REPORT

Care Integration Opportunities in Primary Care for Children, Youth, and Young Adults with Behavioral Health Needs: Expert Convening

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Introduction

In June 2017, the National Technical Assistance Network for Children’s Behavioral Health invited a group of experts to address the topic of improving physical and behavioral health care integration for children, youth, and young adults and their families enrolled in Medicaid, the State Children’s Health Insurance Program (SCHIP), and other safety net programs. In a two-day meeting, the group explored care integration challenges and opportunities in primary care and behavioral health settings and identified evidence-informed approaches. The goal of the meeting was to develop consensus, if possible, and enhance guidance to the field on the values, characteristics, technologies, and financing models associated with an effective care integration continuum for children, youth, and young adults with behavioral health challenges. This paper provides background on the meeting, information about the composition, process, and deliberations of the expert convening, and, most important, describes the consensus achieved by the group with respect to a comprehensive care integration continuum. While recognizing that all children, regardless of payer, have need for behavioral health promotion, prevention, risk, or treatment, participants focused on children in safety net programs given the typically higher level of need, and associated costs, as compared to privately insured individuals.

Background

One in five children or youth will experience a mental health disorder in a given year, and one in 10 children is estimated to meet the federal criteria for a serious emotional disturbance, defined as a mental health problem that has a significant impact on a child’s ability to function socially, academically, and emotionally. Another 16 percent of children and youth have behavioral health challenges that do not meet the criteria for a diagnosis but who need support to address emerging risk issues in which intervening early is paramount. This is true particularly for children ages 0-5 who often do not meet criteria for a diagnosis or for whom professionals and families are reluctant to “label” an issue as a disorder at such a young age. In addition to prevalence, mental health conditions are the costliest health condition of childhood, and children enrolled in Medicaid who use behavioral health care are four times more expensive than their counterparts who do not use behavioral health services. Given this data and what we understand about the impact of toxic stress on children and early brain development, many children and their families need integrated services to address their behavioral health promotion, prevention, risk, and treatment needs. Far too many youth and families continue to have unmet needs, particularly children with mental health conditions.

Despite the growing understanding of the importance of care coordination, there remains a lack of consensus in the pediatric primary care and behavioral health fields about the most effective integrative approaches for


children. In part, this is because of a lack of a common lexicon. Terms such as case management or care coordination do not have a single definition, and terms such as co-location of care are frequently poorly understood as synonymous with integrated care.

Many organizations are working to define care integration to lay the foundation for clarity in approaches and models. In 2014, the American Academy of Pediatrics (AAP) Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee made an important distinction between care coordination and case management, noting that case managers “work with and guide services intrinsic to their specific agency,” whereas care coordinators “work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community.”

Extending beyond the concept of care coordination and case management, the physical and behavioral health care communities have been advancing the concept of integrated care.

The Center for Integrated Health Solutions (CIHS), supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA), defines integrated care as “the care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.” The Rural Health Information Hub defines care integration as “close collaboration in a partly integrated practice or full collaboration in a transformed/merged practice. In this model, providers jointly plan and execute goals, develop integrated care plans, co-manage patients, and maintain shared schedules. Integrated practices use a systematic clinical approach to identify patients who need behavioral health services and engage providers and patients in shared decision-making.”

Further, the CIHS notes that integrating mental health, substance use, and primary care services produces the best health outcomes whether services are organized within primary care or behavioral health care settings.

One of the challenges to determining an effective care integration continuum is that children, youth, and young adults with behavioral health challenges are not a homogeneous population. Children and their families come from varied backgrounds and may have exposure to adverse experiences, with many impacted by external factors that influence health such as poverty. They include those with brief, moderate, and intensive treatment needs; those who are at risk for or are experiencing emergence of mild, moderate, and/or complex behavioral health conditions; very young children to youth who are transition-age; children and youth involved with multiple child-serving systems such as child welfare; and diverse racial and ethnic groups. These broader and varied factors influence the behavioral health needs of children. Further, children are not mini-adults. This distinction bears further attention as the majority of integrated care models refer to the treatment of adults.

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adults. For example, children have much lower prevalence of co-morbid physical health conditions requiring care integration than adults, and they have greater dependence on family and other systems such as education, child welfare, and community supports, to provide information on their behalf and support medical or behavioral health interventions.

 Seventy-five percent of children with diagnosed mental health conditions are seen in the primary care setting, making it, in some respects, a natural setting for identifying and intervening with respect to children at risk for, or experiencing, an emerging or diagnosed behavioral health condition. Many families are comfortable accessing care through their pediatricians, and studies have found that racially and ethnically diverse families especially feel less stigma in pediatric settings than with specialty behavioral health providers. Pediatric primary care providers are well-positioned to detect problems early, and they play a key role in the promotion of healthy social-emotional development, prevention, and early detection for children enrolled in Medicaid through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which provides comprehensive and preventive screening and health care services for children under 21. The persistent shortage of behavioral health specialty providers further contributes to the increased role of primary care in the management of behavioral health conditions.

However, numerous studies have found that primary care practices often struggle with managing child behavioral health conditions. During the past decade, many states have embarked on efforts to establish medical homes for children to improve the coordination of care. Studies suggest that medical homes have struggled with coordinating the behavioral health care needed by children with serious behavioral health conditions. For example, one study found that “all behavioral health conditions except attention deficit hyperactivity disorder (ADHD) were associated with difficulties accessing specialty care through the medical home.” A 2013 study in Pediatrics found that youth of color, lower-income youth, youth from households with limited English proficiency, and those with mental (as opposed to physical) health conditions were less likely to have a medical home where they could obtain routine, family-centered care. There have been similar findings with respect to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. Given the breadth of the needs represented by all children served in a pediatric primary care setting, from health promotion, risk, emergent need, and diagnosable conditions, the behavioral health professional and the whole care team must be adept at meeting these varied needs, yet workforce training often is lacking in this versatility. Other issues compound the challenge of integrated care, including the historic separation between physical health and behavioral health systems, and financing, regulatory, and operational barriers.

As noted above, much of the literature examining integrated care approaches has been devoted to adult populations (e.g., adults with serious mental illness or co-morbid conditions), with less known about which methods or models of care integration yield optimal clinical and functional outcomes across the population of children, youth, and young adults with mild, moderate, and/or complex behavioral health challenges. For example, the Collaborative Care Management model has shown promise with adolescents with depression receiving treatment in office-based settings. Intensive care coordination using fidelity Wraparound has proved effective for children and youth with serious behavioral health challenges who often have multi-system involvement. While a meta-analysis with a random-effects model indicated a significant advantage for integrated care interventions relative to usual care on behavioral health outcomes, Kolko and Perrin (2014) noted “the empirical limitations of this literature also bear mention (e.g., uncontrolled designs, small samples, limited collection of PCP measures, few follow-ups that include downstream health-related outcomes).” Much knowledge is still needed to understand which children could benefit from which integrative approach.

**Expert Convening**

In recognition of the need for an organized effort to further delineate concepts and best-practice approaches to inform a care integration continuum that encompasses the needs of all 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 government, health plans, health systems, provider organizations, trade associations, academia, family and youth-run organizations, and the federal government to discuss known models as well as elements of theoretical future models. (See Appendix A for a list of participants.)

The purpose of the meeting was to examine best-practice approaches and achieve consensus on the elements of a care integration continuum with a focus on children, youth, and young adults with behavioral health challenges enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), and other safety net programs. While recognizing that all children, regardless of payer, require care integration, participants focused on children in safety net programs given the typically higher level of need of children in those programs than among privately insured individuals. However, the group recognized that most of its recommendations are applicable regardless of payer.

The expert panel examined peer-reviewed and gray literature, definitions of pediatric behavioral health care integration and care coordination from leading programs and providers, the TA Network’s work with states, and emerging practice strategies. Deliberations and small-group discussions were held that focused on five areas: (1) understanding the population and its care integration needs; (2) defining effective approaches for children and youth with behavioral health needs in primary care and in behavioral health care settings; (3) defining and using meaningful measures to strengthen accountability and improve outcomes; (4) financing and value-based approaches that support care integration and appropriately attribute accountability; and (5) supporting practice change at the provider and system levels via training and infrastructure enhancements. The small-group deliberations were followed by large-group discussion to determine whether consensus could be achieved.


Emerging Consensus: Care Integration Continuum

Below is a graphic depiction of a Care Integration Continuum that reflects the emerging consensus from the expert convening (Box A).

Care Integration Continuum

INTEGRATION CONTINUUM* (nested within common values/principles)

* Across the continuum: Family and Youth Peer Support/Navigators, Measurement-Based (Metrics Across the Continuum)

All Children

Pediatric primary care services including promotion of social-emotional development; developmental and behavioral health screening, and family psychosocial screening with a focus on broader social determinants of health.

> Could occur in primary care, behavioral health, school-based health, or community settings.

Children with Emerging Needs and Children With Identified Behavioral Needs Treated in Primary Care Settings

Child Behavioral Health Consultation Programs which include consultation, coordination, and linkage to services with a focus on broader social determinants of health.

> Could occur in primary care, behavioral health, school-based health, or community settings.

Low/Moderate Behavioral Health Need

Team-based care with appropriate infrastructure.

> Could occur in primary care, behavioral health, school-based health, or community settings.

Complex Behavioral Health Need

Intensive Care Coordination using Wraparound.

> Could occur in primary care, behavioral health, school-based health, or community settings.

Social determinants of health are defined by the Centers for Disease Control and Prevention as factors that contribute to a person’s current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature. See https://www.cdc.gov/nchstp/socialdeterminants/definitions.html

BOX A: Care Integration Continuum

Participants agreed on the concept of a Care Integration Continuum that is nested in common values and principles, which would be applicable to children and youth at risk for or experiencing an emerging or identified low, moderate, or high/complex behavioral health need; and that the continuum must ensure seamless transitions across the continuum, given that developmental changes occur rapidly in children. Participants stressed the need for developmentally appropriate care that would be adaptable as a child ages and crosses into the adult-serving system; and, ideally, the continuum would extend to transition-age youth (through age 26). Participants agreed on the added value of incorporating family and youth peer support and system navigation within the Care Integration Continuum. There also was agreement that the continuum should be metrics-based and data-informed, with a minimum core set of common performance and outcome measures across the continuum, recognizing that there might be additional variance in measures depending on the sub-population of children (for example, children with intensive needs or youth and young adults in transition).
Care Integration Common Values and Principles

The participants agreed on common values and principles that should underlie the Care Integration Continuum regardless of setting and should be applicable across the population of children, youth, and young adults with emerging or identified behavioral health challenges. The core values and principles should be:

- Family-driven and youth-guided with the needs, strengths, natural supports, level of functioning, and goals of the child/youth and their family determining the intensity of care integration rather than children being assigned to “tracks” along the continuum based on diagnosis
- Culturally and linguistically competent, responsive to the community and sub-populations served
- Trauma-informed with all providers having familiarity with adverse childhood experiences
- Focused on health promotion, prevention, and recovery
- Metrics-based and data-informed
- Committed to a culture of continuous quality improvement

Behavioral Health Consultation

The group recommended that the Care Integration Continuum incorporate promotion, prevention, developmental, social-emotional, and behavioral health screening for all children, including a focus on social determinants of health, such as family psychosocial needs, food and housing stability, and community safety. For children with emerging or identified behavioral health needs, especially those receiving psychotropic medications managed principally in primary care settings, the group recommended the incorporation of psychiatric consultation through systemwide models, such as the Massachusetts Child Psychiatry Access Project (MCPAP) and MCPAP for Moms (see Box B), or through psychiatric consultation embedded within a pediatric setting, such as the Behavioral Health Integration Program (BHIP) at Montefiore Medical Center in New York (see Box C). For all children with identified behavioral health needs, the group emphasized the importance of team-based care, noting, as have others, that co-location is not synonymous with integrated care.

BOX B: Massachusetts Child Psychiatry Access

MCPAP is a statewide system of child psychiatry consultation teams designed to help pediatric primary care providers (PCPs) meet the needs of all children with behavioral health problems. It provides:

- Telephone consultation with a child psychiatrist/APRN or licensed therapist within 30 minutes of request
- Face-to-face psychiatric consultation when indicated
- Care coordination to assist with accessing community-based behavioral health resources, including but not limited to psychiatry
- Bridge treatment when necessary
- Training and education for primary care staff in screening, medications, diagnoses, and community resources (e.g., newsletter, website)

http://www.mass.gov/eohhs/docs/eohhs/state-innovation/mcpappresentation.pdf

Team-Based Care

Participants endorsed the concept of team-based care for children with behavioral health challenges. Team-based care is defined by the National Academy of Medicine (formerly known as the Institute of Medicine-IOM) as “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers — to the extent preferred by each patient — to accomplish shared goals within and across settings to achieve coordinated,
high-quality care.” The IOM notes that team-based care “stresses interdependence, efficient care coordination, and a culture that encourages parity among all team members,” including families/caregivers and youth. Examples of a team-based approach were described by participants from the Behavioral Health Integration Program at Montefiore Medical Center in New York, from the Pediatric Wellness Center in Jacksonville, Fla., and the Cherokee Health Systems in Tennessee (see Box C).

**BOX C: Team-Based Integrated Care Models**

<table>
<thead>
<tr>
<th>Behavioral Health Integration Program (BHIP), Montefiore Medical Center, New York</th>
<th>University of Florida Health Pediatric Wellness Center, Jacksonville, Fla.</th>
<th>Cherokee Health Systems, locations throughout Tennessee</th>
</tr>
</thead>
</table>
| Montefiore is a large health system located in the Bronx, the northernmost borough of New York, and an area with concentrated, extreme poverty and significant unmet health needs. BHIP is staffed by social workers, psychologists, and psychiatrists and includes HealthySteps (prenatal to age 5) and Child and Adolescent Psychiatry/Psychology (CAPP) (ages 5-plus). Montefiore’s 20 pediatric practices, in which 90,000 persons are served annually, engage in universal screening, assessment, treatment, and referral of pediatric and health/development and caregiver mental health. Well-child visits are co-managed and include family assessments and integrated care at each site (hubs and satellites). The visits include use of ACES screening, attention to parental behavioral health, and a “warm handoff” in which the BHIP provider meets with the referred patient during the well-child visit. [https://www.montefiore.org/bhip](https://www.montefiore.org/bhip) and [https://earlysuccess.org/sites/default/files/website_files/Briggs_slides_Alliance-NASHP 2016.pdf](https://earlysuccess.org/sites/default/files/website_files/Briggs_slides_Alliance-NASHP 2016.pdf) and [https://www.cccnewyork.org/wp-content/publications/CCCReport.Concentrated Poverty.April-2012.pdf](https://www.cccnewyork.org/wp-content/publications/CCCReport.Concentrated Poverty.April-2012.pdf) | The Pediatric Wellness Center offers comprehensive primary care for children and youth (birth to 18 years), with special mental and behavioral health needs. Trained providers help families with access to the health and social services required for optimal well-being. Services include:  
- Access to an on-call physician 24/7  
- Assistance with community mental health resources and social services  
- Complete primary health care for children, including vaccines  
- Coordinated care with child and adolescent psychiatrists, psychologists and therapists  
- Referrals given for specialty care and ongoing monitoring of growth and development. [http://partnershipforchildhealth.org/uf-pediatric-wellness-center-prudential-drive/](http://partnershipforchildhealth.org/uf-pediatric-wellness-center-prudential-drive/) | Cherokee Health Systems is a Federally Qualified Health Center (FQHC) and a Community Mental Health Center. Cherokee co-locates behavior therapists, clinical psychologists, and social workers in primary care offices to provide mental health assessments, consultations, and support. Cherokee serves children and adults in an integrated model that:  
- Embeds behavioral health consultants within primary care  
- Offers real-time behavioral and psychiatric consultation to primary care physicians  
- Uses an integrated electronic health care record  
- Includes behavioral health interventions in primary care, telehealth in school, and universal screening of all patients 12 and older for substance abuse. [https://www.ahrq.gov/sites/default/files/publications/files/case_example_7_0.pdf](https://www.ahrq.gov/sites/default/files/publications/files/case_example_7_0.pdf) and [https://www.cherokeehealth.com/professional-training/integrated-care-training-academy](https://www.cherokeehealth.com/professional-training/integrated-care-training-academy) |

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The expert convening agreed that team-based care for children, youth, and young adults with behavioral health challenges could be implemented in primary care or behavioral health settings as well as in school-based health centers. For children and youth with significant behavioral health conditions — a sub-population that is often involved in multiple systems such as child welfare and juvenile justice — there was consensus that a more intensive team-based model, such as Intensive Care Coordination with Fidelity Wraparound (ICC/Wraparound), was needed. ICC/Wraparound is defined by the National Wraparound Initiative as a structured, intensive, individualized care planning and care management process designed to meet the identified needs of children and caregivers to address a range of life areas. Through its team-based planning and implementation process, ICC/Wraparound aims to develop the problem-solving skills, coping skills, and self-efficacy of young people and family members. ICC/Wraparound also emphasizes integrating youth into the community and building the family’s social support network. Various state approaches along this continuum were discussed. Oklahoma’s Section 2703 Health Home model (see Box D) incorporates ICC/Wraparound into an integrated care approach funded through the Medicaid Health Home State Plan Amendment option for children with significant behavioral health challenges.\textsuperscript{20} Wraparound Milwaukee (see Box E) coordinates care across multiple providers and child-serving systems, including primary care, using ICC/Wraparound as the teaming process to identify and implement a plan of care based on the child and family’s goals. Wraparound Milwaukee ensures that every child and youth served has a designated medical home and that there is coordination with the primary care provider, with particular attention to metabolic monitoring for youth on psychotropic medications.

Participants agreed that the Care Integration Continuum should be metrics-based; that is, tied to quality and outcome measures. Small groups identified numerous process, structural, and outcome measures at the provider and system levels appropriate to children, youth, and young adults with behavioral health challenges (see Box F for examples). Such measures could be incorporated into value-based purchasing arrangements, but participants noted the difficulty in attributing responsibility for any one measure to a single provider or system given that the goal is integrated, continuous care (see also, Financing Section, below). Rather, the group discussed the importance of shared accountability and shared success in which all providers operate within a shared plan of care, working to support the success of the child/family and every provider involved.

**BOX F: Suggested Measures**

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Structural Measures</th>
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<tbody>
<tr>
<td>Communication frequency with providers, family, caregivers, child/youth</td>
<td>Accreditation</td>
</tr>
<tr>
<td>Services accessed/used (e.g., counts of visits, time frame between visits/continuity)</td>
<td>Human capital investment measures (social, financial, environmental, educational, personal, staffing ratios)</td>
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<tr>
<td>Follow-up after (e.g., positive screen, procedure/service)</td>
<td>Service mix (type of services delivered, and as connected to outcome measures, e.g., which services are improving outcome measures for which children and youth)</td>
</tr>
<tr>
<td>Indicators of overall well-being (e.g., screening rates, food stability, housing stability)</td>
<td>Penetration rate</td>
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<tr>
<td>Shared plan of care</td>
<td>Provider training/workforce development</td>
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<tr>
<td>Tracking measures over time (to reduce/eliminate ineffective treatment)</td>
<td>o Career pipeline for integration in secondary and postsecondary education</td>
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<tr>
<td>Length of time from referral to treatment</td>
<td>o Licensure issues/advocacy to focus on integration (supervision, practice acts, training, continuing education, etc.)</td>
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<table>
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<tr>
<th>Outcome Measures</th>
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<tbody>
<tr>
<td>Caregiver stress/strain</td>
<td>Change in health-related behaviors and health status</td>
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<td>Decreased assessment scores/increase in child and family functioning</td>
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<td>Engagement/retention in care</td>
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<tr>
<td>Experience of care (child, youth, family, etc.), reduction of parental/familial burden</td>
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<tr>
<td>Family-defined outcomes</td>
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<tr>
<td>Participation index (school, community, etc.)</td>
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<tr>
<td>Perception of access to care, unmet need</td>
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<tr>
<td>Perception of success by provider, child/youth, family (e.g., Patient Perceptions of Integrated Care Survey)</td>
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<tr>
<td>Provider wellness/satisfaction</td>
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<tr>
<td>Psychotropic medication use</td>
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<td>Recidivism/length-of-stay reductions</td>
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<tr>
<td>Reduction in higher-level expenses/inpatient/acute care</td>
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<tr>
<td>Resiliency</td>
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<td>Service utilization</td>
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<tr>
<td>Successful transition across life stages</td>
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<tr>
<td>Youth-defined outcomes</td>
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Suggestions were made regarding validated measures that could be applicable across all child and youth behavioral health populations, such as the Pediatric Integrated Care Survey (PICS), developed at Boston Children’s Hospital in partnership with families (see Appendix D, Citation 23). Two participants also submitted behavioral health integration measure concepts applicable across adult and child behavioral health populations (see Box G). Other participants indicated that measures generalizable to all children with behavioral health challenges and to adults would not be sufficient for some quality goals nor satisfactory to some payers. For example, for children with intensive behavioral health needs who often are in or at high risk for out-of-home settings, payers often insist on measures related to out-of-home placement rates and lengths of stay, which are not necessarily relevant for all children.

**BOX G: Behavioral Health Integration Measure Concepts (All Ages (MCPAP))**

1) Identification:
   a) Behavioral health annual screening rate using standardized screening tool
2) Initiation of Further Assessment and Therapeutic Planning:
   a) Rate of follow-up after referral for positive screen (e.g., to external entity; note, this could be an embedded, integrated provider, not simply a co-located provider)
   b) Access to psychiatric consultation (Yes/No)
   c) Presence of multidisciplinary plan of care for individuals with behavioral health condition and one other chronic condition
3) Continuing Care/Collaborative Care:
   a) Reduction in symptoms — HEDIS measure: Depression Remission or Response for Adolescents or Adults
4) Experience of Care Integration:
   a) Validated family survey such as Pediatric Integrated Care Survey (PICS) for children or the Patient Perceptions of Integrated Care (PPIC) for adults who require care from two or more providers for behavioral condition and one other chronic condition

John Straus, MD, and Richard Antonelli, MD

While the expert convening did not reach consensus on what the common set of measures across child, youth, and young adult populations should include, the group did agree that the Care Integration Continuum must be measurement-based and tied to a continuous quality improvement process. Participants noted that there are few measures related to children’s behavioral health from any national entity (AHRQ, NCQA, HEDIS, NQF, etc.) and agreed that more examination was needed on which measures provided the most salient information to inform clinical and cost effectiveness for children across the continuum of needs, and they called for a dedicated process to inform national process, structural, and outcome measures for children’s behavioral health.

**Care Integration Infrastructure and Workforce Considerations**

Participants agreed on a number of infrastructure and workforce considerations important to effective implementation of a Care Integration Continuum. Participants expressed concern that states, managed care organizations, and other payers were moving toward population health management, with care integration at its core, without attending to the training and capacity building needed for effective implementation. Also, care integration requires the inclusion of child- and family-specific measures, and participants expressed concern that the technology is not in place to support the collection and analysis of data to support care integration goals and quality improvement. Of particular concern was the lack of an effective, affordable, interoperable, and scalable electronic health record (EHR). Such an EHR would not only track individual health measures but also assist practices in managing the health of the population overall. The group thought that any such EHR also should be accessible to parents and caregivers and be able to send messages among clinicians, support services, and families that are secure and compliant with the Health Insurance Portability and Accountability Act. Many participants raised significant concerns about the costs not
only of acquiring such a system, but also those related to maintenance, licensing, and customization. Effective EHRs are even more critical as providers seek to collaborate across pediatric primary care, schools, and other child-serving systems.

The group discussed the importance of shared responsibility and partnerships to support team-based care integration. Suggestions for developing partnerships included cross-training, coaching, and mentoring to foster a shared language and commitment to continuous quality improvement for the health of the whole child and their family. In this respect, the group recommendations echoed those from the American Academy of Pediatrics’ 2014 Framework for Integrating Care for Children and Youth Across Multiple Systems, which noted that “relational coordination” defined as “a mutually reinforcing process of interaction between communication and relationships carried out for the purpose of task integration … [and is] particularly relevant to care coordination for children and youth, because care coordination ‘activities’ are as important as the team (e.g., families, community partners, physicians, nurses, mental health providers, social workers) performing those activities.” Participants also described the need for common consent forms with appropriate state and federal privacy protections, developed with medical legal guidance. Participants also pointed to the need for data-sharing agreements or memoranda of understanding that cross systems, given that children often are served by multiple systems.

The group agreed on the added value to the Care Integration Continuum of “practice extenders,” such as community health workers, telehealth and telephonic models of consultation, “system navigators,” and family and youth peer support partners, with these roles performed especially by those with lived experience and close cultural ties to their communities. The group noted that many “practice extender” models are grounded in culturally and linguistically relevant concepts.

**Financing the Care Integration Continuum**

The group noted several difficulties in the financing of integrated care, including difficulties in securing payment for promotion and prevention activities, including for children at risk of a behavioral health condition but not yet at a diagnosable level; lack of reimbursement for dyadic parent-child work based on parental diagnosis such as depression; absent or insufficient reimbursement for cross-agency or multi-provider collaboration; lack of payment for family or youth involvement in team-based care and for family and youth peer or system navigation support; insufficient home- and community-based services and supports; lack of reimbursement for staff without the patient present or for planning and documentation purposes; and reimbursement for virtual care and telehealth solutions to engage the family and the care team. A few group members accomplished such tasks by relying on institutional or grant support, but nearly all had concerns about the ability to sustain the effort needed to maintain coordinated and integrated care, particularly in recognition that the developmental needs of children change quickly as they age, during care transition, or as acuity of the child’s needs and conditions fluctuated. The group also noted the lack of dollars for the infrastructure needed to support integrated care, such as integrated quality improvement processes, EHRs, training, and coaching.

A few group members shared their experiences and successes in blending and braiding federal and state funds from Medicaid, grants, state general funds, Title V/Maternal Child Health, Title IV-E Child Welfare, juvenile justice, and other funds, to maximize provider reimbursement for assessments, prevention services,
non-face-to-face services, and peer support and community health workers. Participants from New Jersey (see Box H) and Milwaukee (see Box E, above) discussed their respective approaches. Participants noted that success in blending and braiding funds was dependent on political will and state leadership. New Jersey participants described their use of Medicaid as a single-payer entity for multiple, blended funding sources, including Medicaid, SCHIP, block grant, child welfare, intellectual and developmental disabilities, and substance use disorder funding, to support a comprehensive system of care for children and youth with behavioral, intellectual/developmental, and/or substance use challenges, which coordinates with primary care through a Medicaid Health Home State Plan amendment as a core component of the system.

The group noted that more states are moving all Medicaid-enrolled children and youth into integrated managed care arrangements — risk-based approaches that include physical and behavioral health Medicaid dollars — and that a major goal of these arrangements is better integrated care at the child and family (or practice) level. It was pointed out, however, that particularly in the absence of specific attention to the care integration needs of children, youth, and young adults with behavioral health challenges, particularly those with serious behavioral health conditions, integrated, risk-based managed care arrangements have not led to improved care integration at the practice level. The group thought that value-based payment (VBP) arrangements, such as pay-for-performance or shared risk models that tie some portion of reimbursement to quality, costs, and/or outcomes, in which managed care organizations and states have an interest, could lead to improved care integration if VBP arrangements are tied specifically to metrics that are relevant to populations of children with behavioral health needs and are able to assign appropriate accountability for meeting outcomes. Recognizing that pediatric primary care settings must enhance integrated practice to address the needs of all children, selection of metrics that are reflective of these varying populations within a pediatric practice becomes paramount. Given that integrated care improves outcomes for children and youth with behavioral health conditions, participants were interested but cautious about VBP. The lack of robust, nationally recognized child and youth behavioral health measures noted earlier worried many. Even if such measures were adopted and became widespread, difficulty to attribute responsibility for any particular success or failure — and therefore financial reward or risk — to any particular provider, system, or agency was noted.


The group briefly discussed rate structures, including capitation, sub-capitation, case rates, and bundled rates, but was noncommittal. Several said the particulars of the rate mechanism were unimportant as long as it (1) moved away from payment based solely on diagnosis to payment based on acuity and intensity of service need; (2) was tied to agreed-upon outcomes; and (3) included transition planning support as providers and organizations moved from one VBP mechanism to another, and particularly if the payment arrangement included risk-sharing. To the extent that a rate methodology was discussed, the group recommended inclusion of the following:

- Acuity of individuals and families served
- Social determinants of health of individuals and families served (e.g., housing stability, poverty, employment, educational attainment, incarceration) for risk adjustment
- Staff productivity, given the need for cross-training and coaching and documentation
- Planning and coordination services, including those not specific to a particular child or family
- Data collection, analysis, and reporting.

**Conclusion/Next Steps**

The expert convening led to emerging consensus on key aspects of a Care Integration Continuum, including agreement on values and principles and certain operational components, specifically:

- Promotion, prevention, universal developmental and behavioral health screening, and social determinants of health and family psychosocial screening
- Need for care to be family-driven and youth-guided with the needs and goals of the youth/family determining care provided
- Timely access by primary care to behavioral health consultation
- Team-based care regardless of setting
- Implementation of evidence-informed approaches for children with mild to moderate behavioral health needs, such as Collaborative Care Management for adolescents with depression and Intensive Care Coordination with fidelity Wraparound for children and youth with serious behavioral health conditions
- The centrality of a metrics-based continuum, with certain metrics applicable across the continuum
- The value added of “practice extenders,” especially families and youth with lived experience, in outreach and engagement, peer support, and system navigation roles
- The importance of training, coaching, and data systems to support integrated care
- The potential of value-based payment approaches to support the goal of integrated care, though with the expressed need for consensus on appropriate measures across child, youth, and young adult populations to advance value-based payment arrangements tied to meaningful and appropriately assigned outcomes across multiple systems and providers.

The National Technical Assistance Network for Children’s Behavioral Health is continuing to explore care integration arrangements and considerations with additional stakeholder groups, including national Medicaid managed care trade organizations, health plans, and state Medicaid agencies. The TA Network also will periodically reconvene experts to refine guidance to the field on this important topic and welcomes feedback.

## Appendix A – List of Participants

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Appendix B – Participant Biographies

Richard Antonelli, MD, MS
Antonelli has extensive experience working at the national level and in many states in redesigning systems of health care delivery. His efforts have informed the evolution of care coordination functions and activities that enable systems to become high-performing delivery models. The Commonwealth Fund has supported our work to develop a framework and potential measures for comprehensive, multidisciplinary care coordination. The framework is being used to influence the creation of systemwide care coordination in multiple states. In his position as medical director of integrated care at Boston Children’s Hospital, Antonelli focuses his work on developing methodologies, tools, procedures, and measures to facilitate integration of care and evaluate care coordination activities and outcomes. This includes linkages among families, youth, primary care providers, sub-specialists, and community-based organizations. Antonelli was appointed to a second term as the child health subject matter expert on the Measures Application Partnership Coordinating Committee at the National Quality Forum (NQF). He also serves on the NQF’s Care Coordination Standing Committee and was asked to chair the NQF MAP Medicaid Child Quality Task Force.

Rebecca Baum, MD
Baum is division chief of developmental and behavioral pediatrics at Nationwide Children’s Hospital and an associate professor of Pediatrics at Ohio State University. She also serves as co-medical director for the Building Mental Wellness Learning Collaborative with the American Academy of Pediatrics’ (AAP) Ohio chapter and as the physician lead for the Navigate My Care Program at Nationwide Children’s Hospital, designed to improve care coordination, patient flow, and access across a complex health care system. Baum received her medical degree from the University of Pennsylvania and trained in residency and served as chief resident at Children’s Hospital of Pittsburgh. Baum completed a fellowship in developmental and behavioral pediatrics at Nationwide Children’s Hospital after practicing as a primary care physician in central Pennsylvania. Her primary research and clinical interests involve improving service delivery to children with emotional and behavioral disorders. She is chair of the Project Advisory Committee for the AAP’s Practice Improvement to Address Adolescent Substance Use Project and is a member of its Committee on Psychosocial Aspects of Child and Family Health. Before her role as division chief, Baum served as an associate medical director for Partners for Kids, an accountable care organization affiliated with Nationwide Children’s Hospital.

Johanna Bergan, BA
Bergan, executive director of Youth MOVE National, is an advocate for youth with lived experience in the mental health system who is working in the field of youth engagement to promote and encourage the inclusion of youth voice in policy change. Bergan has nine years of experience advocating for important changes in the mental health system to improve the care options and treatment availability for young adults with mental health challenges. Her voice has been heard on several national platforms, including advising technical assistance and research and training centers that support and promote the value of youth voice. Bergan assists chapters of the Youth MOVE network in creating and promoting successful youth-driven organizations working to unite the voices and causes of youth at the local, state, and national levels. Her duties include providing technical assistance and training to youth and adult audiences, with an emphasis on ensuring that culturally diverse youth populations are well represented in systems change work, including historically disadvantaged communities, young adults of color, LGBTQ, rural and urban experiences, teen parents, runaway and homeless youth, and youth with multisystem involvement. This work covers a diverse array of expertise areas, including youth engagement in systems change, policy, youth adult partnerships, issues specific to transition-aged youth, youth leadership, youth-driven evaluation, and applying lived experience as a resource to inform policy and systems change. At Youth MOVE National, Bergan also provides direct technical
assistance to federal grantees in the System of Care and Healthy Transitions grant programs, providing leadership and guidance to the evaluation protocols and process for the Children’s Mental Health Initiative as well as developing products and training materials to support the effective and sustained work of grantees.

Rahil Briggs, PsyD
Briggs is associate professor of pediatrics and associate professor of psychiatry and behavioral sciences at Albert Einstein College of Medicine and director of HealthySteps and pediatric behavioral health services at Montefiore Medical Group. She founded and directs one of the most comprehensive integrated pediatric behavioral health systems in the nation, serving more than 90,000 children and their families each year in the Bronx, N.Y. Briggs’ work concentrates on bringing together mental health specialists with primary care pediatrics to focus on prevention, early childhood mental health and development, and parent-child relationships. She is the editor of *Integrated Early Childhood Behavioral Health in Primary Care: A Guide to Implementation and Evaluation*, published in 2016. Briggs completed her undergraduate work at Duke University (*magna cum laude*) and her doctoral work at New York University.

Eric Bruns, PhD
Bruns is a clinical psychologist and associate professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. Bruns’ research and other professional activities focus on public child-serving systems and how to maximize their positive effects on youth with behavioral health needs and their families. He is nationally known for his research and development work on integrated care coordination for youth with complex mental health needs via the Wraparound process. With Janet Walker, PhD, he co-directs the National Wraparound Initiative and has served as the lead developer of a suite of fidelity measures for Wraparound, now disseminated by the UW Wraparound Evaluation and Research Team. Bruns also is part of the leadership team for the Washington State Children’s Evidence Based Practice Institute and serves as associate director of the UW School Mental Health Assessment, Research, and Training (SMART) Center. He has served as the principal investigator for more than 10 federally funded studies of community and school mental health services and authored 70-plus refereed journal articles and book chapters.

Matt Buckman, PhD
Buckman is a licensed clinical psychologist in Illinois and nationally registered as a health service psychologist. He serves as the clinical director of the Child and Adolescent Division at Egyptian Public and Mental Health Department and Project Connect 2.0 System of Care Expansion and Sustainability Project. He supervises and provides direct services to children, teens, families, and young adults to help improve a variety of emotional and behavioral health issues. Buckman received his doctorate degree from the University of Kentucky and completed his predoctoral internship at the Boys Town Center for Behavioral Health. He has worked in school, medical, and clinical settings with a specialization in child maltreatment. Buckman holds certifications in Managing Adaptive Practices, Trauma Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy, and Neurosequential Model of Therapeutics.

Jean Cobb, PhD
Cobb is a licensed clinical psychologist, employed as a full-time behavioral health consultant at Cherokee Health Systems (CHS) in eastern Tennessee. She provides behavioral health services in an integrated primary care setting with special interests in pediatrics, women’s health, and quality improvement initiatives. She completed her doctoral degree at Georgia State University and works at the Chattanooga, Tenn., location of CHS. She also serves as a member of the integrated care consultation team at CHS to help other organizations across the United States learn about integrated care and successful implementation.

David DeVoursney, MPP
DeVoursney is a branch chief in the Office of Policy, Planning, and Innovation (OPPI) at the Substance Abuse and Mental Health Services Administration (SAMHSA). He joined SAMHSA in 2005 as a project officer working on
violence prevention and behavioral health promotion programs for children and youth. Since then, he has worked as a policy analyst focused on behavioral health in the Office of the SAMHSA Administrator, OPPI, and the Office of the Assistant Secretary for Planning and Evaluation in the Office of the Secretary of Health and Human Services. Across his career, he has worked on a variety of behavioral health issues related to children, youth, and families; the criminal justice system; health service integration and coordination; and broader systems and financing. DeVoursney started his career at a community mental health center in rural Indiana working with children, youth, and families and a group home serving justice-involved youth in central Virginia. He has a bachelor's degree in psychology from Earlham College and a master’s degree in public policy from the University of Michigan.

**Marian Earls, MD, MTS, FAAP**

Earls is the director of pediatric programs for Community Care of North Carolina and was the lead on the state CHIPRA Quality Demonstration Grant (2010-2015). From 1994 to 2012, she was the medical director of Guilford Child Health, a large, nonprofit, private practice that was the pediatric division of Triad Adult and Pediatric Medicine in Greensboro, N.C., and served families at or below 200 percent of the federal poverty level. She is board-certified in general pediatrics and developmental and behavioral pediatrics. She is a clinical professor of pediatrics at the University of North Carolina Medical School. Earls is a past president (2008-2010) of the North Carolina Pediatric Society (NCPS) and was chair of the Mental Health/School Health Committee for NCPS until 2011. She has been a member of the Committee on the Psychosocial Aspects of Child and Family Health of the American Academy of Pediatrics (AAP) and was the lead author on the committee’s clinical report *Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice* (Pediatrics, November 2010). She is a liaison of the AAP to the American Academy of Child and Adolescent Psychiatry (AACAP). She is a member of the executive committee of the AAP’s Council on Early Childhood. She is chair of the AAP’s Mental Health Leadership Work Group, which is charged with national dissemination of mental health integration in primary care pediatrics. She was co-chair of the North Carolina Institute of Medicine’s (NCIOM) Task Force for the Prevention of Child Maltreatment in 2005, Task Force on Early Childhood Mental Health in 2012, and Task Force on Children's Preventive Oral Health Services in 2013. Since 2000, she has been the director of the NC ABCD (Assuring Better Child Health and Development) Project. The purpose of ABCD has been to integrate developmental services (screening, surveillance, parent education) into pediatric practice and include developmental, maternal depression, social-emotional, and autism screening. She was faculty for the AAP Bright Futures Preventive Services Improvement Project Learning Collaborative in 2011. She is faculty on a Breakthrough Series Collaborative working with teams from multiple states, “Strengthening the Role of Primary Care for Families with Young Children Experiencing Trauma or Chronic Stress,” at Johns Hopkins and funded by a grant from SAMHSA. She is national co-chair and improvement advisor for the AAP’s national Bright Futures Preventive Services Improvement Project, which began in 2015. She was appointed in 2016 to the AAP’s National Advisory Board on Screening and is chair of the Screening Learning Collaborative Project Advisory Committee. Earls received her AB degree in biology in 1976 from the College of the Holy Cross in Worcester, Mass., her Master of Theological Studies degree in 1978 from Harvard Divinity School at Harvard University, and her MD degree in 1984 from the University of Massachusetts.

**Kimberly Estep, MA**

Estep is the director of the National Wraparound Implementation Center housed at the University of Maryland School of Social Work. In this role, she is responsible for supporting and managing state and organizational efforts around system of care (SOC) development, health care reform, and Wraparound implementation efforts. She has more than 20 years’ experience in the human service field and started her professional career as a clinician supporting youth that experienced trauma, specifically those who were abused
or neglected. She also has experience in areas of human service, including assessment, evaluation, and research. After moving to Maryland, she began working in grants administration and program development on the local level. She has worked within the SOC continuum at the service delivery, oversight, and policy levels. She has trained and presented across the country on SOC reform and Wraparound implementation with individualized and intensive statewide support provided to 11 states. She has developed extensive Wraparound training, coaching models, and curriculum. In her role as a systems coach through the Technical Assistance Network for Children’s Behavioral Health, SAMHSA’s national TA center for child, youth, and family mental health, Estep provides technical assistance to local jurisdictions and states in various stages of SOC and Wraparound implementation. She works to not only develop systems to support comprehensive service arrays for families of youth with mental health challenges but also to develop a skilled workforce capable of partnering with families to maintain their youth in their homes and communities. She continues in her role as a director, trainer, and coach to improve how families experience and gain support from child-serving systems, other organizations, and states.

Mary Pat Farkas, MAS
Farkas works for the Centers for Medicare & Medicaid Services (CMS) as technical director in the Division of Health Homes, Program for All-Inclusive Care for the Elderly (PACE), and in cost of benefits and third-party liability in the Disabled and Elderly Health Program Group. For more than 10 years, Farkas has worked on a variety of Medicaid program areas at CMS, including Medicaid state plan benefits in the Division of Benefits and Coverage; integrated care programs for duals; PACE; mental health parity; managed care waivers; and managed behavioral health and long-term care policy. Before CMS, Farkas worked for more than 15 years at the Maryland Medicaid Administration in the Department of Health and Mental Hygiene Administration as a health policy analyst. Farkas has a bachelor of science degree from Towson State University and a master’s degree in administrative science from Johns Hopkins University.

Suzanne Fields, MSW
Fields is a clinical social worker with 20 years of experience. Her work has spanned multiple settings, including Medicaid, managed care, mental health and substance use, child and adult services, and child welfare. Fields is a faculty member and senior advisor for health care policy and financing at the Institute for Innovation and Implementation at the University of Maryland School of Social Work, co-leading its work on policy, system design, and financing. Fields also provides consultation and coaching to states involved in the Centers for Medicare and Medicaid Innovation Accelerator Program, including states pursuing 1115 waivers to address substance use disorders, and offers technical support to states regarding compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). She previously served as the senior advisor to the administrator for health care financing with the Substance Abuse and Mental Health Services Administration. In that role, she was responsible for leading the agency’s work on the Affordable Care Act and MHPAEA, including policy, financing, regulations, federal and state implementation, and collaboration with multiple federal partners. Before joining SAMHSA, Fields worked for the Technical Assistance Collaborative (TAC), a national nonprofit consulting firm. In that role, she assisted states in numerous Medicaid, managed care, mental health, and substance use disorder efforts, dissemination of best practices, cross-system financing, system design and delivery, and quality initiatives. Before joining TAC, Fields was director of the Office of Behavioral Health for Massachusetts Medicaid, responsible for the purchasing, delivery, and quality of mental health and substance use disorder services for 1.1 million adults and children through fee-for-service, integrated managed care plans and specialty behavioral health organizations. Additionally, Fields was responsible for the service design and implementation of best-practice services for children and youth under the Rosie D. Early Periodic Screening and Diagnosis Treatment lawsuit.

Ashley Gavin, MPH
Gavin is a public health analyst in the Prevention and Population Health Group at the Center for Medicare and
Medicaid Innovation. She has worked on center-wide policy, strategy, and portfolio management and led the data strategy work for the Accountable Health Communities Model. She is the program lead for a new, pediatric-focused integrated service delivery model. Gavin is a doctoral candidate at the University of Baltimore studying public administration and holds a master’s in public health from Boston University, where she focused on global maternal and child health. While there, she led a research study on adolescent sexual health for the Secretary of Health in Bucaramanga, Colombia, and coordinated programs in pediatric ambulatory care at Boston Medical Center. Gavin is a returned Peace Corps volunteer who served on the Atlantic coast of Colombia, developing and leading programs in youth development, education, and health with her Colombian counterparts.

Jeffrey Goldhagen, MD, MPH
Goldhagen is a professor of pediatrics at the University of Florida College of Medicine-Jacksonville and chief of the Division of Community and Societal Pediatrics. His professional interests focus on maternal and child health, community pediatrics, medical and behavioral health systems development, medical education, hospice and palliative medicine, international health, children’s rights, and child advocacy. Goldhagen’s domestic experience includes serving on the faculty of the University of Minnesota, Case Western Reserve University and, for the past 21 years, UF College of Medicine-Jacksonville. For 13 of these years, he served as the director of public health for Duval County, Fla., where he developed the context for academic-public health linkages and public health systems. As chief of the UF Division of Community and Societal Pediatrics, he has provided leadership in the development of comprehensive systems of care for children’s medical and behavioral health — in particular to communities of children marginalized by complex medical conditions and social and environmental determinants of health. In addition, he is the medical director of the Partnership for Child Health and the Cleft and Craniofacial Program, is director of the fellowship in community and societal pediatrics, and has an endowed professorship, the Neviaser Family Professorship in Pediatric Palliative Care. He works with multiple organizations and colleagues in the United States to further develop and implement the principles and practice of community and societal pediatrics as a model of care for the future of pediatrics. As the project director for the Centers for Medicare & Medicaid Innovation CARE Award in Jacksonville, he is intimately involved with the development of systems of care that serve children and families with complex medical conditions. His international experience includes refugee work in Southeast Asia; rural health development in Ethiopia and several other African countries; health and social development in Romania, and, most recently, multinational endeavors in children’s rights and child health.

Karen Hacker, MD, MPH
Hacker is the director of the Allegheny County Health Department, responsible for overseeing the health of the 1.2 million residents of the Pennsylvania county. Under her leadership, Allegheny County has launched its first Plan for a Healthier Allegheny, which represents a collaborative community process to improve the health of its citizens. Using collective action to solve problems and measuring and monitoring progress is a key focus of her agenda. Before her current position, Hacker was executive director of the Institute for Community Health and the senior medical director for public and community health at the Cambridge Health Alliance, where she oversaw community affairs and conducted community-based participatory research and health services research. Hacker is an adjunct professor in the departments of Health Policy and Management and Behavioral and Community Health Sciences at the University of Pittsburgh Graduate School of Public Health and the University of Pittsburgh School of Medicine. She is an internist and adolescent medicine specialist and holds an MD degree from Northwestern University and an MPH degree from Boston University.

Larke Huang, PhD
Huang is a licensed clinical-community psychologist, a senior advisor in the Administrator’s Office of Policy Planning and Innovation at the Substance Abuse and
Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. In this position, she provides leadership on national policy for mental health and substance use issues for children, adolescents, and families and leads the administrator’s strategic initiative on trauma and justice. She also is the director of SAMHSA’s Office of Behavioral Health Equity, which was legislated by the Patient Protection and Affordable Care Act (health reform). In 2009, she did a six-month leadership exchange at the Centers for Disease Control and Prevention (CDC), where she was the senior advisor on mental health. For the past 30 years, Huang has worked at the interface of practice, research, and policy. She has assumed multiple leadership roles dedicated to improving the lives of people with mental and substance use disorders and improving population outcomes for communities. She works across multiple sectors, including behavioral health, education, primary care, and criminal and juvenile justice. She has developed federal policy documents with the Centers for Medicare & Medicaid Services addressing behavioral health service delivery and financing for mental health and substance use prevention and treatment; developed policy and programs based on the emerging research connecting trauma and health/behavioral health disorders; and crafted policies to reduce disparities in access to quality care for diverse populations. She oversees SAMHSA’s portfolio of programs that focus on trauma, criminal justice, and children/youth and families. She coordinates agency work at the intersection of behavioral health issues and the criminal and juvenile justice system, developing funding efforts to maximize alternatives to and diversion from incarceration/detention for individuals with mental and substance use disorders. In 2003, Huang served as an appointed commissioner on the President’s New Freedom Commission on Mental Health and she has served for more than 10 years on the Carter Center Mental Health Board. Huang recently received the following honors: National Multicultural Summit Elders Award, 2015; American Psychological Association (APA) Nicholas Hobbs Award for Children’s Mental Health, 2013; Presidential Citation, APA, 2011 and 2004; Distinguished Contributions to Psychology in the Public Interest, APA, 2007; Dr. James Jones Lifetime Achievement Award, APA, 2007; Outstanding Psychologist of the Year, National Alliance of the Mentally Ill, 2005; President’s Award for Distinguished Contributions, Asian American Psychological Association, 2004, 2012, 2014; Champion for Children’s Mental Health Needs, Federation of Families for Children’s Mental Health, 2003. She received her doctorate from Yale University.

Bruce Kamradt, MSW
Kamradt recently retired after 20 years as director of Wraparound Milwaukee, which has been a national model in systems of care serving children with serious emotional and mental health needs and their families. Wraparound is a strength-based, highly individualized, family-focused, and community-based approach that has revolutionized care for children with the most complex needs and reduced the utilization of institutionalized care. The model as implemented in Milwaukee with a strong care coordination, mobile crisis, provider network, and family advocacy component was named by the President’s Freedom Commission on Mental Health in 2004 as the exemplary model in the United States and won the Harvard University Kennedy School of Government’s award as the Best Innovation in American Government in 2009. Kamradt has been a consultant to many U.S. states, communities, and the federal government and has worked internationally to promote the model. Kamradt is a consultant with the National Technical Assistance Center for Children’s Behavioral Health (TA Network), the Alliance for Children and Families Inc., and the International Initiative on Mental Health Leadership, and he continues to help states, communities, and nations learn how to implement the model. Kamradt’s previous positions included mental health hospital administrator, child welfare manager, and juvenile court administrator, all of which helped him in designing, developing, and implementing the Wraparound model across multiple child-serving agencies — “One Family-One System of Care.”

Lisa Lambert, BA
Lambert is the executive director of Parent/Professional Advocacy League (PPAL), a Massachusetts statewide,
family-run, grassroots nonprofit organization based in Boston. PPAL is the state organization of the National Federation of Families for Children's Mental Health and has been a Substance Abuse and Mental Health Services Administration-funded statewide family network since 2000. Lambert became involved in children’s mental health as an advocate for her young son in 1989 through the CASSP family network in California. After moving back to Massachusetts, she began supporting families whose children and youth had behavioral health needs. She became involved with PPAL, first on a regional level and then on a statewide level. Her areas of expertise include mental health policy, systems advocacy, and family-driven research. Realizing that individual parent and youth stories need to be supported by data, Lambert authored several family-driven studies that highlighted the challenges families encountered when accessing services, their perspectives on psychotropic medications, and the training needs of family partners. She also authored a chronicle of PPAL’s Worcester-based youth group that highlighted how a strong, youth-guided initiative had an impact on the community. Lambert serves on a number of committees in Massachusetts as well as the Building Bridges Initiative Youth and Family Partnership workgroup. She has been instrumental in working with local and national media to highlight the concerns of families and youth. She is dedicated to ensuring that family voice is included in every state and national conversation about the policies, practices, and services that impact them.

Jody Levison-Johnson, LCSW-C

Levison-Johnson is a licensed clinical social worker and has more than 20 years of behavioral health experience with an emphasis on children, youth, and families. She is assistant vice president of practice improvement at the National Council for Behavioral Health, where she oversees the organization’s consulting portfolio, which includes a focus on integrated health and trauma-informed care. Before joining the National Council, she served as the chief clinical officer for Choices Coordinated Care Solutions, a care management organization that provided Wraparound and care coordination services to youth in four states and Washington, D.C. She was responsible for all program operations as well as service and business development activities. Levison-Johnson served from 2011 to 2014 as the deputy assistant secretary of the Louisiana Office of Behavioral Health, where she was responsible for clinical oversight and management of publicly funded behavioral health services for adults and children, including statewide public sector managed care efforts. Before working in Louisiana, Levison-Johnson served as the vice president of Coordinated Care Services, Inc., a nonprofit management and consulting services organization, where she led all child, family, and adult service quality, system development, and evaluation activities. During her tenure, she led Monroe County’s system of care implementation and provided technical assistance to communities across the country to support human service system improvements. Levison-Johnson has extensive knowledge in the areas of child and family human services, public sector behavioral health, Wraparound and care coordination, residential reform, and managed care implementation and operations.

Jessica Lipper, MSJ

Lipper is a program officer on the Child Health Quality Team at the Center for Health Care Strategies (CHCS). She provides technical assistance, project management, and research support for initiatives focused on improving behavioral health care for children. Before joining CHCS, Lipper was the manager of communications and community outreach for Livingston (N.J.) Public Schools, where she served as the district's spokesperson and managed all facets of strategic communication, media, and government relations programs. She worked for The Arc of New Jersey as the director of governmental relations, where she advocated on behalf of individuals with intellectual and other developmental disabilities with state and federal lawmakers. She also served as an assistant child advocate/legislative liaison for the New Jersey Office of the Child Advocate, where she combined legislative advocacy, investigatory work, and public education to ensure the health, safety, and well-being of children involved with New Jersey’s public child welfare system. Lipper earned a master's in health law/policy from
Elizabeth Manley, MSW
Manley is assistant commissioner for New Jersey’s Children’s System of Care. In this capacity, Manley has direct oversight of the statewide child behavioral health, substance use, and development/intellectual disabilities systems. This includes a wide range of community-based services, inpatient units, and residential treatment centers. Manley is the Department of Children and Families (DCF) representative on the New Jersey Board of Social Work Examiners and the Governor’s Council on Alcohol and Drug Abuse; the principal investigator on New Jersey’s Promising Path to Success, a Substance Abuse and Mental Health Services Administration grant with a focus on improving care for youth in need of an out-of-home intervention; vice chair of the National Association of State Mental Health Program Directors; and has presented at several national conferences. Before joining DCF, Manley was the CEO of Caring Partners of Morris/Sussex, Inc., a care management organization (CMO) specializing in working with youth with complex behavioral health challenges. She worked for Capitol County Children’s Collaboration, which is the CMO of Mercer County, as the director of operations at the time of its inception in 2002. She came to that position after spending 15 years in various positions at SERV Behavioral Health, with her final position at SERV as the director of children’s services for SERV Behavioral Health. Manley earned a bachelor’s degree in health education from William Paterson University and a Master of Social Work degree from Rutgers University.

Marie Mann, MD, MPH, FAAP
Mann is the senior medical advisor and acting deputy director of the Division of Services for Children with Special Health Needs in the Health Resources and Services Administration’s Maternal and Child Health Bureau. Her areas of interest include implementation of the patient/family-centered medical home, youth transition, and quality improvement in child health. Mann received her medical degree from Tulane University School of Medicine and completed postgraduate training in pediatrics at Duke University Medical Center, Tulane University Medical Center, and New Orleans Charity Hospital. She is board-certified in pediatrics and holds a Master of Public Health degree from the University of North Carolina. Before joining the federal government, she practiced general pediatrics and adolescent medicine in Louisiana, North Carolina, and Maryland.

Garrett Moran, PhD
Moran is a Westat vice president and associate director with more than 40 years of experience in public policy, program evaluation, research, and management. His recent responsibilities have included key leadership roles on projects for the Agency for Healthcare Research and Quality (AHRQ), the Substance Abuse and Mental Health Services Administration, and the Office of the Assistant Secretary for Planning and Evaluation within the U.S. Department of Health and Human Services. His major areas of substantive expertise include integrated health care delivery, health care financing, health information technology, and program evaluation. Moran has served as the project director of the AHRQ Academy for Integrating Behavioral Health and Primary Care since 2010. From 1993 to 1996, Moran served as deputy commissioner and then commissioner for community support in the cabinet of the Secretary of the Department of Health and Human Resources for the state of West Virginia. In this role, he guided public policy related to people with mental or substance use disorders, developmental disabilities, and older adults. Moran also is a clinical psychologist whose early career included several years of direct clinical work with people with behavioral health disorders.

Jonathan Muther, PhD
Muther is the director of behavioral health and psychology training at Salud Family Health Centers, a large Federally Qualified Health Center system providing behavioral health services in 12 clinics. He also is a senior clinical Instructor at the University of Colorado School of Medicine, Department of Family Medicine, and a behavioral health clinical integration advisor with the Eugene S. Farley Health Policy Center. His specialty area is integrated primary care psychology and he is involved in direct patient care, training and supervision, program
development and evaluation, and advocacy for health care policy change. His primary areas of interest are working with those traditionally underserved by existing systems and with the Spanish-speaking population. He is committed to providing treatment and program development to address life stress and the full spectrum of mental disorders, behavioral interventions for physical illnesses, and evaluating health outcomes. Additional areas of research and clinical interest include integrated primary care and team-based approaches to care, provision of supervision and training to bilingual psychology trainees, child/adolescent therapy, and acculturation discrepancies within Latino/Latina families.

Sheila Pires, MPA

Pires is a founding partner of the Human Service Collaborative, a policy and technical assistance group in Washington, D.C., specializing in child and family service systems. Pires has more than 35 years of experience in national, state, and local government and nonprofit agencies serving children, youth, and families at risk. She has held senior staff and management positions in the U.S. House of Representatives, the U.S. Department of Health, Education, and Welfare, and the Carter administration. She co-chaired the children’s mental health and substance abuse committee of President Clinton’s Task Force on Health Care Reform and co-authored the children’s issue brief and policy recommendations for President George W. Bush’s New Freedom Mental Health Commission. During the Obama administration, she was invited to present on children’s behavioral health at the Centers for Medicare and Medicaid Services Grand Rounds. She serves as the senior consultant to the Children in Managed Care and Child Health Quality programs at the Center for Health Care Strategies, Inc., and is a core partner of the TA Network, co-leading its work on policy, system design, and financing. Pires served as the deputy commissioner of social services for the District of Columbia and led a reorganization of the city’s child mental health system as head of child mental health services. She has consulted with many states, counties, cities, neighborhoods, and family organizations and has authored numerous publications on systems change, including Building Systems of Care: A Primer. Pires received her BA degree from Boston University and a master’s degree in public administration from Harvard University.

Jennifer Rehm, MD

Rehm is a board-certified pediatric endocrinologist and an assistant professor in the Department of Pediatrics at the University of Wisconsin School of Medicine Public Health. Rehm’s medical interests include working with adolescents, pediatric metabolic syndrome, differences of sex development, and gender identity at the UW Pediatric and Adolescent Transgender Health (PATH) Clinic. Rehm also is a research scholar in the University of Wisconsin’s Building Interdisciplinary Research Careers in Women’s Health (BIRCWH) Program.

Shannon Robshaw, MSW

Robshaw has more than 20 years of experience in state government and nonprofit executive leadership positions focusing on system reform and cross-agency collaboration to improve mental health and health service delivery systems. She serves as a system design and implementation specialist and lead coach/consultant with the TA Network for Children’s Behavioral Health in the Institute for Innovation and Implementation at the University of Maryland School of Social Work. In that position, she works with 22 Substance Abuse and Mental Health Services Administration system of care (SOC) grantees across 10 states. Before this position, she served as executive director of the Continuum of Care (COC) in the South Carolina Governor’s Office, whose mission is to provide care management services for the state’s children and youth with the most serious and complex behavioral health disorders. In that position, she transitioned COC’s practice model to high-fidelity Wraparound and reorganized management and infrastructure to support the practice model. She also served on a multi-agency leadership team developing South Carolina’s statewide Palmetto Coordinated System of Care. Robshaw previously served as the director of the Louisiana Coordinated System of Care and led planning and startup efforts for the governor’s cross-departmental initiative to build a new service-delivery system for
children and youth at risk of out-of-home placements. Past service includes executive director of the Louisiana Health Care Quality Forum, executive management officer in the Office of the Secretary of the Louisiana Department of Health and Hospitals, and executive director of the Mental Health Association in Louisiana.

Earlie Rockette, RN, MN
Rockette is the regional vice president of Georgia Families 360° for Amerigroup Georgia, a wholly owned subsidiary of Anthem, Inc. In this role, Rockette is responsible for all aspects of the $164 million program. Responsibilities include primary accountability for operational, legislative, regulatory, human resource, financial, and contract performance for the product line; state and beneficiary satisfaction; and working with and maintaining internal and external stakeholders’ relationships. She also directly validates that programs are developed and implemented to ensure effective contract performance related to medical and case management activities and has indirect oversight of network development, enrollment and billing, claims, administrative management, marketing, vendor management, and information technology for all Georgia Families 360° beneficiaries. Rockette ensures that health care service needs are met for all enrolled members to include behavioral, medical, dental, vision, social, etc. Rockette is a recognized leader in the successful deployment of large-scale complex projects across the health plan. She successfully developed cross-organizational programs between the Department of Community Health and all of the contracted Georgia Care Management Organizations (CMO) to create Georgia’s Centralized Credentialing portal, Phase I. Rockette demonstrated strong technical expertise in the design, development, and deployment of complex business applications such as the state-led Centralize Prior Authorization project that fostered the automation of key prior authorization functions that had been formerly manually completed. She joined Amerigroup in 2006 after nearly 25 years of experience in women’s and children services. Before joining Amerigroup, she served as the director and clinical nurse specialist over multiple large state-managed hospital and clinic systems. Rockette is a certified women’s health and family nurse practitioner. She earned a master’s degree in perinatal/neonatal nursing from Emory University and is completing a doctorate of education in organizational leadership with an emphasis in behavioral health from Grand Canyon University.

Melissa Schober, MPM
Schober has a vast array of health policy and public health expertise and has spent her career improving access to care for women, children, and adolescents. Before joining the Institute for Innovation and Implementation at the University of Maryland School of Social Work, Schober was a senior consultant at Health Management Associates. Previously, she was the director of the Office of School Health at the Maryland Department of Health and Mental Hygiene (DHMH), where she led initiatives to improve the health of all school-aged children by strategically integrating public health activities carried out in school settings with statewide delivery system reforms. From 2010 to 2014, she served as director of Medicaid policy for the Maryland Mental Hygiene Administration (MHA, now the Behavioral Health Administration), where she focused on expanding access to publicly funded mental health services for children and adolescents through a 1915(i) state plan amendment. She also led efforts to increase care coordination for individuals with chronic physical and behavioral health conditions using a Section 2703 Health Home. Her work with the MHA also included extensive stakeholder engagement as the state redesigned its public system by integrating two state agencies into a single behavioral health administration. Schober also has worked with the Society for Public Health Education, Women’s Policy, Inc., and the MayaTech Corporation on public health advocacy, program evaluation, and reducing health disparities. She received her Bachelor of Arts degree from the University of St. Joseph in West Hartford, Conn., and her Master of Public Management in Health Policy degree from the University of Maryland, College Park.

John Straus, MD
Straus is the founding director of the Massachusetts Child Psychiatry Access Project (MCPAP), which was designed to address the shortage of child psychiatry and the need
for primary care providers (PCPs) to manage behavioral health issues in their practices. He is president of the National Network of Child Psychiatry Access Programs. Child psychiatry consultation programs are now available in 26 states, and it is estimated that the PCPs of more than one-third of the nation's children (25 million) have access to a telephonic child psychiatry consultation. Straus was responsible for the expansion of MCPAP to include MCPAP for Moms to address perinatal depression and perinatal mental illness. He is medical director, special projects at the Massachusetts Behavioral Health Partnership (MBPH), a behavioral health vendor for the Massachusetts Medicaid program and a subsidiary of Beacon Health Options. Straus is a pediatrician, having had a primary care practice for 22 years. He has worked for more than 25 years in managed care. Before his current partial retirement, he was vice president of medical affairs at MBHP and before this position was medical director of the Fallon Community Health Plan. He did his medical training at Columbia University and his pediatric training at Strong Memorial Hospital in Rochester, N.Y. He also was a Robert Wood Johnson Clinical Scholar at Johns Hopkins Medical School. Straus also has a strong interest in health plan quality improvement, having been involved as chair of quality management at Fallon Community Health Plan in the development of the Healthcare Effectiveness Data and Information Set (HEDIS). While working on a Massachusetts statewide project that was a precursor to HEDIS, Straus developed the method of health plan measurement now widely known as the “hybrid method.” He is a member of the HEDIS Behavioral Health Measurement Advisory Panel.

**Beth Stroul, MEd**

Stroul is a consultant specializing in children’s mental health policy. She has completed numerous research, evaluation, policy analysis, strategic planning, technical assistance, consultation, training, and writing activities related to implementing, expanding, and sustaining systems of care (SOC) for children, youth, and young adults with mental health challenges and their families. Stroul is a partner of the Technical Assistance Network for Children’s Behavioral Health coordinated by the University of Maryland School of Social Work, through which she provides technical assistance and consultation to states and communities, in addition to policy analysis and resource development. She also is a senior advisor to the national evaluation of the federal Children’s Mental Health Initiative conducted by Westat. Previously, Stroul was a consultant to the National Technical Assistance Center for Children’s Mental Health at Georgetown University throughout its 30-year tenure, playing a leadership role in many areas of SOC implementation, including planning and organizing the center’s well-regarded national training institutes. She has published extensively in the field, including a seminal monograph that first presented the SOC approach for children’s mental health. She co-edited an SOC book series, and her latest book is titled *The System of Care Handbook: Transforming Mental Health Services for Children, Adolescents, and Families*. Her recent work includes studies on strategies for widespread SOC expansion, financing, and return on investment. She has developed numerous tools for use by states and communities, including a rating tool to measure implementation of the SOC approach. She also has developed a guide for family-run organizations on becoming Medicaid providers of peer support. Stroul served on the mental health working group of the President's Task Force on Health Care Reform and as a consultant to the President’s New Freedom Commission on Mental Health.

**Millie Sweeney, MS**

Sweeney is the deputy director of the Family-Run Executive Director Leadership Association (FREDLA), a core partner in the National Technical Assistance Network for Children’s Behavioral Health. She has more than 20 years of direct experience in navigating child-serving systems with and on behalf of families, advocating at the individual and policy level and building collaborations with professionals and systems. For 12 years, she was part of the management team of a large statewide family organization, participating in the administration of six system of care sites, supporting the development of the statewide Youth MOVE chapter and managing up to 20 local and statewide programs. Before joining FREDLA,
she operated Family Solutions Consulting, providing consultation nationally on program development, parent peer support, and family-driven care. Initially a project coordinator with FREDLA, she specializes in grant and program development, staff supervision and training, parent peer support and family engagement, curriculum development, and systems of care (SOC). During the past decade, Sweeney has leveraged her professional expertise and personal experience as a parent to assist organizations and states with SOC and family-driven program development, consulting nationally on certification and family/youth support services, offering curriculum and training on a variety of topics related to children’s mental health, and participating in policy-making groups at the state and national levels to advocate for family voice and choice in child-serving systems. She holds a Master of Science degree in clinical psychology and lives in middle Tennessee.

Debra Waldron, MD, MPH, FAAP
Waldron is the senior vice president of child health and wellness at the American Academy of Pediatrics. She previously was the director of the Division of Services for Children with Special Health Needs, Maternal Child Health Bureau, in the U.S. Department of Health and Human Services, Health Resources and Services Administration. Waldron was vice chair and professor of pediatrics at the University of Iowa Carver College of Medicine. Her areas of expertise are integrated health systems, population health, and family engagement.

Carol Weitzman, MD
Weitzman is a professor of pediatrics at the Child Study Center at the Yale School of Medicine. She is the director of developmental behavioral pediatrics and the program director of the Fellowship in Developmental-Behavioral Pediatrics. Nationally, she has served on the executive board of the Society for Developmental Behavioral Pediatrics (SDBP), is the chair of the American Academy of Pediatrics (AAP) Section of Developmental Behavioral Pediatrics, is the articles review editor for the Journal of Developmental and Behavioral Pediatrics, chair of the steering committee for the DBP Research Network, and just completed her role as the course director for DB: Prep, the largest developmental behavioral pediatrics continuing medical education course. She is the program chair for the SDBP and the chair of the SDBP Research Scholars Symposium. She was the lead author of the AAP Clinical Report on Screening for Behavioral and Emotional Problems. She is a site principal investigator for a National Institutes of Health study looking at improving the detection and treatment for underserved children with autism through the use of a family navigator. In collaboration with the Centers for Disease Prevention and Control and the Maternal and Child Health Bureau, she conceptualized and developed a national curriculum about autism spectrum disorder called ACT — Autism Case Training. She is a governor-appointed member of Connecticut’s Birth to Three Interagency Coordinating Council, which reviews policy for early intervention in the state.

Sheamekah Williams, MSW
Williams is the senior director of systems of care (SOC) for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Office of Children, Youth and Families. She has a master’s degree in social work from the University of Oklahoma and is under supervision for licensure. Williams is designated as the principal investigator for the Oklahoma Systems of Care Strengthening Our CareNet (SOC2), funded by a grant from the Substance Abuse and Mental Health Services Administration. She worked for several years as a care coordinator in Wraparound, then as a local SOC project director before taking a position with the ODMHSAS in 2009 and being promoted to senior project director in 2011. As the SOC2 principal investigator, she provides leadership and oversight for the SOC Early Childhood Initiative. She brings leadership partners together to address barriers across systems and works actively with the local project directors in day-to-day management and long-term planning. As a local project director, Williams expanded Wraparound in her service area/communities through developing strong partnerships, creating innovative financing solutions, focusing on staff development, and demonstrating her passion for the work. She has done the same at a state level since being hired
to lead Oklahoma System of Care. Under her leadership, Oklahoma completed its goal of creating a statewide infrastructure. She has worked effectively and collaboratively with partners at local, state, and federal levels to overcome multiple barriers, build bridges, and create new programs and infrastructures. She also is a leader for further cultural linguistic competence within Oklahoma. Growing up and experiencing her early career in a largely African-American, marginalized, and poverty-stricken area of North Tulsa, Williams is well aware of how disparities in access and lack of culturally appropriate services and supports adversely affect children and families. Many cross-cultural partnerships exist and thrive throughout OKSOC because of her influence, reputation, and willingness to participate directly in the process.

Larry Wissow, MD, MPH,

Wissow is the James P. Connaughton Professor of Community Psychiatry in the Division of Child and Adolescent Psychiatry at Johns Hopkins School of Medicine. He directs the Center for Mental Health in Pediatric Primary Care, which is involved in developing and disseminating tools for integrated child mental health programs in the United States and globally. The center is part of the National Child Traumatic Stress Network as well as the National Institute of Mental Health “hub” network for scaling up mental health interventions in low- and middle-income countries. Wissow is co-director of Maryland’s Behavioral Health Integration in Pediatric Primary Care Program and a founding board member of the National Network of Child Psychiatry Access Programs.

Michael Yogman, MD, MSc

Yogman is a pediatrician in Cambridge, Mass., and chief of the Division of Ambulatory Pediatrics at Mount Auburn Hospital. He is chair of the Advisory Board of the Boston Children’s Museum and immediate past board chair of the Massachusetts American Academy of Pediatrics Child Mental Health Task Force, and chair of the American Academy of Pediatrics (AAP) Committee on Psychosocial Aspects of Child and Family Health, where he has authored policy statements on fathers’ role with children, perinatal depression, the power of play, and addressing early childhood behavioral problems. He serves as a legislative appointee to the Massachusetts Advisory Board on Child Mental Health and a gubernatorial appointee to the Massachusetts Special Commission Relative to Postpartum Depression. He also consults with a number of child care centers. Yogman also is a trustee of Franciscan Children’s Hospital and the Landmarks Orchestra, a member of the advisory board of Fathers Uplift, and is on the board of advisers of the American Repertory Theater at Harvard. He is a part-time assistant professor of pediatrics at Harvard Medical School, where he teaches and does research on the father–child relationship, developmental interventions including the RWJ randomized intervention of home visiting and center based care for LBW preterm infants, nutrition and behavior, and behavioral health integration in primary care. He has been a fellow of the American Academy of Pediatrics since 1973 and was one of the first pediatricians to be board-certified in developmental behavioral pediatrics in 2002. Previously, he was associate chief of the Division of Child Development and director of the Infant Health and Development Program at Boston Children’s Hospital. He is the editor of several books (In Support of Families; Affective Development in Infancy; and a biennial series, Theory and Research in Behavioral Pediatrics) and author of numerous articles and chapters on the father-infant relationship, infant diet and sleep, and parent-infant play. He received the outstanding children’s museum award on behalf of the Boston Children’s Museum at the White House in 2013. He was awarded the Simms Mann Foundation National Whole Child Award in 2015 and the AAP Senior Child Health Advocacy Award in 2016 for his work on postpartum depression. Yogman received his undergraduate degree from Williams College and his medical degree from Yale University. He holds an MSc degree in maternal and child health from Harvard School of Public Health.
Appendix C – Definitions of Behavioral Health Care Integration and Care Coordination

Various definitions of pediatric behavioral health care integration and care coordination have been proposed in recent years. A wide array of definitions is presented below. Definitions have emerged from the primary care and behavioral health sectors. Please note some definitions have been condensed for space.

Three models of behavioral health care/integration predominate within the primary care sector: consultation, as illustrated by the Massachusetts Child Psychiatry Access Project and Partnership Access Line; co-location in the same physical space, as illustrated by the Positive Parenting Program; and integration with team-based collaboration between primary and behavioral health providers, as illustrated by Partnering to Achieve School Success, Reaching Out to Adolescents in Distress, and Doctor Office Collaborative Care. Although all the models appear to be effective and increase access to behavioral health services, there are clear differences. The telephonic model has the ability to broadly serve a diverse population of children at a relatively low cost. The research related to integrated and co-located programs focuses on a more limited number of conditions and age groups. Although there is increasing interest in fully integrated practices, these models have not been fully evaluated in well-controlled research studies.25

Whatever the model, the American Academy of Pediatrics emphasizes the need for continuous quality improvement and recommends several features to ease data collection and sharing, monitor activities and outcomes, and assess team composition, including electronic health records and electronic coordinated care plans to facilitate information sharing among patients/families and their health care teams, and subsequently, health care teams, community partners, and medical and nonmedical providers; patient registries; team-building with physicians and ancillary staff and working with patients, families, and communities to coach patients/families to optimize their health care and chronic condition management; and secure, internet-based tools to facilitate communication among patients, families, and providers, allow networking, and support skills building.

One model of intensive care coordination for children with complex behavioral health conditions — who often are involved with multiple child-serving systems — has a strong emerging evidence base: fidelity Wraparound. An increasing number of state Medicaid programs are incorporating fidelity Wraparound for high-need child behavioral health populations. The table below summarizes definitions related to care integration and care coordination.

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<th>Organization</th>
<th>Definition</th>
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<tr>
<td>Agency for Healthcare Research and Quality (AHRQ)</td>
<td>Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people and that this information is used to provide safe, appropriate, and effective care to the patient.</td>
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<td>American Academy of Child and Adolescent Psychiatry (AACAP)</td>
<td>Safe and effective mental and physical health care requires collaboration and communication among child and adolescent psychiatrists and other medical professionals. Collaborative relationships must provide integrated care to maximize the pediatric and psychiatric caregivers’ knowledge and abilities, facilitate alliances with families, and work to overcome constraints within and beyond health care systems, such as reimbursement, time limitations, and provider knowledge. Communication should occur after the initial evaluation, change in diagnosis or treatment, and throughout the treatment as indicated. The reasons for communication between professionals must be discussed with the family throughout the treatment. These services and appropriate payment for them must be included in any health insurance plan.</td>
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<tr>
<td>American Academy of Pediatrics (AAP)</td>
<td>Care coordination is a “cross-cutting system intervention” that is “the deliberate organization of patient care activities between at least two participants [including the patient] involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling 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.” Within the context of a high-performing medical home model focused on addressing family-centered needs, care coordination is paramount in developing and fostering partnerships across various settings and communities. In 2014, the AAP’s Council on Children with Disabilities and Medical Home Implementation Project differentiated care coordination from case management. Case managers “work with and guide services intrinsic to their specific agency, often within the constraints of eligibility criteria. In contrast, care coordinators work with and guide the team process, which includes and is driven by the needs of patients and families for services across the community.” Essential functions of care coordination include care planning; building collaboration and partnerships with all medical and non-medical providers; promoting self-care and independence; facilitating care transitions; completing/analyzing assessments; and developing patient- and family-centered care plans.</td>
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<tr>
<td>Boston Children’s Hospital</td>
<td>Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the family’s caregiving capabilities. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes. Key activities of care coordination involve the creation of care plans, care tracking, and timely, structured information for all members of the care team, including the patient and their family.</td>
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<tr>
<td>Families USA</td>
<td>Care coordination is just what the name implies: a mechanism through which teams of health care professionals work together to ensure that their patients’ health needs are being met and the right care is being delivered in the right place, at the right time, and by the right person. Comprehensive care coordination involves coordinating with all the different service providers necessary — physicians, nurses, pharmacists, behavioral health specialists, insurance plans, community-based organizations, and more — to facilitate the patient’s interactions with the health care system and improve their health outcomes.</td>
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<tr>
<td>Institute of Medicine</td>
<td>To establish and support a continuous healing relationship, enabled by an integrated clinical environment and characterized by the proactive delivery of evidence-based care and follow-up. Clinical integration is further defined as the extent to which patient care services are coordinated across people, functions, activities, and sites over time to maximize the value of services delivered to patients. Coordination encompasses a set of practitioner behaviors and information systems intended to bring together health services, patient needs, and streams of information to facilitate the delivery of care. Such coordination can be facilitated by procedures for engaging community resources, including social and public health services.</td>
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<td>Integrated Care Resource Center (ICRC)</td>
<td>The ICRC was established to help states develop integrated programs that coordinate medical, behavioral health, and long-term services and supports for individuals who are dually eligible for Medicare and Medicaid. It is a technical assistance project of the Centers for Medicare &amp; Medicaid Services’ Medicare-Medicaid Coordination Office. Successful integrated care programs depend on care management and coordination. The key functions of care management are to (1) assess an individual’s care needs; (2) develop a care plan with the individual or their designee to meet those needs; and (3) put in place covered services or other interventions to accomplish care plan goals. Care coordination facilitates the communication of information among the care team and allows for timely responses to changes in the individual’s condition, especially during care transitions.</td>
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<tr>
<td>Louisiana</td>
<td>Wraparound is not a treatment service. Instead, Wraparound provides a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are designed to address a range of life areas. Through the team-based planning and implementation process, Wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of young people and family members. Finally, there is an emphasis on integrating youth into the community and building the family’s social support network.</td>
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<tr>
<td>MassHealth (Massachusetts Medicaid Program)</td>
<td>Intensive care coordination (ICC) is a service that facilitates care planning and coordination services for MassHealth youth with serious emotional disturbance (SED) who are younger than 21 and enrolled in MassHealth. Care planning is driven by the needs of the youth and developed through a Wraparound planning process consistent with system of care (SOC) philosophy. ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strengths-based, individualized, family- and youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the youth, are developed through a Wraparound planning process consistent with SOC philosophy that results in an individualized and flexible plan of care for the youth and family. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child-serving systems to enable youth to be served in their home community.</td>
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<td>National Quality Forum (NQF)</td>
<td>NQF has defined care coordination as a “function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.” The framework for examining and understanding care coordination identified five key domains: health care “home”; proactive plan of care and follow-up; communication; information systems; and transitions or handoffs.</td>
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<td>National Training and Technical Assistance Center for Child, Youth, and Family Mental Health (NTTAC)</td>
<td>NTTAC provides training and technical assistance to state, local, and tribal communities to support a system of care (SOC) approach to improving behavioral health among children and youth. Intensive care coordination using high-quality Wraparound is an approach to care that has shown promising outcomes for children with serious behavioral health needs and their families. Rather than a specific service, Wraparound is a structured approach to service planning and care coordination for individuals with complex needs. Built on SOC values, it is a family- and youth-guided, strengths-based, collaborative, and outcomes-driven process that is tailored for the individual. High-quality Wraparound (also called high-fidelity or fidelity Wraparound) includes four phases: engagement, plan development, plan implementation, and transition. It also adheres to specific steps: discovering strengths, needs, and culture; creating a child and family team; developing an individualized plan of care; leveraging natural supports; and monitoring progress.</td>
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<tr>
<td>National Wraparound Initiative (NWI)</td>
<td>NWI works to promote understanding about the components and benefits of care coordination using the Wraparound practice model and to provide the field with resources and guidance that facilitate high-quality and consistent Wraparound implementation. Wraparound is a service planning and care coordination approach that is based on a team approach and supports development and implementation of a strengths-based, integrated service plan. Model-adherent Wraparound aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and efficient and more relevant to the child and family. Wraparound is more intensive than traditional case management or care coordination.</td>
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<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>An approach and model of delivering care that comprehensively addresses the primary care, behavioral health, specialty care, and social support needs of children and youth with behavioral health issues in a manner that is continuous and family-centered.</td>
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<tr>
<td>SAMHSA-Health Resources and Services Administration (HRSA)</td>
<td>Care coordination is the cornerstone of many health care redesign efforts, including primary and behavioral health care integration. It involves bringing together providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care. Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.</td>
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<td>Wraparound Milwaukee (Wisconsin)</td>
<td>Wraparound Milwaukee is a unique care management entity operated by the Milwaukee County Behavioral Health Division that is designed to provide comprehensive, individualized, and cost-effective care to children with complex mental health and emotional needs. A combination of state and county agencies provides funding for the system, including the Bureau of Milwaukee Child Welfare, the county’s Delinquency and Court Services, and the State Division of Health Care Financing that operates Medicaid. Funds from these agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Care coordination services are essential to the design and delivery of services and supports to children with severe emotional and mental health needs that are individualized, strengths-based, and family-focused. Wraparound Milwaukee employs care coordinators who are responsible for convening child and family teams (CFT) from which a Wraparound plan of care is developed for each child and their family. Care coordinators meet the child and family, conduct strengths-based inventory, convene the CFT, and develop the care or treatment plan based on child/family needs, goals, and formal and informal resources available or needed to support the family.</td>
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Appendix D – Meeting Resource List

Below are links to research articles and gray literature documents that are suggested reading as background for the concepts and issues that will be discussed at the meeting.

1. Adams, S.H., et al. (2013). Medical Home for Adolescents: Low Attainment Rates for Those With Mental Health Problems and Other Vulnerable Groups. *Academic Pediatrics, 13*(2): 113-121. Data from the 2007 National Survey of Children’s Health were used to examine rates of medical home attainment among adolescents. The study suggests that family-centered care is particularly difficult to access. This component had the lowest prevalence of attainment, and significant disparities in this component were identified.

2. Ambresin, S.E., et al. (2013). Assessment of Youth-Friendly Health Care: A Systematic Review of Indicators Drawn from Young People’s Perspectives. *Journal of Adolescent Health, 52*(6): 670-81. A meta-analysis reviewed the literature on youth and young adults’ (ages 10 to 24) perspectives on health care with a view toward defining domains and indicators of “youth-friendly care.” Foremost in every study were indicators of patient-centered care: “Feeling respected by the health care provider was one such example that was closely related to trust and friendliness of medical staff and the importance given to continuity of care.”


4. Brown, N.M., et al. (2014). Need and Unmet Need for Care Coordination Among Children with Mental Health Conditions. *Pediatrics, 133*(3): 530-537. The study examined data from the 2007 National Survey of Children’s Health using two outcome measures of interest: (1) prevalence of need for care coordination; and (2) prevalence of unmet need for care coordination in those with a need. The authors found that about 40 percent of parents of children with mental health conditions who reported a need for care coordination also reported that their need was unmet.

5. Coldiron, J.S., Bruns, E.J., and Quick, H. (2017). A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014. *Journal of Child and Family Studies*. DOI:10.1007/s10826-016-0639-7. The authors conducted a comprehensive review, ultimately identifying 206 unique Wraparound-related publications in peer-reviewed outlets. Among empirical studies, 22 controlled studies were found, most finding positive or mixed evidence for Wraparound’s effectiveness. Other empirical studies examined implementation issues such as necessary system conditions and measurement and influence of fidelity. Major gaps include rigorous tests of Wraparound’s change mechanisms, workforce development models, peer support, and the use of specific treatments. The review concluded that literature produced to date has provided useful information about Wraparound’s core components, program-level and system-level implementation supports, and applicability across systems and populations, as well as preliminary information about effectiveness and cost-effectiveness. The Wraparound research base, however, would benefit from additional studies of the model’s intervention and implementation components as well as more rigorous effectiveness studies.

Participating in Project TEACH (CAPES and CAP PC) in NY. *General Hospital Psychiatry*, 36(6): 555-62. Project Training and Education for the Advancement of Children’s Health (TEACH) provides training, consultation, and referral support to build child and adolescent mental health expertise among primary care providers (PCPs). This study describes how TEACH engages PCPs, how program components lead to changes in practice, and how contextual factors influence sustainability. Trained PCPs reported more confidence interacting with families about mental health assessing severity, prescribing medication, and developing treatment plans. Barriers included difficulties implementing screening, time constraints, competing demands, guarded expectations for patient outcomes, and negative impressions of the mental health system overall.


8. Green C., et al. (2017). Which Pediatricians Co-manage Mental Health Conditions? *Academic Pediatrics*. 17(5): 479-486. The authors analyzed responses of general pediatricians from the American Academy of Pediatrics’ 2013 Periodic Survey. The authors found specific educational experiences and interest in further education in managing or treating mental health conditions were significantly associated with co-managing greater than 50 percent of patients, suggesting that enhanced mental health training among pediatricians could increase the co-management of children with mental health conditions.


In 2009-2010, the Parent/Professional Advocacy League (PPAL), a family advocacy organization for children with behavioral health needs, recruited families receiving care from a medical home to attend focus groups and participate in a survey. Families reported low rates of primary care provider communication about behavioral health resources and care coordination, which leads to their perception of ineffective care coordination for children with behavioral health needs.

10. Huang, X., and Rosenthal, M.B. (2014). Transforming Specialty Practice — The Patient-Centered Medical Neighborhood. *New England Journal of Medicine*, 370(15), 1376–1379. The authors discuss that a patient-centered medical neighborhood as it currently exists relegates specialty practices to the periphery with no true integration into the primary care team. A concept they suggest would be more effective than the patient-centered medical neighborhood is the patient-centered specialty practice, which takes ideas from the patient-centered medical home model and applies them to specialty practices with the goals of improving communication between physicians and coordination of care.

11. Kamradt, B., and Goldfarb, P. (2015). Demonstrating Effectiveness of the Wraparound Model with Juvenile Justice Youth Through Measuring and Achieving Lower Recidivism. The TA Network. This brief describes Wraparound Milwaukee, a national model and exemplary system of care for children and youth with serious emotional and mental health needs and their families. In 2014, the single-largest group of youth served was from juvenile justice. Details on Wraparound Milwaukee’s research design and data collection for recidivism prevention is included.

provides a definition of the PCMH Neighbor (PCMH-N) concept, provides a framework to categorize interactions between PCMH and PCMH-N practices, and offers a set of principles for the development of care coordination.


14. Njoroge, W.F.M., Hostutler, C.A., Schwartz, B.S., and Mautone, J.A. (2016) Integrated Behavioral Health in Pediatric Primary Care. *Current Psychiatry Reports, 18*:106. This paper reviewed the state of the literature related to integrated behavioral health services in pediatric primary care, with innovative models of integrated behavioral health care specifically discussed. A literature review found that integrated care models identified in this literature review clearly demonstrate that integration of behavioral health services into pediatric primary care practices can (1) promote accessibility and family engagement in evidence-based behavioral health services; (2) reduce barriers to care; (3) increase the opportunities for providers to reach a greater number of families than standard mental health care; and (4) result in improvements in patient outcomes. When behavioral health providers work collaboratively with primary care providers, children, adolescents, and their families clearly benefit.

15. Pires, S., Gilmer, T., Allen, K., and McLean, J. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures, 2005-2011. Center for Health Care Strategies. This is a preview of the Center for Health Care Strategies’ national analysis of 2011 Medicaid claims data. Highlights of the full report, made possible through support from the Annie E. Casey Foundation, reveal (1) roughly 11 percent of children in Medicaid use behavioral health services, accounting for an estimated 36 percent of program expenditures for children; (2) mean expenses for children in Medicaid using behavioral health services are four times higher than for the general Medicaid child population; (3) children in foster care and those on Supplemental Security Income/disability represent less than 8 percent of the overall Medicaid child population, but 28 percent of children using behavioral health services and 49 percent of total behavioral health service expenses; and (4) almost 50 percent of children in Medicaid who are prescribed psychotropic medications receive no accompanying identifiable behavioral health services such as medication management or counseling. The full analysis, released in July 2018, uncovers patterns of behavioral health service usage for children in Medicaid and is designed to inform state Medicaid efforts to improve services for this population.

16. Sheldrick, R.C., and Perrin, E.C. (2010). Medical Home Services for Children With Behavioral Health Conditions. *Journal of Developmental and Behavioral Pediatrics, 31*(2): 92-99. A detailed examination of the receipt of services among children and youth with behavioral health conditions reveals two primary reasons why such care is less likely to be consistent with a medical home model: (1) parents are more likely to report needing specialty care; and (2) these needs are less likely to be met. This suggests that the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty accessing specialty care than with problems accessing quality primary care.

literature search identified seven studies between 1986 and 2008 that documented the effects of youth receiving Wraparound compared to control groups. Mean treatment effects across outcome domains ranged from medium for youth living situation to small for mental health outcomes, overall youth functioning, school functioning, and juvenile justice-related outcomes. The interpretation of results was complicated by the lack of consistent documentation of implementation fidelity across studies and conditions, variations in target population and intended outcomes, and methodological concerns. The authors conclude that, though the published Wraparound research base is expanding and findings are largely positive, it continues to be in a preliminary state of development.

18. Talmi, A., and Fazio E. (2012). Promoting Health and Well-being in Pediatric Primary Care Settings: Using Health and Behavior Codes at Routine Well-child Visits. *Journal of Pediatric Psychology, 37*(5): 496-502. This article reported seven barriers to creating financially sustainable behavioral health programs in primary care settings. The authors recommend additional research exploring the costs and benefits of integrated models. Additional empirical research also is needed to compare child and family outcomes in integrated versus traditional mental health settings.

19. Taylor, E.F., et al. (2011). Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. *Agency for Healthcare Research and Quality (AHRQ)*. This paper examines the various “neighbors” in the medical neighborhood and how these neighbors could work together better, thus allowing the patient-centered medical home (PCMH) to reach its full potential to improve patient outcomes. Specifically, the paper addresses (1) key components of the medical neighborhood and how the PCMH is situated within it; (2) existing barriers to achieving a well-functioning medical neighborhood; and (3) the approaches and tools available to achieve a well-functioning neighborhood and the strengths and weaknesses of each.

20. Toomey, S.L., et al. (2013). Disparities in Unmet Need for Care Coordination: The National Survey of Children’s Health. *Pediatrics, 131*(2): 217-224. The authors performed a cross-sectional analysis of the 2007 National Survey for Children’s Health to determine (1) the proportion of parents who report a need for and receipt of effective care coordination for their child; (2) whether unmet care coordination needs differ by children with special health care needs status and sociodemographic characteristics; and (3) whether having a personal provider or family-centered care mitigates disparities. The study also was the first to find a differential impact of two different components of the patient-centered medical home: having a personal provider and receiving family-centered care.

21. Turchi, R.M., et al. (2009). Care Coordination for CSHCN: Associations with Family-Provider Relations and Family/Child Outcomes. *Pediatrics, 124*: S428-S434. The authors analyzed data from the 2005–2006 National Survey of Children with Special Health Care Needs and found that when families with children with special health care needs were asked about care coordination, about 40 percent reported it was inadequate. Families that reported adequate care coordination had increased odds of receiving family-centered care, experiencing partnerships with professionals, and satisfaction with services. Families with adequate care coordination reported fewer school absences and emergency department usage and lower out-of-pocket expenses.

22. Tyler, E.T., Hulkower, R.L., and Kaminski, J.W. (2017). Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers. *Milbank Report*. This paper describes promising practices for pediatric behavioral health integration, including consultation, care coordination, and co-location. It also describes actions states can take to support pediatric behavioral health integration: (1) develop a strategic plan to transform pediatric primary care practices to include behavioral health integration.
(BHI); (2) leverage and direct Medicaid funds toward preventive BHI in pediatric primary care; (3) support pediatric BHI through managed care contracts and accountable care organizations; (4) develop quality measures for BHI in pediatric primary care; and (5) design BHI to leverage scarce pediatric behavioral health resources.

23. Ziniel, S.I., Rosenberg, H.N., Bach, A.M., Singer, S.J., and Antonelli, R.C. (2016). Validation of a Parent-Reported Experience Measure of Integrated Care. *Pediatrics, 138*(6): e20160676. The Pediatric Integrated Care Survey (PICS) was created in partnership with families, especially those that have children and youth with special health care needs. PICS can be used to assess medical service delivery but was designed to be broader if desired (e.g., education, community supports, etc.). The instrument asks about the experiences related to the entire care team (from the perspective of the family), but the instrument can be adapted so that it asks families to think about the care integration experience as related to a specific entity (e.g., specific clinic, specific institution, public health and other agency programs, etc.)
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<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tr>
<td>8:30-9 a.m.</td>
<td>Meeting Room Opens, Meeting Check-in, Informal Meet and Greet</td>
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<td>Gladhill Board Room, University of Maryland, Baltimore</td>
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<td>Health Sciences and Human Services Library, 601 W. Lombard St.</td>
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<tr>
<td>9-9:10 a.m.</td>
<td>Welcome</td>
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<td>Jay A. Perman, MD, President, University of Maryland, Baltimore</td>
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<td>Richard P. Barth, PhD, MSW, Dean and Professor, University of Maryland</td>
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<td>School of Social Work</td>
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<tr>
<td>9:10-10 a.m.</td>
<td>Introductions and Purpose of Meeting</td>
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<td>Suzanne Fields, MSW</td>
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- The purpose of this meeting is to address opportunities and issues related to advancing best-practice approaches to care integration in primary care and other health settings for Medicaid/CHIP/safety net populations of children, youth, and young adults with varying behavioral health (mental health and/or substance use) needs, including those with short-term, moderate intensity, and complex behavioral health challenges.
- Purchasers, such as federal and state agencies, and providers, such as primary care and behavioral health, have been implementing approaches to integrating behavioral and physical health care with a major focus on structuring effective health integration and care coordination models within primary care to improve health outcomes and manage costs. At the same time, purchasers may be implementing specialty integration or care coordination approaches, particularly for children with complex behavioral health challenges that are not embedded within primary care, such as behavioral health homes and care management entities.
- Within these approaches, some or all of the following are addressed: financing, delivery system design, clinical practice, quality and accountability, and infrastructure. The extent to which these approaches also focus on social determinants of health varies.
- Much of the literature examining integrated care and care coordination approaches has been devoted to adult populations (e.g., adults with serious mental illness and co-morbid physical health conditions) or, when focused on children, examining children with serious medical conditions. Less attention has been paid to documenting effective care integration arrangements within primary care settings for children, youth, and young adults with behavioral health challenges.
- We know the needs of children are different from adults (e.g., prevalence of chronic conditions) and that the participation of families and youth is integral to the care integration process.
- A growing body of evidence exists to support intensive care coordination using fidelity Wraparound for children with serious behavioral health challenges, which have been implemented outside of primary care settings. In addition to its use for serious behavioral health conditions, some states, communities, and private funders are using it or planning its use with less-complex behavioral health needs. Early results show some success.
- There is a shortage of behavioral health providers. Families and youth also may be more familiar, and therefore more comfortable with, their primary care providers, and both of these factors argue for a greater role for primary care in behavioral health integration. At the same time, many Medicaid pediatric practices are small, two- to three-
provider offices with limited infrastructure such as electronic health record capacity and limited knowledge of behavioral health care, particularly for children with serious emotional disturbance.

- All of us, whether a purchaser, provider, family member, policymaker or researcher, are looking for ways to ensure that children receive health integration and care coordination services that are based on research/other data indicating clinical and cost effectiveness (to the extent available) and appropriate to the level of intensity to meet their needs.

- The intent is to collectively examine these practice approaches — financing, delivery structures, practice change and implementation supports, quality, outcome, and accountability mechanisms — to ensure that children with behavioral health challenges receive care integration within the most effective clinical and financial arrangements.

- We are convening this meeting to gather consensus on how best to organize care integration approaches within Medicaid/CHIP/safety net for the various populations of children, youth, and young adults with mental health and substance use disorders. This is not a homogenous population. It includes young children through emerging adults; racially, ethnically, and gender diverse populations; children in foster care; those on Supplemental Security Income and those enrolled through Temporary Assistance for Needy Families (TANF); children with mild, moderate, and severe behavioral health challenges; and children involved in multiple systems such as child welfare and juvenile justice, as well as commercially insured children whose families have exhausted their benefits.

- Preparations for this meeting have included gathering evidence from empirical studies, findings and insights from gray literature and policy briefs, discussions with each participant in advance, and our own work with states. From these processes, reflected in your pre-meeting material packets, we have identified five critical issues to address.

- Your participation has been sought because of your expertise and what we know you can contribute to this discussion and the field. Through a variation on the Nominal Group technique, we will discuss these five critical issues as outlined in this agenda; identifying areas of consensus and areas where further research, policy development, and/or discussion is required to support advancement in our field.

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<tr>
<th>Time</th>
<th>Session Title</th>
<th>Details</th>
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<tr>
<td>10-11 a.m.</td>
<td>Understanding the Population and Their Care Integration Needs</td>
<td>Sheila Pires, MPA</td>
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<td><em>Large Group Discussion</em></td>
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<td>What do we know about the care integration needs of children in Medicaid who use behavioral health care? The care integration needs of their families? What do we know about their range of physical health needs and range of medical conditions? What do we know about the intensity of their behavioral health needs: short term, moderate intensity, and/or complex behavioral health challenges?</td>
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<td>11-11:15 a.m.</td>
<td>Break</td>
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<td>11:15 a.m.-</td>
<td>Defining Effective Approaches: What Approaches to Care Integration in Primary Care Are Effective for This Population?</td>
<td><em>Small Group Discussion</em></td>
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<td>12:15 p.m.</td>
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<td>What are effective care integration approaches in primary care? For which subset of children with behavioral health needs? What are effective care integration approaches in behavioral health? For which subset of children with behavioral health needs?</td>
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<td>12:15-1:30 p.m.</td>
<td>Lunch-On Your Own</td>
<td>Please see recommended list of area restaurants.</td>
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1:30-2:15 p.m. | Defining Effective Approaches: What Approaches to Care Integration in Primary Care are Effective for this Population?
Large Group Synthesis

2:15-3:45 p.m. | Using Meaningful Measures: How Can We Effectively Measure Care Integration, Move Toward Meaningful Outcomes, and Strengthen Accountability?
Small Group Discussion and Large Group Synthesis
What are meaningful outcomes to measure effectiveness of care integration approaches? And for which populations of children with behavioral health needs? How do we inform the inclusion of measures for this population within broader population-based strategies in which not all people have behavioral health challenges?

3:45-4:30 p.m. | Review of Day 1 and Preparations for Day 2
Large Group Discussion

4:30 p.m. | Adjourn

Thursday, June 8, 2017

8:30-8:45 a.m. | Recap and Goal of Day 2
Suzanne Fields, MSW
- Check-in
- Preview of Day 2

8:45-10:45 a.m. | Implementing Financing and Value-Based Approaches That Support Care Integration and Attributing Accountability
Small Group Discussion and Large Group Synthesis
What are the financing and value-based reimbursement approaches within Medicaid and Medicaid-managed care that support effective care integration for these populations of children with varying behavioral health needs? How do we attribute accountability to tie outcomes to reimbursement?

10:45-11:15 a.m. | Break

11:15 a.m.-12:30 p.m. | Supporting Integration Practice Change at the Provider and System Levels: What Is Needed?
Small Group Discussion and Large Group Synthesis
What infrastructure is needed at the practice level to support effective practice change? What infrastructure is needed at the system level to support effective practice change?

12:30-1:30 p.m. | Putting It All Together
Suzanne Fields, MSW, and Sheila Pires, MPA
Large Group Discussion
- Review of consensus
- Review content and discuss action steps
- Prepare summary and opportunity to review a draft proceedings document

1:30 p.m. | Adjourn
Group Approach for Topical Discussions

Step 1: Privately Generate Ideas
Participants will be divided into three small groups. Small-group participants will be given notecards — one for each question posed by the facilitator as detailed in the agenda — and asked to privately jot down their thoughts. During this period, the facilitator asks participants not to consult or discuss their ideas with others. This stage lasts about 10 minutes.

Step 2: Record Ideas
The facilitator will lead a round-robin discussion in which each person reads their thoughts from their notecards for every question. For each person, this will be done for all questions at once versus question by question. As the round-robin occurs, using large Post-it pads, the facilitator will write down each person’s comments on all of the questions. If a concept has already been stated, content will be added/clarified to the previous comment; it will not be added as a separate comment. The round-robin process continues until all ideas have been presented. There is no debate about items at this stage. This process ensures that all participants get an opportunity to make an equal contribution and provides a written record of all ideas generated by the group. This stage lasts about 15 minutes.

Step 3: Clarify Ideas
Once the round-robin is complete and all ideas have been jotted on the Post-it pads, the facilitator walks through each item under each question and asks: “Are there any questions or comments group members would like to make about the item? What are the group’s reactions to the ideas presented?”

This step provides an opportunity for members to express their understanding of the idea. It is not expected that the original offer of the comment has to be the person providing clarification — anyone in the group can clarify or respond.

Participants are then invited to seek verbal explanation or further details about any of the ideas that colleagues have produced that might not be clear to them. The facilitator’s task is to ensure that each person is allowed to contribute and that discussion of all ideas is thorough without spending too much time on a single idea. The group may suggest new items for discussion and combine items into categories, but no ideas should be eliminated. This stage lasts 30 minutes.

Step 4: Voting
Using the two consensus categories, everyone independently votes on every item. Each person will vote using colored dot labels:

- **Green dot label:** Indicates the voter thinks there is consensus on that item
- **Red dot label:** Indicates the voter thinks there are differing points of view on that item

The group will have a few minutes to approach each Post-it pad and indicate with the green or red dots their view of the group’s consensus on every concept listed on every page. After the voting, immediate results will be visible based on the number of colored dots for each of the consensus categories. This step takes about five minutes.

Step 5: Large Group Synthesis
After the small group completes voting, all three small groups reconvene into one large group. The Post-it pads from all the small groups are displayed for everyone to see. The large group facilitator verbally reviews each concept presented and summarizes the voting.

The facilitator will note where there is concurrence on which of the two consensus categories the item should fall into — consensus or not consensus.

For items where there is not concurrence on which of the two consensus categories the item should fall into, the facilitator will lead a group discussion to confirm the specific aspects that led to the lack of concurrence. These aspects will later be used to determine next-action steps to guide activities.