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## III. Concluding Observations

### Common Characteristics and Challenges

- **Common Characteristics**

The features and approaches incorporated by managed care systems to respond to the needs of youth with serious and complex behavioral health disorders and their families share a number of common characteristics:

- **Broad Array of Services** — The promising approaches involve a much broader array of services and supports than typically is available in managed care systems. In addition to the more familiar behavioral health treatment modalities (such as outpatient therapy, day treatment, inpatient hospitalization, and residential treatment), these systems have incorporated numerous additional service and support options that have proven invaluable for providing treatment and supporting community functioning, ranging from crisis services to mentoring, home-based services, respite care, and family support.
- **Individualized Service Planning Process** — A common feature across these managed care systems is the use of some type of individualized service planning process. This process involves the creation of a service planning team, comprised of the family and youngster (when appropriate), relevant providers, and other individuals of significance to the family. The use of a well-defined, individualized service planning process allows the strengths and needs of each youth and family to be assessed and considered and for a service plan to be designed to specifically target their needs and goals.
- **Flexible Service Delivery** — Many of the promising features described enable much greater flexibility and creativity in service delivery than is possible in most managed care systems. Mechanisms have been incorporated to support flexible “service packages,” innovative service delivery and the “whatever it takes” approach to serving and supporting youth with serious and complex disorders and their families.
- **“Ecological” Clinical Decision-Making Criteria** — The medical necessity, level of care, and other clinical decision-making criteria used by most of these systems are ecological in nature in that they allow for the consideration of psychosocial and environmental factors in clinical decision-making and recognize that, particularly for youth with serious disorders, their ability to function in their homes, schools, and communities are critical factors to address in service delivery.
- **Family Involvement** — The approaches share respect for families and a commitment to family involvement in a variety of ways. Families and surrogate families are integral members of the service planning teams and an ongoing, trusting relationship with families is a goal throughout service delivery. Often, families also are involved at the system level in policy and system management decisions. In some cases, family organizations play a role in advising and supporting the system, and may provide peer support to other families involved in services.

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- **Service Coordinators** — The role of a service coordinator is important in most of these systems, with one person taking primary responsibility for planning, facilitating, and coordinating care. The use of a service coordinator, particularly for youngsters with serious and complex problems, enhances continuity of services; allows one person to develop a genuine understanding of the issues; develops an ongoing, supportive relationship with the family; facilitates communication and coordination among involved service providers; and maintains a “big picture” perspective for assessment of progress over time and adjusting services and supports as needed. Whether they are called service coordinators, care coordinators, care managers, or case managers, their role in these approaches is a major departure from the more narrow care authorization/gatekeeper role seen in some managed care systems.
  - **Cross-System Focus** — Most of the approaches used to serve children with serious disorders within managed care systems recognize that these youngsters have multiple needs and typically are involved with multiple agencies and child-serving systems. The approaches involve input, collaboration, problem solving, and, often, resources from multiple child-serving systems in an attempt to create more coherent and coordinated service delivery.
  - **Culture of Providing Care that Works** — Though all of these systems struggle with issues of resource scarcity and the need for cost consciousness, the primary focus is based on a culture of providing care that works for youth with serious and complex problems. Care authorization processes incorporate flexibility, and denials of services are infrequent.

- **Common Challenges**

All of the managed care systems face significant challenges in their efforts to serve youth with serious disorders and their families. Many of these challenges stem from fiscal pressures; others reflect the complexities inherent in serving this population whether in the context of managed care or not.

- **Financial Constraints** — Financial pressures, particularly in the current environment of fiscal crises and budget deficits, have made it challenging for these systems to continue providing the levels of care that are deemed necessary for youth with serious disorders. In some cases, partner agencies reportedly are unable to maintain their level of financial participation in the system. A number of measures are being taken by systems to maintain their viability given impending or actual funding cut-backs, including reducing eligibility for care, tightening authorization procedures for higher-cost services, reducing length of stay, lowering provider reimbursement rates, and reducing services to uninsured youth, and others. Increased judiciousness in decisions about providing multiple services and increased cost consciousness have resulted from the current economic pressures.
- **Pressure to Control Length of Stay or Limit Services** — Some of the systems have experienced pressure from referral sources to move children out of services after a particular length of time or to decrease length of stay in general. Internal pressures to control length of stay may also exist. These pressures are felt for individual service components, such as inpatient care, and for overall involvement in care. Most of these systems do not have arbitrary limits on care; however, there appears to be an implicit understanding that the goal is to move children out of

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intensive services as quickly as possible both for financial reasons and in order to be able to serve additional children. While such incentives for shorter-term care are associated with managed care, such pressures may create complications when serving youngsters with serious disorders and their families who may require long-term services and supports in order to maintain their progress and stability. Negotiating issues around length of service delivery and the frequent need for long-term care for youth with serious disorders constitutes a formidable challenge.

- **Conflicts of Control, Philosophy, and Mission Across Systems** — Partnerships across child-serving systems are inherently complex and challenging. In these systems, the close partnerships may surface disagreements among agencies as to which agency is the final decision maker, differences in mission and philosophy and lack of understanding of these differences, discrepancies in opinion about what constitutes appropriate care for a child and family, and concerns about the cost of specialized services for these high-need youth. A common example is the frequent difference of opinion between child welfare and mental health staff as to what constitutes active treatment and what constitutes a home/family substitute. The roots of many of these conflicts are in the different ideologies and missions of the systems. “Culture clash” among systems, while not unique to these managed care systems, is the source of continual challenges.
- **Insufficient Service Capacity** — Despite the broad array of services offered through these approaches, most systems reported insufficient service capacity to meet the need. Some systems reported wait lists for services including day treatment, intensive outpatient services, and behavioral aides. In addition, insufficient resources for service capacity development, including start-up capital for new services, is a challenge shared among them. In some cases, even if the managed care system generates savings in children’s mental health services, there is no requirement that these resources be reinvested back into the children’s mental health system. Some systems have looked to grant funding (as from the Comprehensive Community Mental Health for Children and Their Families Program) as a way to further develop services. Thus, systems reported that chronic underfunding and a lack of new resources prevent the development of services to increase capacity. Even with the creation of individualized service plans, some services may simply not be available to children and their families.
- **Ongoing Education, Information, and Training for Stakeholders** — Educating stakeholders in a number of critical areas is a continual challenge for these systems. Stakeholders need to have a basic understanding of managed care concepts, as well as an understanding of how the system operates, how to access care for youth with serious disorders, and what to expect. In addition, education and training is needed about the approach to care used in many of these systems for youth with serious disorders (i.e., an individualized/wraparound approach, family focus, community-based services and supports, etc.). This challenge is complicated by the staff turnover that plagues many child-serving systems, especially among front-line workers. For families, information is needed on what services are available, what they are entitled to, and how to access care.

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- **Family Involvement Across Systems** — Although these promising approaches share a commitment to family involvement, this value is not always shared among front line staff or among partner agencies and systems. Respecting families as experts on their children, enlisting them as partners in their child’s care, supporting them in their caregiver role, and involving them as partners in decision making at the system level are goals that have not been fully achieved in any of the systems. Handling resistance to family involvement and encouraging staff and partner agencies to understand and adopt this value requires attention and persistence.
  - **Convincing Stakeholders that the Approach is Cost-Effective** — A challenge for these systems has been to use data and accountability approaches to substantiate the cost-effectiveness of the service approaches used for youth with serious disorders and their families. Some systems have sought to document cost avoidance in other systems by providing services and supports in the managed care system.
  - **Complaints About Service Authorization Process** — Many managed care systems have experienced complaints about requirements to obtain prior authorization for services and re-authorization for continued care. The authorization requirements and process sets up a dynamic in which providers may feel that their clinical judgment is being questioned, that they have lost their autonomy in providing care, and that they are being micromanaged. Disagreements about what care is appropriate may arise between those providing services and those reviewing and authorizing care. Additionally, some have charged that the authorization processes themselves can be time consuming, cumbersome, and inconsistent and that they significantly increase administrative burden and expense. These systems are challenged by the need to balance the use of managed care technologies to ensure that service utilization is appropriate (and within the system’s established medical necessity and level of care guidelines), with the administrative burden and complaints these processes may generate in the provider community.
  - **Streamlining the Functioning of Service Planning Teams** — Some systems have found that individualized service planning teams may become too large, that meetings may take too long, and that it may be difficult to reach consensus among stakeholders as to the priority issues to be addressed and the appropriate service plan. More explicit and defined guidelines for these teams, streamlining team membership, and mediation training for service coordinators are among the strategies that systems have taken to address this challenge.
  - **Caseload Size** — Service coordinators in some systems are burdened with caseloads that preclude them from devoting as much time or attention to an individual youth or family as may be warranted. Large caseloads impede proactive work with families and the development of the desired level of intensity in the relationship with the child and family. Some of the systems have suggested that a caseload of 8 to 10 is the optimal size for a service coordinator/care manager when serving youth with serious and complex disorders. If caseloads are too large, the work of care coordinators is limited to crisis intervention and individualized care is compromised.

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- **Lack of Expertise to Meet Specialized Service Needs** — Some of the systems reported that their provider networks do not include clinicians skilled to meet specialized needs. Special expertise is needed to work with young children and their families, sex offenders, youth with co-occurring mental health and substance abuse disorders, youth with co-occurring emotional disorders and developmental disabilities, youth with attachment disorders, eating disorders, and more.

## Conclusion

In considering the characteristics shared by the various promising approaches to serving youth with serious disorders, it is clear that they all represent elements inherent in the system of care philosophy. A broad array of services, individualized care, flexible services, family involvement, service coordination, and interagency collaboration are among the key tenets of the system of care philosophy, first espoused in 1986 as a value base to guide service delivery for youngsters with serious emotional disorders and their families.<sup>2</sup> Although not necessarily described in these terms, these managed care systems have incorporated these elements in response to the needs and characteristics of this difficult-to-serve population.

Despite incorporating specific features and approaches to serve youth with serious disorders, all of the managed care systems experience problems, constraints, and challenges, including resource constraints, service gaps, insufficient service capacity, and interagency disagreements. The perennial struggle in managed care systems of achieving an appropriate balance between “managing care” and “managing costs” is particularly acute with respect to serving this high-need, high-utilizer population that often constitutes the most significant expenditures for behavioral health care.

In response to queries about what changes would be made in the approach or feature if it were possible, it is apparent that system managers, while proud of what they have accomplished, recognize much room for improvement. Some of the desired changes include the following:

- Make specialized services/approaches available to a wider population of children, those at risk in addition to those already meeting the criteria for a serious disorder
- Invest in increasing service capacity, including filling service gaps and increasing “slots” in existing services
- Incorporate greater flexibility with regard to the duration of services
- Provide “booster” sessions or follow-up care for a period of time following intensive service delivery
- Upgrade service coordinator staff and work to reduce turnover and increase retention
- Reduce caseload size of service coordinators
- Increase initial and ongoing training for service coordinators
- Increase information and education about the system to other child-serving agencies
- Increase efforts to collaborate with other child-serving agencies at the system level
- Increase the input of clinicians in clinical decision making and authorization processes

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<sup>2</sup> Stroul, B. and Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. (rev ed). Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

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- Increase communication with providers, implement better methods to obtain provider input and to involve providers in a partnership for problem solving
  - Offer more training to providers on values, philosophy, service approaches
  - Incorporate more specialized services in provider networks
  - Increase family involvement at the system level
  - Increase family involvement in decision making in all phases of service delivery