# Transforming Youth Behavioral Health in Nevada

*National Governor's Association Medicaid Transformation Project*

*3/26/2015*

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# Section 1

## System Transformation

The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) as a part of the National Governor's Association Policy Academy seeks the necessary approval authority from the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) to implement an innovative, cost-effective approach to address the behavioral health issues in Nevada's youth population. The vision is a transformed, innovative behavioral health system for Nevada's youth (ages 11 to 18 years) that transitions the current crisis-based service system to a system of prevention and early intervention.

In Nevada, the current system of youth's mental health services predominately identifies children only after they have been unsuccessful in school, had interaction with the criminal justice system, and have been hospitalized. According to the Institute of Medicine, there is a "window of opportunity" when behavioral health symptoms first appear, typically two to four years before the onset of the disorder and subsequent diagnosis (75 percent are diagnosed by age 24). This is the point where Nevada's project will target youth for identification, prevention, and early intervention services. In the words of the National Council for Community Behavioral Healthcare, prevention and early intervention needs to occur "before costs escalate and the prospects of a happy, healthy life disintegrate."

This innovative project will not only reduce lifetime healthcare costs of treating a person with a mental, emotional, and behavioral disorder by moving from an inpatient, crisis-based model to a preventive model, it will also change the trajectory of that person's life.

Nevada is the ideal setting for this intervention because the need is so vast in our state. Most national studies identify Nevada as a state with several "high risk" markers and a state that has not effectively addressed child and family well-being. For the last several years, the State of Nevada has been identified in the top percentage of youth suicide rates (4th highest, Office of Suicide Prevention, 2013), youth high school dropout rates (Nevada ranks last for high school graduation, 2014, America's Health Rankings) and teen pregnancy (15$^{th}$ highest teen birth rate, NCSL.org, 2011). Nevada recently ranked 49$^{th}$ in the country for "needing but not receiving mental health services among youth" (Parity or Disparity: The State of Mental Health in America: 2015). Nevada ranks 37$^{th}$ for "Attempted Suicide Among Youth." It is highest in the nation for youth with "prevalence of" and "ongoing" emotional, behavioral and developmental issues and for youth consistently uninsured.

In order to transform the service delivery system for youth, Nevada proposes the introduction of a new Medicaid determinant known as "rising risk" that is defined prior to a formal

"diagnosis." Rising risk is defined as youth that have a number of risk factors but have not yet exhibited clinical or behavioral signs that result in a diagnosis that require intensive and costly levels of service delivery. Historically, behavioral health and mental health screening and identification have been associated with significant stigma. Mental illness is a serious condition but often the diagnosis, or even suggestion of illness, leads to treatment avoidance and isolation. In order to screen all youth, the process must eliminate that stigma universally associated with behavioral health disorders.

Screening of all youth in Nevada for behavioral health needs is an unprecedented undertaking. Screening fragile, potentially at risk or emotionally disturbed youth requires a certain level of skill and training by individuals who are linked to a behavioral health network of care. Nevada proposes to train traditional and non-traditional providers to perform a comprehensive pre-crisis behavioral health screening. The screening providers will also have an additional requirement that they be integrated into a system of care that provides prevention, early intervention, and treatment when indicated. The opportunity to screen could occur at schools, juvenile justice facilities, after school programs, and health centers.

Medicaid has already provided tools to its providers that ensure appropriate screening and services for this population. Nevada plans to use and enhance these tools by increasing utilization and identifying at risk youth. Unfortunately, EPSDT has historically been used as a diagnostic, not screening, tool to identify youth with behavioral health diagnoses. All youth need periodic exams, but data in Nevada show a significant underutilization of EPSDT screenings.

This project will:

- Increase utilization of screening tools
- Incentive holistic and integrated services
- Improve access to preventive services

By approaching health care from the standpoint of behavioral health illness avoidance and prevention, Nevada can transition youth's behavioral health from *crisis treatment* to *prevention and early intervention*. With approximately four million young people suffering with mental disorders that affect their life at home, at school and with peers in our nation (NAMI-Child and Adolescent Action Center & NIH), Nevada strives to transform behavioral health for youth and implement system changes from which other states can learn. This innovative Medicaid transformation proposal will address all of Nevada's youth with and without behavioral health indicators. It also encompasses more than Medicaid eligible youth, but all youth regardless of their health insurance and income status. This innovation has support from the Governor's Office, Nevada Superintendent of Schools, and the Commissioner of Insurance.

### Transformation Goals

The Medicaid transformation goals of this project include the following:

1. Increase the percentage of patients aged 11 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, confirm a follow-up plan is documented on the date of the positive screen. (CMS2v1, NQF 0418, age modified).
2. Increase the percentage of youth aged 11 to 18 years who receive a comprehensive screening with substance use, behavioral health, and suicide.
3. Increase prevention and intervention services for youth identified as at-risk of developing a behavioral health diagnosis.
4. Decrease the number of youth and young adults that require more costly inpatient and residential behavioral health services.

## Section 2

### Target Population: Rising Risk

In Nevada, the current system of care only identifies the two extremes within the delivery model - severe mental illness or no diagnosis. Nevada's proposal seeks to identify the at risk youth. Nevada will identify these youth as "rising risk" or those youth that have been identified via a behavioral health screening. The rising risk youth will not meet criteria for a behavioral health disorder diagnosis, but they have subthreshold symptoms putting them are at risk to have increasing symptoms that could affect their functioning within their schools, homes and communities and may result in a more serious diagnosis in later adolescence or early adulthood if no intervention for prevention is provided. Initially, this program will focus on those youth entering the 7$^{th}$ grade to better identify a subset of the population, typically between 11 and 13 years of age, to subsequently expand to those aged 11 to 18 years.

By recognizing the connection between early life trauma, behavioral, mental and physical health disorders, as well as exposure to substance abuse, Nevada will transform the system from *crisis intervention to prevention and early intervention*. From a public health perspective, Nevada is taking the "upstream" or primary prevention approach to behavioral health instead of a secondary or tertiary prevention approach where intervention occurs after the onset of illness. This means that youth will get appropriate services prior to receiving a behavioral health diagnosis that will improve his or her overall life outcomes. These services will assist in preventing the continued adverse events that can lead to decades of suffering, leading to mental illness and the need for more serious crisis treatment. In order to accomplish this vision, Nevada will develop a system to identify those children at risk for developing a behavioral health diagnosis later in life - this will be the rising risk youth.

# Section 3

## Early Identification: The Screening Tools and Screening Process

Nevada proposes to use the EPSDT authority, as well as a comprehensive multi-part screening tool, to identify the rising risk youth. EPSDT ensures that youth receive appropriate medical care, behavioral health services, and developmental services.

The behavioral health screen will have multiple components. The elements of the screening tool will include screening for trauma, behavioral health symptoms, suicide risk, and substance abuse. For the screening process, Nevada will leverage the knowledge gained through nationally recognized tools commonly used in the field to develop its own screening tool. The rising risk determination will be made based on the number of risk factors identified and the scores on the subsequent tools.

Prior to entering the 7$^{th}$ grade, the screening will occur. Nevada has chosen this entry point as there is a current school entry requirement for an immunization, and this mandate has been very successful in ensuring immunization compliance. This age is also when youth begin to display behaviors that may indicate early warning signs. Mandating screening would also de-stigmatized for behavioral health by requiring all youth to receive this screening. Nevada, like other states, has behavioral health provider shortages. In order to address this challenge in Nevada, non-traditional providers in a variety of settings where youth naturally locate will be trained in the screening administration. Proof of the screening will be provided for school entry.

The screening process could begin in one of two ways: a self-assessment utilizing a standardized paper screening or a face-to-face screening with a service provider. If the self-assessment results in a rising risk designation, the youth will then receive a face-to-face screening to confirm results. The face-to face-screen would be completed by a well-trained traditional or non-traditional provider. Qualified providers who have the greatest access to the youth to be screened will be trained to make the appropriate referrals for prevention and early intervention and in some cases to treatment. Nevada is considering the following potential non-traditional providers/settings:

School Settings

- School Counselors;
- RNs/School Nurses;
- After School Program providers
- School Social Workers
- School-Based Health Centers

Court/Government Office

- Juvenile Justice and Parole and Probation Officers;

Child and Family Services Offices

- Government-based providers;

Public/Health Clinic Settings

- Community Health Workers
- Federally-Qualified Health Centers

Office /Clinic

- Mental Health Counselors

The screening providers must be linked to a "system of care" to ensure that any youth identified as risking risk is referred for appropriate follow up. It is Nevada's goal that the rising risk population receives screening and assessment in a holistic approach that will address all aspects of their life. In the event a youth has a previous determination of Serious Emotional Disturbance (SED), they would be exempt from the rising risk screening, but the provider identifying the exemption would be incentivized to complete or refer for completion of the medical well-child exam portion of the EPSDT to ensure all the youth's health needs are identified and addressed. Parents will be contacted when youth are determined to have possible SED or high risk behaviors (ex: suicide ideation). These youth also will be immediately referred for services such as Mobile Crisis or School Based Mental Health. In addition, the child will receive the comprehensive referral for medical and social services to complete the EPSDT.

To sustain the system transformation, our proposal includes developing a reimbursement mechanism for screening and services that includes a variety of payer sources, including Medicaid. Additionally, Nevada proposes to develop a pay for performance program for providers who coordinate an EPSDT and behavioral health screen and refer for intervention when necessary.

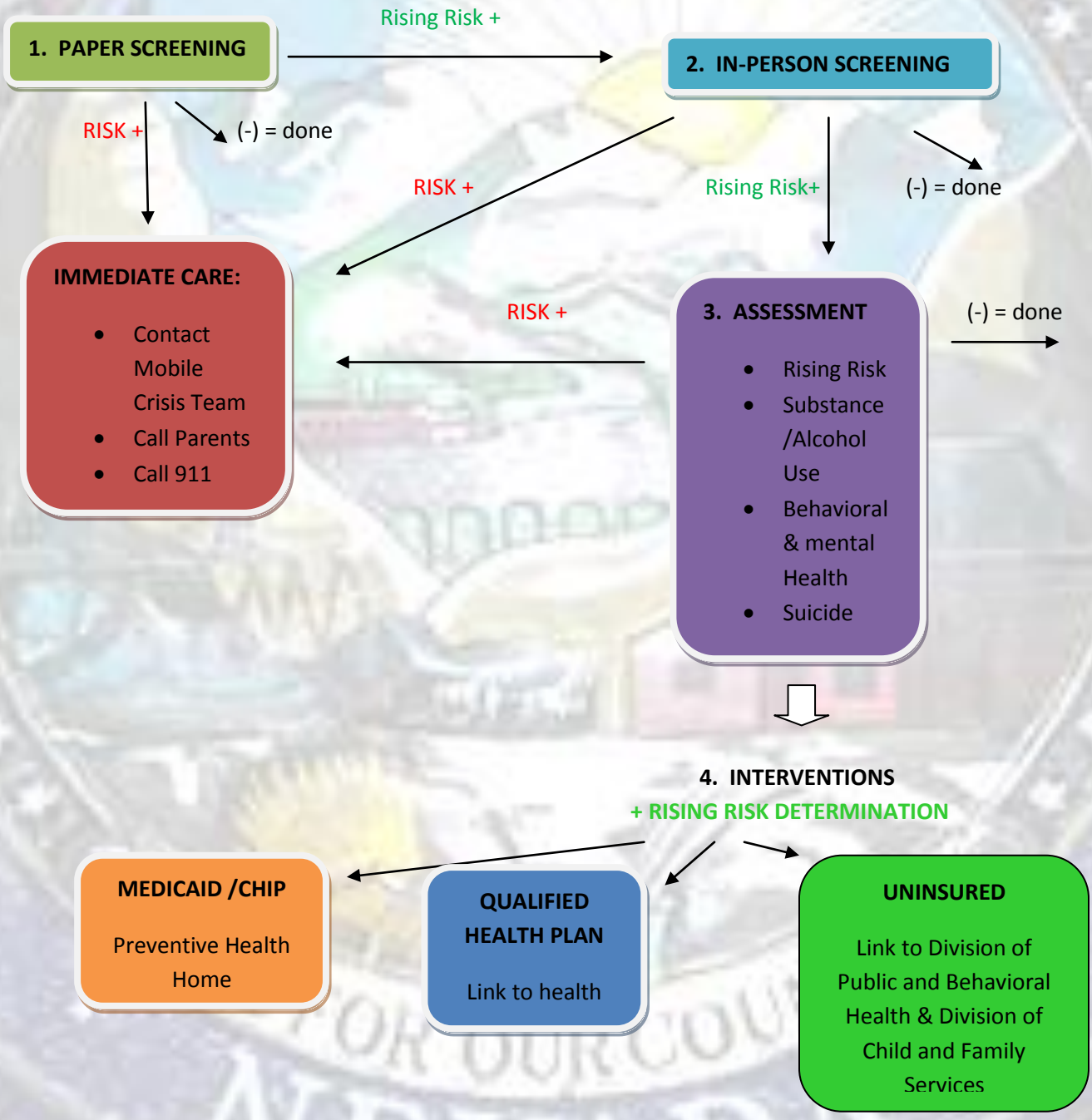
In addition to using evidence-based behavioral health, substance use, and suicide screening tools, Nevada is proposing to include early trauma in the screening. As was shown in the Adverse Childhood Experiences (ACE) Study, early trauma is a predicator of a variety of unfavorable health consequences later in life. ACEs are adverse childhood experiences, such as verbal, physical or sexual abuse, neglect, trauma and family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation). It has been determined that certain experiences are major risk factors for the leading causes of illness and death combined with a poor quality of life in the

United States. Additionally, increased ACEs in youth are associated with numerous risks, including:

- Mental illness;
- Cardiovascular illness, diabetes, cancer and premature mortality;
- Poor school performance (increased truancy and drop-out rates);
- Increased interaction with the criminal justice system;
- Increased risk of substance use; and
- Increased suicide ideation.

## Child Behavioral Health Screening Flowchart

- Child begins at #1 or #2.
- Those with BH/MH diagnoses are excluded from the mandate.
- If family provides proof of a negative BH screening from the pediatrician, PCP or other approved provider, no further screening is needed. If they provide a positive screening, they are provided linkages to assessment and intervention options, if not already done by provider.
- Parents are notified of all positive findings and recommendations throughout the process.
- RISK+ = Risk to self/Risk to Others; Suicidal threat or ideology



## Prevention and Early Intervention Services

Once a youth receives a rising risk determination, he/she will be referred for prevention and early intervention services. The "screener" will be responsible to ensure the youth and parent/guardian receives all information regarding referrals for intervention. Youth and families will have access to the following services either through Medicaid, private insurance or the Division of Public and Behavioral Health. Collaboration on this project has already been established between the Department of Health and Human Services and the Division of Insurance. Such services may include:

- Parent Education
- Substance Abuse Interventions
- Family to Family Support
- Peer to Peer Services
- Respite Care
- Case management that includes further health and behavioral health assessment if needed
- Education/Psycho-education
- Short-term, brief, solution focused individual and family therapies

# Section 4

## Outcome Measures

In addition to the goals identified earlier in the project, the following outcomes measure will be tracked. In the 2013-14 Nevada MCO Medicaid Performance Measure Rates and HEDIS Percentile Ranking for well child visits (EPSDT) were as follows:

| HEDIS MEASURE | HPN* RATE | HEDIS Ranking | AGP** RATE | HEDIS Ranking |
|---|---|---|---|---|
| Well-Child Visits in the First 15 Months of Life (6 or More Visits) | 54.50% | 10th to 49th percentile | 53.47% | 10th to 49th percentile |
| Well-Child Visits 3–6 Years of Life | 54.74% | < 10th percentile | 63.08% | 10th to 49th percentile |
| Adolescent Well-Care Visits | 42.09% | 10th to 49th percentile | 37.96% | 10th to 49th percentile |

*HPN = Health Plan of Nevada **AGP = Amerigroup

The chart below shows the Nevada MCO Check Up (CHIP) Performance Measure Rates and HEDIS Percentile Ranking:

| HEDIS MEASURE | HPN* RATE | HEDIS Ranking | AGP** RATE | HEDIS Ranking |
|---|---|---|---|---|
| Well-Child Visits in the First 15 Months of Life (6 or More Visits) | 63.01% | 10th to 49th percentile | 54.05% | 10th to 49th percentile |
| Well-Child Visits 3–6 Years of Life | 73.72% | 50th to 74th percentile | 78.74% | 75th to 89th |
| Adolescent Well-Care Visits | 54.26% | 50th to 74th percentile | 58.22% | 75th to 89th |

*HPN = Health Plan of Nevada **AGP = Amerigroup (Nevada does not track behavioral health screenings separately so there is no HEDIS data to indicate the percentages of these that are completed. EPSDT policy does include it as a component of the wellness visit.)

In order to track the progress of the program and make it sustainable and replicable by other states, along with the project goals, CMS 416 EPSDT report, and the HEDIS measures, Nevada will also monitor:

- Youth suicide
- Teen pregnancy
- School dropout
- Truancy
- Costly in-patient acute care treatment, decrease in the number of youth needing in state or out of state residential treatment
- Number of youth and families receiving appropriate behavioral health services
- Number of youth and families receiving prevention and early intervention services
- Number of youth reporting substance use

Budget Neutrality: The state anticipates that the cost savings realized through the shift from *crisis intervention to prevention and early intervention* will result in actualized cost savings over time.

# Section 5

## Potential Vehicles and Challenges/Opportunities

The DHCFP must identify the best practices for incentivizing complete, integrated medical and behavioral health screenings to ensure our youth's holistic health needs are being addressed. We are requesting assistance in designing a new Medicaid delivery model, including funding opportunities that encourage the desired outcomes while maintaining the current state funding levels. This new model must improve the outcomes of our target rising risk population. As such, Nevada would like to explore and identify what the best options are for our state.

EPSDT allows the state the flexibility to address a present condition based upon the findings of a screening, or to "correct or ameliorate" the condition by providing medically necessary services. In our program, there would not be a diagnosis as the Rising Risk determination needs to be made before the condition reaches the level of a diagnosis. CMS has indicated it is within the state's control to determine how we qualify appropriate non-traditional providers and allow them to bill for behavioral health screenings of Medicaid eligible youth in a variety of settings as noted previously. The state would appreciate confirmation from CMS that this EPSDT benefit can be modified to accommodate our vision and also provide for payment for treatment without a diagnosis.

Once youth are screened and are identified as rising risk, the youth will be provided access to preventive and early intervention services. The state also would like to confirm that these services may be covered by Medicaid when provided to Medicaid eligible youth. Also, can services be covered under existing authorities or is new authorities needed?

The DHCFP has the ability to leverage its MCO contracts in support of behavioral health screenings in children. While our entire "focus" population is not enrolled in an MCO, the majority is. The DHCFP would like to discuss innovative ideas on how to otherwise incentivize managed care to promote these services.

## Preventive Health Home Authority

A Preventive Health Home could include a variety of nontraditional providers and services: respite, peer to peer groups, and family to family support, along with the financial encouragement for managing the whole child appropriately. Preventive services are less intense and more cost-effective. In the best circumstances, they prevent a child from escalating to the need for a higher level of more intensive and costlier services. The DHCFP is requesting assistance in determining what authority could be utilized to develop this preventive health home for our Rising Risk population.

Health Homes (Section 2703)

Is this authority an option for the state to use to provide a "Preventive" Health Home to our Rising Risk youth?

1915(i) Home and Community-Based Services

Would this home and community base service authority be able to be utilized in a way that would provide an option for the state to target the Rising Risk population and provide a "Preventive" Health Home?

1115 Research and Demonstration Project

Would it be necessary for Nevada to use this authority to target the Rising Risk population and provide a "Preventive" Health Home?

### Identified Challenges

The system change is proposing to eliminate the stigma around behavioral health screening, but if a child is identified as Rising Risk or needing mental health services, the stigma and possible parental resistance from accessing behavioral health services likely will remain.

Prior to achieving the cost-savings from averting crisis treatment, up-front funding for screening and preventive treatment is necessary. As the state has limited funding to contribute towards the non-federal share, the state hopes to leverage existing resources embedded within the public health, social services and juvenile justice system.

The development of workforce capacity, even with the utilization of non-traditional providers, is necessary.

Preventive services have a long-term return on investment. The return is based on global population data. Directly linking the prevention treatments to the changes in global statistics (e.g., reduced truancy, improved dropout rates, reduction in suicides) is a challenge.

### Stakeholder Campaign and Working with Partners

An aggressive parent education program is warranted to achieve the high level of support and buy-in that is needed to make this program a success. Educating stakeholders is one area that will utilize Department of Education funding. We have identified the following groups as targets for this campaign: the pediatrician/primary care provider community, parents/guardians/care givers, religious groups, community health workers, school advocates, peer to peer programs, family to family support programs (such as NV Parents Encouraging Parents), FQHCs, and school-based health centers. By requiring the behavioral health screening Nevada expects to increase compliance rates, but stakeholder buy in remains an important component to achieving the goal of moving from crisis treatment to prevention and early intervention.

## Section 6

### Conclusion

The National Alliance on Mental Illness (NAMI) reports that early identification and treatment prevents the loss of critical developmental years that cannot be recovered and helps youth avoid years of unnecessary suffering. Further, early and effective treatment can prevent a significant proportion of delinquent and violent youth from future violence and crime. By

intervening early, the youth is able to develop socially and to fully experience the developmental opportunities of childhood.

Nevada has ranked amongst the worst in the nation for many indices including the adequate and early assessment and treatment of our state's youth. The current system of care is crisis driven. Until we reevaluate and make investments to improve the way and time services are delivered the system will continue to be reactive and responsive, not preventive. Nevada believes the proposed health reform will improve health outcomes which not only benefits the target population, but also will results in Medicaid spending reductions over the longer term. Nevada looks forward to the opportunity to collaborate with CMS on an innovative sustainable project to address behavioral health issues in our youth at a preventive level, improve our behavioral health rankings as a state and serve as an example to other states experiencing similar issues.