

Section 4

Financing and Sustaining the Early Childhood Mental Health Model of Integrated Care



To sustain the early childhood mental health model of integrated care in the Pediatric medical home, you need successful ways of financing your project. There are a variety of ways to receive funding, including grants, partnerships and foundation, and third-party reimbursements.

You should also be aware of some challenges surrounding billable hours and how to bill hours for roles such as the Family Partner (FP). In this section, learn how to evaluate the model and push for investment in it. Also find out more about where this model stands in the landscape of changing healthcare guidelines and needs.

Table of Contents

Objectives

Quick Links

1) Financing: Adopt the Model to Match Your Funding Landscape

- Identify Potential Sources of Funding to Support this Model in Your Medical Home, Including Third-Party Reimbursement, Grants, Foundations and Hospital Partnerships

- [Intro: Adopt the Model to Match Your Funding Landscape](#)
- [Potential Funding Sources: Where to Look](#)
- [Issues Surrounding Billable Hours](#)

2) Evaluating the Impact of Your Model for Integrated Mental Health in Pediatric Primary Care

- Recognize the Value of Evaluation in Advocating for Children's Social and Emotional Health Services and Systems
- Use Preliminary Outcomes from the MA ECMH Partnership to Help Advocate for an Investment in this Model in Your Medical Home
- Define Evaluation Questions to Understand the Impact of this Model on Your Medical Home, Using Examples from the MA ECMH Partnership
- Explore Various Data Collection Strategies to Assess the Impact of this Model in Your Medical Home
- Identify Common Barriers Faced in Data Collection and Potential Strategies To Try in Response

- [Intro: Evaluating the Impact of Your Model](#)
- [Advocating for this Model: ECMH Partnership Preliminary Outcomes](#)
 - [LAUNCH Demographics and Outcomes, Oct 2013](#)
 - [Project LAUNCH Provider Survey Outcomes](#)
- [ECMH Partnership Evaluation Questions and Measures](#)
- [Focus Groups and Survey Tools](#)
 - [Study Plan for Focus Groups with Project LAUNCH Staff](#)
 - [Mass LAUNCH Provider Survey Questionnaire](#)
- [Assessing Challenges to Family Engagement and Retention in Evaluation](#)

Objectives

Quick Links

3) Sustainability of the Medical Home in a Changing Healthcare Policy Landscape

- Recognize the Impact of the Affordable Care Act and Payment Reform on Funding Mental Health Integration in Primary Care in Massachusetts
- Identify Strategies to Position Your Medical Home for Integrated Care in the Context of a Changing Financial Landscape, Including Movement from Fee-For-Service to Global Payments

- [Intro: Sustainability of the Medical Home in a Changing Healthcare Policy Landscape](#)
- [Reaching Self-Sustainability in Your Medical Home: Three Strategies](#)

For a complete list of the URLs mentioned in this section, view the [Glossary of Links](#).

1) Financing: Adopt the Model to Match Your Funding Landscape

Without a doubt, figuring out how to pay for the services you want to provide in a sustainable way is one of the most challenging aspects of integrating behavioral health into the Pediatric medical home. The challenge is to find funding that aligns with the services your clients need. The reality is that often, it's the other way around: The kind of funding you acquire in large measure determines what services you can provide.

There are two important points about this discussion:

- 1) The model suggested here aims at optimal service delivery. Important features of this model are not generally reimbursable at present. These elements are:
 - Integrated Early Childhood Mental Health (IECMH) staff who are available as needed to provide consultation to staff and/or families.
 - IECMH staff time that is set aside to provide training to medical staff.
 - Regular promotion and prevention services available to families, such as family game nights and back-to-school groups.
 - A warm handoff for more involved mental health services.
- 2) Medical practices regularly carry out non-billable activities, sometimes by absorbing the cost reimbursement for billable services, and sometimes by finding outside funding from grants, contributions or other sources. Some of the services you may want to offer will fall into this category if you want to provide the most comprehensive and helpful support to families and children. In your practice, you will need to determine what non-billable activities are worth this investment.

Ultimately, it is likely that you will need to combine reimbursement with grant or general practice funds to cover staff involved in early childhood mental healthcare.

This section includes information on funding possibilities, including grants, foundations and third-party reimbursement considerations. Also find information on billable hours and working billing into the staff processes.

POTENTIAL FUNDING SOURCES: WHERE TO LOOK

Grants

About Grant Funding

Grants are an obvious and helpful way to get started. You may be able to find an ongoing grant to support some small number of activities (such as a weekly “Learn to Play with Your Child” group) from organizations that support prevention, early literacy, school readiness, or other family support activities (Healthy Families, First Step to Parenting).

Or, you could be seeker a larger grant that would allow you to begin the entire cadre of services with a plan to develop a sustainability plan as part of the project.

Places to look for grants include:

- American Psychological Association
- Private Insurance Companies
- Department of Public Health
- US Department of Health and Human Services
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Administration for Children and Families

Grant Organizations

Here is a [list of organizations](#)¹ that provide charitable grants.

Many grantors identify specific areas they are more likely to fund and it is often that they identify categories such as “health,” “families,” “children.” All of these are categories to apply for, and you may benefit from hiring a grant writer that can help you fit your needs into a funding opportunity.

Keep in mind, grants come with predefined expectations. Often times, this includes outcome measures, data reports and actual evaluations. They may also require attendance at meetings and regular participation in activities that the grantors sponsor.

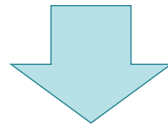
As you consider grant opportunities, carefully review the expectations you will need to fulfill if you were to be funded.



Private Foundations

Private foundations are a hopeful choice because often the restrictions and expectations can be more relaxed or fluid. The process of working with a private foundation can be more personal, with some agreements made together at the beginning of the process. Private foundations often want to fund something that has already been proven to work, and they are invested in funding projects that have a built-in sustainability plan.

Often private foundations are specific to your particular area, with a desire to fund locally. It is always helpful to have a connection to the particular foundation you would like to approach. To identify larger private foundations, use the link to organizations on the previous page.



Hospital Partnerships

Practices that are affiliated with larger institutions, hospitals or networks may be able to obtain partial funding to support mental health integration as a best practice model. This kind of support may be seen by the institution as a short-term investment en route to a reformed payment system more aligned with medical home principles.

Third-Party Reimbursements

Insurance reimbursement is a viable option for some of the services you will be hoping to fund. Services that are easily reimbursed are the classical services such as individual, family and group therapy. States vary in the breadth of their Medicaid funding for mental health, and opportunities to pay for early childhood integrated care through reimbursement will vary accordingly.

Note that coverage may even be available for some case management activities and/or for peer mentoring support (the role played by your Family Partners). Medicaid generally funds consultation provided to parents and provider consultation if it is not within the same practice and is provided in person. Private insurances generally fund only direct therapy services with the named client in the room.

Important Note

All mental health services that are paid for by insurance require that the client have a diagnosis.

This means that a provider who is working with a child who is at risk, but does not qualify for a diagnosis, cannot bill for those services. Also, in many states, to bill for therapy services you need to be a licensed mental health clinician. Many medical practices can obtain such a license, so do not let that get in your way.

Limitations

While it makes sense to pursue reimbursement for any portion of your mental healthcare that is covered, it is also important to note the limitations you are likely to encounter when you bill.

First and most important, there is not real parity between medical and mental health coverage. Rates paid for mental health visits are generally much lower than rates paid for medical visits. This is not entirely explained by provider salaries: While pediatricians are generally paid more than non-MD (and in some cases, MD) mental health clinicians, the ratio of reimbursement to salary is lower for mental health, and also have their own processes for authorizing payment. In MassHealth, the Massachusetts Medicaid program, mental health services for children are carved out and covered by a stand-alone company that provides a wide array of services.



ISSUES SURROUNDING BILLABLE HOURS



As a result of the idiosyncrasies of mental health reimbursement, medical homes often find they are not receiving full reimbursement for services billed. Over time, they may develop the expertise required to optimize billing given a particular constellation of payers.

Another option, though, is to partner with a mental health organization that is willing to hire staff and outstation them in your practice, while taking on billing for their services. Established mental health practices have the infrastructure to bill for services, generally with an expertise that could take a while for a medical practice to acquire.

In Massachusetts, this arrangement also has the advantage that only specific mental health providers are qualified to bill for Family Partners (or other peer mentors). It makes sense to find out if there are similar advantages to such relationships in your state as you design an integrated health program.

Read on to find out more about billable hours, co-billing, and how Family Partners can bill hours.

Billing Considerations

Billable Hours

In mental health clinics, generally clinicians bill for 22-30 hours per week to cover a full-time position. If there is funding either through a grant, from medical home operational funds or from another source for part of the clinician's time, the hours spent providing traditional therapy can be reduced, allowing more opportunities for promotion and prevention activities.

Co-Billing

One creative way to capture funds for behavioral health integration activities is to co-bill for a mental health clinician with a medical professional. This can be done either in an individual appointment or in a group. In an individual appointment, a medical provider can schedule and bill for a behavior check visit with a behavioral health provider.

After a brief time, the medical professional can attend to another patient while the behavioral health clinician completes the visit. In a group setting, a medical professional and a behavioral health staff could co-facilitate a group on a shared issue, such as ADHD, nutrition, anxiety or similar topics.

Family Partners and Billing

Our experience has revealed only one way to bill for Family Partner services, and that is to partner with a mental health agency, as described above (see Third-Party Reimbursement information in the previous pages). In this model, the mental health agency employs and bills for the FP, but outstations the

FP to a medical home site. A major constraint of this option is that it limits FPs to work with children who have diagnoses, making this a short-term and partial strategy for covering the role at best.

There are fewer options for reimbursement for FPs than clinicians, and due to the pivotal role the FP plays, we recommend prioritizing use of other funds to cover the salary and benefits for an FP.



2) Evaluating the Impact of Your Model for Integrated Mental Health in Pediatric Primary Care

As a medical home adopts this model, the Core Team should explore the impact of new services and systems on families and providers. Evaluation is critically important in understanding the efficacy of new integrated services and advocating for sustained funding for this model. Effective evaluations have the potential to shape policy and funding streams at a state and national level. Evaluation data is needed to advocate for the investment in children's mental health services in pediatric primary care.

The Massachusetts Early Childhood Mental Health Partnership is using a unified approach across MYCHILD and LAUNCH demonstration sites to evaluate the prevention and intervention efforts implemented for young children's social and emotional health. The longitudinal evaluation consists of process and outcome measures collaboratively developed by public health agencies, medical homes, families and federal funders. Though differences in funding streams have led to some discrepancies in the evaluation methods between projects, the research questions posed to assess the impact are fully aligned. While the evaluation of this model at demonstration remains in progress, there are promising preliminary findings regarding families enrolled.

Both evaluations drew upon the expertise of professional evaluators: Abt Associates for MYCHILD and the Northeastern Institute on Urban Health Research and Practice for LAUNCH, as evaluation was a required budgetary component of these federal grants. We recognize health practices adopting this model are unlikely to have funding to contract with another agency for evaluation; therefore, this section aims to support health practices in developing and conducting a feasible evaluation of service impact by summarizing methods of and lessons learned by the MA ECMH Partnership.

This section will support your Core Team in defining evaluation questions and protocols to identify the impact of this model on your medical home. Materials describe the methods and preliminary outcomes of demonstration sites as well as offer adaptable tools to evaluate the impact of the model in your medical home.

ADVOCATING FOR THIS MODEL: ECMH PARTNERSHIP PRELIMINARY OUTCOMES

Preliminary data from the ECMH Partnership may help your Core Team advocate for investment in this model for integrated mental health in pediatric primary care. While the evaluations for MYCHILD and LAUNCH demonstration sites remain ongoing, preliminary data is consistently analyzed and shared across Core Teams and families to help medical homes advocate for sustaining this model and identify areas for improvement.

This typically occurs at the MYCHILD-LAUNCH Learning Sessions, during which evaluation teams present outcomes followed by a discussion among families and providers on what the findings suggest about new services and systems at their medical homes. Dissemination and discussion of this data supports Core Teams to advocate for sustained funding of the model in their medical home, given promising outcomes to date.

As of October 2014, **on average, there has been improvement in reported parent and child outcomes encompassing domains of behavior and stress**, as measured by the Children's Behavioral Checklist and Parental Stress Index. These outcomes must continue to be closely monitored as more data is collected and the length of follow-up increases.

The section provides preliminary data of process and outcome measures for MYCHILD and LAUNCH demonstration sites. It includes both demographic data regarding who has participated in services as well as aggregate outcome data for families choosing to participate in the evaluation. This data may help you in advocating for resources to support adoption of this model in your medical home. Click on the outcomes documents below to view the PDFs. For the Project LAUNCH Survey Outcomes, see the following pages.



- 1) [LAUNCH Demographics and Outcomes, Oct. 2013 \(See below.\)](#)
- 2) [LAUNCH Medical Home Staff Survey Outcomes \(See below.\)](#)
- 3) MYCHILD Child and Family Outcomes, (Coming Soon)
- 4) MYCHILD Housing and Support Outcomes (Coming Soon)

EVALUATING LINKING ACTIONS FOR UNMET NEEDS IN CHILDREN'S HEALTH (PROJECT LAUNCH) IN MASSACHUSETTS

Institute on Urban Health Research and Practice, Northeastern University
Beth E. Molnar, ScD; William F. McMullen, Ed.D; Charles Selk, MBA; Madeline Garcia-Gilbert, BA

Sites

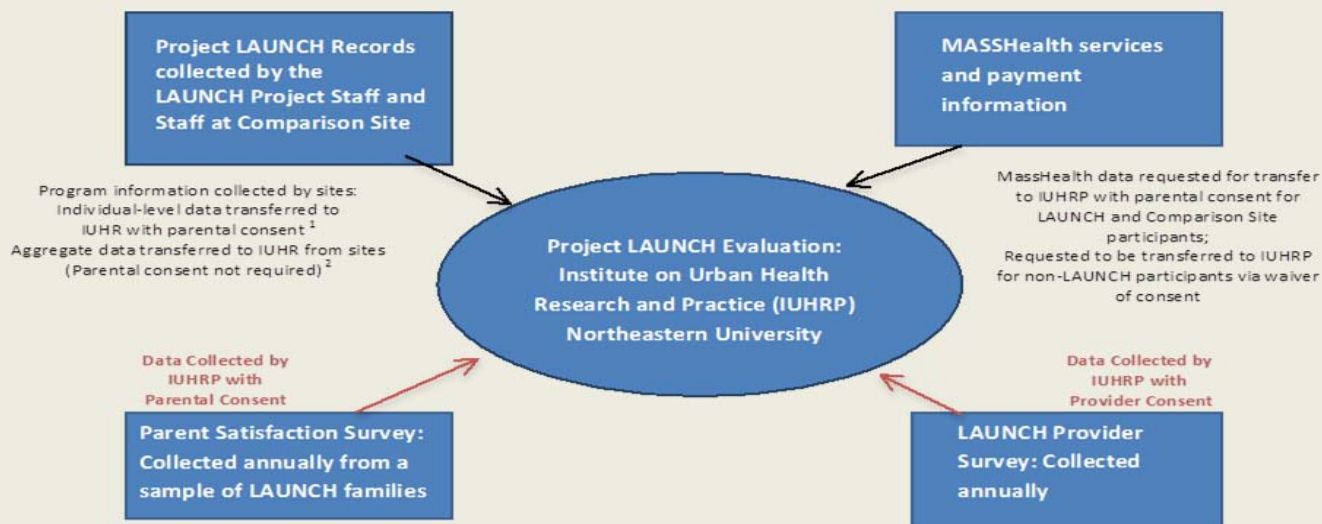
- Boston Medical Center Pediatric Clinic
- Codman Square Health Center
- Martha Eliot Health Center
- The Dimock Center (comparison site)

Qualitative Data Collection

- Focus Groups
 - LAUNCH Family Partners and Clinicians (2 of 3 times completed)
- Systems Changes
 - MA Young Child Wellness Council survey
 - Process data collected by Dept. of Public Health
 - Meeting notes
 - Survey of Learning Collaborative participants

Quantitative Data Collection (below)

Diagram of LAUNCH Evaluation Data Collection and Flow

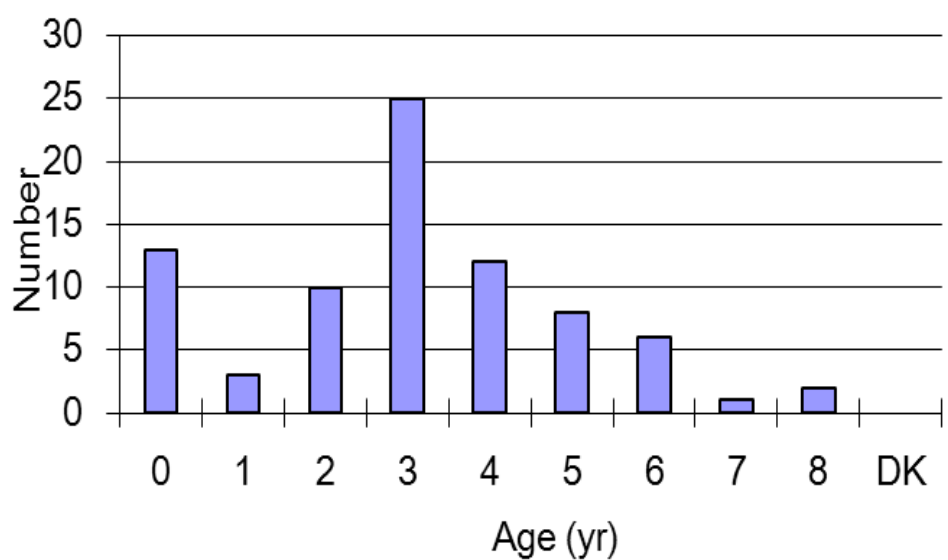


¹ Program record information: (1) family demographics such as number of children, LAUNCH child's sex, age, race/ethnicity, parental education; (2) child measures such as PEDS, PSC, ASQ-SE, CBCL; (3) parent measures such as PSI-SF, PHQ-9 and PHQ-2 at LAUNCH sites but not comparison site; (4) services provided such as type of service (home visit, mental health treatment, etc), date of service, providers, etc.

² Aggregate program record information from Project LAUNCH sites: such as number of individuals receiving each LAUNCH service, number of children by age group, sex, race, ethnicity, and number of families with each risk factor.

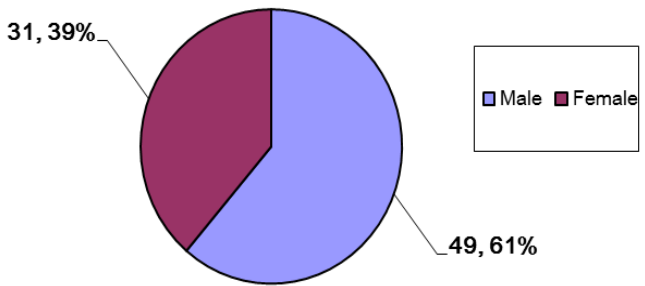
Demographics*

Age of LAUNCH Children

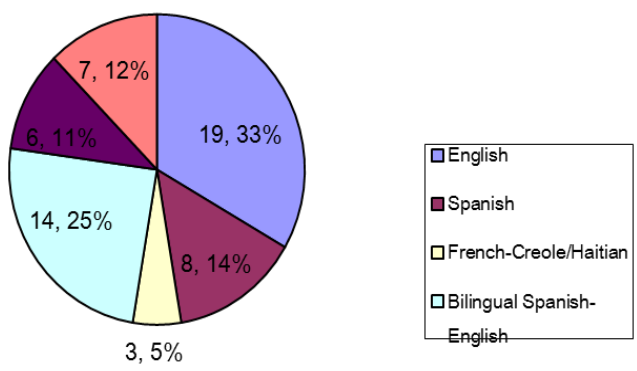


*Based on 83 children who received LAUNCH services for the first time between Oct. 1, 2012 and March 31, 2013

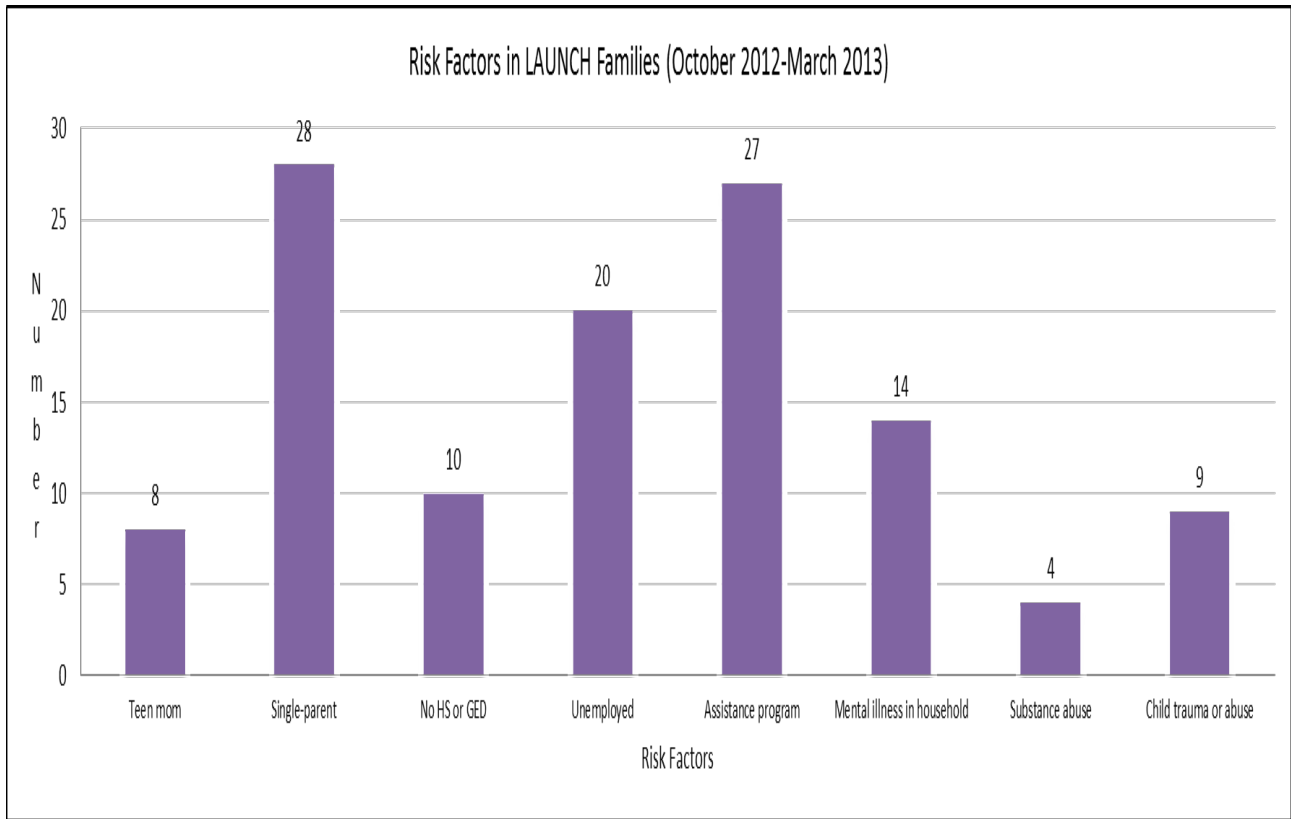
Gender of LAUNCH Children



Primary Language in Household of LAUNCH Children



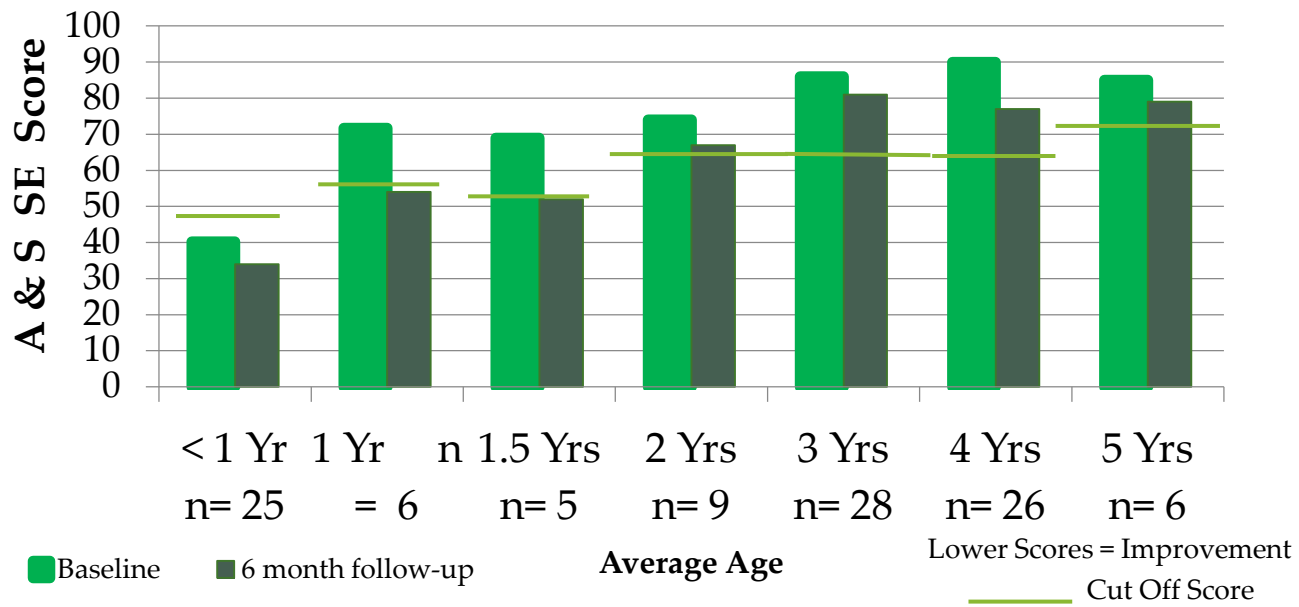
Risk Factors



Big Question: Are Children Improving?

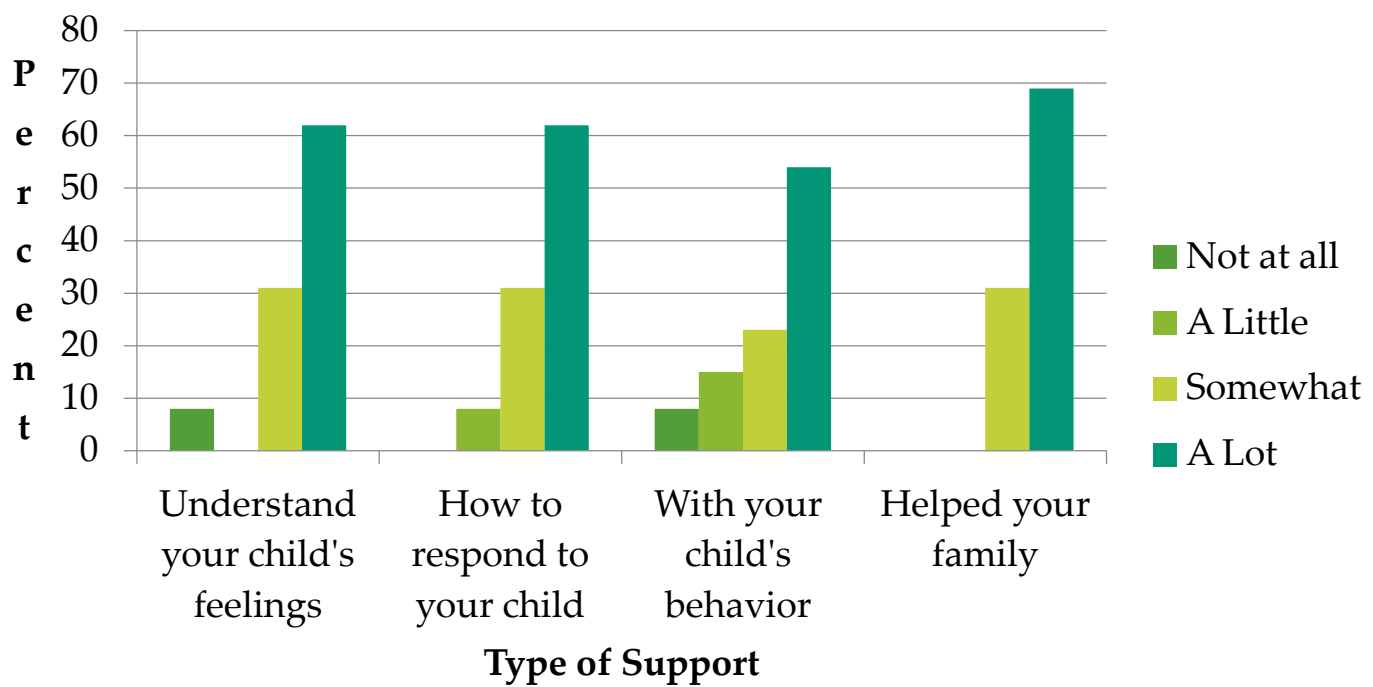
(N=106 children with two time points)

Six Month Change in Ages and Stages SE Score, by Age



Are Parents Satisfied with Project LAUNCH Services?

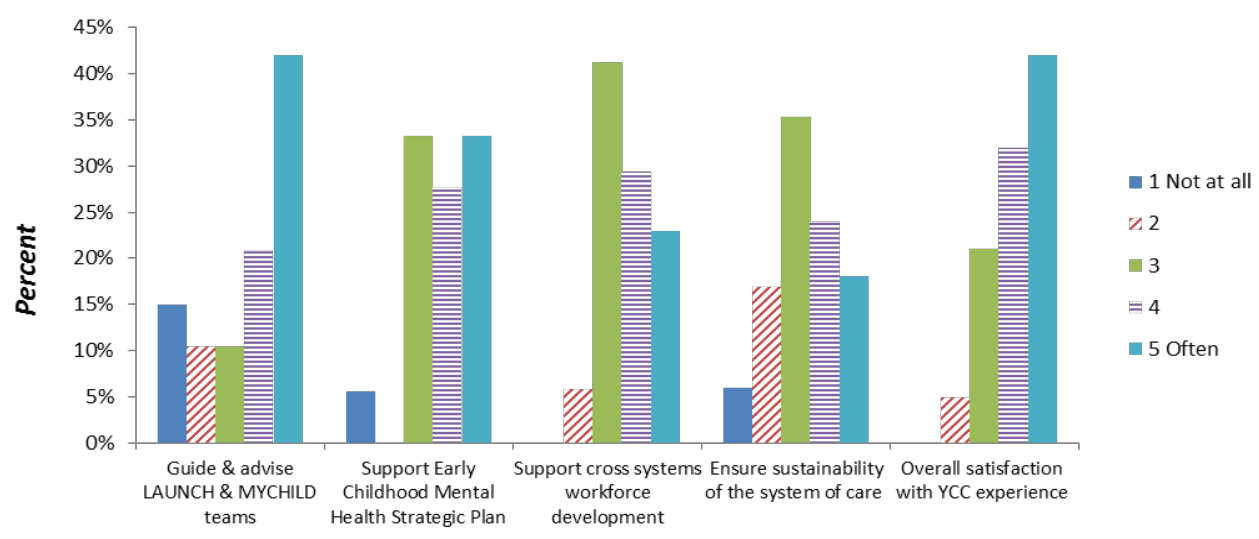
Has Project LAUNCH helped you to...?



Collaborative Efforts by the State Partners

(MA Young Children's Wellness Council)

Council members participation in YCC roles and overall role satisfaction.



Role Participation & Overall Satisfaction

Practitioner's Survey

N=6 physicians (so far)

1) Have there been changes in your practice related to the LAUNCH program?

- Easier to refer for behavioral issues that do not rise to the level of diagnosis.
- Able to refer families to services to which they would not otherwise have access.
- More frequent referrals for behavioral and developmental concerns.
- Improved coordination with behavioral health and school services.

2) Changes in your work setting?

- LAUNCH team on site during clinic hours.
- My patients are connected with meaningful support service.
- Improved connections to primary care.
- Improved behavioral health integration with primary care.
- An essential service that complements patient medical care.

Focus Group: Family Partners and Clinicians

➤ Themes:

- Knowledge gained
- Impact on practice
- Understanding of and ability to implement model
- Barriers, suggestions for improving the model
- Overarching issues



THE PROJECT LAUNCH MEDICAL HOME STAFF SURVEY

Institute on Urban Health Research, Northeastern University

Beth E. Molnar, ScD, Principal Investigator; William F. McMullen, M.S.W., Ed.D., Evaluator

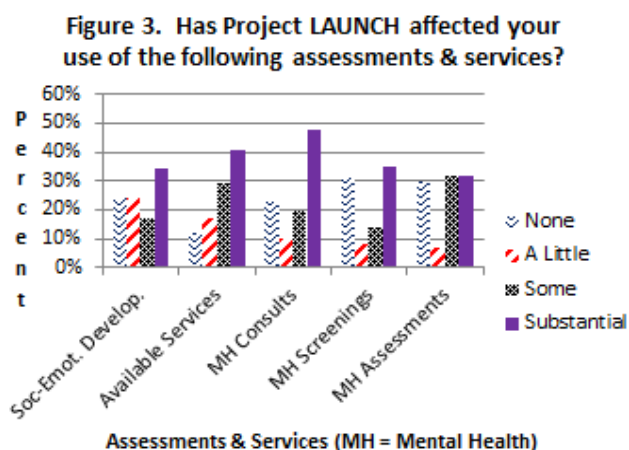
Survey Basics

The survey was distributed online at the three LAUNCH sites using the Qualtrics system from the second week of October 2013 and remained open until December 6. Forty-one practitioners from all three sites completed the survey. Medical doctors made up the majority of the participants (61%), followed by mental health practitioners (12%), nursing (7%), and 20% listed under other profession, which included Administration, Special Education, and Medical Social Work.



In addition to the survey questions, the participants completed three open-ended questions that asked “As a result of Project LAUNCH” what changes have they have made to their work practices, what changes have occurred in their work setting, and other comments they wished to share. There were 78 responses to the three open-ended questions, which are summarized below.

The largest effect of Project LAUNCH reported by providers was an increase in knowledge of child-related mental and behavioral health services (70% reported substantial or some). Almost as many cited improving knowledge of available services for children with behavioral health issues (68% reported substantial or some change) (Figure 3). Project LAUNCH has increased their use of mental health consultation (68%), screenings (63%), and assessments (64%) for these children.



The following two tables describe a content analysis of answers to the three open-ended questions on the survey.

Table 1: What Changes Have You Made to Your Work Practice?

Description of the Change	Number of Times the Change Was Referenced	Number of Times Referenced Under Additional Comments
Easier to provide a mental health referral for issues that do not rise to the level of diagnosis	10	1
Able to refer families to LAUNCH services to which they would otherwise not be eligible	4	2
Able to consult with LAUNCH staff regarding families	1	
More knowledge of community and school services, and improved access	2	1
Improved communication with school services	4	1
Improved identification of child with multiple needs	2	
Improved follow-up with connecting families with behavioral health and other needed services	1	1
Improved family-centered approach to developmental and behavioral concerns	6	2
More attentiveness to the interactions between parents and their children.	3	
None. I was not made aware of how to access the services	1	1
Early screenings for behavioral health issues	4	1

Table 2: What Changes Have Been Made to Your Work Setting?

Description of the Change	Number of Times the Change Was Referenced	Number of Times Referenced Under Additional Comments
The LAUNCH team is on site during clinic hours and available for referrals and consultation	5	
More parents are being connected to primary care and meaningful support services	4	2
Improved integration between behavioral health and medical services	3	3
Ability to serve a wider, high risk population with unmet needs	2	7
More aware of early childhood developmental and behavioral health issues and resources	6	2
More events and opportunities for parents to be engaged in health services	3	1
Improved practitioner interaction and communication with families	1	1

Final Analysis

In addition to a series of responses that Project LAUNCH is an “excellent,” “most helpful,” “productive,” “fantastic,” etc. program, many comments referenced specific aspects of the program and the support it provides to families, practitioners and the work setting. Given the overall positive responses, it is unfortunate that the one practitioner who was “amorphously aware” of Project LAUNCH and found the services “difficult to access” did not inquire further or make these concerns known.

Among the services mentioned were:

- ✓ Improvements in mental health referrals, consultation, and follow-up connecting families with behavioral health and needed services
- ✓ Early screenings for problems
- ✓ Knowledge of early childhood and developmental issues
- ✓ Attention to a family-centered approach
- ✓ Improved community outreach
- ✓ Improved integration of school services within the medical home

The integration of school services within the medical home has been a particular focus for LAUNCH with regards to increased community based activities for parent and children, school registration, and improved communication among the medical center, parents and the schools.

In the schools, a particular focus is on children involved with special education. This has been important with regards to the prevention of

service duplication with practitioners being unaware in the past that a child was being referred for the same assessment at the medical center and as a part of a special education evaluation.

Practitioners also reported positively on the case coordination function of the LAUNCH team, which has served to improve the integration of services at the medical center and with community-based support services. They report that more families who are at high risk and have numbers of unmet needs are being connected to these services.

LAUNCH activities at the community level have improved awareness of child wellness, increased referrals among agencies and increased service integration and service capacity with the community, enhanced cultural competence among providers, and increased family participation in Project LAUNCH services.



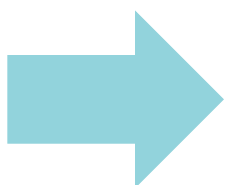
ECMH PARTNERSHIP EVALUATION QUESTIONS AND MEASURES



The grid below summarizes the research questions posed by MYCHILD and LAUNCH evaluations and the corresponding methods used to collect data.

These questions were collaboratively developed by public health agencies, demonstration sites, professional evaluators, and families. For each question, there are corresponding quantitative and qualitative measures that LAUNCH and MYCHILD sites is collecting to answer the question.

These measures include validated pediatric assessment tools, focus group questions, surveys and Medicaid data. Most of the validated assessment tools selected were either implemented as part of the service delivery model (then approved for evaluation use by the Institutional Review Board) or mandated by federal funders. For brevity, these assessment tools are written as acronyms that are defined at the end of grid.







[Click here to view the LAUNCH-MYCHILD Evaluation Questions grid in a PDF.](#)



Most family and child outcome data in MYCHILD and LAUNCH are obtained through interviews with individual caregivers using validated assessment tools. However, both MYCHILD and LAUNCH evaluation teams also developed focus groups and surveys to more broadly understand the impact of this model on knowledge, attitude, and behavior of providers and families in the medical home. These methods offered a more flexible approach to exploring family and provider perspective on children's mental health services and systems.

This section provides copies of tools developed to facilitate focus groups and survey providers. Focus groups were led by experienced facilitators who did not provide direct services to families participating, as to allow unbiased responses among participants. Organizing these focus groups did require arranging transportation, childcare and food for participating families, as to optimize accessibility. Provider surveys were administered electronically via email addresses and required Core Team Primary Care Champions to help facilitate response among colleagues.

Click on the following links to view the MYCHILD surveys as separate PDFs and to view the LAUNCH surveys within this document:

-  [MYCHILD Family Focus Group Questions](#)
-  [MYCHILD Healthcare Provider Survey](#)
-  [Study Plan for Focus Group with Project LAUNCH Staff](#)
-  [Project LAUNCH Provider Survey](#)

Sample 1: Study Plan for Focus Group with Project LAUNCH Staff

Purpose of the Focus Group

In order to understand how Project LAUNCH has impacted the medical home model, we plan to conduct focus groups with Project LAUNCH staff to understand their perceptions about the impacts of LAUNCH on their knowledge, practices and on the medical home model.

Hence, the discussions are designed to:

- Discuss the degree to which Project LAUNCH has impacted their knowledge and practices related to child mental health services
- Discuss the degree to which Project LAUNCH staff has impacted the model
- Identify facilitators, barriers and gaps to a sustainable medical home model
- Recommend solutions

Recruitment

During the end of each project year (late October to early November), we will conduct a focus group with Project LAUNCH staff (one family and one Mental Health Clinician at each site). The total number of participants is six.

An invitation letter will be sent out to Project LAUNCH staff. We will provide light refreshments and food and a \$20 store gift certificate to compensate the participant's time.

In addition, we will provide parking vouchers to a parking lot next to the Institute on Urban Health Research conference room where the focus group will be held.



Focus Group Process

Focus groups will be conducted by a team of two people so that responsibilities of facilitation and note-taking can be shared and information systematically recorded. One person will facilitate the discussion and take notes on a poster board and the other person will take notes on notepads. In addition, the focus group discussion will be audio-taped to ensure that we capture all critical information in the discussion.

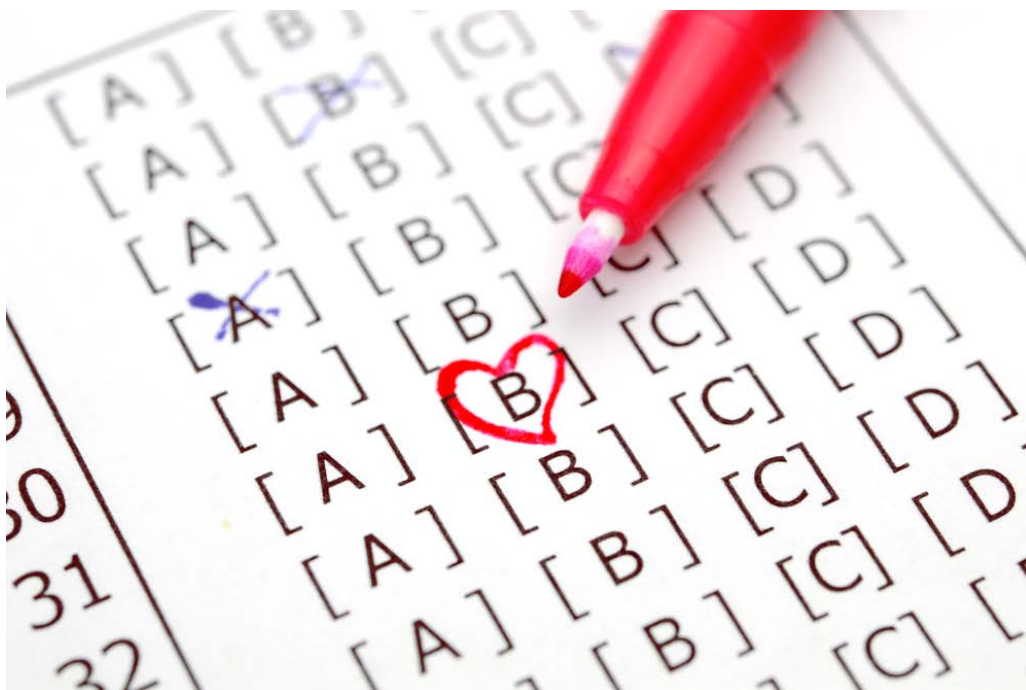
We will use a segmented approach to eliciting the group's ideas. For example, we will ask: "What are the major barriers and gaps in the implementation of Medical Home model in your work setting?" We will offer each person a chance to respond and identify key factors based on the content and enthusiasm of the group's comments. Then, we will write these factors on poster board and open the question up for discussion. After that, we will choose the most important factors and work with the group to develop and hone their ideas.

Analysis

After each focus group, the facilitator and recorder will discuss and reach a preliminary agreement on the themes for the group.

Then, the facilitator and recorder will develop a table of the themes and important points noted on the poster board and notes, and review the discussion tape recording to ensure that all important points have been included.

The evaluators will review the notes and prepare a summary of people's comments within each theme. We will create a grid that allows us to present summaries by the theme, so we can compare how frequently a topic comes up, and the intensity of discussion around that topic in each group.



Focus Group Information

Time: _____

Location: _____

Participants:

Name	Position/Title	Organization	Contact Info.	Reached	Agreed

Project LAUNCH Focus Group Questions

Thank you for agreeing to participate in this focus group. We would like to learn from you about the impact of Project LAUNCH on your knowledge and practices, and on Medical Home model, and factors facilitating or impeding the implementation of Medical Home model. There are no right or wrong answers.

- 1) How have you been involved in Project LAUNCH?
 - What is your training/discipline background?
 - What have you done in Project LAUNCH?
- 1) As a result of your involvement in LAUNCH training and services, how much has Project LAUNCH affected your knowledge of children's socio-emotional and behavioral health development?
- 1) As a result of your involvement in LAUNCH training and services, how much has Project LAUNCH affected your knowledge of the available options for follow-up services for children with mental or behavioral health issues?
- 1) As a result of your involvement in LAUNCH training and services, how much has Project LAUNCH affected your use of mental health consultation for children with mental or behavioral health issues?
- 1) As a result of your involvement in LAUNCH training and services, how much has Project LAUNCH affected your use of mental health screenings of children, such as PEDS and PSC, in your work settings?
- 1) As a result of your involvement in LAUNCH training and services, how much has Project LAUNCH affected your use of mental health assessment of children, such as ASQ-SE and CBCL, in your work settings?
- 1) Based on your involvement, to what extent do you feel Project LAUNCH impacts the Medical Home model in your work setting?
- 1) As a result of your involvement in LAUNCH training and services, what are some changes that have occurred in your work settings?
- 1) What are the major barriers and gaps in the implementation of Medical Home model in your work setting?
- 1) What other suggestions or thoughts would you like to share?

Sample 2: Mass LAUNCH Provider Survey Questionnaire

A. Site

- ☐ BOSTON MEDICAL CENTER
- ☐ MARTHA ELLIOT HEALTH CENTER
- ☐ CODMAN SQUARE HEALTH CENTER

B. Study ID: _____

C. Date: _____

Thank you for agreeing to take part in this survey. Your answers will help us to better understand how Project Launch is being implemented and any gains you might have had from participating in the project. The survey will take no more than 5 minutes to complete.

Please answer the following questions based on **your experiences in the last 12 months**. **here are no right or wrong answers**. Please just answer each question based on your knowledge, experiences and opinions. You may choose to skip any questions you do not want to answer. Your answers are completely confidential, which means we will not share them with anyone outside of the study. The answers you provide will not be used for employee performance evaluation.

I. Provider Information

1. What kind of programs/services does your agency provide? (Check all that apply)

- ☐ HOME VISITING PROGRAM
- ☐ PARENTING RELATED SERVICES
- ☐ PRIMARY CARE SERVICES
- ☐ MENTAL HEALTH SERVICES
- ☐ OTHER PROGRAM OR SERVICE (PLEASE SPECIFY) _____

2. What type of provider are you? (Please pick one)

- ☐ FAMILY PARTNER/ FAMILY TRAINER/FAMILY GROUP LEADER
- ☐ PRIMARY CARE PROVIDER
- ☐ NURSE
- ☐ PARAPROFESSIONAL IN PRIMARY CARE SETTING
- ☐ MENTAL HEALTH CLINICIAN
- ☐ OTHER (PLEASE SPECIFY) _____

3. What is your training/discipline background?

- ☐ NURSING
- ☐ MEDICAL DOCTOR
- ☐ MENTAL HEALTH PROVIDER
- ☐ PARAPROFESSIONAL
- ☐ OTHER (PLEASE SPECIFY) _____

4. What is the main function of your role?

- ☐ PHYSICAL HEALTH CARE
- ☐ MENTAL HEALTH CARE
- ☐ SOCIAL SERVICES
- ☐ OTHER (PLEASE SPECIFY) _____

II. Impacts of LAUNCH

The following questions are about your experience participating in the LAUNCH project, and how LAUNCH might impact your knowledge and practices. For each question, select the response that best fits you.

5. As a result of your access to LAUNCH-related program/services, how much has Project LAUNCH affected your knowledge of children's socio-emotional and behavioral health development?

- ☐ NO CHANGE
- ☐ NO CHANGE, I ALREADY HAD A HIGH LEVEL OF KNOWLEDGE
- ☐ A LITTLE CHANGE
- ☐ SOME CHANGE
- ☐ SUBSTANTIAL CHANGE

6. As a result of your access to LAUNCH-related program/services, how much has Project LAUNCH affected your knowledge of the available options for follow-up services for children with mental or behavioral health issues?

- ☐ NO CHANGE
- ☐ NO CHANGE, I ALREADY HAD A HIGH LEVEL OF KNOWLEDGE
- ☐ A LITTLE CHANGE
- ☐ SOME CHANGE
- ☐ SUBSTANTIAL CHANGE

7. As a result of your access to LAUNCH-related program/services, how much has Project LAUNCH affected your use of mental health consultation for children with mental or behavioral health issues?

- ☐ NO CHANGE
- ☐ NO CHANGE, I ALREADY HAD A HIGH LEVEL OF KNOWLEDGE
- ☐ A LITTLE CHANGE
- ☐ SOME CHANGE
- ☐ SUBSTANTIAL CHANGE

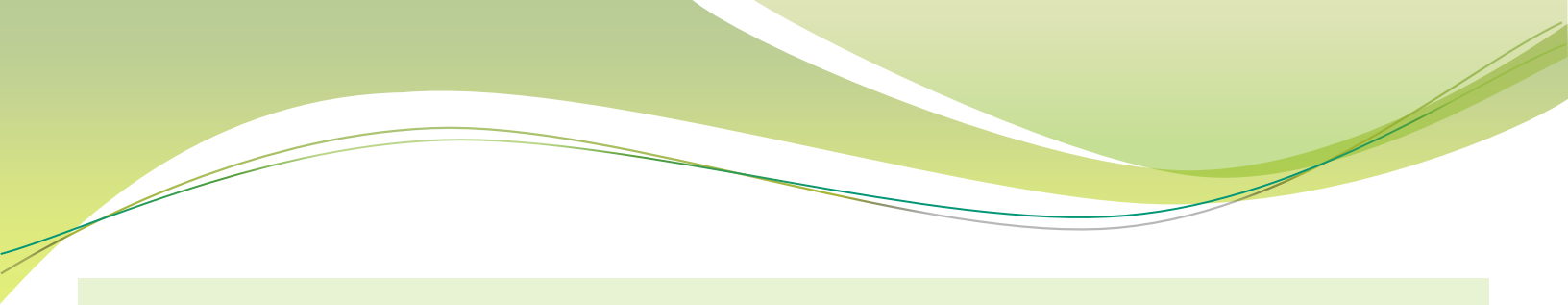
8. As a result of your access to LAUNCH-related program/services, how much has Project LAUNCH affected your use of mental health screenings of children in your work settings?

- ☐ NO CHANGE
- ☐ NO CHANGE, I ALREADY HAD A HIGH LEVEL OF KNOWLEDGE
- ☐ A LITTLE CHANGE
- ☐ SOME CHANGE
- ☐ SUBSTANTIAL CHANGE

9. As a result of your access to LAUNCH-related program/services, how much has Project LAUNCH affected your use of mental health assessment of children in your work settings?

- ☐ NO CHANGE
- ☐ NO CHANGE, I ALREADY HAD A HIGH LEVEL OF KNOWLEDGE
- ☐ A LITTLE CHANGE
- ☐ SOME CHANGE
- ☐ SUBSTANTIAL CHANGE

10. As a result in your access to LAUNCH-related program/services, what are some changes you have made to your work practices?



11. As a result in your access to LAUNCH-related program/services, what are some changes that have occurred in your work settings?

12. Any other comments you want to share with us?

Thank you for taking the time to complete this survey.

ADDRESSING CHALLENGES TO FAMILY ENGAGEMENT AND RETENTION IN EVALUATION



This summary describes challenges faced by demonstration sites and grant administrative staff in implementing the MYCHILD and LAUNCH evaluations. These descriptions can help a health practice anticipate barriers they may encounter in designing and implementing an evaluation of this integrated model in their medical home. Many of the barriers identified are common challenges to evaluating healthcare or mental health service delivery in general, and your medical home may be quite familiar with such barriers.

The summary below can be used to facilitate meaningful discussion throughout the medical home on the topic of evaluation engagement and retention in service delivery and brainstorm response strategies. For each challenge, response strategies used by the MA ECMH Partnership are listed as potential approaches to reduce barriers to family participation in evaluation.

Challenge #1

Distrust in Evaluation



For many reasons, families often distrust the word “evaluation.” Families have heard examples of evaluators using their personal information for “research” without full respect to their privacy and without benefit to their community.

Often, families do not know how evaluation can benefit themselves and their communities because they have been historically excluded from the design of the evaluations, the outcomes from data collection, and the use of outcomes in healthcare policy. Families rarely know where their information goes and the impact that it can have. Furthermore, the stigma around mental health raises additional fear of participation among families receiving children’s social and emotional health services. For these families, engagement in services may be difficult enough, let alone engagement in an evaluation process.

Strategies:

1.

Employ Parents as Data Collectors: Just as Family Partners may improve family engagement in mental health services, including parents in all aspects of evaluation design and implementation may improve the acceptability of the evaluation. Involve parents from the very beginning of the process—the design of the evaluation questions. Parent representatives can help identify meaningful indicators of parent participation and service impact in their communities.

2.

Partner with Parent Organizations: It may be hard to find individual parents in the community to serve as part-time evaluation advisors and data collectors given the required flexibility in administrative meetings and data collection interviews. One strategy is to partner with a family-run organization that has a wealth of expertise in fostering parent leadership. For example, MYCHILD partnered with the Federation for Children with Special Needs to train and hire parents who could lead evaluation interviews in a flexible, part-time basis given their broader work with the organization.

3.

Consider Focus Groups: While parents and children may be hesitant to participate in individual meetings with an evaluator, they may be more likely to participate in a focus group involving peers. Seeing other parents participate in the evaluation may help a parent feel comfortable in sharing their opinions on service impact. Also, the comments of one parent may help another parent in the group better understand and articulate their own thoughts. See “Focus Groups and Survey Tools” in this toolkit section.

4.

Disseminate Key Findings Throughout the Medical Home: As previously said, families are often excluded from the evaluation process before and after their data is collected. Make sure your Core Team has a clear plan for disseminating evaluation findings to both families and providers throughout your medical home. Provide clear summaries of the findings and use of the data to the families that participate. Bringing this information back to families is critically important to partnering with families on the implementation of this project.

Also, it enables families to share this knowledge with their peers, building community trust for the services and perhaps fostering further parent participation in evaluation efforts to improve children’s social and emotional health services. There are many ways to disseminate evaluation outcomes, such as individual meetings with participants, group information sessions, handouts given in primary care visits, posters in clinics, or newsletter updates. The best method may depend on the culture and literacy of the population in your medical home.



Challenge #2

Barriers to Accessibility

The evaluation must include all families participating in services, regardless of primary language and socioeconomic barriers. To optimize accessibility, the evaluation should offer opportunities for participation in home and community settings. This parallels the need for accessibility in service delivery itself. The prospect of data collection in home and community settings poses challenges for medical homes serving linguistically diverse populations, as interpreters may not be available for off-site services. It is important that the evaluation not exclude families whose primary language is not English, as the impact of services on these families would be unknown and the evaluation would be misrepresentative of the medical home.

Strategies:

1.

Offer Home and Community Visits: Ensure your evaluation team has the ability to do interviews or focus groups outside the health practice. Ask families to identify convenient locations and partner with local agencies to use spaces. Explore the availability of free spaces such as meeting rooms in libraries and community centers. Consider reimbursement for transportation to these sites.

2.

Offer Weekend and Evening Times: For focus groups or individual interviews, ensure your evaluation team can offer families weekend or evening times. Without this, parents that work full-time or multiple jobs will be unlikely to engage in the evaluation. This requires flexibility from interviewers and focus group leaders; working with a parent-run organization to identify potential interviewers may be helpful. Alternatively, offer flexibility to Core Team members who prefer to designate one evening a week to work in return for other hours off.

3.

Ensure Your Tools Are Culturally Effective: Ensure that your evaluation methods take into account the language diversity of your community. Use assessment tools that are validated in multiple languages; also, if you are planning a focus group, ensure that the questions are reviewed first by native speakers so the concepts are well-represented in the translation of materials.

4.

Partner with Community Cultural Groups: Make connections to local cultural organizations that are well-respected by patients in your medical home. These can identify individuals in the community who could serve on your evaluation team, advising on how to engage a cultural group in the evaluation and perhaps offering data collection for families who speak a certain language. Alternatively, individuals from a cultural group could serve as paid interpreters for other staff trained to lead evaluation interviews or focus groups, to enable all families to participate.

Challenge #3

Disengagement Over Time

Many evaluations will ask for family participation in focus groups or interviews at multiple points in time to assess change over time. While families may initially opt to participate, retention over longer periods is another barrier that the evaluation team may face. Families may face multiple challenges to ongoing evaluation participation, such as competing demands on caregivers' time, continued instability in housing, frequent changes in phone numbers and addresses, and family health crises.

Strategies:

1.

Broaden Communication Strategies with Parents: Strategies to consider include texting caregivers as evaluation reminders, scheduling interviews/focus groups at the time and location of parent's choice, (including evenings and weekends), aligning interviews/focus groups with clinic visits, and coordinating with health practice receptionists to update contact information.

2.

Invest in Relationship Building: MYCHILD and LAUNCH found that the biggest motivator for continued evaluation participation is the enrollee's relationship with the evaluation interviewers. Choose your evaluation interviewers carefully, prioritizing familiarity with your patient community as to facilitate strong evaluation team partnerships with families. Again, consider partnership with local parent-run organizations or cultural agencies.

3.

Use Primary Care Providers as Allies: Primary Care Providers (PCPs) often have long-term, trusting relationships with the children and families they follow. Use PCPs as allies in fostering participation and retention in the evaluation. PCPs can endorse the evaluation during primary care visits, which may greatly impact a family's trust in the evaluation process.

4.

Analyze "Loss to Follow Up": As a Core Team, try to identify reasons for refusals and missed opportunities for family evaluation enrollment. Practices will vary in the most common reasons for refusal; for MYCHILD demonstration sites, the most notable reasons for missed enrollments have been families in crisis and families not engaging in the program due to a variety of factors, including return to countries of origin, custody changes and housing instability. Analyzing loss to follow up trends in the evaluation may help identify key patterns that can be addressed. For example, if families of a certain cultural background tend to refuse participation in the evaluation, perhaps a member of that cultural community can advise on how to better engage these families in evaluation efforts.

Challenge #4



Staff Turnover

Your Core Team will have to designate who collects the data for your evaluation. For some teams, it may be the Family Partner or Clinician, given that these staff implement initial service assessment tools that could be used for evaluation purposes. However, for other Core Teams, there may be additional medical home staff or community partners that are best suited to collect evaluation data with families, either through surveys, focus groups, or individual interviews. Regardless, staff turnover of your evaluation team will pose a significant challenge to engaging new families in evaluation and retaining family involvement over time.

While you cannot guarantee the long-term commitment of your evaluation staff, you can prepare your Core Team for potential staff turnover. As with any other job, there is a substantial investment in training your evaluation team, particularly if employing parents or community partners as data collectors. In addition, an IRB must be modified and approved to accurately reflect new staff participating in data collection. For MYCHILD and LAUNCH, staff turnover interfered with follow-up interviews at 6 month and 12 month intervals, though project leaders creatively addressed these staffing gaps to ensure that as many follow ups could be completed as possible.

Strategies:

1.

Use a “Team Approach”: Ensure that oversight of the design and data collection of your evaluation rests with a team, rather than one or two individuals. The Core Team should all be involved in and trained on the evaluation process. If you are using parent or community interviewers, try to train more than one individual at a time, so that the loss of staff members does not entirely halt your evaluation efforts, especially given the time it takes to re-hire positions.

2.

Develop a Standard Evaluation Training: The Core Team should develop a training in partnership with other medical home staff involved in IRBs and evaluation efforts, so that there is set approach to orient and train new staff members on how to implement the evaluation. See the MYCHILD Sample Training Outline grid below as an example of initial training components. In addition to these initial topics, evaluation interviewers received ongoing coaching from a lead evaluation administrator.

Evaluation Training Topics	Time Commitment
<ul style="list-style-type: none">• Evaluation Overview• <i>Lunch</i>• IRB Training	4 hours
<ul style="list-style-type: none">• Roles and Responsibilities• Cultural Responsiveness• Informed Consent and Enrollment• Medical Translation Procedures• Safety Protocols• Participant IDs	4 hours
<ul style="list-style-type: none">• Evaluation Components and Processes• Review of Evaluation Measures• Entering Data Information	6 hours
<ul style="list-style-type: none">• Role Plays: Enrollment, Consent, Interviews, Data Entry	6 hours



3) Sustainability of the Medical Home in a Changing Healthcare Policy Landscape

The strategies discussed above are aimed at maximizing funding for an integrated pediatric model in the context of prevailing reimbursement regulations. In Massachusetts, as in other states, those regulations create important barriers to financing of integration; as long as they prevail, a fully integrated model will always require a patchwork of funding, and some subsidization of the model with outside funding sources.

This section looks to the future, describing a funding environment in which the model described in this toolkit can be self-sustaining. It is included as a guide to advocacy, which has always been part of the pediatric agenda but has particular salience now, at a time of active debate about reform of healthcare financing. That said, it is important to note that none of the strategies discussed in this section requires structural change in financing to be feasible; each is achievable within the context of the current system.

REACHING SELF-SUSTAINABILITY IN YOUR MEDICAL HOME: THREE STRATEGIES

There are three key strategies you can use to bring self-sustainability and long-term funding to your medical home under the integrated ECMH model. Find out more about each of them below.

Strategy #1: Removing Barriers



First, you need to take on the structural barriers to the provisioning of primary and preventive care by early childhood mental health clinicians.

- This means insurance plans providing reimbursement for promotion and prevention activities, not requiring a mental health diagnosis for these service. In this instance, change can come from payers or from negotiations between purchasers and payers. It is particularly important that it become part of Medicaid regulation and Medicaid negotiation with contracted Managed Care Organizations, since Medicaid is the single largest source of coverage for children.
- It also means providing clear guidelines in relation to documentation of dyadic care for parents (usually mothers) and children. This latter may sound like a paperwork (and thus, trivial) issue to those outside the system; to those inside, it can be a deal-breaker. We need ethical guidelines at the state or federal level, assuring the legal protection of information about a parent's mental health that goes in a pediatric chart or providing for an alternative approach to charting, that assure parent privacy in the context of pediatric care.




Strategy #2: Financial Parity



Second, we need to achieve true financial parity between mental health and pediatrics.

At present in Massachusetts, a fully-covered, 50-minute child therapy session conducted at a community health center brings in 0-90.00 in reimbursement from Medicaid's mental health vendor. This is about 0-200% of the clinician's salary for that hour (it covers 200% of the clinician's salary *if* there is full reimbursement, which happens very little of the time, and reimbursement at all only occurs 25% of the time), and about 25% what a pediatrician seeing the child would bring in at the same time. This creates an obvious disincentive to sites that might otherwise embrace the integration of mental health care into pediatrics.



Note: Equity need not be defined as the same rate for mental health and pediatric visits. The two types of visits are of different duration and frequency (mental health visits are more likely to be ongoing with a defined time frame) and involve providers at very different salary levels. What is critical is that reimbursement for mental health visits permit sites to cover a reasonable portion of salary and other costs. One industry benchmark is 75%.

Strategy #3: Paying Family Partners




Third, we need to assure that payment for Family Partners (and peer mentors for teens and adults with mental health needs) is built into the system. This could be done in either of two ways; in fact in the current system which includes both capitated and fee for service care, it would make sense to do both.

In 2012, the Centers for Medicaid and Medicare, the federal agency that governs the two programs at a national level, issued a provision: Notably, section 5313 of the Affordable Care Act (ACA) authorized the Centers for Disease Control and Prevention to issue grants to organizations to improve health in underserved areas through the use of community health workers. While unfortunately Congress did not appropriate funds for these grants, the ACA has nevertheless generated health system changes² that have already increased the role of community health workers, opening the door to payment for a wide range of community health workers and other so-called "clinician extendors" who carry out preventive functions.

The growing body of experience indicating the effectiveness and the cost effectiveness of these roles makes a compelling case for the implementation of this option in any state effort aimed at improving care and patient experience while controlling (or reducing) cost. This would require a process to establish appropriate rates, but states have extensive experience with such processes, so the real barrier lies in the realm of political will.


Promoting Models of Capitated Care

At the same time, we can and should promote models of capitated care that incorporate payment for care coordination – part of the Family Partner role – into payment for pediatric care. This approach entails risk, but also has important advantages over fee-for-service (FFS) coverage for FPs.



The risk of a capitated approach to payment for FPs (and other community health worker roles) into pediatrics is that payment will be set too low to really permit practices to fill the role, and will simply become an enhancement to the pediatric rate and a disincentive to enhanced care. This occurred in Massachusetts when Medicaid first moved to managed care and designed a payment structure offering primary care clinicians (“PCCs” were identified as the gatekeepers for patients in the managed care system, and the funded source of care coordination) a \$5 add-on to payment for a pediatric well visit.

In the average 1,500 child practice, this might have added up to about \$11,250 per year (1500×1.5 average visits per year \times \$5) – not enough for the practice to hire someone in the role. The result was a very limited care coordination role for the practice – generally limited to making referrals to pediatric clinical services and, optimally – follow-up with specialty providers.



The strength of a capitated system, if the capitation rate is adequate to cover a person in this role, is its flexibility. Fee-for-service payment for a FP encourages standardization of the role to fit into a visit schedule with a limited number of visits permitted per family. Capitation allows the practice team and the family to drive FP services, permitting the unit of service to be anything from a five-minute phone conversation to a full day spent helping a family solve a particularly thorny problem.

Presently in Massachusetts, as in many other states, there are openings for discussion on both the FFS and the capitation front. The framework for both is the very active policy discussion going on nationally about what it means to be a medical home. The term, which originated in pediatrics, has been widely adopted but with a much less comprehensive vision driving discussion. It is critical that the voices of providers, families (especially those whose children have mental health needs) and advocates be heard calling for a system that support a model of care based on an understanding of the critical importance of attention to social and emotional development in early childhood, and a recognition that paying attention be part of our definition of the pediatric medical home.

Glossary of Links

A complete list of the online links to Web and PDF resources found in this section of the toolkit.

Foot note #	Subsection Title	Link Title	URL
1	Potential Funding Resources: Where to Look	List of organizations	http://www.fundsnetservices.com/searchresult/21/Human-Services-Grants/10.html
2	Reaching Sustainability of Your Medical Home: Three Strategies	Generated health system changes	http://www.chlpi.org/wp-content/uploads/2014/06/ACA-Opportunities-for-CHWsFINAL.pdf

