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ISSUE BRIEF #2

System Integration Across Child Welfare, Behavioral Health, and Medicaid

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OCTOBER 2022

Overview

Children and families involved in the behavioral health and child welfare systems are often the most vulnerable and in need of the most support, but fragmented systems of care across child welfare, behavioral health, and Medicaid often lead to families "falling through the cracks." This in turns leads to increased use of high-cost services that separate families and poorer outcomes and perpetuates and exacerbates trauma to children and families. It's also exposed states and local jurisdictions to class action lawsuits.

Current State

For children and adolescents who are experiencing a behavioral/mental health emergency (e.g., serious emotional disturbances, suicidal ideation/attempts, homicidal ideation/attempts, psychosis, aggression, high risk substance use, etc.), there are often frequent trips to the emergency department (ED), incidences of psychiatric boarding in the ED, or indefinite stays in inpatient hospitals or residential treatment centers (RTCs). Oftentimes extended stays in hospitals or RTCs can be due to social placement reasons, and this can compound the trauma they experience. Studies have shown that recurring exposure to stressful or traumatic events that children experience before the age of 18 can have long- term impacts known as Adverse Childhood Experiences, or ACEs.[1] If toxic stress is not properly addressed and reduced, it can lead to long-term behavior issues, health complications, and diseases that are caused by ACEs.[2] Read our case scenario.

Legal Ramifications for the Child Welfare System

Consent decrees for child welfare systems are a type of class-action lawsuit that is resolved through a judge's order based on an agreement between the parties, rather than continuing the case through trial or hearings. A consent decree gives a judge ongoing supervisory power to enforce the decree that details the various requirements and standards with which the state child welfare agency, under the jurisdiction of the court, must comply.[3] These orders focus on the improvement of safety, permanency and well-being of children served by states.

A child welfare consent decree only places the burden on the child welfare agency when in fact it is the failure of a collaborative approach that creates the vulnerability. Until we build behavioral health competencies within child welfare leading to parallel systems to Medicaid and state behavioral health and often exposing the fault lines across Medicaid, behavioral health, and child welfare we will fail to mitigate the underlying causes of poor outcomes for children. However, without visionary leadership across all three, siloed approaches do not lead to solutions mitigating the underlying causes of poor outcomes for children.

[1] Shonkoff, J. P. & Garner, A.S. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics: Official Journal of the American Academy of Pediatrics*, 129(1), e232–e246.
[2] What are ACEs? | Joining Forces For Children
[3] Child Welfare Consent Decrees - Casey Family Programs

Where We Need to Go

Effectively meeting the needs of these children and youth requires a collaborative approach across multiple systems, including child welfare, behavioral health, and Medicaid. Key elements of a cross-sector approach designed to improve clinical outcomes for children/youth and their families must include:

- Building strong crisis response and stabilization models
- A full array of community-based interventions
- Well-resourced system of care that is agnostic to system entry

Designing an approach that incorporates all these elements is critical to supporting shared goals of safety, health, well-being, and the educational and lifelong workforce

Now is the Time

There are several factors creating unprecedented opportunities to integrate the system of care; new models of reimbursement in Medicaid and new models of child welfare service delivery resulting from the Families First Prevention and Services Act (FFPSA) have created new opportunities. Across the country, states are carving children's behavioral health into managed care Medicaid. Originally, the idea of integrated care emerged as a cost containment strategy. However, over time it has generated a focus on how to design treatment models for children and youth who have experienced abuse and/or neglect and sustained trauma. Often poverty as a root cause combined with stress on families, a paucity of services, failure to provide caregivers with respite, lack of parent education and supportive resources, and under-reporting of behavioral health needs leads to poor child rearing outcomes.

A focus has also been on those who are at increased risk of abuse and/or neglect due to high acuity behavioral health needs. The field of child welfare has pivoted to a more prevention-oriented practice, with whole family approaches that include preventing youth exposure to toxic stress through providing safe and nurturing environments, helping children cope with adversity, and building resilience to reduce ACEs exposure.[4] These components are critical to reduce the risk of youth entering foster care and to limit reliance on congregate care for children in foster care that will become the norm to satisfy the spirit of FFPSA.

Additionally, as more states seek to implement certified community behavioral health centers (CCBHCs) there are new opportunities to provide integrated care, be reimbursed for previously unfunded services, and shore up the outpatient system to support children and families to prevent entry into the child welfare or residential behavioral health systems.

This paper outlines design elements where integrated and collaborative policymaking, practice models, and financing strategies can lead to a stronger system of care supporting the most vulnerable children and their families building sustainable approaches to achieve the goals of FFPSA and mitigating risk for states.

[4] Shonkoff, J. P. & Garner, A.S. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics: Official Journal of the American Academy of Pediatrics*, 129(1), e232–e246.

The state of New Jersey, for example, is a model state for the integration of child welfare, behavioral health, and Medicaid with a twenty-year history of evolving to its current state of responsiveness. The early evolution of New Jersey's integrated system was also greatly impacted by the court mandated changes in the state's child welfare system and the support and direction of Governor Whitman that established the Children's System of Care (CSOC).[5] This reform set out to create a comprehensive and integrated system of care for maintaining and delivering effect clinical care and support to NJ families and their children. Implementation of the CSOC began and 2001 and was statewide by 2006.[6] Today, NJ's CSOC provides comprehensive services to families including crisis mobile crisis response, treatment that incorporates trauma informed care and care management services for individuals and families. Since the inception of the NJ's CSOC, there has been a significant drop in out of home place and out of state placements, a decrease in children and adolescents' utilization of EDs due to mobile crisis response and increased engagement in outpatient treatment.

To have a high-functioning integrated system of care for children, youth, and their families, child welfare, Medicaid, and behavioral health systems need to focus on the following 4 core design elements:

Improving Service Delivery

- An integrated and interoperable system ensures a whole family approach to addressing the complex needs of children, youth, and their families
- Interoperating systems should provide a truly integrated "no wrong door" approach to service access and service delivery across the public and private systems of care.
- Interoperating systems can run the risk of violating privacy and confidentiality, which should be assessed, addressed, and the risk mitigated.
- The measurement plan should address service delivery as one cluster of indicators and will include process measures of delivery, along with client satisfaction, as an outcome.

Reducing Access Barriers for Eligible Beneficiaries

The availability of an integrated eligibility platform that integrates across 40 plus programs that have eligibility requirements will greatly enhance program integration – with reuse of data, real-time eligibility across multiple programs and services, and improved access in the community using an assisted methodology that involves community-based organizations.

- Success of this integration should be evaluated regularly.
- Monitor data reflecting reductions in redundancies and cycling in and out of care.

[5] DCF | Children's System of Care (nj.gov)
[6] REQUEST FOR PROPOSALS FOR New Jersey Task Force on Child Abuse and Neglect OJJDP FY10 Byrne Congressionally Mandated Earmark Programs (nj.gov)

Improving Payment Accuracy

Mature data capabilities should be able to detect discrepancies about a specific client across the enterprise, so payment accuracy will reduce costs and raise the cost-benefit of interoperability.

- It is also intended to provide greater transparency, leading to increased accountability and higher performance within organizations.
- Measurement plans should focus on routine audits to ensure accuracy and timeliness of payments
- Monitoring of provider outcomes and supporting goals of performance-based contracting

Improving Administrative Efficiency

- A generative integrated delivery system with a nimble and responsive technology system should reduce points of redundancies and improve efficiencies.
- The measurement plan should focus on administrative efficiency as a key component of cost-benefit.

STRATEGIES AND KEY PERFORMANCE INDICATORS

Once these design elements are in place, the system needs to track several key performance indicators (KPIs) such as the ones listed below. These KPIs will measured through specific metrics and more. For the KPIs to have maximum impact they will need to be monetized to determine the value and savings from an integrated and well-functioning system and a roadmap for shared savings and reinvestments to continue to strengthen a resilient integrated child-serving system that ensures safety, well-being, and permanency for all children in the state:

- Decrease service duplication
- Early Intervention
- Reduce costly ED visits and hospital admissions
- Reduce child welfare entries for neglect due to parent inability to access needed services
- Reduce the need for long-term high-cost residential/congregate placements
- Improve educational outcomes

Strategies for Improving Service Delivery

- Expand access to school-based mental health – school-based wellness centers, community schools, etc.
- Support community-based organizations in integrating and linking public-private child-serving systems.

- Youth suicide prevention and intervention and school-based mental health access expansion (e.g., school-based dialectical behavioral therapy).
- LGBTQIA+ youth mental health models and integration of youth peer services.
- New models for crisis intervention, trauma treatment prevention and innovative and responsive foster care models of care, especially for provider networks and managed care as well as for the delivery of infant and early childhood mental health services.
- Address social drivers of health within the behavioral health system of care.
- As states implement the CCBHC model, consider all systems serving children and families that need to be integrated.

Strategies for Reducing Access Barriers for Eligible Beneficiaries

- Support early intervention, wellness services models that are cross sectoral.
- Address the challenges of hospital overstays for children and youth and support their families and their interactions with public systems.
- Systems integration across child welfare, juvenile justice, Medicaid, children's behavioral health, courts, education, public safety and offer these services across both state and county systems.
- Implement a single point of entry to access all services for behavioral health for children in need including for those children and youth involved in the child welfare system.

Strategies for Improving Payment Accuracy

- Support the development and sustainability approaches for systems of care and service using multiple fund sources, including Medicaid and CHIP, SAMHSA funding, others, peer support services, children's behavioral health.
- As states implement the CCBHC model, including the prospective payment system (PPS) rate, consider all social drivers and additional services that will incent and support whole-person care.
- Develop creative financing models that will leverage cross system funds to serve cross system children, youth and their families.

Strategies for Improving Administrative Efficiency

States must address the challenges of hospital overstays for children and youth and support their families and their interactions with public systems.

- Support community-based organizations in integrating and linking public-private child serving systems.

Conclusion

Our children and families deserve better from the public agencies that are established with taxpayer dollars to keep children safe and to meet their needs for permanency and wellbeing. A well-functioning system that supports the needs of multi-system children, youth, and their families should be the norm and not the exception. Best practices should be replicable, and the safety net should be resilient and well-resourced. The integration across systems will significantly improve the opportunity for improved outcomes for children, youth, and their families and greater efficiencies within the operating departments. Using a collaborative, inclusive and equity-driven approach, HMA has supported providers and systems in making these critical changes through technical assistance and consultation.

Case Scenario

Damion Taylor is a 14-year-old African American youth diagnosed with autism living with his grandmother since his mother passed away from a drug overdose when he was 8 years old. His father has never been involved in his life. Still growing, he is 5' 11" tall and weighs over 200lbs. His grandmother is 68 years old and lives on a section 8 voucher. She has diabetes and hypertension and is generally in poor health. Her adult son and his two younger children recently moved in when he lost his job and his home. This transition has been hard on Damion as any change is upsetting to him. He has become aggressive towards the younger children of his uncle and is increasingly difficult to handle. On two separate occasions, police officers had to be called to the home when his behaviors escalated to the point where his grandmother could not calm him down. In one instance police and EMS arrived and he was taken to the emergency department in 4-point restraints in an ambulance. This experience has been traumatizing for Damion and his family and created a fear of police and EMS.

Damion has an IEP at his school, and with virtual learning due to COVID 19, has not been doing well. With all the changes in his life, his guidance counselor at school has reached out to child welfare as he believes that Damion's grandmother is very stressed and is not able to meet his needs. His uncle is protective of his children and generally, the home environment is not helping Damion. The uncle believes that Damion needs additional support in the home, but the waitlists for such support are significant (6 months or more), or to be moved into a more structured residential setting (which also has a significant waitlist). His grandmother is a little frightened of Damion but loves him deeply and wants what is best for him.