided or funded by state agencies.



Coordinated Family Focused Care

Governance structure

- ◆ **Statewide Steering Committee:** responsible for program implementation, quality management, training, and evaluation. Committee is comprised of representatives from state child serving agencies, the Massachusetts Behavioral Health Partnership, and two family organizations, the Federation for Children with Special Needs and the Parent/Professional Advocacy League
- ◆ **Local Steering Committees:** assist with quality management activities, community resource monitoring and development, family-specific issues or themes that indicate access and care coordination challenges, and public relations




Coordinated Family Focused Care

- **Child and Family Teams:** provide services through a wraparound planning process that results in an individualized plan for the child and family
- **Caseload size:** 10 children and their families
- **Team members:** the child and family, the care manager, the family partner, school personnel, relatives, primary care physicians, clergy, professional providing services to the child, and others identified by the family
- **Goal:** at least 50% of the team members are identified by the family



Coordinated Family Focused Care

- Components of Care Plan
 - ◆ Individualized and family-focused interventions and supports
 - ◆ Behavior management plans and supports
 - ◆ Education and support for family members
 - ◆ Links between family, school, community resources and natural supports
 - ◆ Facilitation of a positive relationship between the child/family and staff/resources of the child's school
 - ◆ Advocating with the family to the school for needed special education and school resources
 - ◆ Identification of after-school community resources and therapeutic programs




Continuous Treatment Teams Magellan Health Services/TennCare

- Sites: Statewide-offered by 18 Community Health Agencies
- Goal: to prevent out-of-home placement through multidisciplinary teams that emphasize family strengths, family involvement, and offer a range of services; provides longer-term comprehensive treatment and rehabilitation services (length of stay: 7 months to 1 year)



Continuous Treatment Teams

- Team composition: 4 full-time case managers, psychiatric and nursing consultation
- Staff to youth ratio: 1:6
- Services offered: crisis intervention and stabilization, counseling, skill building, therapeutic intervention, advocacy, educational services, medication management, school-based counseling
- Expectation: provide at least 12 hours a month of direct face-to-face services per youth, with a minimum of 8 hours delivered in home/community



Continuous Treatment Teams

- Treatment planning: multidisciplinary, family and child actively involved and sign the treatment plan
- Outcomes: reduction in hospitalization and use of crisis services, more respect for families
- Role of Tennessee Voices for Children: subcontract to measure program fidelity and assess youth and family satisfaction
- Use of informal resources: given lack of flex funds, case managers rely on churches, YMCAs, volunteer mentors




Child and Family Teams Value Options/Arizona Department of Health Services

- Site: Maricopa County, Arizona (Phoenix)
- Goal: to provide behavioral health services to children through family-centered practice that is coordinated, flexible, and family-driven
- Values: the 12 Principles of the Arizona Vision
- Family Involvement Center: recruits Family Support Partners; co-designed two-week training program for case managers and Family Support Partners



Child and Family Teams

- Child and Family Team: includes at a minimum, child and family, a behavioral health representative, Family Support Partner, and any individuals important in child's life who are identified and invited to participate by child and family
- Clinical Liaison: an individual who has met ADHS credentialing standards. Responsible for supporting family in development of Child and Family Team, providing clinical oversight and consultation to team, advising on services and natural supports, securing all covered services that will address needs of child and family



Child and Family Teams 12 Principles

- Strengths and Needs-Based Planning
- Partnerships with Families
- Consensus
- Jointly Established Service Plans
- Natural and Informal Supports
- Collaboration
- Ongoing Assessment
- Child-Family Participation in All Decisions that Affect Them
- Crisis Planning
- Flexibility
- Single Point of Contact
- Cultural Competence



Common Characteristics of Promising Care Management Approaches

- Articulated and shared set of values and principles
- Small caseload; 24/7 availability
- Use of a wraparound process
- Use of child and family teams
- Emphasis on both formal services and natural supports
- Crisis/safety plan
- Advocacy with other systems (school, juvenile justice)



Common Challenges

- Recruitment and retention of qualified case managers and family partners
- Availability of needed services, including crisis care, outpatient treatment
- Identification and development of informal supports
- Fidelity to the model
- Hearing the family voice: "Believed that we had before, but had no idea what it really met"



Recommendations

- Begin with a shared vision and principles and then develop a care management plan
- Lay out comprehensive, sequential steps for implementation (e.g. development of billing codes for process activities)
- Do not go to scale immediately
- Procure start-up funds, especially for training
- Need ongoing training, monitoring, and coaching



Clinical Decision Making Guidelines Project Overview

- Examines use of clinical decision-making guidelines for children's behavioral health care by states or management entities in states within a managed care environment
- Includes a sample of 13 states or management entities using formal clinical decision-making protocols for child/adolescent behavioral health
- Describes: protocols; reason for use; experiences to date; stakeholders perceptions of impact on access, quality, consistency and cost; strengths and challenges of particular approaches; compatibility of formal protocols with individualized, family-focused care; "lessons learned"



Methodology

- Identification of state examples through Health Care Reform tracking Project State Surveys
- Semi-structured telephone interviews with key state and management entity informants (e.g., state child mental health directors, evaluators, local management entity clinical leadership)
- Review of clinical protocol documentation provided by key stakeholders and/or available on websites



High-Level Grouping By Following Categories

- **Group 1:** Primarily using state specific “homegrown” protocols (may be nested within an individualized, wraparound approach)
- **Group 2:** Primarily using existing standardized instruments, e.g., proprietary (may be combined with access to an individualized, wraparound approach)
- **Group 3:** Using non-open, proprietary level-of-care at state level
- **Group 4:** Primarily using an individualized, wraparound approach (standardized instruments may be key elements with this approach)



4 Sites with State Specific, Public Protocols “Homegrown”

(may be nested in individualized Approach)

- | | | |
|--------------|---|--|
| Arizona | → | Arizona Uniform Behavioral Health Assessment Tool |
| Delaware | → | Clinical Services Management Criteria |
| Pennsylvania | → | Guidelines for Mental Health Necessity Criteria (“Appendix T”) |
| Texas | → | Child and Adolescent Texas Recommended Authorization |



5 Sites Using Standardized Protocols

Proprietary and/or Standardized Protocols
(may be used with an individualized Approach)

- | | | |
|--|---|--|
| Hawaii | → | Multiple instruments (e.g., CAFAS, CALOCUS, CBCL, YSR) |
| Michigan | → | Child and Adolescent Functional Assessment Scale (CAFAS) |
| Clinton, Eaton, Ingham Counties (Michigan) | → | Child and Adolescent Functional Assessment Scale (CAFAS) |



5 Sites Using Standardized Protocols

Proprietary and/or Standardized Protocols
(may be used with an individualized Approach)

- | | | |
|----------------|---|---|
| New Jersey | → | Child and Adolescent Needs and Strengths (CANS) |
| North Carolina | → | Child Levels of Care Criteria with CAFAS |



1 Site Using State Specific Proprietary Protocol

Proprietary instrument sponsored by Tennessee State Medicaid system

- | | | |
|-----------|---|---|
| Tennessee | → | Non-open, proprietary, state-specific level-of-care criteria (TennCare) |
|-----------|---|---|



3 Sites Using Wraparound Protocols

Individualized, Wraparound Approach (combined with formal measurement using Standardized instruments)

- | | | |
|--|---|--|
| Dawn Project Indianapolis | → | Also uses multiple formal instruments (e.g., CAFAS, Wraparound Fidelity Index) |
| Massachusetts Mental Health Services Program For Youth (MHSPY) | → | Also uses multiple formal instruments (e.g., CAFAS, CBCL, YSR, CGAS) |
| Wraparound | → | Also uses multiple formal instruments (e.g., CAFAS, CBCL, YSR) |



Factors Related to Instrument Selection

- Easy for provider to use
- One, or least number of measures possible
- Not proprietary
- Applicable to all populations
- Quantifiable



Examples of Identified Characteristics Of Particular Instruments

CAFAS

- Fast, relatively simple to use
- Relevant to QI
- Supports long term planning with trends observed overtime
- Does not lend itself to concurrent service planning
- Questions about relevance for youth with co-occurring ED/DD



Examples of Identified Characteristics of Particular Instruments

CANS

- Works well as practice tool for ongoing service planning
- Can be used by both clinicians and non-clinicians
- Pragmatically oriented-levels the playing field for team members
- Promotes information sharing and communication while maintaining clinical sensitivity
- Incorporates the concept of strengths



Examples of Identified Characteristics Of Particular Instruments

Wraparound Fidelity Index

- Fast to use
- Relevant to QI
- Provides program-or system-level data
- Not useful at an individual child/family level

CALOCUS

- Provides minute to minute acuity monitoring
- Relevant to QI in tracking decision outcomes
- Incorporates concept of strengths



Multiple Uses/Different Stakeholder Needs

- Eligibility determination
- Medical necessity determination
- Level of care placement
- Service planning
- Outcome monitoring (system level, treatment level)
- Program Evaluation
- Quality Improvement
- Cost containment



Three Main Purposes

- “After-look”; retrospective performance review, can be used for system QI, sub-category population analysis (i.e. girls, 6-12 year olds) or individual outcome evaluation
- “Concurrent review”; allows real-time access to information that can be used to inform care decisions while treatment is in process
- “Distribution of resources”; access, equity and eligibility criteria



Multiple (and Many Similar) Stated Goals: I

- Ensure that children receive the appropriate type and amount of service
- Ensure appropriate access to (limited/expensive) services
- Align practice with system goals (e.g., prioritize children with SED; reduce “deep end” placements; promote use of evidence-based practices)
- Promote consistency and equity in service provision
- Provide data to better inform practice



Multiple (and Many Similar) Stated Goals: II

- Provide visible progress indicators to families (“promote resiliency”)
- Improve the quality of care
- Provide data to monitor the clinical progress of children served
 - ◆ For service planning
 - ◆ For treatment outcome monitoring
- Monitor system-wide performance (e.g., allow for comparisons across local management entities)



Multiple (and Many Similar) Stated Goals: III

- Increase the accountability of the system
- Increase consistency of “level of care” decisions
- Provide justification for resource distribution
- Fortify medical necessity criteria
- Create data to guide state-wide decision making and structure for communication to stakeholders about implications for change



Reported Challenges and Issues

- Lack of capacity and/or interest among those expected to use protocols
- Lack acceptance by clinicians of face validity of protocols
- Evidence-base versus community standard
- Rigidity among some using formal instruments
- Consistency versus individualized service planning
- Cultural sensitivity of some instruments (e.g., translation issues – under-identification)
- Getting managers/clinical supervisors to take advantage of protocols for quality improvement and utilization management



Commonly Identified Barriers

- Costs associated with staff training and re-training
- Costs associated with collecting and analyzing data at a child/family level
- Lack of resources (staff, time and dollars) at both a program and system level to analyze and use data
- Costs associated with discarding old systems and establishing new ones
- Need for clinical staff to do documentation (may be increased documentation and/or learning new system)
- “Scaling up” – i.e., going statewide



Lessons to Share

- Make protocols transparent to all stakeholders
- Select protocols that are meaningful to stakeholders
- Utilize protocols within a systemic, values-based context
- Provide adequate staffing/support to implement a protocols-based system
- Keep open lines of communication with those using/affected by the protocols (e.g., providers, clinicians, families)
- Ensure resources for adequate training and re-training for fidelity maintenance



Lessons to Share

- Establish quality control over protocol
- Don't use outcome data based on the use of protocols to "beat up on" providers
- Do use data for quality improvement
- Integrate protocols into everyday documentation requirements
- Make protocol use part of the system (agency) culture
- Use data to document overall system results (i.e., stakeholder feedback, promote sustainability)
- Allow adequate time to see change