

Buying What Works Pays Off: Cost-Effectiveness of Evidence-Based Interventions



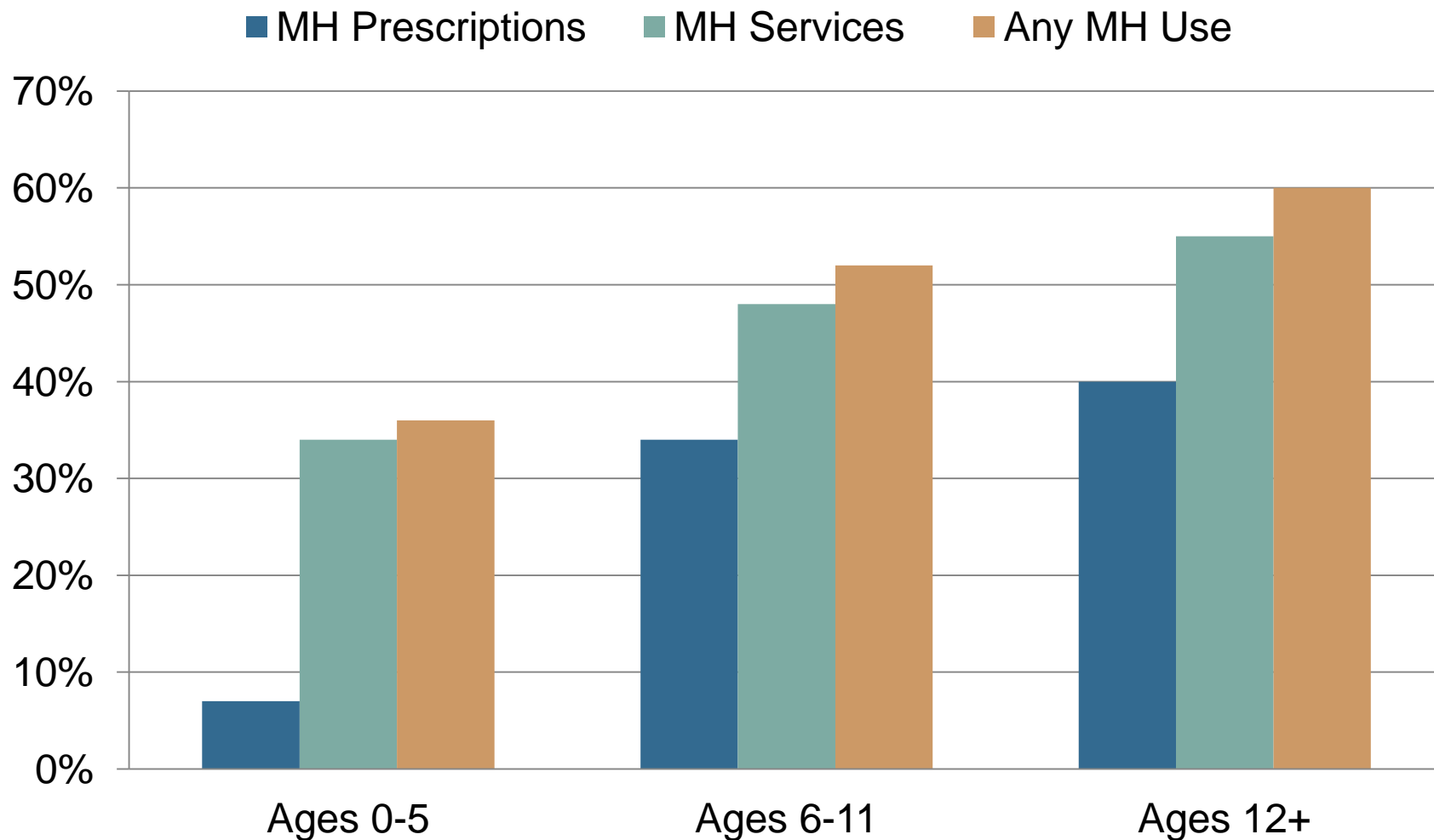
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CMS ENCOURAGES USE OF EPSDT TO IDENTIFY TRAUMA AMONG CHILDREN WHO HAVE BEEN MALTREATED

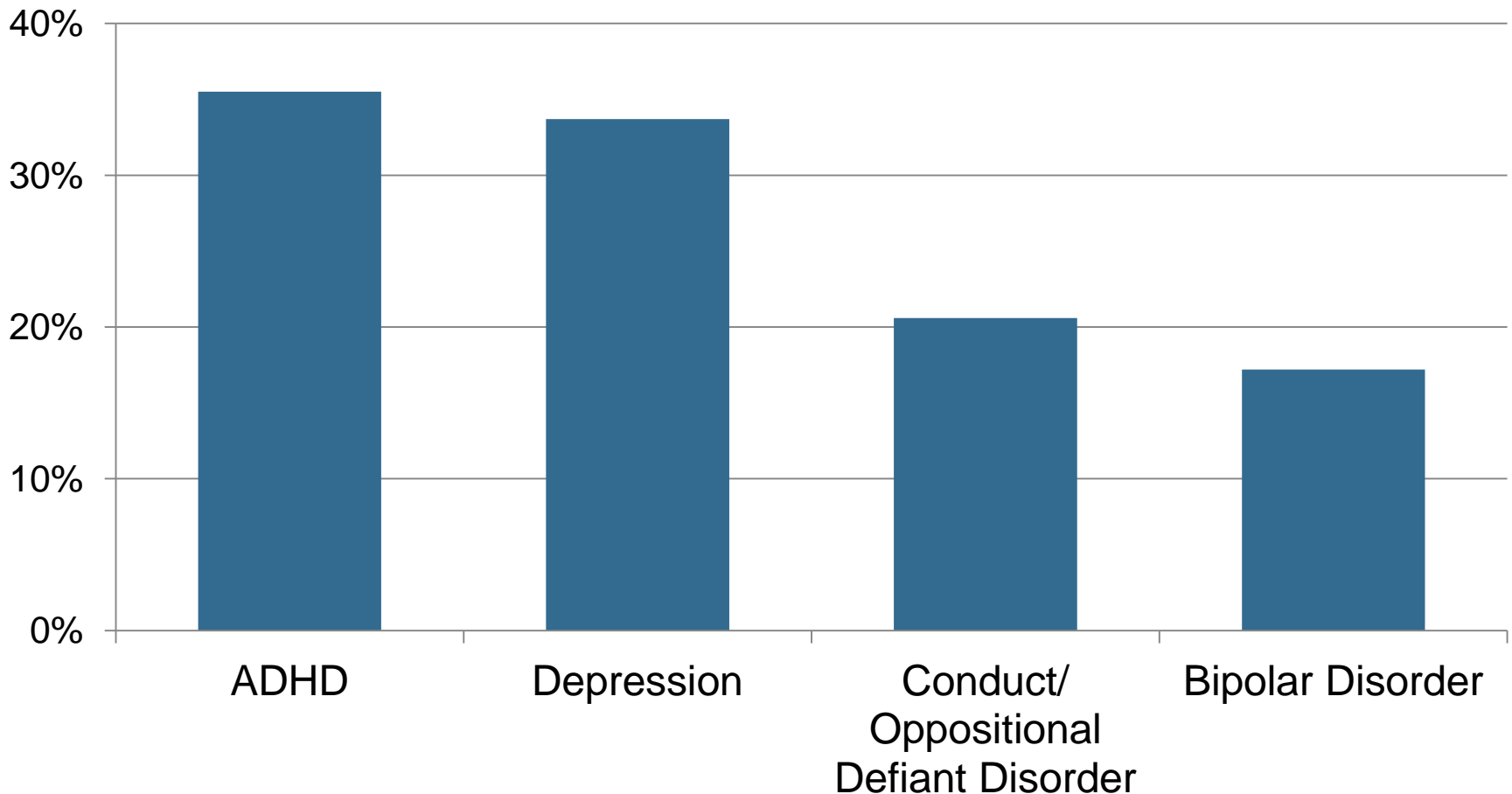
- CMCS Informational Bulletin dated March 27, 2013:
Prevention and Early Identification of Mental Health and Substance Use Conditions
- Highlights that “**Children exposed to trauma, including maltreatment, family violence, and neglect**, exhibit symptoms consistent with individuals diagnosed with post-traumatic stress disorder, attention deficit/hyper-activity disorder, depression, and conduct disorder/oppositional defiant disorder.”
- Outlines elements of EPSDT benefit that are particularly relevant to prevention and detection of mental health and substance abuse disorders.



MENTAL HEALTH IN CHILD WELFARE



MOST COMMON MENTAL HEALTH DIAGNOSES AMONG CHILDREN IN FOSTER CARE RECEIVING PSYCHOTROPIC MEDICATIONS

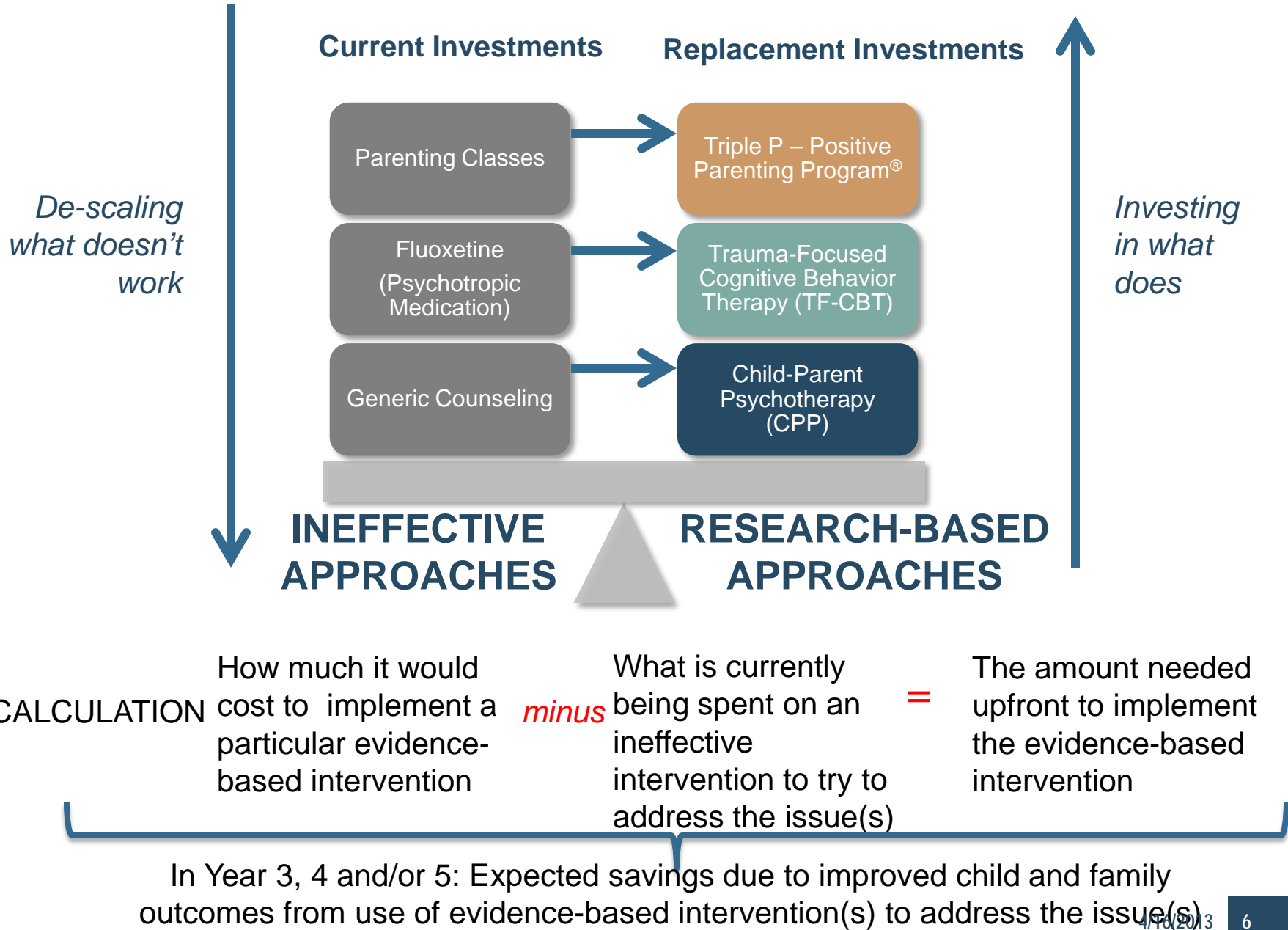


MEDICAID IS ALREADY PAYING FOR TRAUMA INTERVENTIONS: SYMPTOMS THAT OVERLAP WITH CHILD TRAUMA AND MENTAL ILLNESS

| Mental Illness | Overlapping Symptoms | Trauma |
|---|---|---------------------|
| Attention Deficit/Hyperactivity Disorder | Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity | Child Trauma |
| Oppositional Defiant Disorder | A predominance of angry outbursts and irritability | Child Trauma |
| Anxiety Disorder (incl. Social Anxiety, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, or phobia | Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction | Child Trauma |
| Major Depressive Disorder | Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties | Child Trauma |

(Griffin, McClelland, Holzberg, Stolbach, Maj, & Kiesel , 2012)

ESTABLISHING A COST-EFFECTIVE SERVICES ARRAY



AROUND THE COUNTRY: EBPs REIMBURSED BY MEDICAID

Multidimensional Treatment Foster Care (MTFC)

- Hawaii, Nebraska, California, Tennessee

Parent-Child Interaction Therapy (PCIT)

- New Jersey, Delaware, Iowa, DC, Illinois, Oklahoma

Multisystemic Therapy (MST)

- Tennessee, New Jersey, Arizona, DC, New Mexico

Functional Family Therapy (FFT)

- New Jersey, Louisiana, DC, Washington

Cognitive Behavioral Therapy (CBT)

- New Jersey, North Carolina, Delaware, South Carolina

Incredible Years (IY)

- Oregon, Florida, Texas, New York

SCREENING AND ASSESSMENT UNDER EPSDT

“[Massachusetts] implemented new regulations requiring primary care providers to screen for developmental and behavioral problems for all MassHealth members younger than 21 years. **Providers are required to use validated, standardized screening tools from a list provided by the state and are currently reimbursed approximately \$10 for each screening test performed and an additional \$25 for face-to-face evaluation and management time for a positive screen.** Prior to these regulations, even the mandated screening under EPSDT did not require the use of specified tools and was not a distinct, uniformly reimbursable service.”

Table. Assessment Tools^a

| Tool | Abbreviation | Age Range |
|---|--------------|-----------------|
| Ages & Stages Questionnaire: Social-Emotional | ASQ:SE | 3-60 mo |
| Brief Infant and Toddler Social and Emotional Assessment | BITSEA | 12-36 mo |
| Child Behavior Checklist/Youth/Adult Achenbach System of Empirically Based Assessment | CBCL | 1.4-20 y |
| Car, Relax, Alone, Forget, Friends, Trouble (specific to substance/alcohol use) | CRAFFT | 14-18 y |
| Parents' Evaluation of Developmental Status | PEDS | 0-8 y |
| Modified Checklist for Autism in Toddlers (specific to autism) | M-CHAT | 16-30 mo |
| Patient Health Questionnaire 9 (specific to depression) | PHQ-9 | 18-20 y |
| Pediatric Symptom Checklist | PSC YPSC | 4-16 y ≥11 y |

^aAdapted from *MassHealth-Approved Standardized Behavioral Health Screening Tools for Children Under the Age of 21*.²³

A COMMITMENT TO PROMOTING WELL-BEING FOR CHILDREN AND FAMILIES MEANS:

1. Focus on child & family level outcomes
2. Monitor progress for reduced symptoms and improved child/youth functioning
3. Proactive approach to social and emotional needs
4. Developmentally specific approach
5. Promotion of healthy relationships
6. Build capacity to deliver EBPs