Innovations in Children's Behavioral Health:
Tiered Care Coordination Expert Convening

Meeting Summary

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Background

Care coordination is a component of service delivery that has experienced tremendous growth and adaptation in recent years, driven in part by the Patient Protection and Affordable Care Act of 2010 (ACA) and supported by large-scale initiatives from Centers for Medicare and Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and other federal and private partners. Definitions of care coordination vary across implementation settings, and after review of almost forty unique characterizations of care coordination, the Agency for Health Care Research and Quality settled on the following description:

> "*Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.*"[1]

Care coordination is viewed as especially critical for populations with chronic health conditions, co-morbid health and behavioral health issues, and for children who are involved with multiple service systems, such as child welfare and behavioral health. In children's behavioral health, care coordination is typically a flexible and responsive way of bringing together resources with and for a child, youth and family in an effort to streamline care across multiple providers and payers, not only for children with complex behavioral health challenges but for those with less intensive needs as well. The capacity of care coordination to create a linkage between primary care and behavioral health providers is important regardless of severity of behavioral health issues. With health reform, new and exciting challenges have arisen in states and communities moving forward with design and implementation of best practices for populations with diverse needs, including building an effective continuum of tiered care coordination that is responsive to populations based on their intensity or complexity.

Care coordination activities are built into service arrays across a variety of systems, including physical health, behavioral health, and intellectual/developmental disability, as well as in child welfare and juvenile justice systems. The approach to care coordination can vary greatly depending upon the population of focus, financing and payment, staffing structure, and desired clinical and functional outcomes, among other factors. Health and behavioral health platforms for care coordination that have garnered attention in recent years include health homes, patient centered medical homes (PCMH), managed care organization (MCO) care coordination, accountable care organizations (ACO), care management entities (CME), and certified community behavioral health centers (CCBHC).

> A CARE MANAGEMENT ENTITY (CME) IS AN ORGANIZATIONAL ENTITY THAT SERVES AS A CENTRALIZED ACCOUNTABLE HUB TO COORDINATE ALL CARE FOR YOUTH WITH COMPLEX BEHAVIORAL HEALTH CHALLENGES WHO ARE INVOLVED IN MULTIPLE SYSTEMS, AND THEIR FAMILIES. A CME PROVIDES: (1) A YOUTH GUIDED AND FAMILY-FAMILY DRIVEN, STRENGTHS-BASED APPROACH THAT IS COORDINATED ACROSS AGENCIES AND PROVIDERS; (2) INTENSIVE CARE COORDINATION USING FIDELITY WRAPAROUND; (3) ACCESS TO HOME- AND COMMUNITY-BASED SERVICES AND PEER SUPPORTS AS ALTERNATIVES TO COSTLY RESIDENTIAL AND HOSPITAL CARE FOR CHILDREN AND ADOLESCENTS WITH SEVERE BEHAVIORAL HEALTH CHALLENGES.
>
> (CENTER FOR HEALTH CARE STRATEGIES, 2011)

In May 2013, CMS and SAMHSA issued a federal bulletin on behavioral health services for children, youth, and young adults with significant mental health conditions. The bulletin sought to help states design a Medicaid benefit for this population that incorporates seven key services and supports—one of which is intensive care coordination (ICC) using the Wraparound

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[1] Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies: Volume 7—Care Coordination. <u>Technical Review</u> (Publication No. 04(07)-0051-7).

approach. The CMS/SAMHSA bulletin specifically references Wraparound as an effective approach to ICC for children with significant mental health conditions.

With the exception of specialty care management entities and other fidelity Wraparound approaches, the design, delivery, and research related to care coordination models is often driven by the needs of an adult population with chronic co-morbid physical health conditions, and it is critically important to factor in the different and special needs of a child and youth population prior to implementation[2] [3]. There has not been a systematic attempt to study the differing approaches and delineate the levels of care within a tiered care coordination approach across children and youth with varying behavioral health needs. States and communities are currently looking for ways to customize delivery platforms and financing strategies to meet the specialized needs of children and youth with behavioral health issues across varying levels of clinical need. In an effort to improve health outcomes, manage costs, and ensure quality care, states are considering how to ensure that children and youth with behavioral health issues receive care coordination that is tailored to intensity or complexity of need. As Medicaid behavioral health care is increasingly organized within a capitated managed care arrangement, states are trying to determine the tiers of care coordination for children, youth and young adults that are optimally provided by the MCO by providers of individual services, by PCMH and health homes, or by specialty ICC approaches, such as care management entities or other arrangements using a fidelity Wraparound process.

WHAT IS WRAPAROUND?

Wraparound is not a service, but rather a structured approach to service planning and care coordination for individuals with complex needs (most often children, youth, and their families) that is built on key system of care values (e.g., family- and youth-driven, team-based, collaborative, individualized and outcomes-based) and adheres to specified procedures (e.g., engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress).[1]

The Wraparound process can be employed in conjunction with intensive care coordination to holistically address behavioral and social needs. The Wraparound approach to intensive care coordination incorporates a dedicated full-time care coordinator working with small numbers of children and families. Families involved in intensive care coordination using Wraparound also have access to family and youth peer support services. Care coordinators engage youth and their families to develop an individualized child and family team that develops and monitors a strengths-based plan of care. Teams address youth and family needs and strengths across domains of physical and behavioral health, social services, and natural supports. In some states, intensive care coordination using Wraparound is provided through dedicated Care Management Entities, and in others, through Wraparound teams embedded in supportive organizations. Some states also are applying Wraparound principles to populations of children with less intensive needs, making adaptations in care coordination ratios, time spent in face-to-face meetings with youth and families, and the like.

Learn more from the National Wraparound Initiative: http://nwi.pdx.edu/wraparoundbasics.shtml

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As mentioned above, a body of research exists on care coordination, especially in healthcare settings focused on adult populations with complex co-morbidities. Some studies have been published on care coordination for children and youth with positive or mixed findings; however, the literature is limited to youth with highly complex needs or small cohorts of adolescents with specific clinical diagnosis[4] [5]. More research is needed to further identify effective designs across diverse youth populations. Little to no research has been found on tiered care coordination models – for example, comparative studies

[2] Bachman, S., Comeau, M., Jankonvsky, K. (2015). The Catalyst Center: Improving Coverage and Financing of Care for Children and Youth with Special Health Care Needs. Lucile Packard Foundation for Children's Health; Boston, MA.

[3] Pires, S. (2013). Customizing Health Homes for Children with Serious Behavioral Health Challenges. Human Service Collaborative; Washington, DC.

[4] Archer J., et al. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*. 10. Art. No.: CD006525. DOI:10.1002/14651858.CD006525.pub2.

[5] Burns, B., et al. (1996). A Randomized Trial of Case Management for Adolescents with Serious Emotional Disturbance. Journal of Clinical Child Psychology. 25 *(4)*.

across clinical levels of care or among two or more entities implementing one or more delivery approaches to look at effectiveness and outcomes.

In addition, there has not been an organized effort to collectively examine these various approaches and develop consensus on effective ways to ensure that children with behavioral health challenges receive the right amount and intensity of care coordination within the most effective arrangements. There is a need for continued innovation in care coordination approaches for this population.

Meeting Overview

In recognition of the need for an organized effort to further delineate concepts and best practice approaches to inform a tiered care coordination model for children, youth and young adults with behavioral health challenges, The National Technical Assistance Network for Children's Behavioral Health (TA Network) convened experts from state leadership, health plans, provider organizations, academia, family and youth-run organizations, and the federal government to discuss the emerging areas of tiered care coordination. The purpose of this meeting was two-fold: to establish what is currently known and agreed upon regarding tiered care coordination for children and youth; and to discover which approaches require more testing, review, and design focus for the field. The focus was on all children, youth and young adults with behavioral health challenges, not only on those with the most intensive or complex needs.

The expert panel examined quantitative data, gray literature, and emerging practice strategies, and formulated action steps, as described in the final section of this summary. Strategies were discussed not only to ensure that children receive the right amount and intensity of care coordination to match their needs, but to also ensure that systems are designing sustainable, high quality infrastructures that support effective care coordination. Deliberations and discussions were held in both small and large group forums, with the agenda focused on six priority areas: models of care coordination; care coordination locations; identification and stratification of populations; rate structures and payment approaches; workforce and implementation supports; and quality and outcome measures. (See Appendix B)
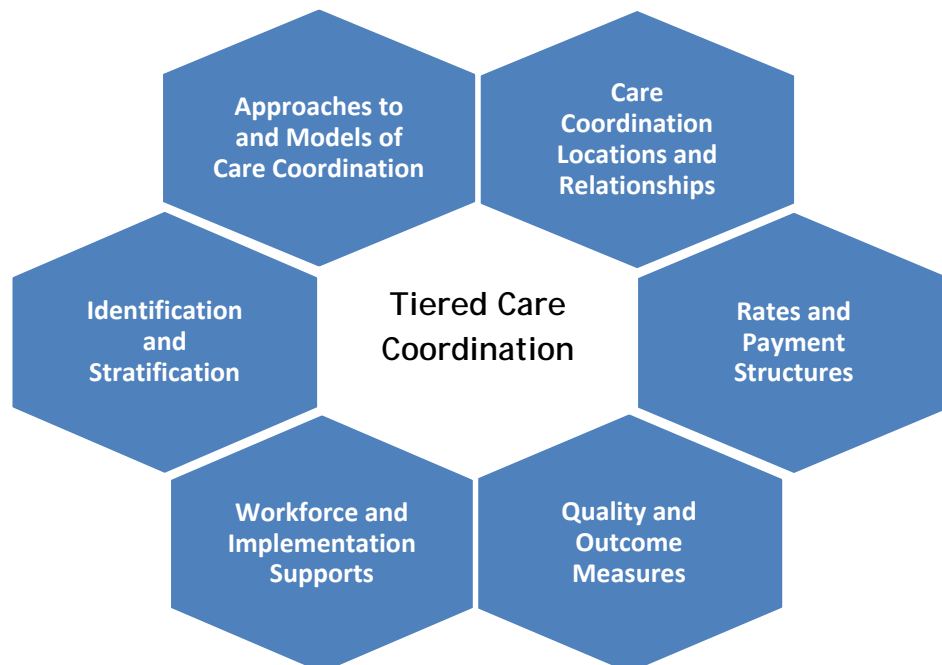
Meeting Summary

A summary of each discussion area is provided, along with key takeaways. The meeting discussion highlights are synthesized by main topic area and include points of agreement and areas for further exploration and research.

Approaches / Models of Care Coordination

This discussion identified various approaches and practices to coordinating care for children, youth and/or young adults with behavioral health challenges or subpopulations within this group. Similarities and differences in staffing ratios were considered across the identified approaches, including how staff to child/youth ratios might align with and impact the approach selected for the tiers of care coordination. Small group discussion resulted in suggested ways to delineate the number of tiers of care coordination in a continuum.

Overall, the experts agreed that Wraparound implemented with fidelity is an effective and evidence-supported model for care coordination for children and youth with intensive and/or complex behavioral health issues. The provision of ICC using a fidelity Wraparound process was the only defined practice model specifically identified by the group as effective for children and youth with the most serious behavioral health issues. It was posited that this model also may be beneficial to children and youth with more moderate behavioral health concerns who are at risk for deeper systems involvement in the absence of effectively coordinated care. However, there was interest in learning more about the evidence of effectiveness of high fidelity Wraparound (HFW) with this group of children and youth with a moderate level of clinical need. In general, the group was interested in further defining youth who may fall in a category of need that is more moderate and determining a model of care coordination that may be a good match and lead to positive outcomes. Some examples were shared by participants of initiatives and systems that have focused on this population of youth in the mid-range of need. For example, New Jersey employs a HFW approach for youth with both intensive and less intensive needs. It has adapted this approach as the basis for its approved Section 2703 health home for children with serious emotional disturbance and co-occurring chronic physical health conditions. Overall, however, the group identified a knowledge gap regarding which care coordination approaches may be most effective with children and youth with less intensive needs, and whether care coordination of lower intensity and higher caseloads can truly reflect the Wraparound principles and practice models as defined by the National Wraparound Initiative and studied in research.

Care Coordination approaches reviewed:

- ❖ Health Homes
- ❖ Accountable Care Organizations
- ❖ Patient-Centered Medical Homes
- ❖ Collaborative Care Management
- ❖ Population Care Management
- ❖ MCO Care Coordination
- ❖ First Episode Psychosis
- ❖ Fidelity Wraparound

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Other approaches discussed included health homes, PCMH, and care coordination provided by MCOs. These approaches as they are currently organized in most states were not universally agreed upon as appropriate and effective for children and youth with serious behavioral health issues. Some exceptions were noted. With respect to health homes --New Jersey and Oklahoma --which have approved health homes for children with intensive behavioral health needs, use a Wraparound approach. New York is in discussion with the CMS to employ a trauma-informed approach in its health homes for children. With respect to PCMH, it was noted that there has been at least one study with promising results on the use of Collaborative Care Management for adolescents with depression in

primary care[6]; however, not enough is known about the applicability of this model to children and youth with intensive, complex behavioral health needs. In general, PCMH and Care Coordination provided by MCOs were viewed as lacking sufficiently low care coordination caseload ratios and defined models with an evidence base to be appropriate for children with intensive or complex behavioral health needs.
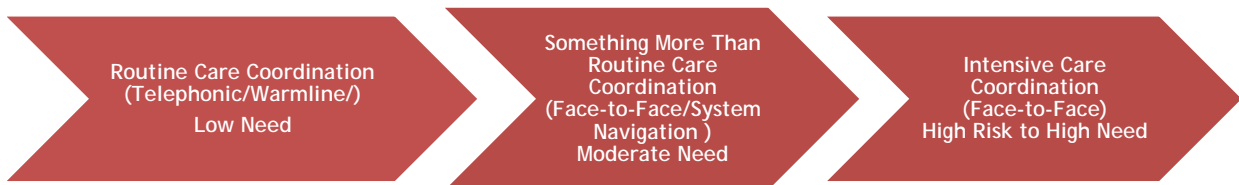
The group also noted that care coordination may also be delivered as an embedded component of another model of care, for example, Multi-Systemic Therapy (MST), or other evidence based services that deliver a package of services, such as Transition to Independence (TIP), which is a model that includes care coordination as an element of its service delivery for transition-age youth and young adults with behavioral health issues. It was also acknowledged that there may be treatment approaches incorporating care coordination that are well-developed but not considered 'models' in terms of having a concrete, manualized approach, but could be useful to refining recommendations, for example, intensive in-home service programs that are not MST.

Role of Peer Support and Navigation

Parent- and caregiver-led family navigation and support or youth-led peer navigation and support were also raised in relation to care coordination and recognized as a valuable resource to families, youth, and the system at-large. Peer navigation was described as a discrete service within the system of care and as a component of care coordination. The group was in agreement that peer support as a service is critical to positive outcomes for families and youth and noted this is consistent with recommendations from the May 7, 2013, Joint Bulletin from SAMHSA and CMS, and related research on the impact of such services.[7] While there was not consensus on peer support as a care coordination model in and of itself, there was consensus that peer support adds value as a component of care coordination approaches.

Number of Tiers

The group noted that varying the intensity of care coordination in a purposeful way that aligns with the needs of youth and families and guides implementation of care coordination is an increasingly common goal in service systems. Specifying the number of tiers available across a system – and the eligibility requirements and practice expectations (e.g., caseload, service intensity, case rate, etc.) across each tier – is likely to be related to a combination of factors such as financing, needs of the population of focus, and delivery platform. In general, within a Medicaid context, the following levels of care coordination were identified as possible levels of increasing intensity within a care coordination continuum:

Routine Care Coordination (Telephonic/Warmline/) Low Need	Something More Than Routine Care Coordination (Face-to-Face/System Navigation) Moderate Need	Intensive Care Coordination (Face-to-Face) High Risk to High Need

The group settled on three tiers as a suggested starting point for a spectrum of care coordination, with routine care coordination available to all children and youth at the lowest level of need, something more than routine for children with moderate needs, and ICC using fidelity Wraparound for youth at high risk for or currently identified as having intensive needs. The group reached consensus on the routine care coordination "Low Need" category and the ICC "Highest Need" category; however, there was not consensus on how to define children and youth in the middle of the continuum, how to delineate their needs, nor consensus on the approaches or models that would be most effective. While

[6] Richardson, LP, Ludman, E, McCauley, E, Lindenbaum, J, Larison, C, Zhou, C, Clarke, G, Brent, D, and Katon, W. *Collaborative care for adolescents with depression in primary care: a randomized clinical trial*. JAMA, 2014 Aug 27; 312 (8); 809-816
[7] United States Department of Health and Human Services, Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration. (2013). *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*. Retrieved on May 20, 2016 from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

the group settled on three tiers of care coordination with only one "middle" catchall category, the group noted that the "murkiness" in understanding the distinct needs of this middle group has led states to implement more than three tiers. Overall, the group had concerns about having more than three tiers and agreed that three tiers balances what we know as a field at this point in time. Overall, more practice-informed data are needed to further define how many tiers would be beneficial and how tiers are developed in accordance with clinical need, especially for care coordination designs that are focused on serving youth with a moderate range of needs.

The group emphasized that care coordination should be designed with consideration for how children and youth will move through or among different tiers, with special attention given to the prevention of rapid churn among different care coordination approaches. Frequent movement across care coordination strategies, or having too many strategies, has the potential to create disruption for families. The group also discussed the viability of having the same providers deliver care coordination for both the moderate and intensive needs populations of children, while leaving routine care coordination to MCOs and/or to primary care practices. Additional data are needed from states and communities implementing a multi-tier system across different models and with diverse populations to inform the field. In addition, the group noted that insufficient data are available about the intensity of care coordination that primary care providers are providing for children with behavioral health needs.

Care Coordination Ratios

Meeting participants noted that care coordination caseload ratios vary greatly across the approaches and populations of focus. While participants agreed that the highest level of community-based care coordination requires low caseloads of 8:1 or 10:1 (especially when being implemented with a specific approach such as Wraparound), there is less consensus on recommended caseload sizes for lower intensities of care coordination. A range of caseload ratios was identified by the group across settings and level of intensity from what is known from the field and/or currently being implemented:

Range of Known Caseload Ratios by Delivery Platform and Level of Need					
	Unspecified Setting/Delivery Platform	Managed Care	Health Home	Care Coordination in Treatment Program	Collaborative Care for Adolescents with Depression[8]	Care Coordination in Crisis/Hospital Transition Programs
Routine Care Coordination Low Need Telephonic	1:100-1:500	1:150-1:250				
Moderate Intensity Care Coordination Face-to-Face (F2F)	1:15-1:35	1:20	1:40	1:50	1:50	
Intensive Care Coordination for High Risk to High Level of Need (Blended caseload-F2F)	1:14 (blended caseload)	1:30*	1:20*	1:15-1:20*		1:30-1:50
High Intensity Only (F2F)	1:8-1:10 (Wraparound)		1:12 (HH using Wrap)			

[8] Richardson, LP, Ludman, E, McCauley, E, Lindenbaum, J, Larison, C, Zhou, C, Clarke, G, Brent, D, and Katon, W. *Collaborative care for adolescents with depression in primary care: a randomized clinical trial*. JAMA, 2014 Aug 27; 312 (8); 809-816

Many relevant and helpful questions were raised in relation to caseload ratios, intensity of care, and delivery setting. Generally, more information is needed to further define appropriate caseload recommendations for low to moderate levels of care coordination. Caseload ratios for children with low to moderate needs seem to vary widely. For example, telephonic care coordination for children with low needs that is provided to managed care enrollees tends to have high caseload ratios ranging from 1:100 to 1:500. Similarly, face-to-face care coordination approaches for children with moderate intensity of need ranges from 1:15 up to 1:50, depending on the setting.

Valid questions were raised about how to define the primary activities for each tier of care coordination and the implications for workload and staffing. These questions relate to other themes, including workforce support, that were discussed throughout the meeting. For some panelists, they felt that youth in the "murky middle" benefit less from another defined tier, and benefit more from a well-defined care coordination model like fidelity Wraparound, with enhancements based on complexity (for example, duration and dose enhancements). The group did agree that common principles and values, based on a system of care framework, should be applied across all tiers.

(See Appendix C)

Care Coordination Locations and Relationships

The location where care coordination is delivered is an important consideration in program design and implementation. Ideas were generated on the most effective locations to house various tiers of care coordination. Many of the approaches outlined in the *Care Coordination Models* session were again described in this topical discussion. The primary recommendation was not a specific location for care coordination; rather, the group focused on the necessity of a "hospitable" organization, that is, one in which leadership adopts common values and principles, for example, those associated with systems of care (See Appendix C), and integrates them across care coordination tiers.

The group also noted that the type of staff person to implement care coordination also varies greatly across approaches. Examples of staff providing coordination include: nurse care managers, peer mentors, community health workers, system navigators, Wraparound care coordinators, and case managers, to name a few. The functionality of positions at each tier of care coordination should be further defined so that appropriate staffing decisions can be made. There was agreement that positions and roles should be defined in a way that ensures a diverse workforce and enables hiring in a field where there are often workforce shortages. The group felt that some universal definition of job functions across care coordination tiers would be helpful as well.

Identification and Stratification

At the Policy/Planning Level

The group noted that, at the systems level, states and purchasers need to plan for implementation and costs by projecting how many children and youth will be served across distinct tiers of care coordination. The key to these high level planning decisions is data from various sources including, but not limited to, Medicaid utilization data, data from providers, child and family assessment data, and data from other child-serving systems, such as child welfare. Qualitative data are also important, and though it can be time consuming and expensive to gather, it can be a very worthwhile source of information and feedback. The group also noted a need for better predictive analytics methods focused on children, youth and young adults with behavioral health challenges, which might better guide identification and stratification.

The group identified various approaches to designing tiers of care coordination currently used, including population-based approaches, in which populations of youth with complex needs, who are in or at high risk of residential placement or other services that are likely to incur high costs, are identified through the use of standardized assessment data, utilization data, or a combination of both. Some states are also identifying an at risk population of children and youth that are likely to end up

using higher levels of care (e.g. residential or inpatient treatment) if earlier intervention via care coordination were not available, for example, very young children or youth with first time, non-violent offenses.

Concerns about the lack of predictive analytics tools that addressed the unique needs of children and youth with behavioral health challenges were expressed, and this group had an interest in informing the development of such tools. Reservations also were expressed by several participants about certain current methods that are primarily adult-centric and rely heavily on historical data. The group noted that there are limits to the relevance of such approaches, as they do not account for the developmental nature of children's needs, which change, oftentimes rapidly as children grow; nor do they account for the fact that children may not have a long history of claims or encounter data to analyze. Data based on utilization and claims can become stagnant due to the sometimes long windows afforded to providers in the submission of claims for payment. In addition, within the context of health reform, states are implementing innovations (including care coordination approaches) that may be expected to change historical utilization patterns; therefore, relying only on historical utilization data may not accurately predict future use.

At the Service Delivery Level

The group agreed that, once population parameters are in place, clinical level of intensity criteria need to be established and standardized approaches to identify children and youth who meet the criteria. Many states and localities currently use standardized screening and assessment tools, such as the Child and Adolescent Needs and Strengths (CANS), the Child and Adolescent Service Intensity Index (CASII), or the CAFAS (Child and Adolescent Functional Assessment Scale), among others. Some states have developed their own algorithms, typically based on a combination of diagnosis and system issues, such as multi-agency involvement or involvement or risk for involvement in facility-based care (e.g., inpatient psychiatric hospitalization, residential treatment, day treatment), to set clinical criteria. Other states have taken their existing benefit array and stratified by levels of care, such as low, medium or high intensity services, and then require each service to incorporate care coordination, thereby using the level of care as a proxy for the amount and frequency of the care coordination received.

The group agreed that a standardized process of determining the appropriate intensity of care coordination is needed at the service level to ensure uniformity of decision making across care coordination referral sources. A common approach to standardized assessment across all tiers of care coordination in a system was universally recommended as a way to ensure improved access to the right level of coordination needed, and support transitions across levels, if clinically needed. A variety of tools is available, and several were put forth by the group as options, including, as noted above, the CANS, CASII and CAFAS. In addition, even as states and communities adopt common assessment approaches to establish structure and consistency, the group recommended that some flexibility for clinical judgment should be built in for exceptional circumstances and ongoing case review. The standardized assessment should include questions and assessment of a family's and youth's voice and choice in establishing goals of care, roles in the process, and services to include in the plan. In other words, assessments that inform care coordination should encompass the same values as those that underpin care coordination approaches, which include important principles of family and person-centered input and decision making.

Rates and Payment Approaches

Rates and payment structures are directly linked to key aspects of effective care coordination. There are many ways to set up reimbursement in a Medicaid system, and the method selected will be informed by factors such as the system's overall financing structure, orientation to risk-based payment, and single or multiple funding sources. Risk-based capitation, administrative management fees, fee-for-service, bundled service rates, and population case rates are examples of rate structure designs applied to care coordination approaches. A range of payment methodologies can be implemented simultaneously – for example, fee-for-service reimbursement for standardized screening and

assessment can facilitate enrollment into care coordination approaches, whereas other financing arrangements, such as population-based case rates or bundled care coordination rates, can be paid to care coordination providers that create an incentive to manage desired quality and cost outcomes, such as movement away from residential toward home- and community-based services. The group noted that, with more states moving Medicaid populations into managed care arrangements, there will be increasing interest on the part of MCOs and providers to implement value based purchasing approaches to which effective care coordination is key.

The group noted that building a rate structure for a specialized system of care coordination for children and youth can be challenging in today's Medicaid managed care environment where MCOs are responsible for multiple adult and child populations and the management of both physical and behavioral health care. The group concurred that building a rate structure for a specialized system of care coordination for children and youth requires particular attention, including ensuring rate consistency across regions or counties since providers often cross over geographical areas. In some states, for example, MCOs are allowed to negotiate care coordination rates based on the region(s) they cover, which can create special challenges for providers who cross regions, who then end up with different rates for the same care coordination approach. The group felt that the importance of leaders from within the child-serving system weighing in on these issues with state Medicaid decision makers cannot be overstated.

The group further discussed value based payment approaches, that is, tying reimbursements to quality, costs and/or outcomes. Currently, it would appear that most value based purchasing efforts are adult-focused with minimal inclusion of child behavioral health populations; and that providers of care coordination for children with behavioral health challenges are operating within either a fee-for-service or bundled care coordination per member per month rate. With few exceptions, most care coordination providers are not at risk for total costs of care, nor are they benefitting from any shared savings or bonus opportunities. It was noted that care coordination approaches, particularly for children with intensive needs, may be best supported by a combination of state and local funding and not only Medicaid. Combined, cross-system funding better supports population case rate approaches that may allow providers to assume risk for the total cost of care. These other funding sources tend to add flexibility to program design and reimbursement strategy as well.

The group discussed the variation in care coordination rate structures. Capitation, sub-capitation, rates, fee-for-service, and case rates, including blended and bundled case rates, are examples of rate structures found within care coordination. In addition to the standard items such as staff positions, salary, administration, quality oversight, direct and indirect costs of operation, the group recommended the inclusion of the following factors in any rate development methodology:

- Acuity of caseload
- Size of caseload
- Productivity expectations
- Performance incentives, for example, to keep caseloads low, keep children in their homes, or implement evidence based practices
- If costs are not included in capitation payments, allowance for enhanced payments for particular subpopulations of children
- Staff effort should be measured and rates should reflect the level of effort.

Workforce and Implementation Supports

Workforce, Training, Certification/Credentialing

Recommendations related to workforce focused on quality supervision and ongoing coaching and training supports. Many in the group felt it is important to develop supervisors that can serve as the in-house experts on the selected care coordination approach both in terms of values and practice. Supervisors should be developed as coaches who can lead internal efforts within their own organization and system. Tools to support effective supervision and employee development, such as electronic

health records, will provide important feedback mechanisms and data to the supervision process. Training is an ongoing process rather than an isolated event, and a variety of methods should be used to train and supervise, such as field-based supervision and case reviews. Standardized training for staff should include tools to measure skills over time. If certification is a part of the care coordination program, staff should be routinely reviewed even after certification is achieved. Certification for Wraparound programs, for example, has shifted to supervisors rather than only frontline workers.

Cultural and Linguistic Competency

The group noted the importance of cultural and linguistic competencies in the design and implementation of care coordination approaches. Care coordination efforts that include a focus on the impact of race, ethnicity, language access, and other community factors support engagement and effective transitions. While Wraparound incorporates a focus on culture, race, ethnicity and the social determinants of health as a core principle of the model, the group noted that more information is needed about how other models take these factors into account.

Quality and Outcome Measures

Quality and outcome measures provide critical information that guides decision making at multiple levels, including system oversight and management, individual and program level performance improvement, and determining whether the specific needs of individual children, youth and families served are being met. Data gleaned from quality and outcomes measurement can also be used to gain support for sustaining and expanding effective care coordination approaches, engage new stakeholders across child-serving agencies, and support a case for return on investment. Small groups described a vast array of quality indicators that could inform tiers of care coordination in terms of both process measures and system and youth/family level outcome indicators. Quality indicators that would be valued by youth and families were put forward, with a recommendation to include families and youth in the process of developing quality measures and ensure that their priorities are included in designing questions and indicators. Finally, the quality and outcomes discussion covered items that could be incorporated into value based purchasing efforts that incentivize quality care and good outcomes.

A number of potential quality and outcomes measures were identified for a robust continuous quality improvement framework. A list of indicators suggested by participants is presented below by general theme.

Suggested Measures	
Process Measures	- Fidelity to a model of care, such as Wraparound (e.g. ratio of informal/natural supports vs. paid supports, meeting frequency, match between plan of care strategies and family needs) - Staff effort (e.g. time spent on specific activities, matching cost to effort) - Client satisfaction, including family interviews - Engagement with primary care - Movement in/out of services (e.g. service disruption) - Duration of services or length of stay - Staff ratios, qualifications - Engagement with families
Clinical Measures	- Decrease in suicide attempts - Improved physical health - Decrease in substance use - Caregiver status – e.g. depression, substance use, trauma - HEDIS measures – medical, behavioral health

Functional Measures	- Living with family - School functioning - Reduced involvement in juvenile justice - Decrease in ER/Hospital/crisis - Youth and family/caregiver well-being, strain, needs and strengths - Acceptance among peers - Resiliency factors/empowerment - Engagement - Quality of life – social determinants - Increase in work skills/employment - Young adults – social connectedness - Age, race, ethnicity factors (e.g. disparities in outcomes) - Transition success
Access to Care & Placement	- Increase in family's ability to manage health issues/knowledge of system - Evidence based use of psychotropic medications - Increase access to care - Change in mix of service use including increase in use of HCBS Placement and Transitions - Transitions between levels of care or out of care - Community services vs. institutional - Institutional recidivism - Placement (in-home vs. other institutional or foster care, etc.) - Access to care at the population level – including, wait times for services, penetration rates
Measures Prioritized by Youth and Families	- Quality of life and sense of making progress - Young adults' sense of social connectedness - Acceptance by care coordination team - Hope, respect, responsiveness - Caregiver perception of quality of relationship with his/her child - Choice - being heard by those helping and/or treating child or youth - Quality of services - Reduced barriers - Empowerment/resiliency - Increased family knowledge of the system - Transitions - Family should individually decide - family vision - WFI-EZ (Wraparound tool) that usually involves a caregiver and youth interview - Family/youth functioning/assessment scores
Cost Savings, Avoidance and Returns	- Cost - unavoidable costs to undesired service utilization; cost is dangerous to measure alone; do not just rely on total costs; value is more than cost - Return on Investment (e.g. disrupted family employment due to child's challenges versus stability)

Putting It All Together: Recommended Strategies and Action

Summary

This Expert Convening launched an opportunity for leaders in children's behavioral health to generate key questions and create momentum for policy and systems design explorations that will drive the customization of care coordination for children and youth with behavioral health challenges across a multitude of settings. There was consensus from the group on important areas related to care coordination. Areas of agreement are reflected in the below highlights:

- Currently, based on review of evidence and group consensus, the best defined and generally most successful approach for serving children and youth with intensive and/or complex behavioral health issues in the community is a fidelity Wraparound care coordination model.
- Fidelity Wraparound may be appropriate for children with less intensive needs, but more data are needed.
- Certain evidence based treatment programs that incorporate care coordination as a defined component, for example, MST, are appropriate for children with moderate to intensive needs.
- A *hospitable environment* must be created within the organization providing care coordination that includes leadership's commitment to adhering to standards of quality, defined practice models, and common values and principles across treatment programs and care coordination tiers. *Continuous quality improv*ement processes should be in place from the planning stage that include systems, program, and youth/family level outcomes. Families and youth should inform the development of quality indicators and help define what quality of care means from the family and youth perspective.
- Workforce development should emphasize data-informed supervision to research-based standards, with supervisors trained to effectively support the care coordination approach in an ongoing fashion, becoming, in effect, internal trainers, rather than the system relying solely on one-time or periodic training of care coordination staff.

More information is needed in the following areas:

- Effective care coordination approaches for children with moderate (less intensive) needs.
- Number of tiers in a system that ensures the most clinically effective and cost effective care coordination benefit array while also minimizing system complexity.
- Optimal mechanisms for supporting effective transitions across tiers that minimize disruptions to care received by youth and families.
- Populations of children with behavioral health challenges for whom primary care practitioners have the capacity and willingness to provide effective care coordination.
- The most effective care coordination approaches for the varying behavioral health needs of children (low, moderate, high) as provided by:
    o PCMHs
    o Health Homes that are using a non-Wraparound approach
    o MCOs.

Next Steps

There are a number of areas where knowledge gaps exist in the design, implementation, and oversight of high quality care coordination for children and youth with behavioral health challenges. Next steps include:

- Queries to individual states and communities with current tiered care coordination approaches that are working with children and youth – either as a whole population or with specific emphasis on children with behavioral health issues. Through this outreach, a better conceptualization of the landscape of care coordination activities can be gained, including important detail related to the stratification of youth across tiers, how youth with a moderate level of need are faring in a multi-tier system, and which approaches are the most effective.

- More information will be gathered through conversations with professionals in the health care sector, including primary care physicians' perspectives on working within a care coordination framework with children, youth and families.

- A process will be initiated to examine predictive analytics tools for children's behavioral health – an area which this expert group wanted to pursue. A scan of predictive analytics tools from the health field will be an initial activity to inform actionable steps to developing, customizing and implementing such tools within children's behavioral health.

- Related activities include a survey of providers to identify value based payment approaches being applied to care coordination for children with behavioral health challenges.

- The topic of tiered care coordination approaches will be incorporated into the TA Network's managed care meetings with states and with trade groups in the field.

APPENDIX A: Participant List

Candace Body	Director I HCM/Clinical Lead I Georgia Families 360°, Amerigroup Community Care (Georgia)
Charles Freed	Chief Medical Officer for Behavioral Health, United Healthcare Community Plan (Tennessee)
Cheryl McClatchey	Director, TennCareSelect and Behavioral Health Integration , TennCare Select (Blue Care)
Eric Bruns	Associate Professor, University of Washington
Jack Simons	Assistant Director, Children's Behavioral Health Initiative, Massachusetts Health & Human Services
Jody Levison-Johnson	Chief Clinical, Officer, Choices Coordinated Care Solutions
John Lyons	Senior Policy Fellow, Chapin Hall, University of Chicago
Kelly Hyde	CEO, Fidelity EHR
Kim Estep	Director, National Wraparound Implementation Center; The Institute for Innovation & Implementation
Knute Rotto	CEO, Beacon Health Options (Connecticut)
Lana Earle	Deputy Director, Office of Health Insurance Programs, New York State Department of Health
Larke Huang	Director, Office of Behavioral Health Equity, SAMHSA
Leigh Steiner	Director, Clinical Applications, Care Management Technologies
Lenya Robinson	Section Manager, Behavioral Health – Population Health and Managed Care Programs, Colorado Department of Healthcare Policy & Financing
Leslie Schwalbe	Senior Vice President, State and Local Government Programs, Optum
Lisa Brockman	Manager, Wyoming Care Management Entity and Children's Mental Health Waiver Program, Wyoming Department of Health – Division of Health Care Financing- Medicaid
Lisa Lambert	Executive Director, Parent Professional Advocacy League (Massachusetts)
Elizabeth Manley	Assistant Commissioner, Children's System of Care, New Jersey Department of Children & Families
Marlene Matarese	Co-Deputy Director, National Technical Assistance Network for Children's Behavioral Health; The Institute for Innovation & Implementation
Mary Jo Meyers	Director, Wraparound Milwaukee
Michelle Zabel	Director, National Technical Assistance Network for Children's Behavioral Health; The Institute for Innovation & Implementation
Shawn Cole	Manager, Illinois Department Healthcare & Family Services
Shawn Thiele Sacks	Principal, Mercer
Sheila Pires	Partner, Human Service Collaborative
Suzanne Fields	Senior Advisor for Health Care Policy & Financing, National Technical Assistance Network for Children's Behavioral Health; The Institute for Innovation & Implementation
Traylor Rains-Sims	Director of Policy & Planning, Oklahoma Department of Mental Health & Substance Abuse Services

APPENDIX B: Meeting Resources

A full compilation of resources gathered for this meeting and final agenda can be found here:

http://innovationmeetings.wix.com/meetings#!2016tiered-care-coordination/ldxrp

APPENDIX C: Systems of Care Values and Principles[9]

The core values of systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.

2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.

3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

GUIDING PRINCIPLES / Systems of care are designed to:

1. Ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.

2. Provide individualized services in accordance with the unique potentials and needs of each child and family, guided by a strengths-based, Wraparound service planning process and an individualized service plan developed in true partnership with the child and family.

3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice-based evidence, to ensure the effectiveness of services and improve outcomes for children and their families.

4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.

6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system level management, coordination, and integrated care management.

7. Provide care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.

9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.

10. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.

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[9] Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.

12. Protect the rights of children and families and promote effective advocacy efforts.

13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and ensure that services are sensitive and responsive to these differences.