Goal: To create a seamless integrated continuum of health services for all children and their families (prenatal to 22 years old) that includes efforts directed at health promotion, prevention and early intervention to intensive treatment and long term supports. The integrated system is designed to provide services and supports to the family unit, not just the child ultimately increasing the care experience and using resources effectively.

Hypothesis: Providing health promotion, prevention and early intervention including education and skill development will produce more favorable outcomes at a lower cost than the current practice of waiting until circumstances are bad enough. This will be better care for children and families and allow for more effective use of the resources.

Regulatory Framework: Federal Medicaid EPSDT mandate requires coordination with all services (Maternal and Child Health; Title V; Title IV-E and IDEA part B and part C as well as other social programs). Global Commitment provides for one regulatory and managed care framework across all children's programs and more readily aligns with holistic care required by EPSDT and Vermont's healthcare reforms efforts lead us to population based services, positive experience of care and reduced per capita costs.

Content Areas: prenatal, early childhood development, mental health and social emotional health, developmental needs and disabilities, substance use and abuse, special health care needs, strengthening families and parent skill development*, integration and working partnerships with all health care providers.

System Change Efforts Include

- Family systems, strength based & informed decision making by families
- Intervene earlier and community based
- Functional needs considered not just diagnosis
- Common and consistent intake, screening, and assessments with multi-disciplinary teams and one plan of care
- Unified AHS guidelines, criteria & common documentation
- Identified lead care coordinator
- Integrate funding with unified & simplified reimbursement & oversight – payment reform drives service delivery reform
- Outcome based contracts
- Modern IT structures to share information & reduce redundancies
- AHS contracts with the provider network will be combined and duplication eliminated

Targeted Funds

- All AHS funds that provide some level of treatment, support or intervention in the identified content areas; for further discussion is the inclusion of all child healthcare dollars
- Inventory of the funding in the content areas is approximately $145M (does not include medical services)
- Purposefully redistribute treatment and intervention funding towards health promotion, prevention and early intervention as payment reform creates opportunities for service delivery reform on the high end

The Pilot Region

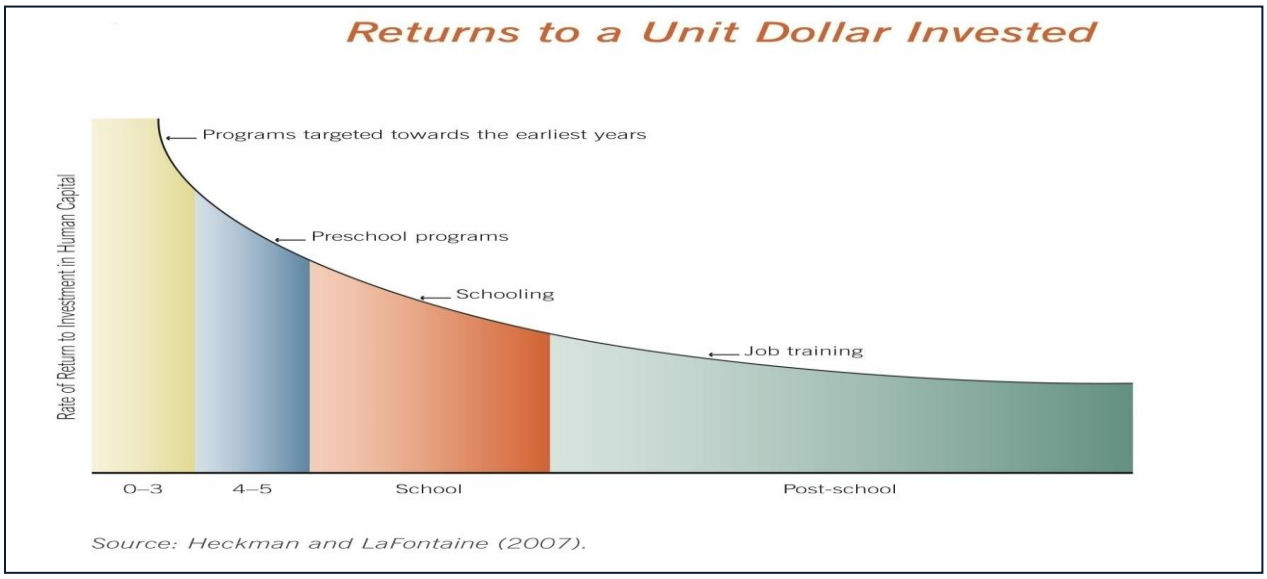
- Streamlined documentation
- Created a Per Member Per Month payment
- Created flexibility that didn't previously exist
- Allowed more prevention services, short-term interventions and more creative community based intensive services

- Focus is now on outcomes and quality of services instead of how many services were provided
- Created formal Local Agreements that include: local governance and decision making, roles and responsibilities of providers, service priorities including prevention and early intervention, clinical triage and utilization management, treatment/family support planning and outcome tracking for the children and families in their given region.
- AHS Agreements now have unified and simplified grant requirements including service definitions, reporting, outcomes tracking and quality oversight expectations. Additionally there is an aggregate annual cap, service flexibility, no prior authorizations or service limits which created more flexibility to serve the regional population in a preventive manner, provide consultation and easier access to health promotion and/or short-term interventions.

Financial Model

- Global Budget/Aggregate Annual Cap: The local budget and subsequent provider contract is based on current state obligations and historical caseload
- Caseload Targets and Incentives: Annual Caseload targets are established using historic averages
- Incentive Payments: Based on utilization and expenditures (adjusted for rate increases) of intensive services that are prior authorized and paid centrally by the State and historically not under the direct control of any one local provider (may need to change due to ACO model). Savings must be used for local programs that support protective factors in Strengthening Families.

Healing is Economic! Where Science, Policy and Experience Meet. The Economist are Listening



Many of our social problems, such as crime, are traced to an absence of the social and emotional skills, such as perseverance and self-control, that can be fostered by early learning. Crime costs taxpayers an estimated $1 trillion per year.

-James Heckman, Nobel Prize Winning Economist, *University of Chicago*

**Dr. Felitti –Author: Adverse Childhood Experiences stated the number one public health issue is parenting skill development*

Integrated Family Services - Re-design Includes:

Healthcare connection

- Services in a **similar manner as Blueprint and Healthcare Reform** – prevention, early intervention and integrated care are key
- Integration of the mental health, substance abuse and developmental services and integration with the **medical/health home** and **community health teams**
- **Creation of incentives for communities to address social determinants of health and reduce the likelihood of adverse childhood experience** and thus reduce negative health outcomes.
- **Infusion of population based health promotion and prevention activities** for mental health, early development and family wellness in every delivery system statewide.
- **Integration with medical homes and providers in home and community based settings.**

Wellness, Prevention and Family Focused

- Provision of **early intervention**, **prevention** and **specialty care** with a paradigm shift for **promotion of wellness**, **mental health** and treatment of emotional and behavioral problems from a **family perspective.**
- **Family Based Approach –** work with families from the beginning not just when there is an issue identified
- **Alignment and integration of the way providers organize and deliver care to children and families** to promote a seamless continuum of EPSDT services from enhanced prenatal care, early screening, intervention and family wellness through age 21.
- **Decrease risk factors and improve health for children** by providing immediate and early intervention to address trauma.
- Designing and testing of **peer support/family engagement models**.
- Designing and testing of **population-based developmental and behavioral health promotion and prevention practices** for statewide implementation.
- Continued work with Dr. Hudziak and the Vermont Center for Children, Youth and Families which includes:
    - Goals to: (1) keep families well, (2) protect at risk families from developing emotional and behavioral problems and (3) effectively treat those who already experience problems.
    - The broader early childhood, developmental and mental health workforce will receive training in the family wellness model, applicable to every family.
    - For those who are already experience problems, psychiatry staff, under the direction of Dr. James Hudziak, will provide specialized consultation and if needed treatment for families experiencing the most complex of social, emotional or behavioral issues, including substance abuse.

Payment Reform

- **Reduce the utilization of intensive and more costly Medicaid/CHIP services** and share demonstrated savings with local regions to support family wellness and early care (will need to be explored with ACO model).
- **Review and refine IFS payment model** including but not limited to: finalizing methods for tracking expenditures typically paid centrally by multiple state programs (PNMI, Substitute Care, Inpatient, etc.) and calculating savings and refine methodology of determining payment.

System and Workforce

- Create **Regional Technical Assistance** Staff and **System Facilitators**.
- **Improve coordination and create standards for uniform EPSDT** developmental screening, assessment and treatment planning across physical and mental health, early childhood, and school based Medicaid and CHIP programs.
- **Workforce training and provider development** to support: early intervention; family centered clinical models; family wellness; local governance and affiliation agreements; mitigation social determinants of health, etc.
- Create new **utilization management tools** for state and provider staff.

Quality Improvement, Information Technology and Data

- Design and implement **HIE interfaces, communication and integrated clinical information sharing** and IT structures (state and local).
- **Analysis and align data dictionaries** and **create core data reporting** requirements across programs including standardization and streamlined provider reporting requirements.
- Create **new business processes** and **state IT tools** for standard decision support and outcome tracking.
- Create new **quality oversight standards** and site visit tools for state staff.

Partners in this Work

- Designated Agencies – Community Mental Health and Developmental Service Agencies
- Specialized Service Agencies
- Parent Child Centers
- Youth Service Bureaus
- Home Health Agencies
- Local Schools and the Agency of Education
- Families and Family Advocacy Organizations
- Primary Care including FQHCs
- Vermont Center for Children Youth and Families – Dr. Jim Hudziak - UVM
- Vermont Child Health Improvement Program - UVM