

Guiding Principals for an Integrated Health Home for Children with Serious Emotional Disturbance

A System of Care Approach for Iowa

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Background

Childhood mental, emotional and behavioral disorders are the most costly and prevalent of all childhood illnesses. About 20% of children are estimated to have mental disorders with at least mild functional impairment. It is estimated that approximately 5-9% of children ages 9-17 have a serious emotional disturbance (SED). The National Research Council, Institute of Medicine (2009) estimated the financial costs of childhood behavioral disorders at \$247 billion; and the non-financial costs related to distress, life disruptions, lost productivity, burden on education, social and health care systems, and suicide are immeasurable.

Children with chronic medical conditions have more than two times the likelihood of having a mental health disorder. Conversely, we would expect that children with behavioral disorders are at greater risk of developing chronic medical conditions. It is well known that adults with serious mental illness have higher rates of physical health disorders than the general population. The prevalence of disorders such as obesity, cardiovascular disease, diabetes, asthma and other pulmonary disease are higher in persons with a serious mental illness. This is particularly true for persons with co-occurring mental illness and substance use disorders.

How is SED Defined?

"*Serious emotional disturbance*" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance. (From: Iowa Children's MH Waiver definition – Iowa Administrative Rules Chapter 83.)

Goals of an Integrated Health Home for Children

Magellan of Iowa is thoughtfully exploring the best approach for meeting the prevention and intervention needs of children and youth with Serious Emotional Disturbance (SED) and their families where they live, learn, play and work. Our initial focus is in four primary areas:

1. Integrate prevention and intervention in both the behavioral health and physical health systems

2. Ensure our model embraces and exemplifies the values and philosophy of systems of care, public health approaches and health homes
3. Craft a model that builds on Iowa's strengths and infrastructure
4. Establish a model that is sustainable over time

To meet these goals, we are building on the framework from Systems of Care, Health Homes as described in the Affordable Care Act of 2009, and a Public Health framework.

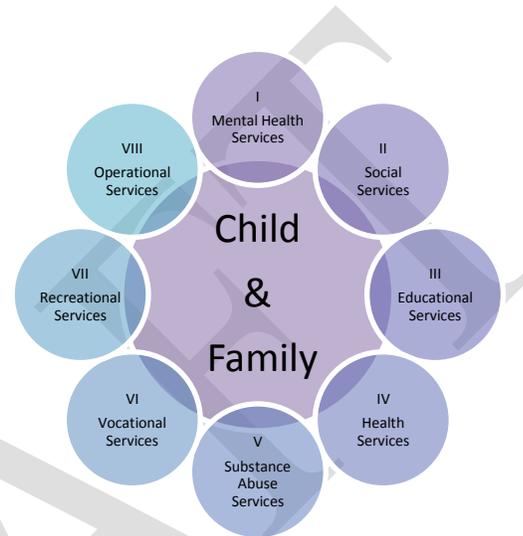
System of Care Framework¹

A SYSTEM OF CARE IS “a broad, flexible array of effective services and supports for a defined population(s) that is organized into a coordinated network; integrates services/supports planning, service coordination and management across multiple levels; is culturally and linguistically competent; builds meaningful partnerships with families and youth at service delivery, management and policy levels; and has supportive management and policy infrastructure.”

A SYSTEM OF CARE INCORPORATES a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels.

THE CORE VALUES of the system of care philosophy are that services should be community based, child centered and family focused and culturally and linguistically competent. The guiding principles specify that services should be:

- Comprehensive,
- Individualized,
- Provided in the least restrictive, appropriate setting,
- Coordinated both at the system and



Core Values²

- The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
- The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is

¹ Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev.ed.) Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

² *ibid*

clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult services system as they reach maturity.
9. The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics and services should be sensitive and responsive to cultural differences and special needs.

Health Homes (Affordable Care Act of 2009)

The Affordable Care Act of 2009 gives States the option to provide health homes for Medicaid enrollees with a serious mental illness or those with two or more other chronic health conditions, including mental health condition, substance use disorder, asthma, diabetes, heart disease and being overweight (BMI >25). Health homes are defined as “a designated provider or a health team, selected by an eligible individual with chronic conditions to provide health home services”. The goals of the health home are to:

- Lower rates of emergency room use
- Reduction in hospital admissions and readmissions
- Reduction in health care costs
- Less reliance on long-term care facilities
- Improved experience of care
- Improved quality of care outcomes

Public Health Framework

The public health approach builds on the existing public health and mental health care systems and promotes integration with other systems and structure that impact children. This integration of systems and structures is guided by a common understanding and language, values, guiding principles and purpose.

More specifically, the public health framework calls for:

- The children’s mental health care system to incorporate public health concepts in its approach to children’s mental health
- The public health system to place a greater emphasis on children’s mental health
- Other child-serving systems and sectors to work as partners in a comprehensive and coordinated children’s mental health system.

The guiding vision for this effort is that communities, as well as society at large will:

- Work to positively shape and strengthen children’s physical, social, cultural, political and economic environments in ways that promote optimal mental health and help prevent mental health problems
- Provide a full continuum of services and supports, from promoting mental health and preventing problems to treating problems and reclaiming mental health, which help all children manage environmental, social and emotional challenges, thrive and be contributing members of society.³

These approaches have many commonalities which form the basis for the proposed Integrated Health Home for children with SED that follows.

Magellan’s Integrated Health Homes (IHH) for Children with Serious Emotional Disturbance

The proposed Integrated Health Home model for children with SED is a combination of and consistent with the Systems of Care approach, the health home model and the public health framework – their core values and guiding principles. Health homes are:

- Family-centered: families and youth play a central role in care coordination and share responsibility in decision making
- Coordinated: care among multiple providers is coordinated through the health home
- Continuous: the same providers are available to the child and family throughout childhood and adolescence and assist with transition to adulthood
- Accessible: children and their families have access to an array of preventive, acute and chronic care services
- Comprehensive: the service array addresses all behavioral and physical health needs
- Child related systems are involved in the health home including: behavioral health services, physical health services, education, child welfare, juvenile justice
- Compassionate: providers get to know the child and family, their culture and their needs
- Culturally effective: providers are responsive to the cultural, racial and ethnic differences of the populations they serve.⁴

³ Miles, J., Espiritu, R.C., Horen, N., Sebian, J. & Waetzig, E. (2010). *A Public Health Approach to Children’s Mental Health: A Conceptual Framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

⁴ Foy, J.M. & Earls, M. (2011). Linking and Integrating with Primary Care: The Medical Home Model for Children’s Mental Health. American Academy of Pediatrics.

The Integrated Health Home is a framework in which providers form a collaborative partnership and the child and their caregivers are fully participating members of the treatment team. Incorporated into this partnership model is an emphasis on peer coaching, wellness and a strengths-based approach. Treatment is customized to the individual, based on their unique combination of physical and behavioral health conditions, and utilizes evidence-based approaches.

Key components are:

1. **Behavioral health providers serve as the health home for children and youth with SED.**
The behavioral health provider is responsible for coordinating services among all providers and supports that are engaged with the child and his/her family as well as accessing needed services and supports that are not currently engaged. The behavioral health provider works with other providers to develop an integrated service plan, monitor progress toward goals and amend strategies as necessary.
2. **Health homes are staffed by provider-based health coordinators and family support/peer specialists.** The provider-based health coordinators are the key points of contact for children and their families and assist them in navigating the system and accessing needed services and supports. Health coordinators coach parents and other caregivers to become better care coordinators for their children and they are assisted by parent peer supporters who have children with similar challenges. Especially in rural areas, telehealth technology will be used to give both physical and behavioral health clinicians access to pediatric specialists.

Expected Quality Outcomes:

- Reduce inappropriate use of emergency rooms and urgent care
- Reduce preventable hospitalizations
- Increase community tenure and reduce hospital readmissions
- Improve health status indicators
- Improve functional status
- Improve experience with care

Standards:

Overview

- Each member with a Serious Emotional Disturbance (SED) has an ongoing therapeutic relationship with a personal provider responsible for linking them with the primary care, wellness, prevention, behavioral health, and social/community support. Care should be member and family centered, quality-driven, cost-effective, and culturally competent.
- Each member will have a person-centered coordination plan that coordinates and integrates all of the member's health care and other needs. The Integrated Health Home provider is responsible for coordinating and assuring all of the member's health care, basic needs and taking responsibility for arranging care with other professionals and other systems.

- Children and youth will be automatically linked to an integrated health home, based on their past service and geographic profile. Parents or caregivers of enrolled child and youth will have the ability to decline to participate, or opt-out, at their discretion and choice.

1) Family engagement and support, and community resources

- Family support and engagement, using a strengths-based approach, is the foundation of this model. All families receive services from family support specialists that promote empowerment and self-advocacy including how to talk with their primary care and behavioral health teams to make their needs known
- Ask parent/caregiver to complete release of information document for sharing information across providers.
- Care and coordination delivered is culturally and linguistically competent
- Provide parents/caregivers and older youth with self-management tools and education aimed at helping the member identify and achieve their health and wellness goals including opportunities offered by health advocacy groups.
- Leverage web-based health education and wellness planning tools (e.g. American Diabetes Association's MyFoodAdvisor tool)
- Offer Parent support partners to provider parents and caregivers with support around wellness (healthy eating, stress management, etc) as well as empathy and coping skills for parenting children/youth with behavioral or emotional disturbances.
- Support members/parents/caregivers with accessing a wide range of community resources and maximizing coordination with community-based service providers. Examples include health education resources, classes taught by qualified instructors, support groups, transportation, school services and other social services

2) Behavioral Health Care

- Child and family teams will provide care in accordance with the Systems of Care approach described above, with the needs of the child and family guiding the types and mix of services provided. A wrap-around model of care forms the foundation of this approach. The family/caregiver is invited to the planning meeting, along with others involved in the child's care. At the planning meeting, the entire team discusses the child's strengths, beliefs, and traditions and brainstorms ways to get support from friends and family members. The team then puts together a plan of care, including services and supports that help build on the child's strengths and abilities and leverages natural and community supports. At subsequent meetings, the child's successes are celebrated and the plan is subsequently revised when the family's needs change or if the current plan is not working. Overall, the child and family team process consists of 1) engagement and team preparation, 2) initial planning, 3) implementation, and 4) transition. The quality of the child and family team process will be assessed using the Wraparound Fidelity Index developed by the University of Washington,

which measures the 10 principles of the wraparound process, with 4 items dedicated to each principle.

3) Recognition/Certification

- Follow state-endorsed standards as they develop, and/or national standards for health homes, including CARF and JCAHO
- Meet the requirements of an IHH as established by Magellan.

4) Increased access to care

- Assesses if the member has a primary care clinician, and if not, link the member to a primary care clinician
- Provide for 24/7 access to the care team to avoid unnecessary emergency room visits and hospitalizations, e.g. having a practitioner on call for emergencies.
- Standards in place for appointment reminders and follow-up strategies for individuals who miss their appointment
- Expand uses of telemedicine
- Encourage use of email, text messaging, or other technology as available to communicate with members/parents/caregivers.
- Make language services available for members/parents/caregivers with limited English proficiency.

5) Prevention and Gaps in Care

- Prior to starting the child and family team planning process, the Parent/caregiver completes health risk screening to assess health and wellness needs, including physical activity, nutrition, immunizations, lead screening, well-care visits, medication follow-up, body mass index, alcohol/tobacco/drug prevention, teen pregnancy prevention, sleeping patterns, and dental care.
- Care coordinator identifies any gaps in care based on analysis of past medical and behavioral claims history.
- Care coordinator communicates results of health risks screening with primary care team.
- Based on results of health risk screening and gaps in care analysis, care coordinator shares this feedback during the child and family team planning process. A coordination plan is then incorporated in the child and family plan, with the care coordinator helping the family with arranging follow up visits, appointments with the primary care provider, linkages to community-based health and wellness resources, etc.

6) Whole Person Orientation - Provision of basic physical health services to include prevention, early intervention and health promotion and evidence-based practices

- Develop memo of understanding with primary care clinics to ensure primary care needs of youth/adolescents are effectively met. Determine collaborative arrangements to offer families teaching on self-management tools on topics such as diabetes, asthma, and other chronic health conditions. Ensure a comprehensive physical and medication review at time of enrollment and ensure routine screenings are completed.
- Develop and establish collaborative agreements with community agencies to offer families a range of support services including healthy eating (shopping, meal planning, simple recipes, etc.), exercise, tobacco prevention and cessation, developing resiliency factors for substance abuse prevention, support and prevention of on-line or other types of bullying, yoga, salsa and other dance, pain management, and appropriate use of medication, active lifestyle, tailored to each family's strengths and needs.
- Develop and establish collaborative agreements and relationships with providers with expertise in oral health

7) Coordinated/Integrated Care - Enhanced coordination

- The provider shall designate specific staff with responsibilities for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, appointment reminders, community services, dental care, wellness services, and assisting with transitions of care.
- Track the following:
 - Results of health risk assessment
 - Tracking and coordination of screenings and Preventive services
 - Tracking and coordination of wellness and community support services
 - Tracking and coordination of dental care services
 - Referrals to specialists, including clinical details, administrative details, and tracking status
 - Resiliency services and social health services available in the community
 - Follow up visits needed
 - Systems in place to proactively receive information about hospital admissions or members receiving care in other facilities
 - Aftercare coordination and follow up for those with hospital admissions
 - Joint rounds as needed between providers

8) Pharmacy management

Pharmacy management that includes:

- Commitment to evidence-based prescribing / management of medication adherence

- Specific attention paid to physical health sequelae to use of psychotropic medications
- Coordination with physical health prescribers
- Interventions with providers regarding polypharmacy
- Interventions with members/parents/caregivers regarding missed medication refills

9) **Quality, outcomes and accountability**

- Use of Consumer Health Inventory - Children or other established instrument which includes both behavioral and physical health functional status measures
- Regularly provide data on selected outcomes measures. These will include clinical outcomes, experience of care outcomes, and quality of care outcomes.
- The integrated health home has systems in place to identify the provider's most frequently seen diagnoses, most important risk factors in the member population, and physical health conditions that are clinically important in the member population.
- Participate in learning collaborative process with other integrated health care providers focused on quality improvement efforts