Comments to the State's Children's Health Home Workgroup

The Coalition of Behavioral Health Agencies, Inc. appreciates the opportunity to provide comments on how the health home model should be tailored to meet the needs of children and families. The Coalition is committed to ensuring that health homes have the expertise and experience working with children and families and are able to meet all of their needs. The Coalition solicited feedback from our members on the following three elements of a health home model. Their responses are included below.

Health Home Network Requirements

It is essential that Health Homes develop a network to assure comprehensive coverage of the full spectrum of services to children and families. Provider eligibility should be based on geographic area, experience working with the designated population, capacity, and services available. We must ensure that the network of providers has the set of skills, expertise, experience and cultural competence to serve this population. It is crucial that we do not lose agencies and programs that have the knowledge and experience to serve special populations and provide specialty services. The network must have the capacity to serve children and families at every level of care.

The network must include a comprehensive array of providers. It is crucial that the network include community-based agencies (e.g. Article 31 clinics, Article 28 clinics, 822 substance use clinics), that provide quality services insured through a rigorous oversight system. Providers should include the following: (1) primary care physicians/pediatricians, (2) mental health care providers (e.g. OMH HCBS waiver providers, residential providers, case management providers, day treatment providers, rehabilitation providers, Article 31 clinics, respite providers, crisis service providers), (3) substance abuse providers, including residential care, (4) OCFS providers (e.g. foster care agencies, B2H providers, respite providers), (5) health care providers (e.g. Article 28 clinics, Article 16 clinics, FQHCs), (6) dental care providers, (7) vision care providers, (8) early intervention providers, (9) hospitals (e.g. state operated children's psychiatric centers, private and general hospitals), (10) juvenile justice providers, (11) school-based health and mental health providers, and (12) family/social support providers.

Specific indices to evaluate the quality and readiness of the network should include:

- Adequate number of child-serving providers with the expertise and capacity to serve children and adolescents with behavioral health needs
- Access to services that are culturally and linguistically competent to serve minority populations (e.g. Asian, Black, Latino)
- Providers' prior experience and service array that cater to high-risk and high-need children and families
- Providers' prior experience and service array that cater to children of transitional age
- Providers' prior experience and service array that cater to children under the age of five
- Providers' prior experience in serving cross-systems children
- Providers' prior experience in person-centered and family-centered modalities/approaches and child and adolescent evidence based practices
- Pediatricians and psychiatrists that are well versed in psychotropic medication
- Providers with flexible hours to insure that families can easily access services

- Documented success in keeping high risk children in the community at the lowest level of care
- The qualifications of the service providers and their staff should include all of the professionals recognized under OMH Part 599 and OASAS Part 822 Regulations
- Provisions to ensure communication and collaboration between care managers serving adults and those serving children

Approach to Delivery of Six Core Care Management Requirements

The children's system is generally more complex than the adult system of care because many more entities might be involved in the child's life necessitating highly skilled and knowledgeable care managers. Family/parent engagement and involvement is a significant component of a child's treatment. Collaboration between family members and/or legal guardians, schools, and other service providers leads to more positive outcomes for children. Health Home care management for children must not only be "whole-person" and "person-centered" but also "family-centered".

Modifications to the delivery of the six core functions of the health home model must be made for children and families. They are as follows:

- Comprehensive Care Management
  - Parents/legal guardians are often the gatekeepers of a child's treatment. There needs to be more of an emphasis on engaging them in the process and educating them on the importance and value of receiving services, including behavioral health services
  - Some providers noted that the CANS assessment tool does not adequately capture essential information about the child. Other common assessment tools must be identified in order to ensure that critical information needed to accurately determine a child's level of need (e.g. GAF, prior use of behavioral health services and hospitalizations) is obtained.
  - The interdisciplinary team that conducts case reviews must include representatives from all of the child-serving systems that assist children and families. In particular this must be ensured for those children who are currently served through multiple systems.
  - Children's care management must have an increased focus on engagement for the child, family members and/or legal guardians
  - There are additional custody/consent issues that exist when working with children that must be addressed. In addition truancy, along with other behaviors, can make outreach, engagement and enrollment more difficult. Therefore, modifications must be made to the outreach process/requirements.

- Care Coordination and Health Promotion
  - Given the complexity of working with children caseloads need to remain small. This will enable case managers to properly perform all of the face-to-face services and additional services that are necessary when working children and families.
  - Implement more intensive in-home and crisis intervention services
  - If whole families (parents, siblings, children, etc.) are engaged in a health home there must be a mechanism for the care managers serving the adults and care managers serving children to regularly communicate with one another and reflect work efforts on the care coordination plan.
  - It may be beneficial to create a "family care manager" that will bridge the adult and children's systems when you have a family in the same health home (e.g. 1 parent and 2 children).

- Comprehensive Transitional Care
  - Particular attention and modification must be made for special populations; including children in foster care and juvenile justice
  - Special attention and modification must be made for children being discharged from hospitals and going to "step-down" programs/services

- Given that children transition rapidly from one system to another we need to ensure that there is open communication between care managers
- Providers need to have discretion as to when a child should be transitioned from a care manager serving children to a care manager serving adults

- Individual and Family Support
  - It is essential peer and family advocates play a key role in the health home model, not just in the individual and family support core function

- Referrals to Community and Social Support Services
  - Currently there is a dearth of community services geared towards working with children and families (e.g. recreation, afterschool programs, homework help, rehabilitation, skill-building, socialization, habilitation, vocational/employment services, transitional age programming). It is important care managers keep in mind the accessibility of services when making referrals to community and social support services

- Health Information Technology
  - A designated funding stream must be made for the implementation of HIT for children's providers

Health Home Eligibility Criteria/Requirements

Diagnosis alone should not be the eligibility criteria for children. The eligibility criteria to be enrolled in a health home should be based on the following: (1) SED or SUD diagnoses, (2) special health conditions as defined by the Federal government (3) involvement in the juvenile justice and/or OCFS system, (4) level of functionality, or limitation, (5) at risk or repeated use of out of home placement, (6) repeated use of crisis response services and/or emergency room services, (7) unstable family environment, (8) exposure to traumatic events, and (9) family/parenting risk and strengths, psychiatric or SUD history and/or diagnosis. Please note, this list is not exhaustive.

Oftentimes, children included in the medically fragile population have mental health and/or substance use issues. Therefore, planning for the inclusion of children into the current health home model must include a discussion about how, or if, the medically fragile population will be served.

Children with mental health issues often are also involved in the OPWDD system (e.g. they are served in Article 16 clinics). Therefore, planning for the inclusion of children into the current health home model must include a discussion with OPWDD about how, or if, the developmentally disabled population will be served through health homes or DISCOs.

Chronicity needs to be rethought because chronic substance abuse, health conditions, and trauma look different in children than in adults. The number of youth with "chronic" mental health conditions is small, as children are developing. Most youth do not have "two chronic conditions". The eligibility criteria of "one single qualifying condition of SMI" will also be harder for children to meet. A child/adolescent's diagnosis can be fluid, as they enter different systems and receive different diagnoses, often based more on their behavioral presentation. The ACE measurement tool could be used to indicate predictively the likelihood of chronic health issues, rather than the current existence of these issues. Other assessments that could be used to determine eligibility are the GAF, DLA-20, CANS and prior use of behavioral health services and/or hospitalizations. These tools capture difficulties in current and daily functioning. Providers also identified the Conner Scale as a possible tool/assessment to help determine eligibility. While the Conner Scale is used only to assess ADHD it collects information from the child, parents and teachers to obtain a comprehensive inventory of the child's behaviors. This type of assessment could be beneficial to determine health home eligibility.

There needs to be special attention and careful planning on how to ensure that special populations, including foster care and juvenile justice, are enrolled in health homes. We need to be able to identify and list the specific "conditions" they may have that would make them eligible for a health home.

Currently, DOH identifies individual's that are eligible for health home services using historical claims data and encounter information. The "number of encounters" data is not the same and/or straightforward for children. Therefore, the eligibility criteria must be determined by other standards/measures.

Additional Comments/Questions

As the health home model is tailored to meet the needs of children and families the State needs to consider the following:

- Health homes must contract with child-serving agencies. There should be no expectation that adult-serving providers currently within the health home be allowed to serve children and families unless they meet the required criteria proposed for children's providers.
- Children's providers must be given a leadership role (e.g. administrative, oversight) and be a part of the decision making process in Health Homes
- Agencies with a history of working with children/adolescents should be included in determining a child's eligibility and acuity.
- Additional training must be provided to care managers who will be working with children about "child-specific" medical issues and the various child-serving systems. It is essential care managers understand the cross system collaboration that is necessary when working with children and families
- It is important schools be able to make referrals directly to health homes
- OMH and OCFS's waivers provide care coordination and a number of valuable services. There is concern that the waiver and wraparound services will be lost. It is crucial to maintain these essential services for children and families; which are the equivalent to 1915(i) services.
- The success of the current OMH HCBS waiver and OCFS B2H waiver is partly due to the availability of flex funding and wrap-around dollars. Therefore, there should be designated funding within a health home for flex funding and wrap-around dollars for children and families
- It is essential that the State track the dollars that are taken from the children's behavioral health system and put into health homes to ensure that they are being spent on serving children and families
- The State will need to modify some of the regulations to enable agencies to provide the most flexible services to children and families; particularly to children who have complex psychosocial/behavioral needs and who are involved in multiple systems
- The PMPM has to be able to cover the expense of care coordination for children, as it is very labor intensive and requires care managers to work across multiple systems
- Special attention needs to be given to the additional HIPAA consent issues that exist when working with children
- Funding from the Regional Centers of Excellence should be used to pay for services that are currently being provided to the non-Medicaid population in programs that will be transitioned into health homes (e.g. case management, waiver)

As the health home model is tailored to meet the needs of children and families the State needs to address the following questions:

- Will HCBS Waiver (OMH) and B2H Waiver (OCFS) continue to be distinct programs/services?
- Currently, there are children enrolled in case management who do not have Medicaid. There are also children enrolled in OMH's home and community based services waiver who would not be eligible for services with out the Medicaid waiver due to family income. What will happen to the children currently enrolled in these programs and those identified in the future to need these services? There has to be a mechanism in place to ensure children can access these services in a health home environment regardless of Medicaid status.
- What methodology and data will the State use to determine acuity tiers?

    - The methodology that is currently used to determine the acuity rate for adults must be re-evaluated and modified for children
    - Providers need to be able to reassess acuity for children as they go through the various developmental stages (their acuity may change more frequently than adults)
- What will the plan be for “legacy” slots? Will the plan used for adults be used with the youth already enrolled in case management?
- What will CSPOA’s role be (e.g. will referrals go through C-SPOA)?
- The State has worked with the Federal government on these new initiatives long enough to understand federal guidelines. The plan to include children into the existing health home should realistically mesh with current federal guidelines.