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Meeting Families Where They Are: Developing and Implementing a Tiered Care Coordination System for Youth Behavioral Health Needs

Tony Bonadio, Kim Estep, and Eric Bruns

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Who Are We?

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UNIVERSITY of WASHINGTON

Overview

- RECENT CMS EPSDT GUIDANCE
- WHY TIERED CARE COORDINATION SYSTEMS ARE IMPORTANT
- INTERMEDIATE CARE COORDINATION ALONGSIDE INTENSIVE CARE COORDINATION (WRAPAROUND)
- CONSIDERATIONS WHEN IMPLEMENTING TIERED CARE COORDINATION SYSTEM

Hot off the Press:

Federal Guidance to States on Adhering to Federal EPSDT Requirements

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 24-005

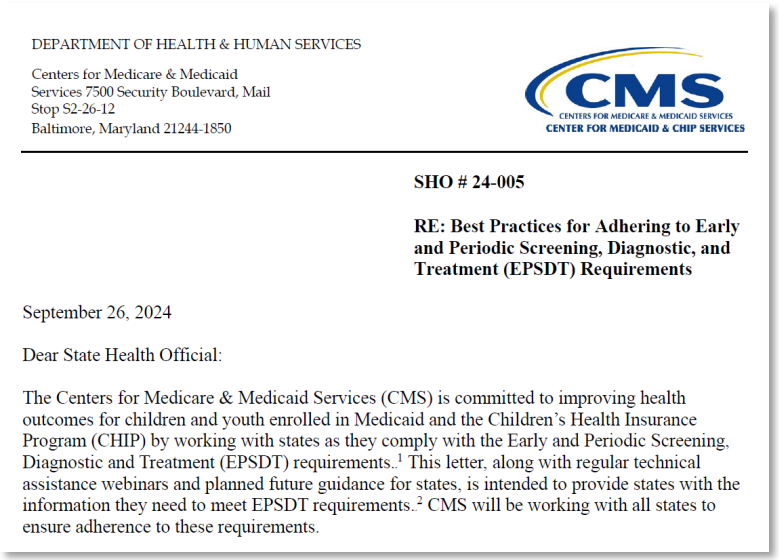
RE: Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements

September 26, 2024

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is committed to improving health outcomes for children and youth enrolled in Medicaid and the Children's Health Insurance Program (CHIP) by working with states as they comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements..[1] This letter, along with regular technical assistance webinars and planned future guidance for states, is intended to provide states with the information they need to meet EPSDT requirements..[2] CMS will be working with all states to ensure adherence to these requirements.

Care coordination is a **requirement**



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- "Care coordination and case management are used to describe a range of activities that link individuals to services and can vary in intensity depending on a child and family's needs.
- Care coordination is the organization of a patient's care across multiple providers and may focus on a specific service or condition, such as referring and connecting individuals to other programs that support mental health recovery.
- ***MCPs are required to provide medically necessary care coordination to enrollees."***

The only care coordination strategy for youth with consistent evidence is **Wraparound**

Clin Child Fam Psychol Rev (2009) 12:336–351
DOI 10.1007/s10567-009-0059-y

Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis

Jesse C. Suter · Eric J. Bruns

J Child Fam Stud
DOI 10.1007/s10826-016-0639-7

ORIGINAL PAPER

A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014

Jennifer Schurer Coldiron[1] · Eric Jerome Bruns[1] · Henrietta Quick[1]

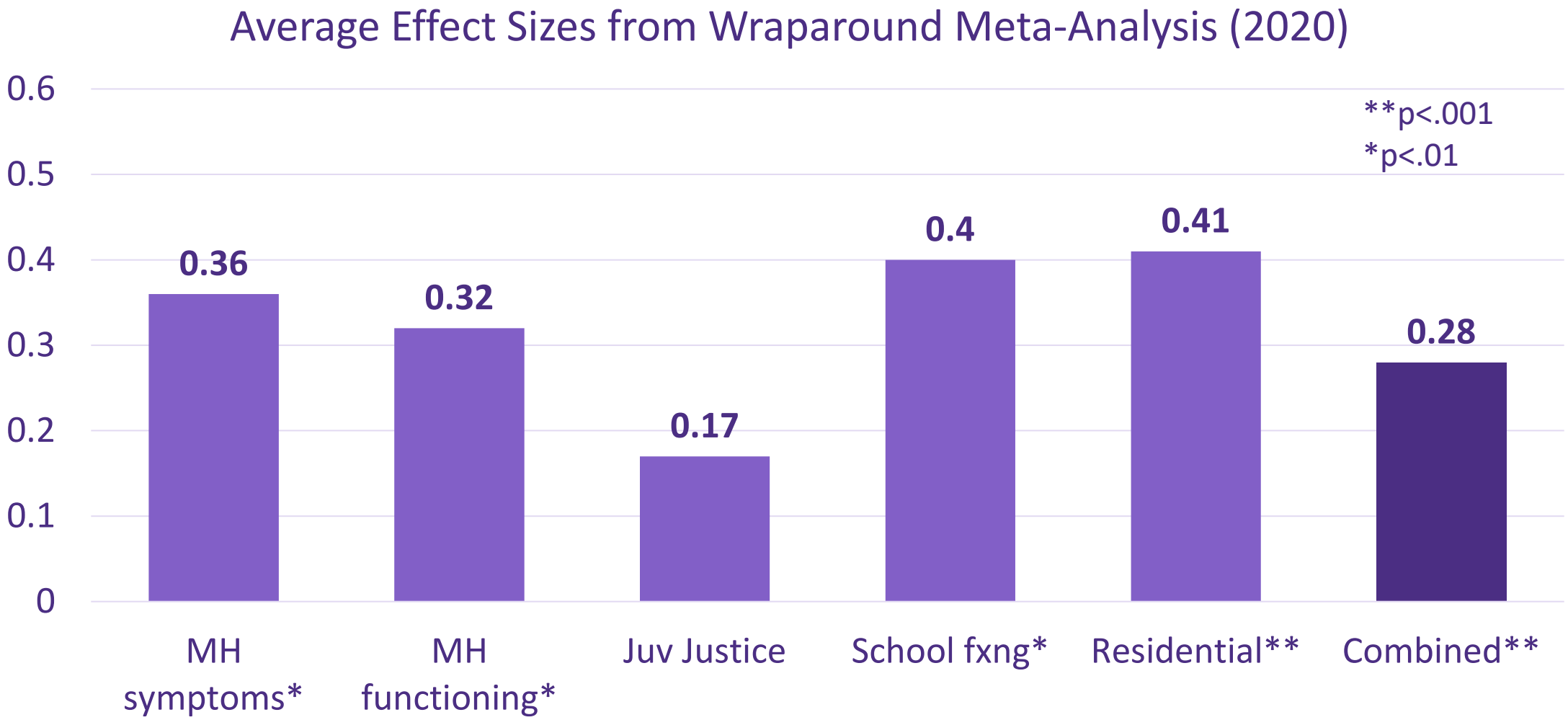
META-ANALYSIS

Check for updates

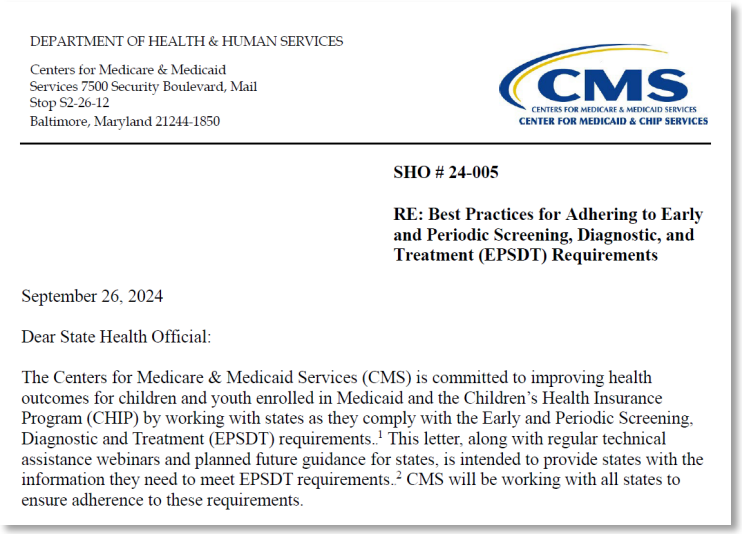
Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents

Jonathan R. Olson, PhD, Philip H. Benjamin, MA, Alya A. Azman, BS, Marianne A. Kellogg, BA, Michael D. Pullmann, PhD, Jesse C. Suter, PhD, Eric J. Bruns, PhD

Significant effects for Wraparound found across an array of critical outcomes



We must ensure care coordination matches family complexity and is not duplicative



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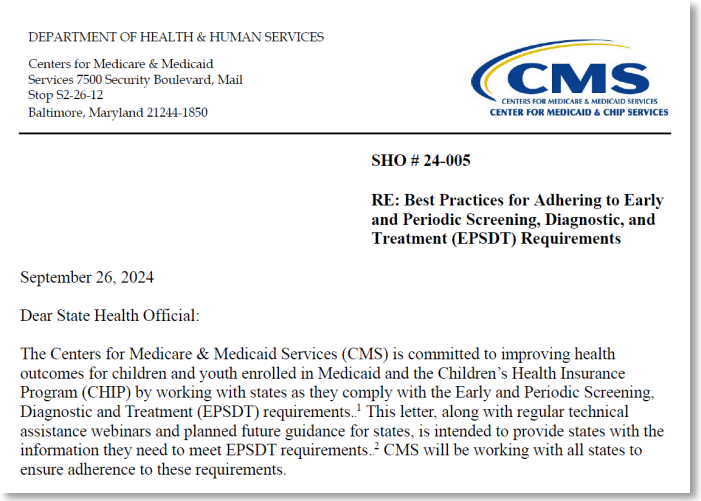
- "The level of care coordination and case management must be appropriate for the complexity of the beneficiary's situation and one approach may not be sufficient to meet varied needs.

- When a state has multiple approaches for care coordination and case management or is considering adding another approach, the state should ensure that these approaches are streamlined to minimize the risk that an EPSDT-eligible child will experience a duplication of services."

CMS Recommends use of ***Care Management Entities*** with Tiered Intensity of Care Coordination



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Global Implementation Research and Applications
https://doi.org/10.1007/s43477-021-00008-1

Check for updates

Influences of Inner and Outer Settings on Wraparound Implementation Outcomes

Jonathan R. Olson[1] · Alya Azman[1] · Kimberly M. Estep[2] · Kimberly A. Coviello[2] · Shannon Robshaw[2] · Eric J. Bruns[1]

Received: 3 October 2020 / Accepted: 15 March 2021

Abstract
In recent years, implementation researchers have focused on associations among organizational characteristics (inner settings), policy and funding drivers (outer setting), and implementation outcomes. The current study evaluated the influence of outer setting drivers on implementation of Wraparound care coordination for youth with complex behavioral health needs. Data were drawn from two sources. First, we examined the impact of outer setting drivers on Wraparound implementation

- "Use community-based care management entities (CME) to coordinate care for children who need moderate or intensive care coordination.
- "Limited care coordination is delivered by MCPs for children with typical care coordination needs.
- "For children who need moderate or intensive care coordination, the state utilizes community-based CMEs whose care coordinators develop a care plan that is guided and driven by the child and their family.
- "This level of care coordination is more extensive and frequent, and involves links to services and resources, and coordination with providers."

Poll Qs

- In your current system, do you have an intermediate care coordination model or level of care/intensity (something other than Wraparound)?
  - Yes
  - No
  - I don't know
- If families don't go to Wraparound, where do they go?
  - Referred to community-based providers
  - Residential Treatment Centers
  - I don't know because everyone goes into Wraparound

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Defining Care Coordination

Care Coordination - Adults

Care Coordination is the organization of consumer care activities including collaboration of various healthcare providers to ensure communication and information sharing among providers, monitoring and managing medication regimens, coordinating medical and psychiatric appointments, providing access to community resources, and ensuring that care is provided in a culturally sensitive and appropriate manner.

Care Coordination – Child, Youth, & Family

Care coordination, managed by a dedicated care coordinator, is the deliberate organization of services and supports in partnership with the child, youth, young adult and/or family to ensure continuity of care across settings and facilitate appropriate access and delivery of needed social, behavioral, and somatic health care. Organizing care involves ongoing engagement, review, and adjustment of relevant providers, natural supports, and other resources to successfully align needs with services and supports.

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Traditional Case Management Approach

Provided to individuals who belong to a specific category or population: Behavioral Health Challenges, Neurodivergent, Chronic Conditions or System Involvement

Assessment and Service Planning

Referral and Linkage to Services

Ongoing Monitoring and Follow-up

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We CANNOT simply pull Wraparound apart as financing and systems expand and shift

01

Fidelity and Quality

Critical elements are designed to build on one another and work together

02

Consistency

Different definitions or operationalization of the practice model impact families' experiences of Wraparound

National Wraparound Implementation Center

Advancing Systems o Enhancing the Workforce o Improving Outcomes

03

Staffing Ratios

Limits: 1:8-12

04

Workforce

Varying expectations impact skill development and staff retention

Risk Factors are Different

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Intermediate Care Coordination

- Behavioral Health Needs
- Social Determinants of Health
  - Economic Stability
  - Education
  - Social and Community Context
  - Health and Health Care
  - Neighborhood and Built Environment
- Developmental Delays
- Single System Involvement

Wraparound/Intensive Care Coordination

- Complex Behavioral Health Needs
- Multi-System Involved
- High risk of out-of-home placement
- Elevated risk of crisis

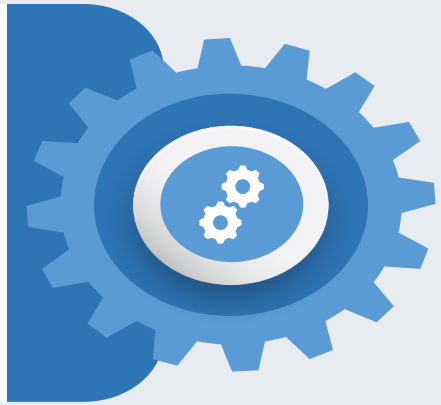
May be compounded by:

- Social Determinants of Health
- Developmental delays

Why Tiered Care Coordination is Important

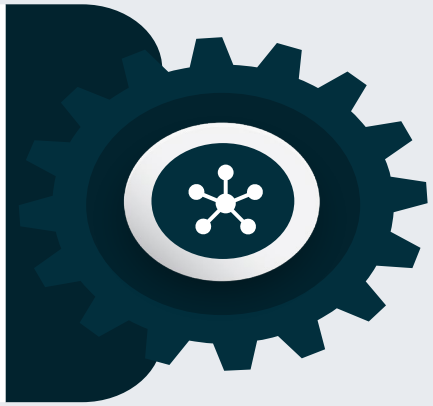
Efficient Allocation of Resources

Customization of Services and Supports



Prevention of Crisis Escalation

Support for Systematic, Coordinated Care



Improved Outcomes and Accountability

Sustainable and Scalable

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Why Intermediate Care Coordination is Essential

Prevents escalation of needs by addressing moderate concerns early

Offers cost-effective services tailored to those who don't need intensive care

Supports a larger population without overwhelming high-intensity programs

Promotes stability and continuity of care for children who need ongoing, structured support.

Enhances system efficiency and prevents unnecessary use of expensive resources.

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Tiered Care Coordination

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All children, youth, young adults, and their families

Health care, screening, social determinants of health

Voiced/Identified Need

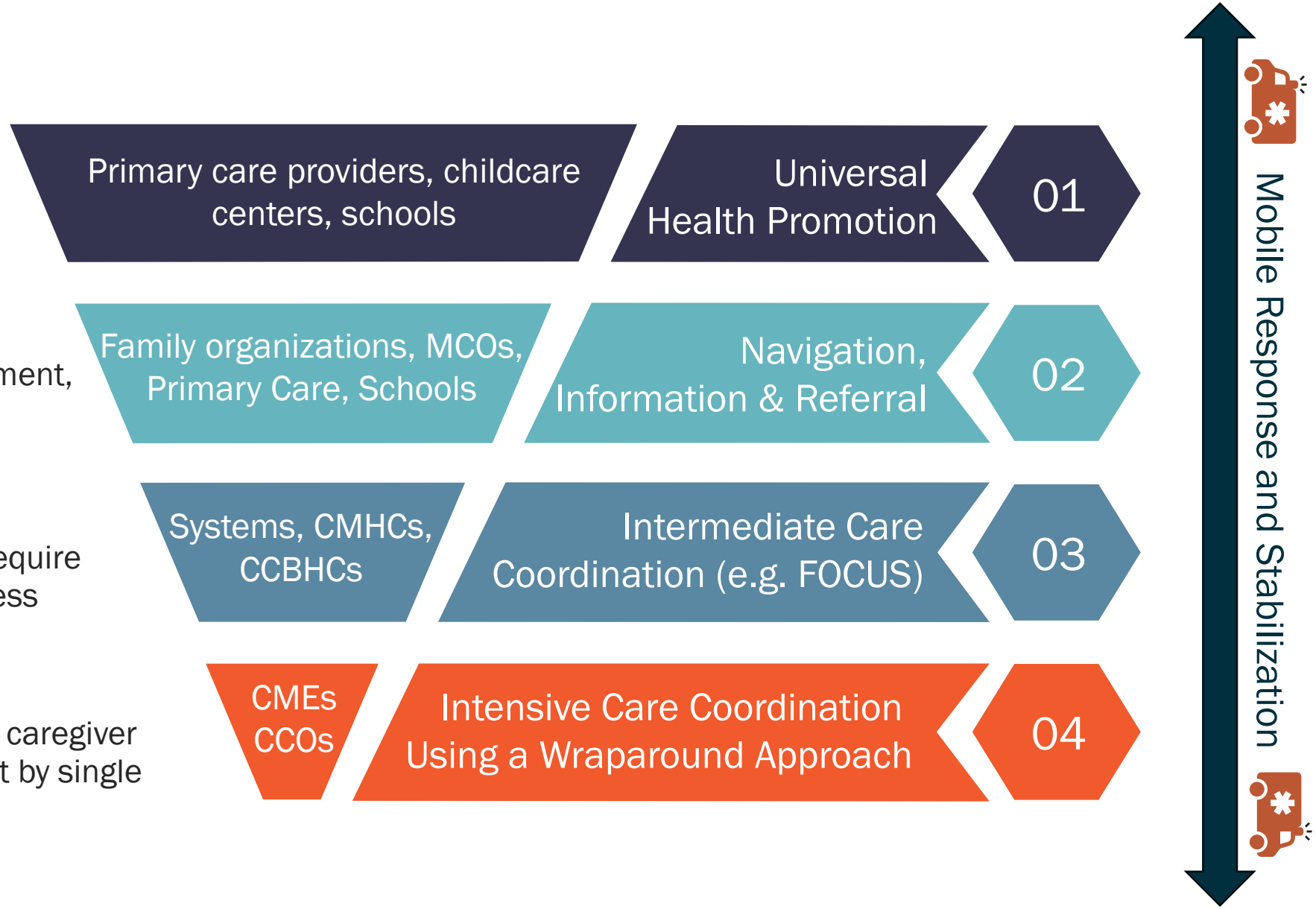
Concern something is wrong, assessment, early intervention

Moderate Need

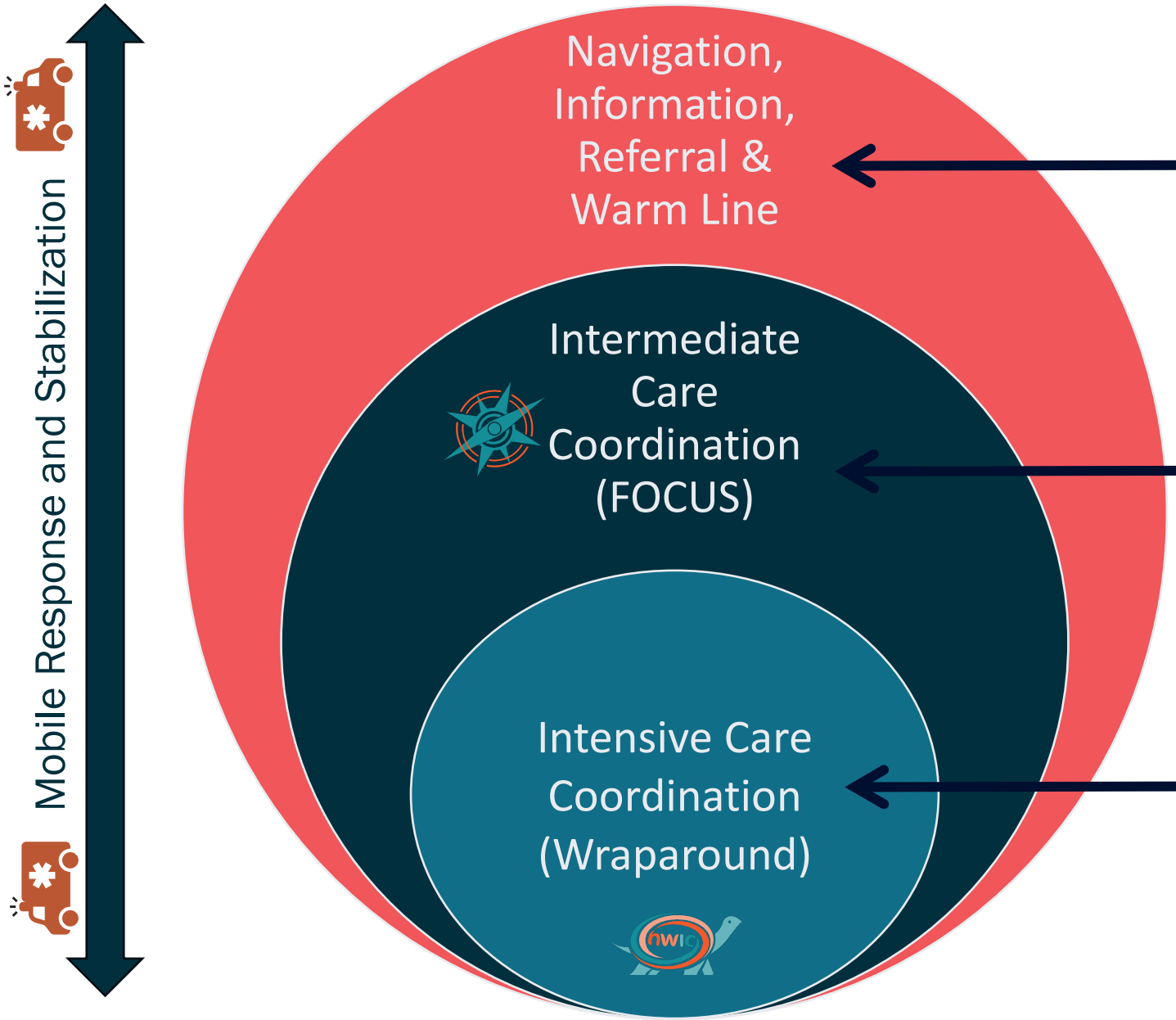
High caregiver stress/strain, needs require multiple services & supports to address

Complex Need

Significant challenges, high risk, high caregiver stress/ strain, multiple needs not met by single system or service



Care Coordination Continuum & Provider Types



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Let’s talk about what an intermediate care coordination model looks like

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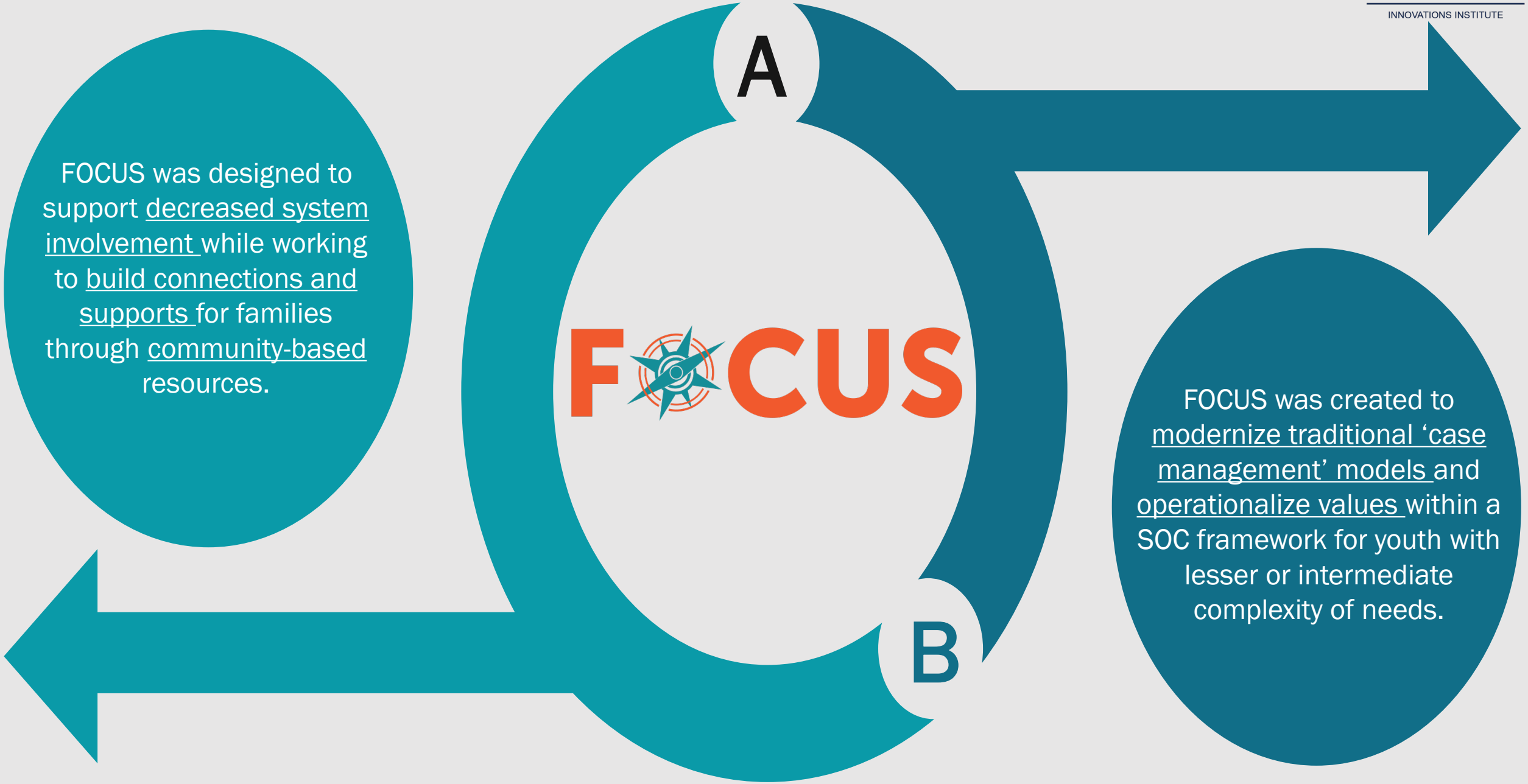
FOCUS was designed to support decreased system involvement while working to build connections and supports for families through community-based resources.



FOCUS was created to modernize traditional 'case management' models and operationalize values within a SOC framework for youth with lesser or intermediate complexity of needs.

FOCUS

Leading the Way in Coordinated Care

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- Families are experiencing meaningful connections - positive relationships are necessary for healing
- Outcomes – things are getting better
- Coordination – everyone works toward a common goal
- Unconditional Positive Regard – genuine acceptance no matter what
- Short-Term process – build sustainable connections to community resources, minimize system reliance

FOCUS
Leading the Way in Coordinated Care

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Key Components

Individualized

- Builds from the uniqueness, skills, interests, hopes, and desires of each person in the family.
- Incorporates things the family is good at into the planning.
- Includes family's preferences and creative solutions.

Comprehensive

- Accesses community options and evidenced based practices
- Planning around all areas of need including medical needs.
- Includes multiple perspectives in the planning process.
- Accountable for outcomes across systems and environments.

Accountable

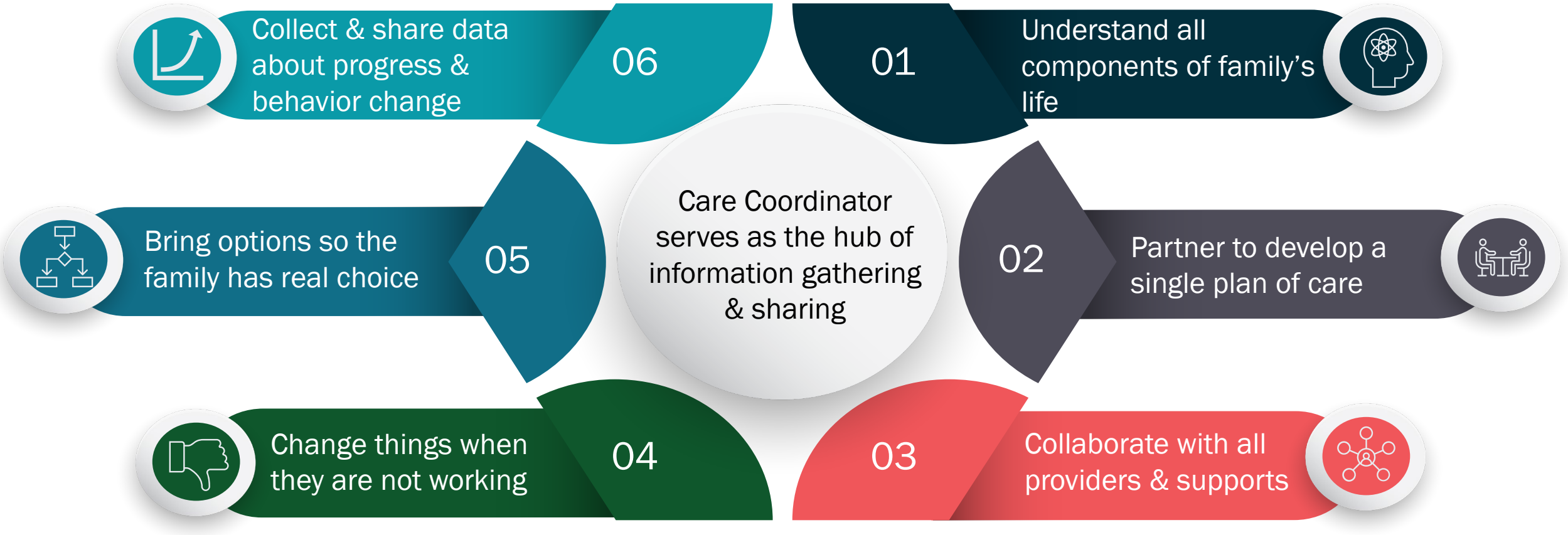
- Monitors services and supports for completion, impact and satisfaction.
- Progress openly discussed and the plan is reviewed and adjusted often if things are not getting better.
- Time limited ensuring that the plan serves the family's needs

Family Anchored

- Partnerships with the family
- Families report out around need being met, satisfaction with care, and modifications to the plan.
- Family shares what will be helpful and what has worked in the past

Care Coordinator Role

FOCUS
Leading the Way in Coordinated Care



- Builds relationships with child-serving agencies & other support organizations
- Incorporates information from people involved in the family's life

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The Process of Care Coordination

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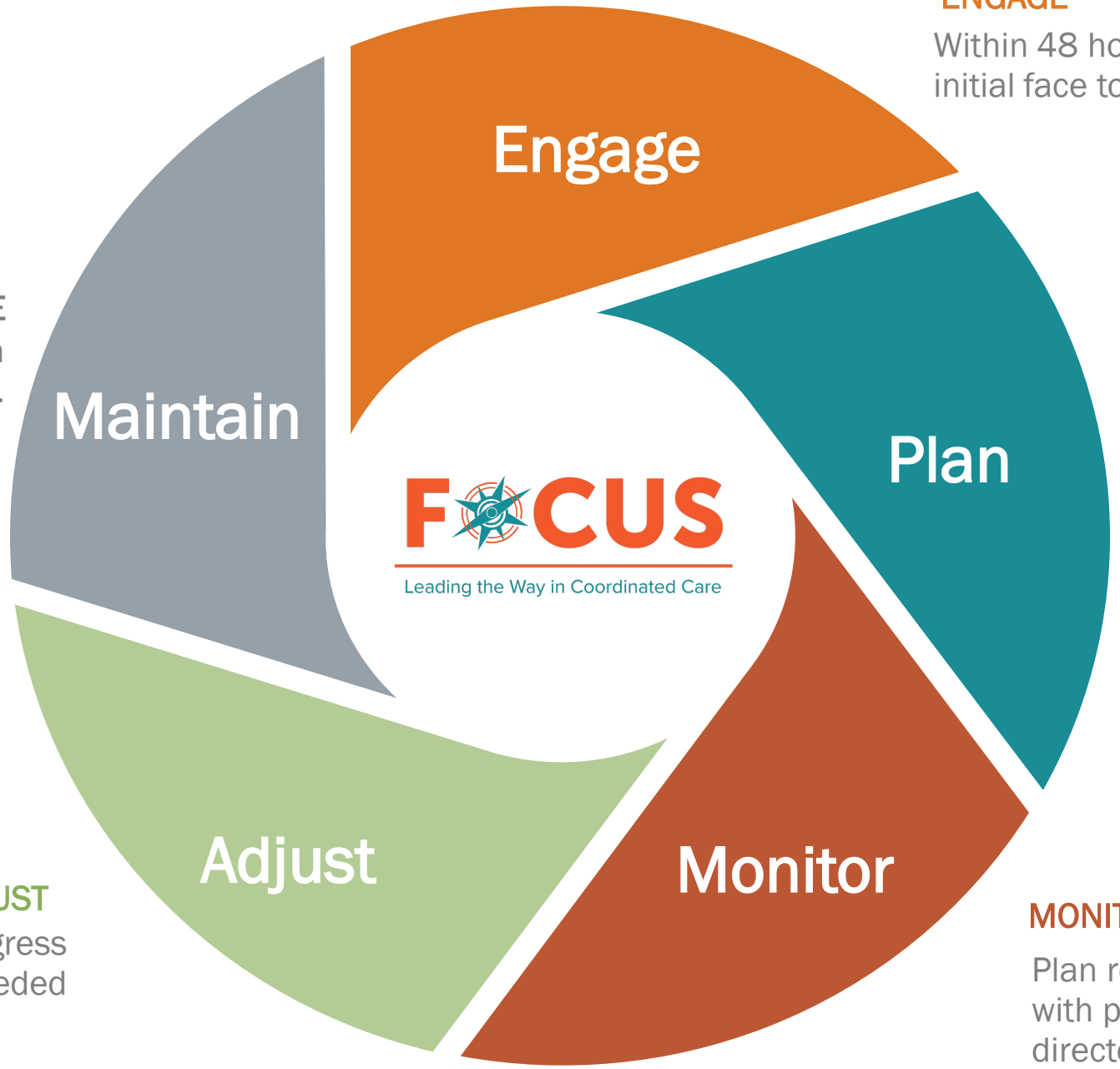

ENGAGE
Within 48 hours of referral & initial face to face within 5-7 days

PLAN
Plan of Care created within 30 days

MONITOR
Plan review monthly; connect with providers & supports as directed in POC

ADJUST
Based on satisfaction & progress data, plan is adjusted as needed

MAINTENANCE
Short term process; Transition occurs by 6 - 12 months.

FOCUS

Leading the Way in Coordinated Care

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FOCUS Certificate Program launching January 2025!

Empower Your Team & Elevate Care Coordination for Children, Youth & Families

Offered by Innovations Institute,
University of Connecticut School of Social Work, Continuing Education

Registration open now!
https://innovations.socialwork.uconn.edu/focus-certificate-program/

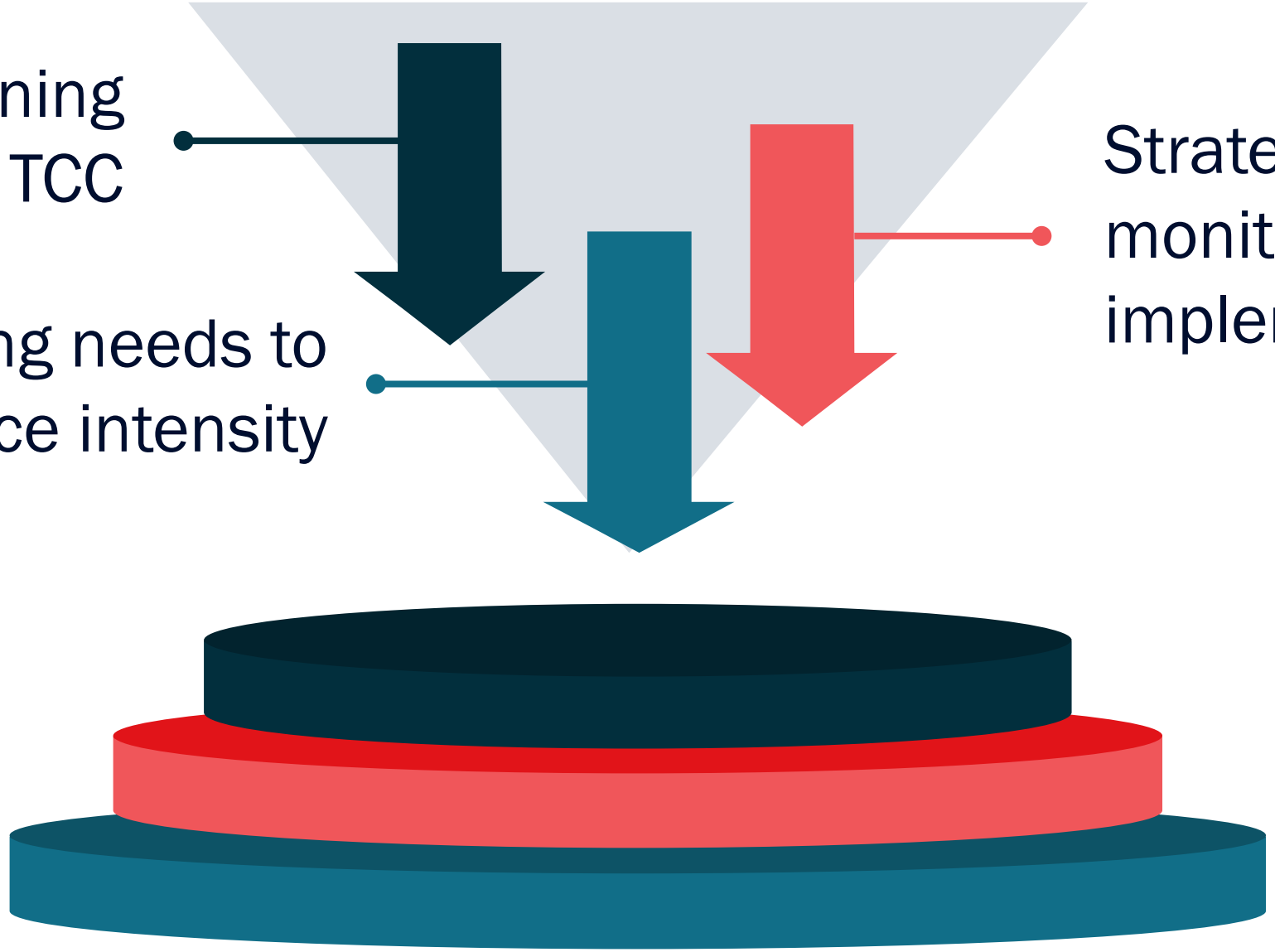
For more information, email us at: FOCUSinfo@uconn.edu or
Contact Lisa Spera, FOCUS Manager, lisa.spera@uconn.edu

Let's learn about considerations when implementing a tiered care coordination approach

Implementing a Tiered Care Coordination (TCC) System

System Planning for TCC

Matching needs to service intensity



Strategies for monitoring implementation

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Pathway for Effective TCC

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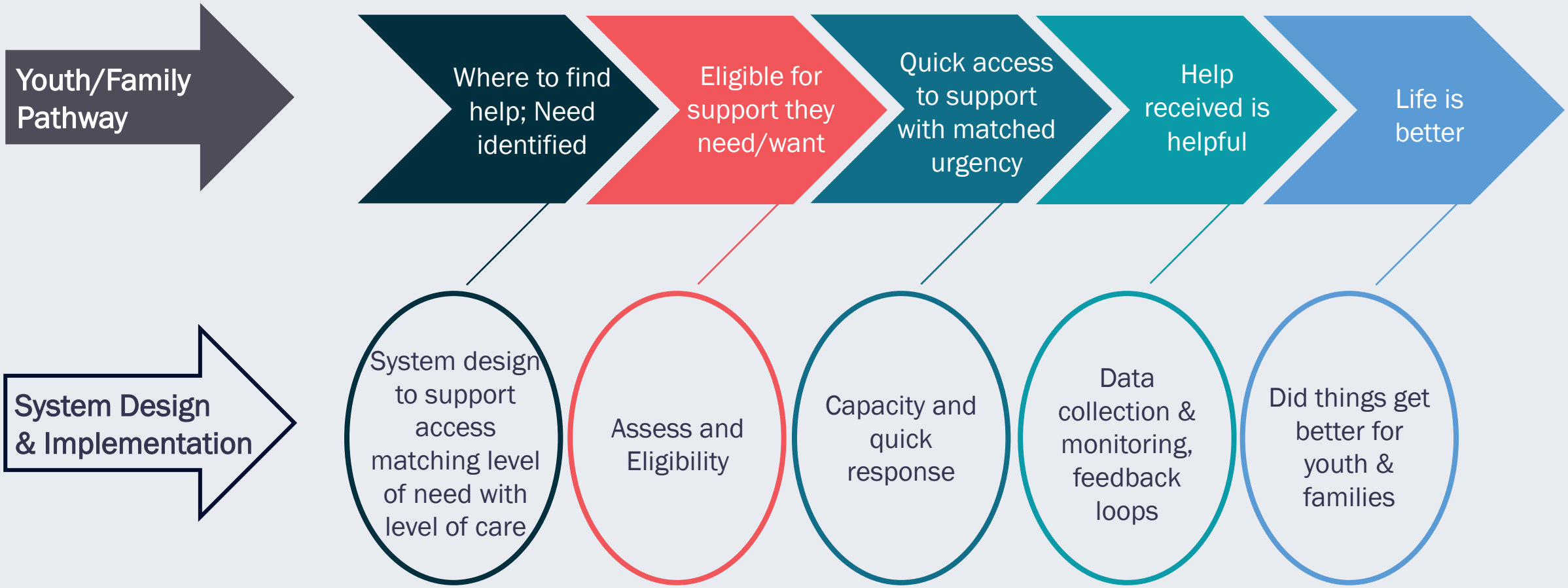
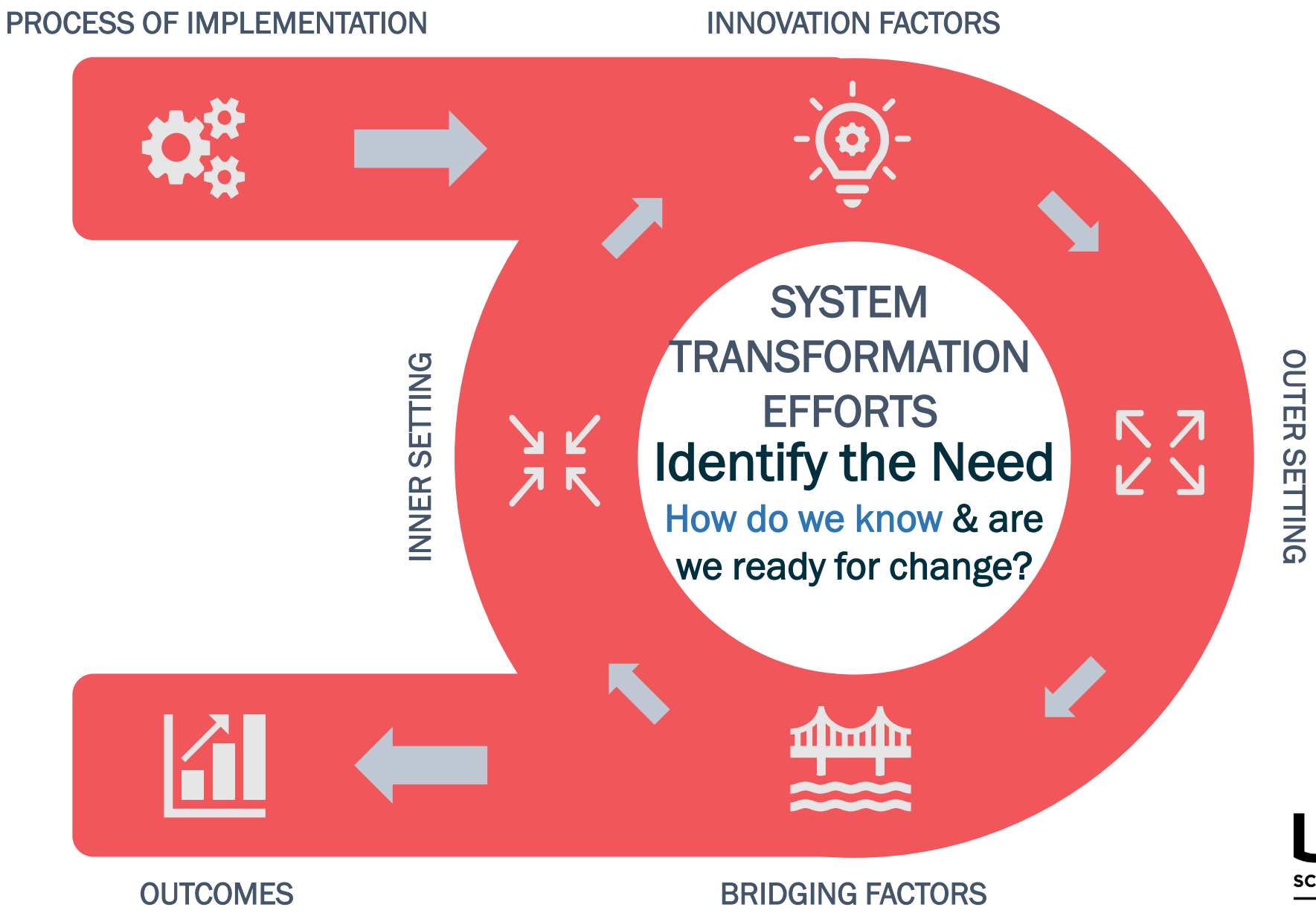


Using Implementation Science as a Guide



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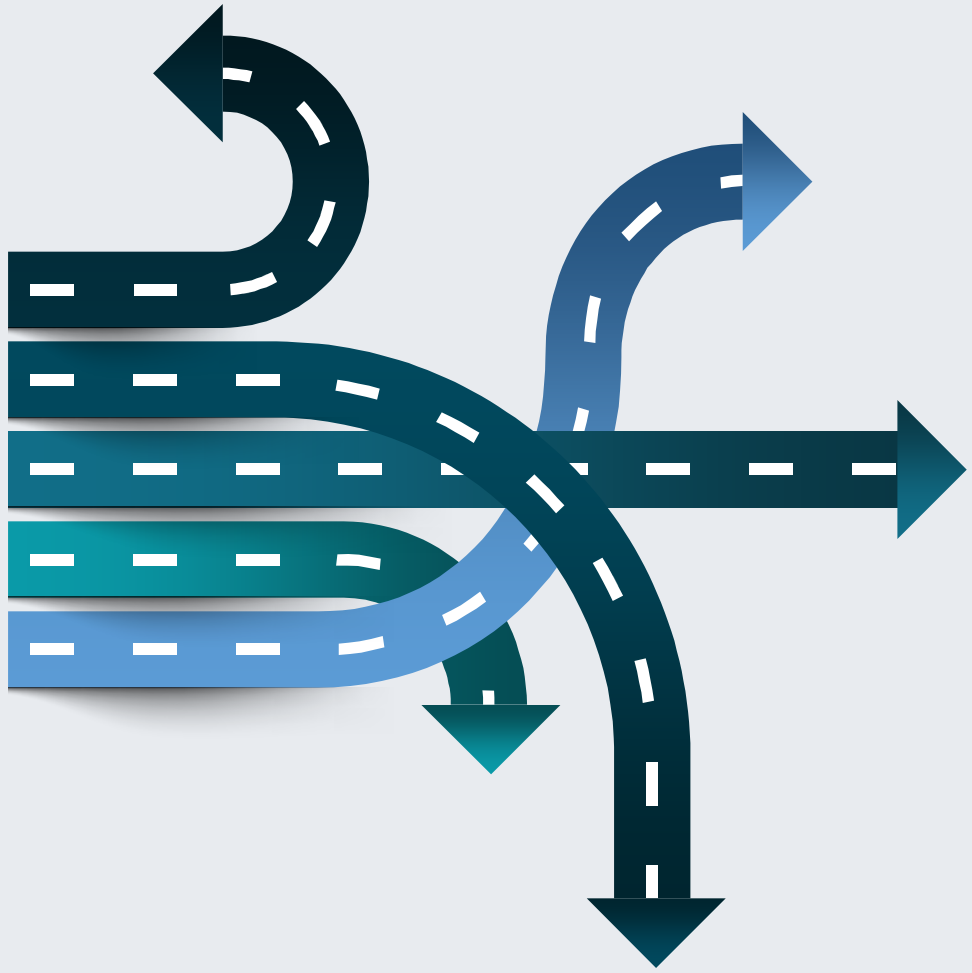
System Planning

- Assessing system needs
- Identifying goals and target populations
- Understanding the pathway to TCC



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Tiered Care Coordination

All children, youth, young adults, and their families

Health care, screening, social determinants of health

Primary care providers, childcare centers, schools

Universal Health Promotion

01

Voiced/Identified Need

Concern something is wrong, assessment, early intervention

Family organizations, MCOs, Primary Care, Schools

Navigation, Information & Referral

02

Moderate Need

High caregiver stress/strain, needs require multiple services & supports to address

Systems, CMHCs, CCBHCs

Intermediate Care Coordination (e.g. FOCUS)

03

Complex Need

Significant challenges, high risk, high caregiver stress/ strain, multiple needs not met by single system or service

CMEs CCOs

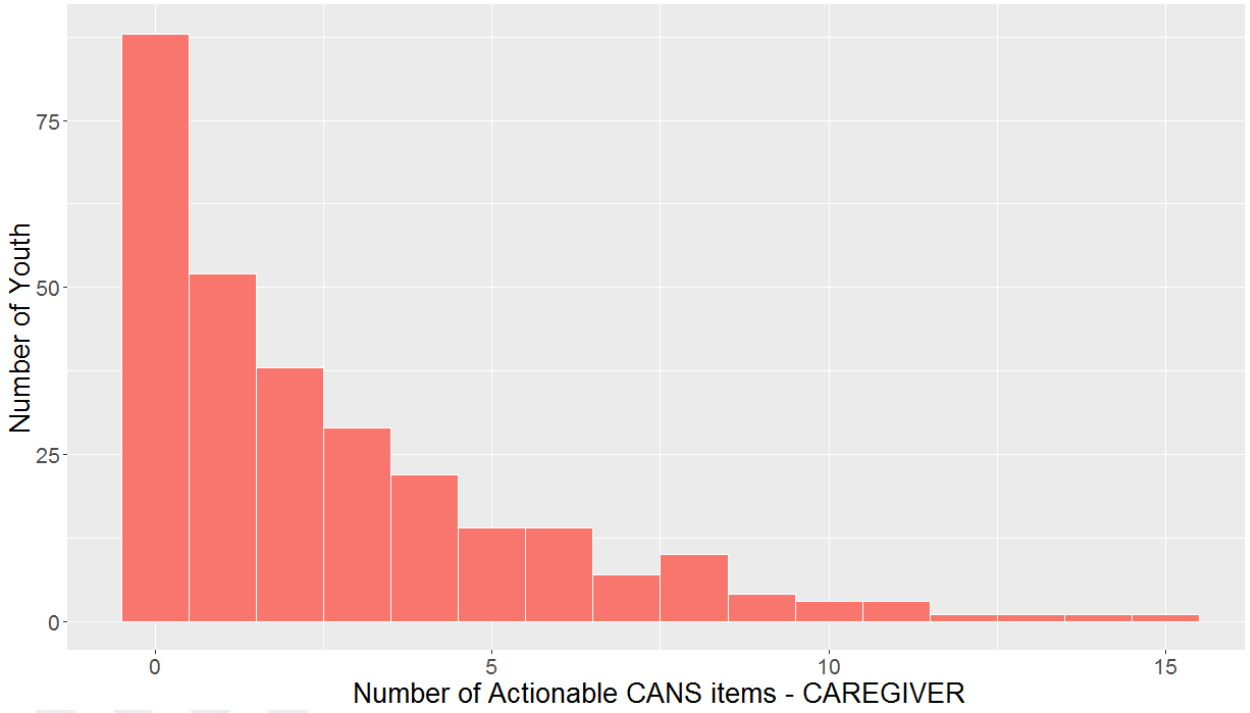
Intensive Care Coordination Using a Wraparound Approach

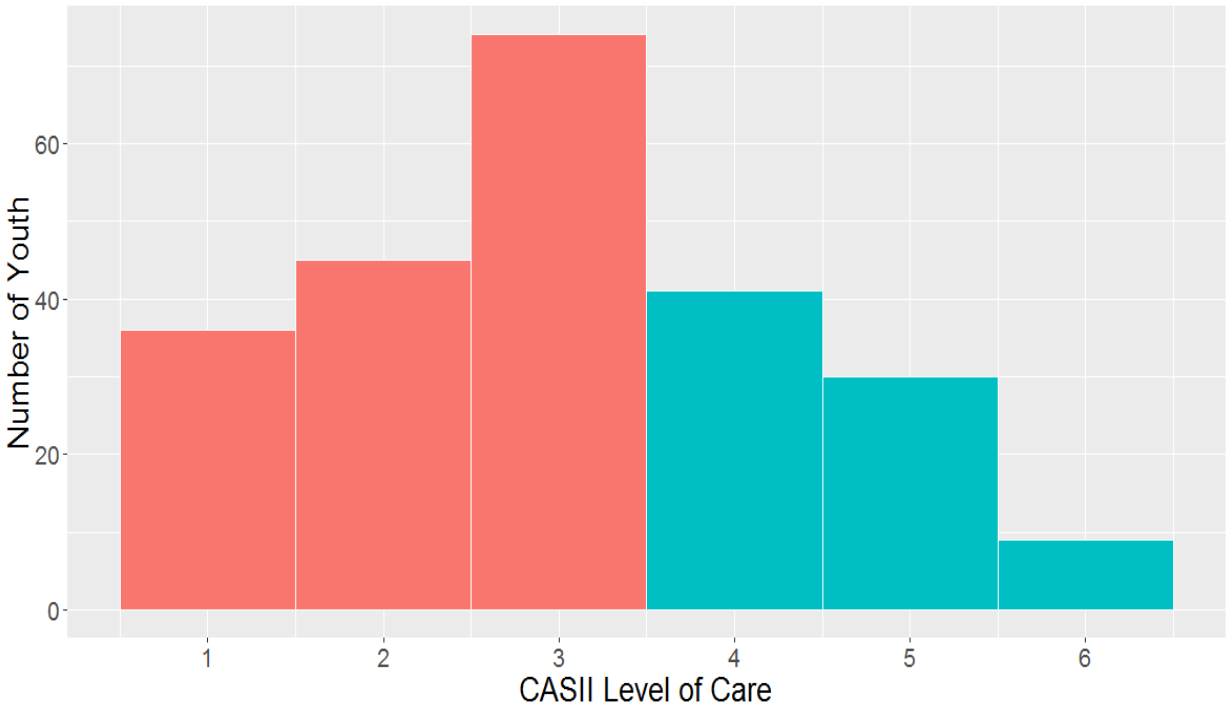
04

Mobile Response and Stabilization

Assessing System Needs

Using available data to assess needs within your population.





Burton, Christiansen, Taycher, Hensley, & Bruns, 2019

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Define the Population

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Intermediate Care Coordination

- Behavioral Health Needs
- Social Determinants of Health
  - Economic Stability
  - Education
  - Social and Community Context
  - Health and Health Care
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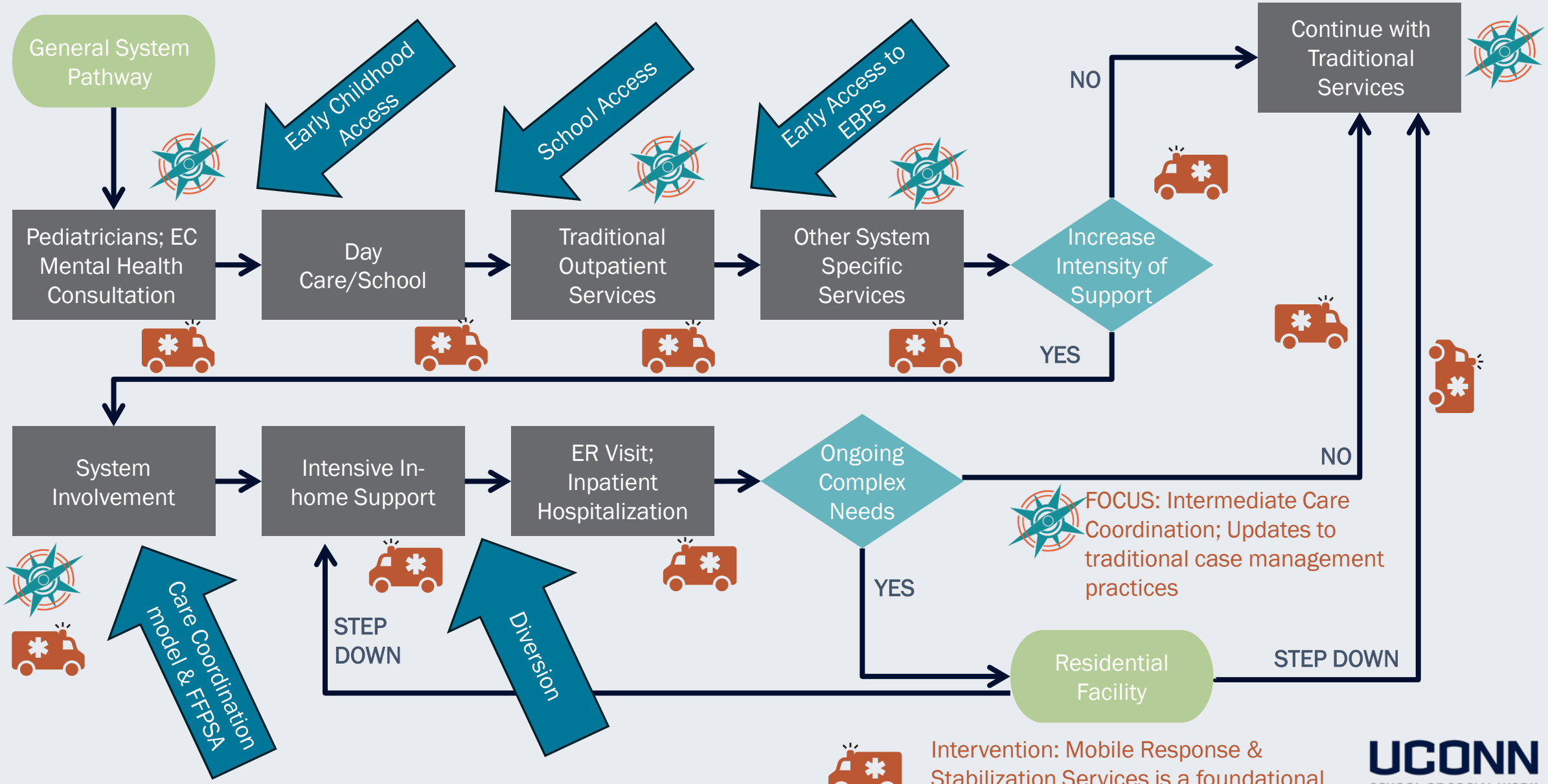
- Complex Behavioral Health Needs
- Multi-System Involved
- High risk of out-of-home placement
- Elevated risk of crisis

May be compounded by:

- Social Determinants of Health
- Developmental delays

Where can Intermediate Care Coordination interrupt current experiences to make things better?



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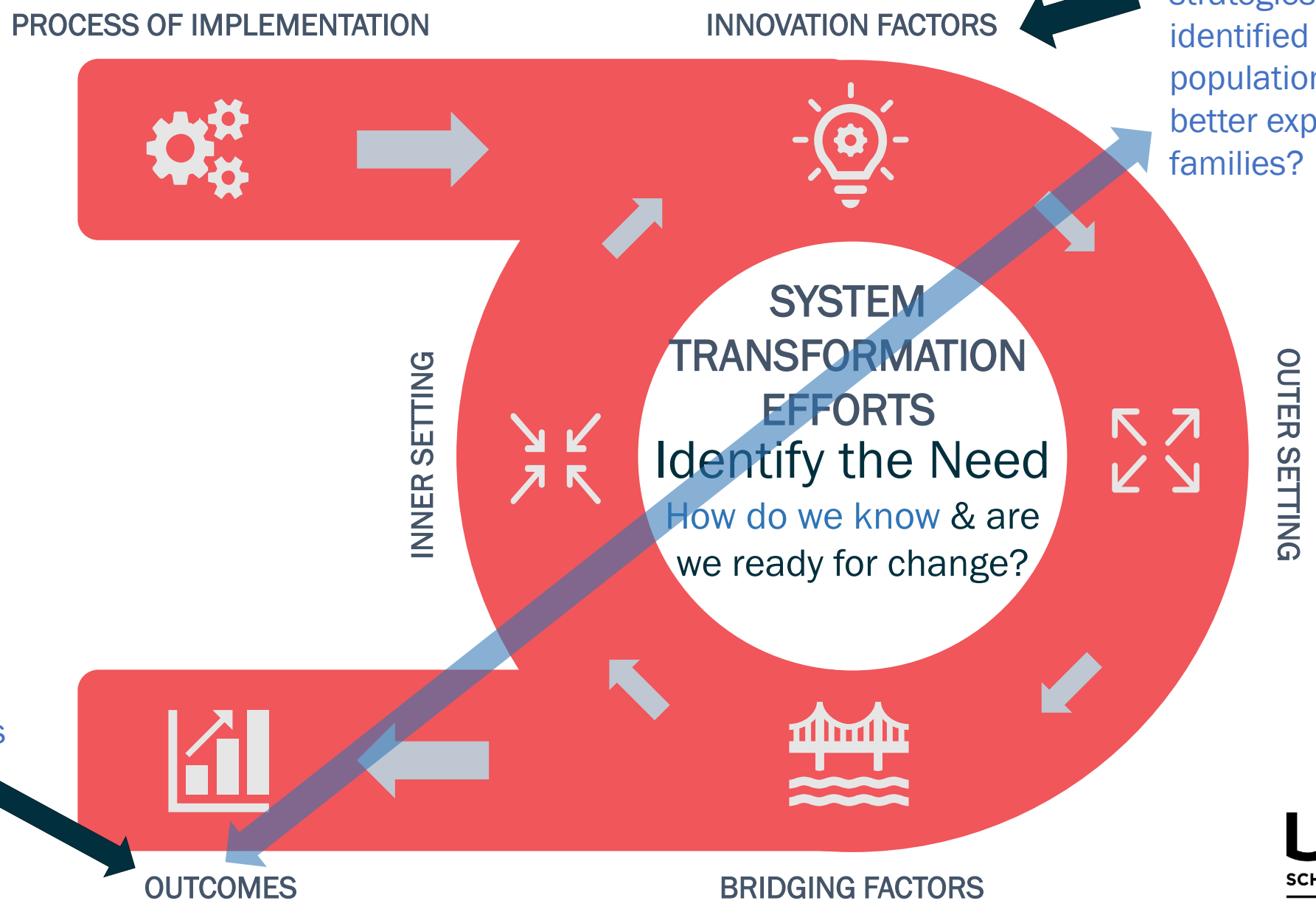
Defining System Goals

- Fit – will the proposed strategies impact the identified problem or population and create better experiences for families?



- If the named need is met, what will be different?

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Matching Intensity to Need

Assessing families needs

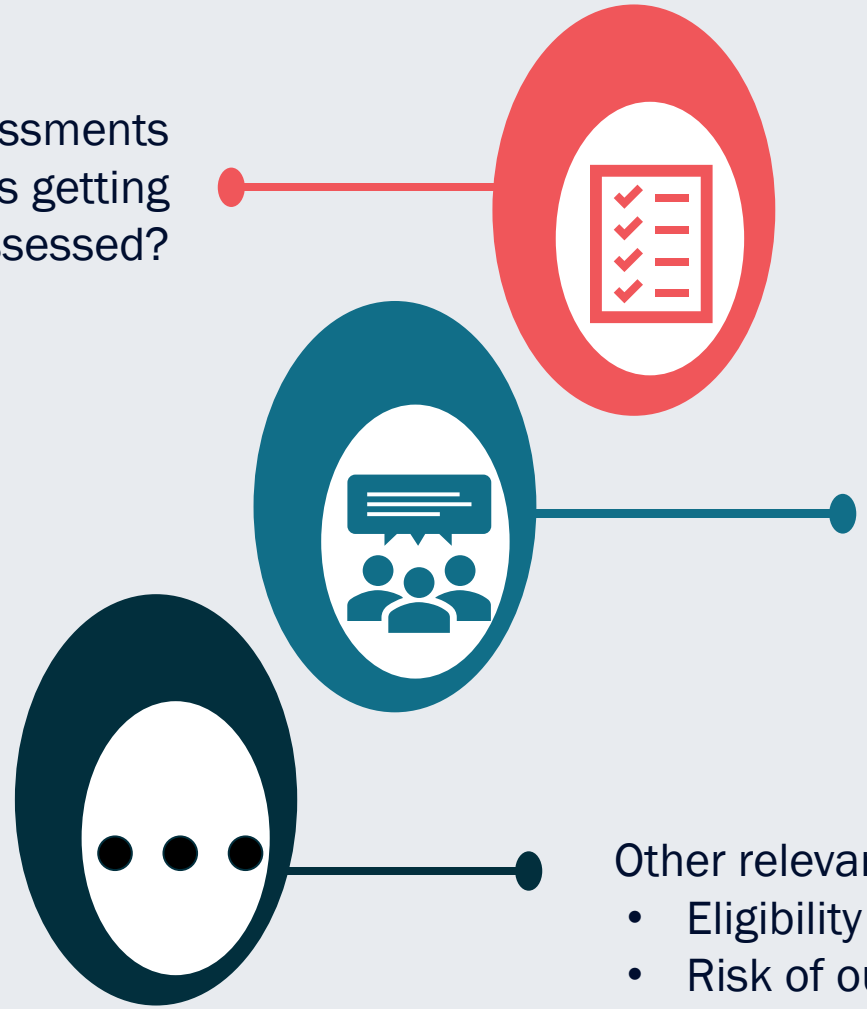
- Meeting requirements – SED
- Standardized Measures – Clinician vs Self-report
- Other indicators – System involvement, risk

Decision support protocol

- Data informed decision making
- Recommends level of care coordination

Assessing Family Needs

Who is doing assessments and when are families getting assessed?



Considerations for selecting measures

- Type of measure: Clinician-completed vs Self/Caregiver-report
- Relevant constructs: Mental health, caregiver strain, social determinants of health

Other relevant indicators

- Eligibility
- Risk of out of home placement

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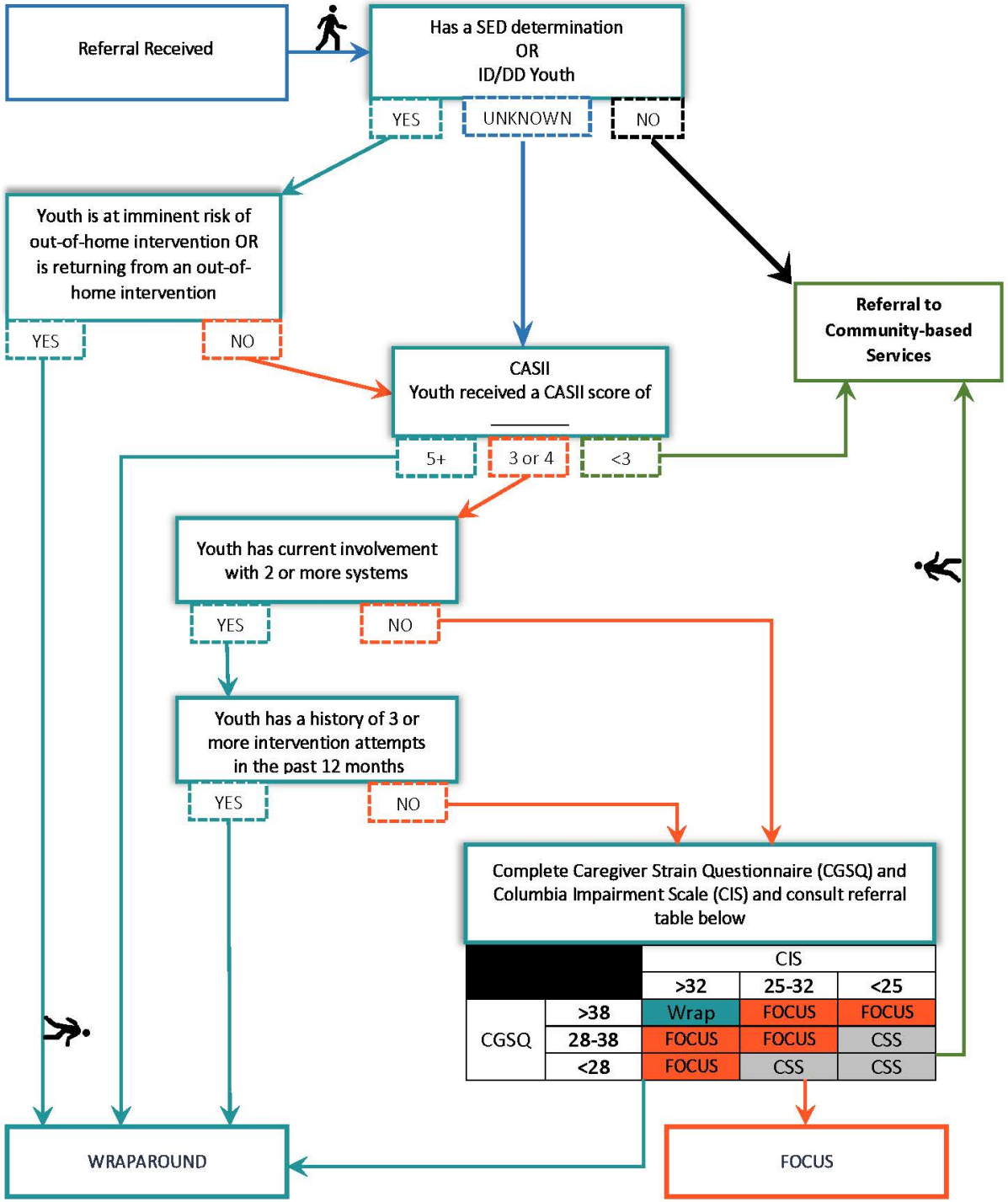
Referral Received
Has a SED determination OR ID/DD Youth
YES
UNKNOWN
NO
Youth is at imminent risk of out-of-home intervention OR is returning from an out-of-home intervention
YES
NO
Referral to Community-based Services
CASII
Youth received a CASII score of
5+
3 or 4
<3
Youth has current involvement with 2 or more systems
YES
NO
Youth has a history of 3 or more intervention attempts in the past 12 months
YES
NO
Complete Caregiver Strain Questionnaire (CGSQ) and Columbia Impairment Scale (CIS) and consult referral table below
CIS
>32
25-32
<25
CGSQ
>38
Wrap
FOCUS
FOCUS
28-38
FOCUS
FOCUS
CSS
<28
FOCUS
CSS
CSS
WRAPAROUND
FOCUS

Supporting Implementation

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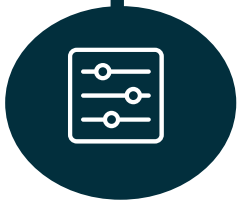
01



Are families getting to the right level of care coordination?

- Are families needs consistent with the level of cc?
- Are families moving between levels of cc?
- Is the decision support protocol providing appropriate recommendations?
- Are the families who need care coordination being reached?

02

Are the various levels of care coordination being implemented effectively?

- How long are families waiting to be assessed?
- How quickly are families moving from assessment to starting with their care coordinator?
- Are the care coordination models being implemented with fidelity?

Continuous Quality Improvement

- Check – *implementation* of change
- Rapid cycle reporting
- Data driven decision making & course correction

- Study – *Impact* of change
- Quarterly/Annual reporting
- Did it matter

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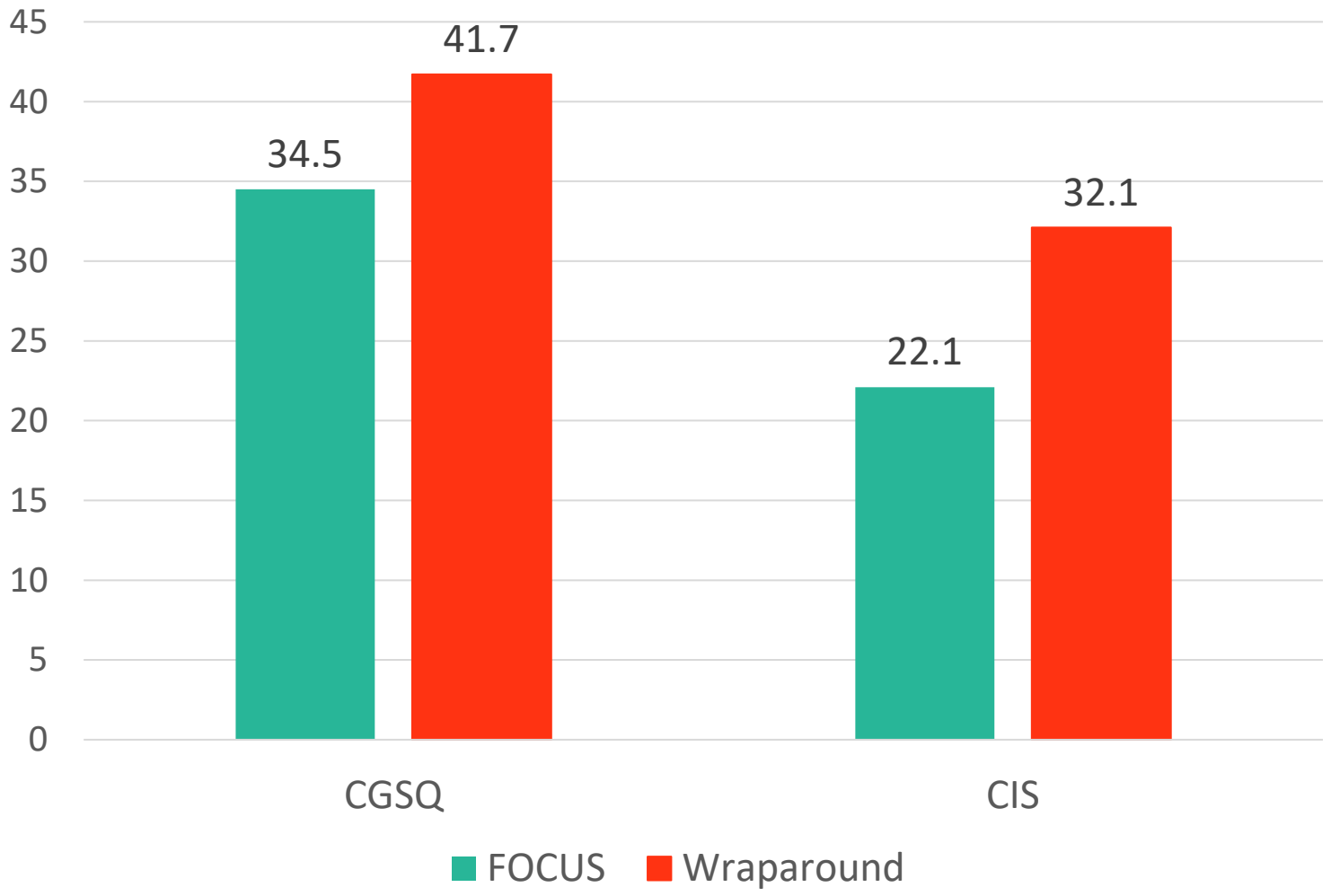
Matching Needs to Level of Care Coordination



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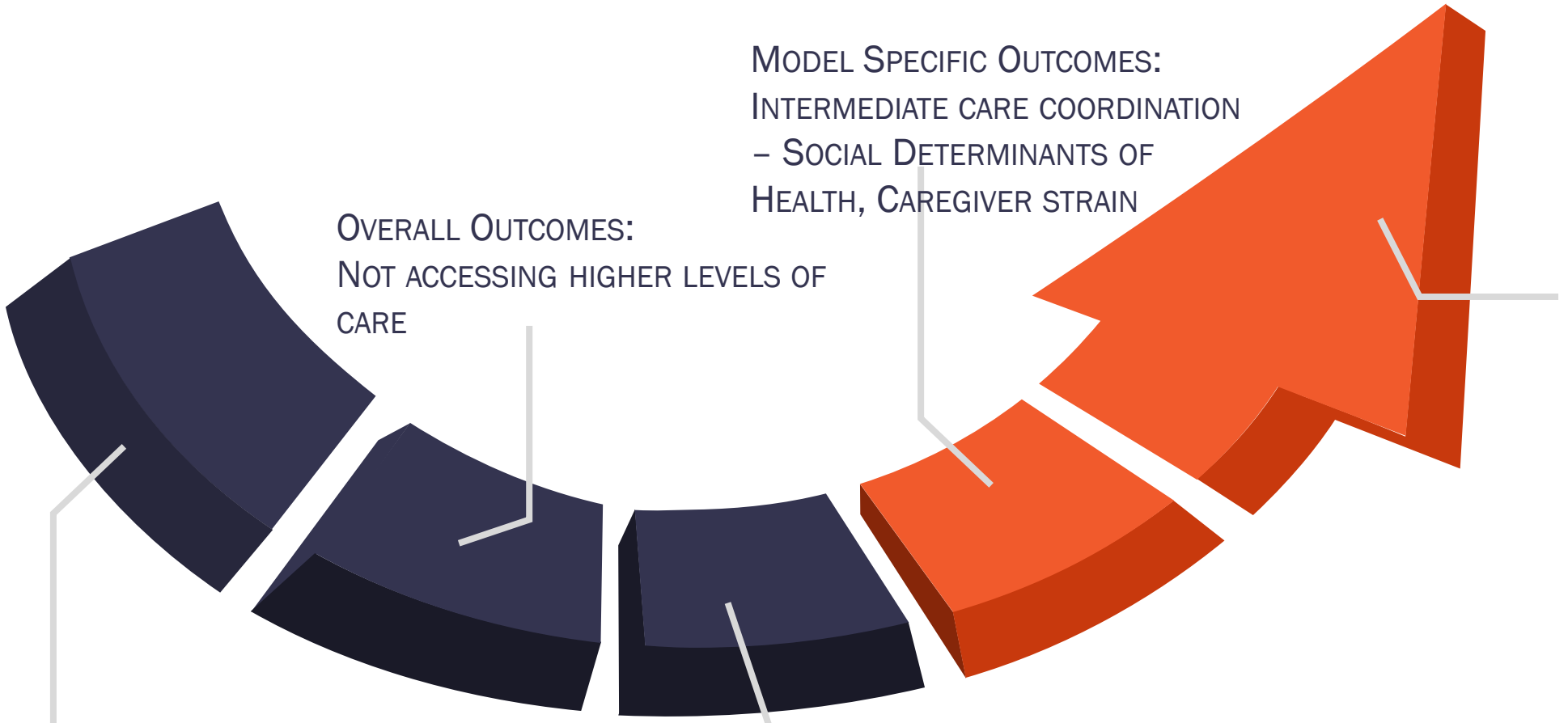
CQI: Monitoring Outcomes



Overall Outcomes:
Meeting Goals

Overall Outcomes:
Not accessing higher levels of care

Model Specific Outcomes:
Intermediate care coordination – Social Determinants of Health, Caregiver strain

Overall Outcomes:
Family Satisfaction

Model Specific Outcomes:
Wraparound – At home? In school? Out of trouble?

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Right Intensity, Right Time

All children, youth, young adults, and their families

Health care, screening, social determinants of health

Voiced/Identified Need

Concern something is wrong, assessment, early intervention

Moderate Need

High caregiver stress/strain, needs require multiple services & supports to address

Complex Need

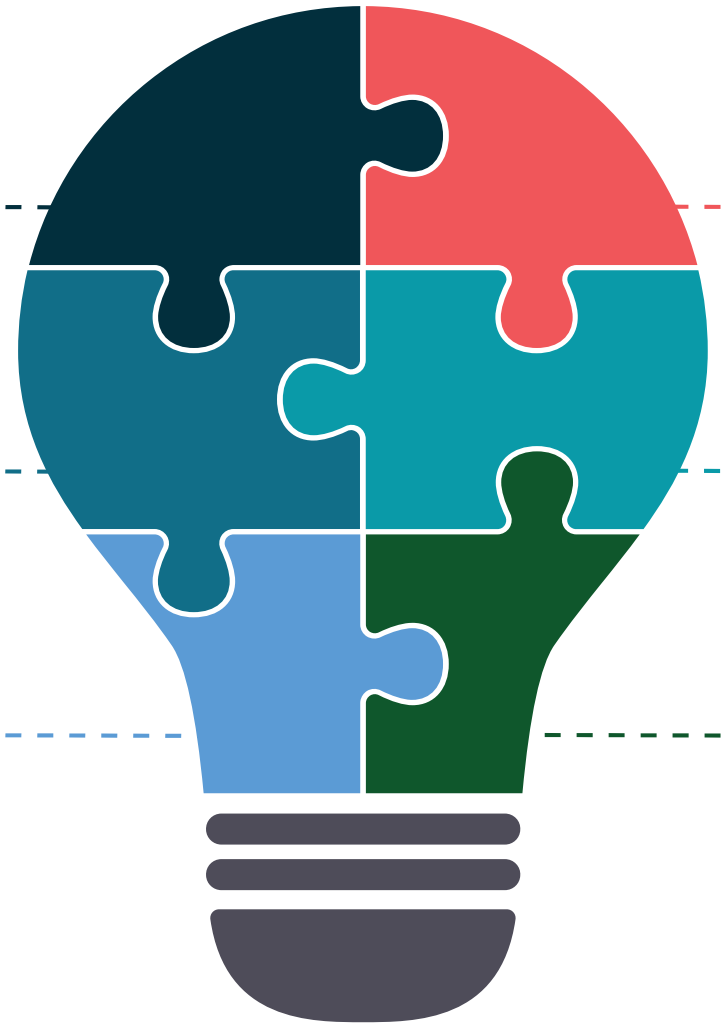
Significant challenges, high risk, high caregiver stress/ strain, multiple needs not met by single system or service

Wrap-up and Recommendations

Thinking more downstream/prevention

Match needs and support available

Support workforce to develop expertise in one level



Be data-informed

Define practice expectations

Leave Wraparound whole – don't pull it apart

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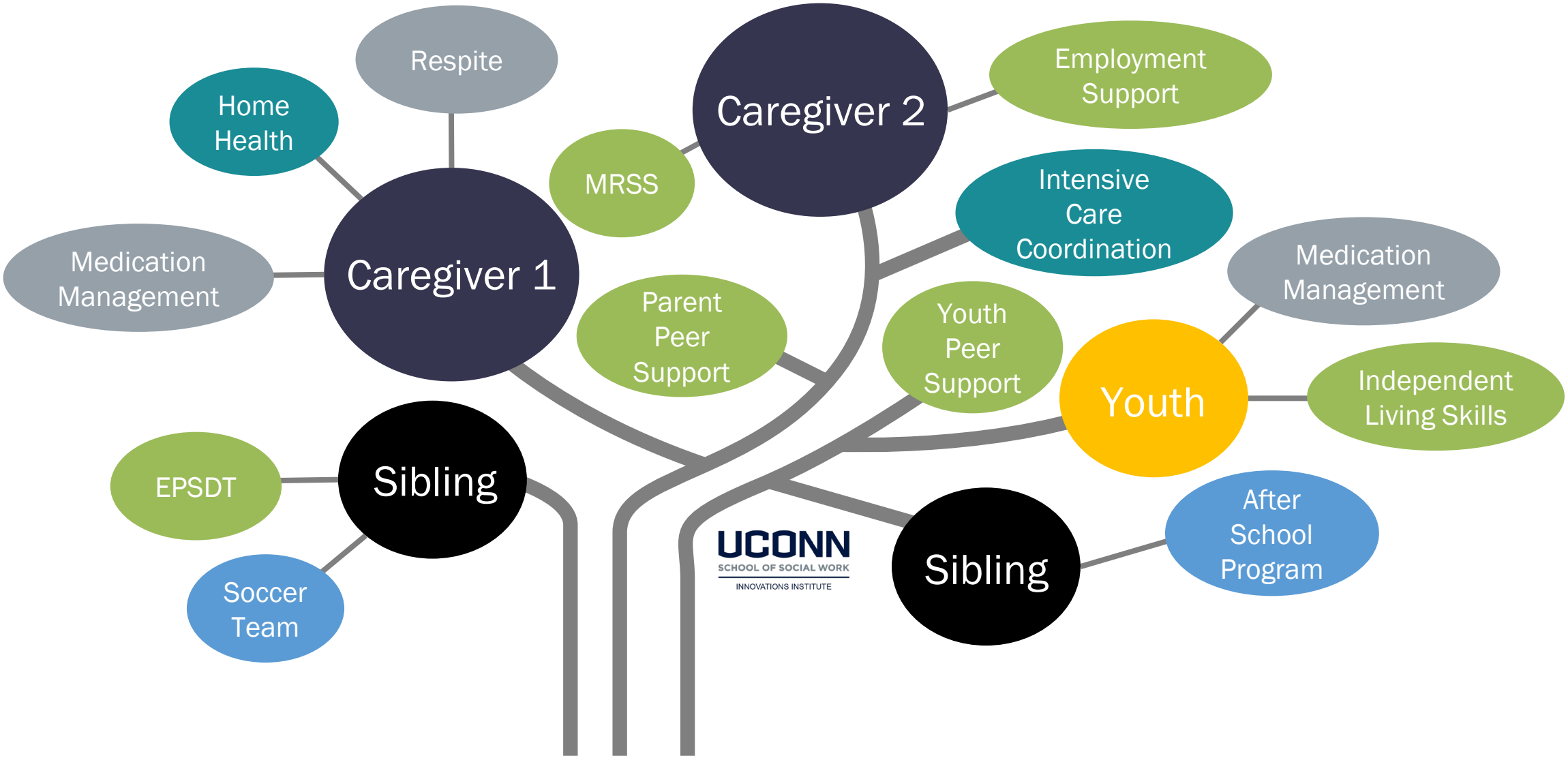
Children grow up in families & communities: addressing family needs are critical



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#WhatCouldBe

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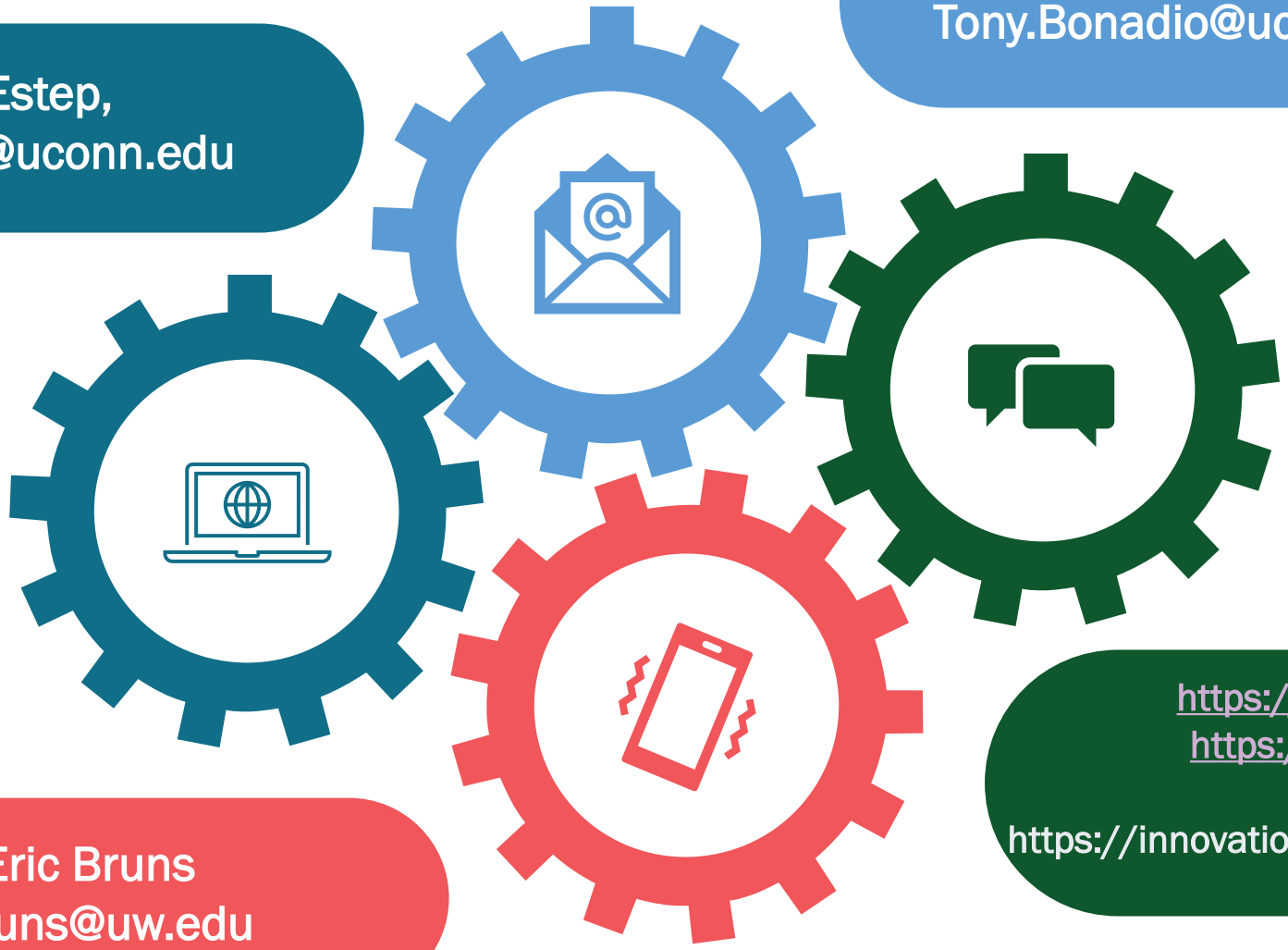

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