Mental and Physical Health:
Barriers to and Strategies for Improved Integration

Volume I: Synthesis of Case Study Report Findings

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Synthesis of Case Study Report Findings

I. Introduction

Children with special health care needs (CSHCN) are generally considered as having one or more chronic physical, developmental, behavioral, or emotional conditions that affect their ability to function (McPherson, et al., 1998; Stein et al., 1993). Individuals, organizations, and agencies working to improve systems of care for CSHCN share the goal of providing coordinated care to these children and their families. Indeed, the Maternal and Child Health Bureau includes coordinated care as a central component of its definition of a system of care for CSHCN (Division of Services for Children with Special Health Needs, 1999).

The importance of coordinating care for CSHCN stems from the fact that these children and their families often require an array of services from multiple systems, including the medical care, early intervention, and special education systems. In addition, growing evidence points to the importance of coordinating mental health care services with the array of other services typically needed by CSHCN. Approximately one in five children and adolescents experiences signs and symptoms of a DSM-IV disorder during the course of a year (DHHS, 1999). For these children, whether or not they also have physical conditions requiring medical attention, linkages between the medical and mental health systems are critical. For example, CSHCN with a chronic physical condition may experience and need treatment for mental health or behavioral problems; many CSHCN are likely to need counseling related to the challenges of growing up with a physical health problem, and some may suffer from more serious problems such as depression. In addition, in some cases, mental or behavioral health issues may be interfering with compliance with medical treatment. For children whose primary diagnosis is a mental health condition, access to medical care is important because they, like all children,
need regular medical care and because their behavioral problems may, in fact, be related to an underlying physical condition. In addition, some children have disorders that are very difficult to classify as either physical or mental but, rather, lie on the boundary (e.g., autism, eating disorders, and genetic conditions with both physical and mental manifestations) and whose nature necessitates an integrated treatment and management approach. It is important to note also that, while these examples include references to “physical” and “mental” health problems, there is an inseparable relationship between the mind and the body (DHHS, 1999) which itself a fundamental reason for better integrating systems of care.

The argument for better coordinating physical and mental health care systems is supported by studies documenting the hidden cost of untreated psychological problems to the health care system. Studies have found that as many as 20 percent of children who present to pediatric clinics have somatoform disorders—that is, physical symptoms that cannot be linked to a physical condition and may be assumed to be the result of psychological factors—which result in multiple clinic and hospital visits as well as diagnostic tests (Walker, McLaughlin & Greene, 1988; Robinson, Greene & Walker, 1988; Kronenberger, 2000). Other studies have found that children with mental health problems make more use of medical care services for non-mental health reasons than do others (Zuckerman, Moore, and Glei, 1996; Bowman and Garralda, 1993). These studies illustrate the importance of collaboration between pediatric and psychiatric professionals in addressing children’s health care needs, a theme highlighted in the recently released landmark Surgeon General’s report on mental health (DHHS, 1999).

Despite the growing recognition of the benefits that could result from better coordination between the physical and mental health care systems for CSHCN, these systems remain largely fragmented (Bazelon Center for Mental Health Law, 2000; Hill, Schwalberg, Zimmerman et al., 1999; Stroul, Pires, Armstrong et al., 1998). Furthermore, trends within the managed care industry favoring carve-out arrangements for mental health may exacerbate the separation between physical and mental health care systems. On the other hand, it has been noted that carve out arrangements may have such benefits as a more defined focus on mental health, a broader array of mental health services, and more competitive reimbursement arrangements for
mental health providers (Steinberg, 2000; Steinberg, Gadomski, and Wilson, 1999, Bazelon Center for Mental Health Law, 1999).

To explore the issues related to ongoing systems fragmentation and to identify opportunities for improvement, in late 2000 Health Systems Research, Inc. (HSR) undertook a study to identify the barriers to and strategies for integrating mental health and physical health systems of care for CSHCN. HSR carried out this study as part of its role as a partner in the National Policy Center for CSHCN\(^1\) funded by the Federal Maternal and Child Health Bureau, Health Resources and Services Administration. In this role, HSR was particularly interested in identifying recommendations that would support the six core goals for an optimal system of care for CSHCN outlined in the 10-year action plan being developed by the Maternal and Child Health Bureau’s Division of Services for Children with Special Health Needs as a companion to Healthy People 2010. These goals are as follows:

- All children with special health care needs will receive coordinated ongoing comprehensive care within a medical home.
- All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.
- All children will be screened early and continuously for special health care needs.
- Services for children with special health care needs and their families will be organized in ways that families can use them easily.
- Families of children with special health care needs will partner in decision-making at all levels, and will be satisfied with the services they receive.
- All youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work, and independence.

The two-volume report produced as the major outcome of this study is intended to provide its readers—including program officials and agency administrators, policymakers, health care

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\(^1\) Other partners in the National Policy Center for CSHCN include the Johns Hopkins University School of Hygiene and Public Health and Family Voices.
providers and administrators, families, researchers, insurers, persons concerned with health care financing, and other interested parties—with insights into those factors that impede as well as those that foster integration between physical and mental health systems. Furthermore, it is intended to provide practical guidance, based on the experiences of the five case study sites explored under this research effort, of steps that can be taken at the Federal, state, and community and program levels to improve integration between these services and systems and to further the Maternal and Child Health Bureau goals for an optimal system of care for CSHCN identified above. The content of the two volumes is as follows:

# Volume I continues with a description of the methods through which this study was conducted, followed by an overview of the findings from the five case studies conducted by the research team. The final sections include conclusions and recommendations regarding strategies for improved integration.

# Volume II includes detailed descriptions of the structure and experiences of the five case study sites.

II. Methodology

To guide the development of the study design, HSR convened an advisory group of experts in the fields of mental health, pediatrics, child development, health policy, and children with special health care needs. This group, including representatives from government agencies, research organizations, advocacy groups, managed care organizations, parents with CSHCN, and service agencies, convened in Washington, DC on 18 October 2000 to determine the focus and methodology for the study. At this meeting, participants provided guidance on identifying the research questions as well as determining the study design and methods. After conducting the study, HSR once again convened the expert group in April 2001 to present study results and work with participants to shape the recommendations included in this report for improved integration of children’s mental and physical health services. A list of the members of the advisory group is included as Appendix A.
The remainder of this section presents the research questions developed by the advisory group, discusses the study design and site selection process, and describes the approach used to carry out the site visits.

A. Research Questions

Three major categories of research questions guided the conduct of this study. These were:

- Barriers to and strategies for integration;
- Services and delivery systems; and
- Financing.

Within each of these categories, several questions were identified. These are presented in Table II-1. These questions formed the basis for the development of the interview protocols, the analysis of interview findings, and the development of recommendations.

B. Study Design and Site Selection

In addition to participating in the development of the research questions, the other major charge to the advisory group at its first meeting was to provide HSR with guidance about the methodology to be used in carrying out the study. The group agreed that a case study approach, involving in-depth study of a small group of selected sites, would be the best way to address the research questions.

Given that only a limited number of case studies could be conducted as part of this study, HSR also asked the advisory group for input as to the criteria that should be used to guide the selection of sites. The group agreed that it would be important to look at mature programs, those that had been in place long enough to have results to share. In addition, they recommended that HSR identify a diverse set of sites to ensure that a range of approaches
### Table II-1.
**Research Questions**

#### Barriers and Strategies

- What are the major barriers to integration of physical and mental health services for CSHCN?
- What are potential strategies for coordination of physical and mental health services?
- How do different service delivery and financing models affect the coordination/ integration of services?
- What are the potential models for delivering and financing integrated physical and mental health services for children?

#### Services and Delivery Systems

- How should the mental health needs of CSHCN be assessed and identified?
- How adequate are insurance/MCO benefit packages to meet the mental health needs of CSHCN?
- What is the makeup, capacity, and quality of the service delivery system for children with physical and mental health needs?
- How can coordinated systems support families’ access to appropriate services?
- How do different models for coordination affect families of CSHCN?
- How is the success of different models evaluated and monitored?

#### Financing

- What are the sources of funding for coordinated services?
- How can financing systems be designed to support coordination of services?

would be able to be studied. Specifically, the group agreed that HSR should identify sites using a variety of program models, using different types of strategies for integrating physical and mental health services, and supported by diverse funding sources. In addition, they urged HSR to identify sites targeting different populations, including children of different ages, and to identify sites addressing the needs of children with different types of conditions, including those serving children with physical health problems as their primary diagnosis as well as those primarily addressing the needs of children with serious mental health disorders. Finally, the group agreed that it would be important to identify sites in different areas around the country that included representation in both urban and rural areas.

Based on this guidance, HSR developed a short questionnaire to use to screen the potential sites, including those suggested by the advisory group as well as those identified by HSR.
through subsequent research. Of the approximately 25 potential sites that were identified, only
11 were considered as possible sites, typically because their activities were not sufficiently
focused on the integration of physical and mental health services for children or their efforts
had only recently been implemented. The 11 finalist sites are identified in Table II-2. The five
sites that were ultimately selected for study are italicized in this table and described in more
detail in Section III of this report.

C. Site Visit Approach

Once the case study sites were selected, HSR researchers contacted the sites to obtain
background information and to schedule site visits during the early winter of 2001. Multi-day
site visits were conducted for four of the five case studies; for the fifth site (the Dawn Project
in Indianapolis), all interviews were conducted by telephone.

During these visits, researchers conducted individual and group interviews with the range of
key informants. To permit investigators to collect consistent information across sites, HSR
developed a set of seven structured interview protocols for the major categories of key
informants, including:

# Program administrators;
# Representatives of state and local agencies, including mental health, child
  welfare, Medicaid, and juvenile justice;
# State Title V/Maternal and Child Health agency representatives (who were
  interviewed for background information on the state’s systems of care for
  CSHCN);
# Managed care organizations;
# Local providers of care, including primary care physicians and mental health
  providers;
# Care coordinators; and
# Parents of CSHCN.
<table>
<thead>
<tr>
<th>Site</th>
<th>Location (urban/rural)</th>
<th>Setting</th>
<th>Specific Target Population***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center for the Vulnerable Child, Children’s Hospital Medical Center*</td>
<td>Oakland, California (urban)</td>
<td>County hospital</td>
<td>Children who are homeless or at-risk of homelessness, including foster children</td>
</tr>
<tr>
<td>Cherokee Health Systems**</td>
<td>Eastern Tennessee (rural)</td>
<td>Non-profit managed care organization</td>
<td>General pediatric population</td>
</tr>
<tr>
<td>Colorado Coalition for the Homeless, Homeless Children’s Program</td>
<td>Denver, Colorado (urban)</td>
<td>Health center and child care center</td>
<td>Clients who are homeless or at-risk of homelessness</td>
</tr>
<tr>
<td>Dawn Project*</td>
<td>Marion County, Indiana (urban)</td>
<td>Non-profit managed care/care management organization</td>
<td>Children with serious emotional disturbance</td>
</tr>
<tr>
<td>Pediatric Rapid Evaluation Program (PREP)</td>
<td>Kennebec and Somerset Counties, Maine (urban)</td>
<td>Pediatric center</td>
<td>Children entering the foster care system</td>
</tr>
<tr>
<td>Children’s Village*</td>
<td>Yakima, Washington (rural)</td>
<td>Family service center (affiliated with hospital)</td>
<td>CSHCN</td>
</tr>
<tr>
<td>Massachusetts Mental Health Services Program for Youth (MHSPY)*</td>
<td>Cambridge and Somerville, Massachusetts (urban)</td>
<td>Non-profit managed care organization</td>
<td>Children with serious emotional disturbance</td>
</tr>
<tr>
<td>Iowa’s Individual Evaluation and Planning Clinics (IPEC)</td>
<td>Iowa (statewide) (mainly rural)</td>
<td>14 regional clinics</td>
<td>High-risk children</td>
</tr>
<tr>
<td>Nurse Visitation Program with infant mental health component</td>
<td>Four regions in Louisiana (urban and rural)</td>
<td>Home-based model</td>
<td>High-risk mothers and their young children (up to age two)</td>
</tr>
<tr>
<td>Metropolitan Hospital Center*</td>
<td>East Harlem, New York</td>
<td>City hospital</td>
<td>General pediatric population/CSHCN</td>
</tr>
<tr>
<td>Project SELECTT, University of New Mexico Health Sciences Center</td>
<td>Albuquerque, New Mexico (urban)</td>
<td>Hospital</td>
<td>Children from birth to three whose parents have psychosocial risk factors for poor health outcomes</td>
</tr>
<tr>
<td>DAYAM Adolescent Health Services, University of Medicine and Dentistry NJ</td>
<td>Newark metropolitan area, New Jersey (urban)</td>
<td>Clinic/Service center</td>
<td>Adolescents infected with HIV</td>
</tr>
</tbody>
</table>

*Site selected as a case study site.
**Additional limited interviews were conducted with Cherokee Health Systems to supplement information collected through the five case studies.
*** While all of these sites serve CSHCN, some focus on a specific subset of this broad population.
These protocols, which together addressed the set of research questions identified by the advisory group, explored the details of the programs in the five sites. Specifically, the protocols included questions about the model or approach used by the site, the strategies used to facilitate integration between physical and mental health services, how children in the target population are identified, services provided, providers who deliver the services, financing strategies, evaluation efforts, and lessons learned. Information was also collected about the broader service delivery systems in which the programs operate.

In addition, the protocols included questions designed to characterize the various strategies used by the sites to integrate physical and mental health services for children. Researchers conceptualized integration of services as a continuum that also includes coordination and collaboration of services, with different factors influencing the ability of organizations and agencies to provide services that are coordinated, collaborative, or integrated. To explore this construct during the key informant interviews, researchers asked interviewees to rate key strategies as well as their overall programs along a continuum including coordination, collaboration, and integration. The following definitions were provided for this purpose:

- **Coordination.** Two or more entities operating independently that are exchanging information and altering activities to the benefit of the client and the coordinating agencies. Coordination may be characterized by case conferencing, sharing copies of care plans or treatment notes, or developing and/or using a shared resource directory.

- **Collaboration.** Two or more entities operating independently who share a common objective (at the client or agency level) and are engaged in one or more aspects of joint planning, delivery, or management of services. Collaboration may be characterized by joint home visits, interagency agreements, or shared records.

- **Integration.** Two or more independent entities mixing or blending together into a unified whole some aspect(s) of the planning, financing, delivery or management of services. Partners come together through a new structure to address a shared vision, and resources are pooled. Integration of services may be characterized, for example, by the development of a joint care plan, shared staffing, blending of financial resources, and/or use of a common record/reporting system.
This approach recognizes that "full" integration of services may not be possible or appropriate for all organizations or at all times and, furthermore, that achievement of a particular outcome for a child may be most effectively obtained through a process of coordination, while a different outcome may be achieved through collaboration. Finally, there are some outcomes that can best be obtained when programs or activities are planned and provided as an integrated whole.

Following the site visits, researchers developed individual state case study reports, which are included in Volume II of this report. The next section presents a synthesis of the case study findings.

III. Case Study Findings

This chapter presents a synthesis of the findings from the five case studies that were conducted under this study. The first section presents an overview of the programs that were the focus of the case studies, as well as definitions of study terms. This is followed by a detailed discussion of the major strategies used by these sites to improve integration between mental health and physical health services and systems.

A. Overview of Sites

Under this study, HSR researchers conducted in-depth case studies of five sites using alternative approaches and strategies for integrating physical health and mental health services for CSHCN.

The five sites, profiled in Table III-1 below, represent a diverse mix of projects. As illustrated in the table, the sites include two hospital-based programs, one freestanding service center/clinic, and two based in non-profit managed care plans (one of which is a health maintenance organization). They also serve a diverse range of target populations, including the general pediatric population, CSHCN, children who are homeless or in foster care, and children with serious emotional disturbances. Numbers of clients served per year and major funding

<table>
<thead>
<tr>
<th>Site Description</th>
<th>Numbers of Clients Served Per Year</th>
<th>Major Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based 1</td>
<td>5,000</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Freestanding 2</td>
<td>3,000</td>
<td>Private</td>
</tr>
<tr>
<td>Non-profit 3</td>
<td>2,500</td>
<td>State</td>
</tr>
<tr>
<td>Non-profit 4</td>
<td>1,500</td>
<td>Federal</td>
</tr>
<tr>
<td>Managed Care 5</td>
<td>1,000</td>
<td>Managed Care</td>
</tr>
</tbody>
</table>

Health Systems Research, Inc.
sources are also presented in the table, which is followed by brief descriptions of each of the sites.

<table>
<thead>
<tr>
<th>Site</th>
<th>Project Setting</th>
<th>Target Population</th>
<th>Clients/Year</th>
<th>Major Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Hospital Center East Harlem, NY</td>
<td>City hospital clinic</td>
<td>General pediatric population/ CSHCN</td>
<td>350</td>
<td>Public and private health insurance reimbursements; funding of physician salaries by New York Medical College, Federal grant (Maternal and Child Health Bureau)</td>
</tr>
<tr>
<td>The Center for the Vulnerable Child Oakland, California</td>
<td>County hospital clinic</td>
<td>Foster children Homeless children</td>
<td>500</td>
<td>Federal grants (Bureau of Primary Health Care), state and local grants, county contracts</td>
</tr>
<tr>
<td>Children’s Village Yakima, Washington</td>
<td>Family service center/clinic</td>
<td>CSHCN</td>
<td>2600</td>
<td>Capital campaign (funds from corporations, individuals, and foundations), grants (state Title V/MCH), contracts (IDEA Part C Early Intervention Services), insurance reimbursements, state mental health funds</td>
</tr>
<tr>
<td>Massachusetts Mental Health Services Program for Youth (MHSPY) Cambridge and Somerville, MA</td>
<td>Non-profit health maintenance organization</td>
<td>Children with serious emotional disturbance</td>
<td>30</td>
<td>Foundation;* participating state agencies**</td>
</tr>
<tr>
<td>Dawn Project (MHSPY) Marion County, Indiana</td>
<td>Non-profit managed care/care management organization</td>
<td>Children with serious emotional disturbance</td>
<td>150</td>
<td>Foundation;* participating state and county agencies;*** Federal grant (Center for Mental Health Services/Substance Abuse and Mental Health Services Administration)</td>
</tr>
</tbody>
</table>

*Initially funded as Mental Health Services Program for Youth (MHSPY) replication sites by the Robert Wood Johnson Foundation

**The Massachusetts Departments of Education, Mental Health, Social Services, and Youth Services, and the Division of Medical Assistance jointly fund the capitated rate paid to Harvard Pilgrim Health Care (including Neighborhood Health Plan as a subsidiary) to serve MHSPY clients.

***The State Division of Mental Health, Department of Education/Division of Special Education, Marion County Office of Children and Families, and Juvenile Probation in Marion County jointly fund the capitated rate paid to Indiana Behavioral Health Choices, the managed care organization contracted to serve Dawn clients.

# Metropolitan Hospital Center. Housed within the pediatric service at Metropolitan Hospital Center in New York City are CSHCN Specialty Clinics and a Developmental Clinic designed to promote the integration of physical, behavioral, developmental, and mental health services for children with chronic
health problems or disabling conditions. Through this system, children may be referred to the CSHCN Specialty and Developmental Clinics from the general pediatric clinic, the neonatal intensive care unit, or the community. Selected staff from the hospital’s Department of Child and Adolescent Psychiatry are on site at the CSHCN and Developmental Clinics during designated times to consult with medical care providers and families on behavioral/mental health concerns and needs of children attending the clinics. While this is a hospital-based service, extensive links with community health care providers, social service agencies, and the school system have been developed. Care coordination is a key component of this program focusing on coordination of services provided within the hospital complex and those available in the community. The program serves an inner-city population that is linguistically and culturally diverse.

# The Center for the Vulnerable Child. The Center for the Vulnerable Child (CVC) in Oakland, California provides case management and direct mental health services to integrate mental and physical health care for children who are homeless or at-risk for homelessness, including foster children. Located within Oakland Children’s Hospital, the Center represents a hospital-based care coordination model serving a special subset of disadvantaged children with a multitude of psychosocial risk factors. Using this care coordination approach, children who otherwise may not be able to access physical and mental health services are linked to community providers. CVC care coordinators also provide direct mental health services to make up for gaps in the county’s mental health service delivery capacity. In addition to providing services and referrals, the Center conducts health services research and policy analysis on issues affecting the vulnerable populations that it serves.

# Children’s Village. Children’s Village is a facility that houses several social service delivery agencies serving CSHCN in the Yakima Valley in Washington State. The Village provides a facility where various services are co-located, but also a framework in which different agencies can combine funding and coordinate services in a manner that facilitates families’ ability to access services needed by their CSHCN. The funding to build the main facility in Yakima was raised through a capital campaign that drew on the resources of the local community. Funding for the services provided within the Village come from a variety of sources, including Maternal and Child Health/Title V funding, early intervention funding under the Individuals with Disabilities Act, and Medicaid. Family resource coordinators assist the families that receive services through the Village. There is also a Behavioral Assessment Team that provides mental health services for children and families of CSHCN.

# Massachusetts MHSPY. The Massachusetts Mental Health Services Program for Youth (MHSPY) began in 1996 as a collaborative project of the Massachusetts Departments of Education, Mental Health, Social Services, and
Youth Services, the Division of Medical Assistance, the school systems of Cambridge and Somerville, and Harvard Pilgrim Health Care, a managed care organization. The project received its initial funding through a planning grant from The Robert Wood Johnson Foundation's Mental Health Services Program for Youth Replication grant program. The program's goal is to provide integrated medical, mental health, family support, and wraparound services for children with severe emotional disturbance within a Medicaid managed care system. The MHSPY program's administration is housed at Harvard Pilgrim Health Care, a health maintenance organization that serves enrollees in MassHealth, the state's Medicaid managed care program. The program serves a total of 30 children at any one time and is currently operating only in the cities of Cambridge and Somerville. The MHSPY pilot represents a creative attempt at integration of services at the administrative, supervisory, and client levels. Care managers with small caseloads work intensively with families to meet the full range of their needs, supervisors from the participating agencies meet regularly to discuss the administration and management of the program, and the leaders of these agencies have worked closely together to blend funding and continue to form the project's Steering Committee.

# Dawn Project

The Dawn Project is an interagency initiative based in Marion County, Indiana to create a more integrated system of care for children with serious emotional disorders. Launched with a MHSPY Replication Grant from The Robert Wood Johnson Foundation, this project is supported by the combined funding of several state and community agencies that serve children with emotional and behavioral disorders. Together, these agencies pay a capitated rate to a non-profit managed care entity to cover the costs of residential care for children who need this resource, as well as a range of wraparound services such as mentoring to support the care of children with serious emotional problems at home or in other community-based settings. Dawn uses an intensive service coordination model to link clients to services and community resources, with the intent of moving families toward their identified goals. While physical health issues are routinely assessed and addressed as needed, the Dawn model of care for children with serious emotional disturbance focuses largely on the mental health, educational, child welfare, and juvenile justice systems.

B. Strategies for Integrating Mental and Physical Health Services

The study sites were chosen to represent diversity in their locations, settings, target populations, and funding sources. Despite these differences, the five sites showed remarkable
consistency in the strategies they used to achieve the integration of mental health, physical health, and social services for high-risk children.

In most sites, service integration efforts took place on both the system and the client levels. System-level integration efforts include activities on the state or local levels to develop an infrastructure that supports integration, including activities related to planning, financing, and the development of service delivery mechanisms that promote integration. The major system-level strategies employed by the study sites include the development of interagency and other community relationships, the use of shared financing mechanisms, and the co-location of services. Client-level activities focus on the direct services delivered to clients and aim to integrate or coordinate the services that they receive. The major client-level strategies used by the case study sites were care coordination and information sharing. These strategies are discussed in turn below.

1. Community Relationships

In order to be successful at serving CSHCN, health care providers need to build strong community relationships with the many individuals, agencies, and organizations that touch the lives of their client population. The study projects all have multiple ties to a variety of community groups. The types of relationships include those between agencies, community organizations, individual providers, and family members. Many of them face similar challenges building community ties and working with other organizations whose missions sometimes differ from their own. However, these organizations have been able to develop strong relationships that lead to more integrated care for CSHCN and their families.

There are a number of ways in which community relationships are important for the model programs studied.

# Project Development. Three of the projects were developed as interorganizational efforts to improve the quality of care for children with special needs. The Dawn project in Indianapolis and the Massachusetts MHSPY project both received initial funding from a Robert Wood Johnson Foundation grant with the expressed goal of providing integrated medical,
mental health, family support, and wraparound services for children with severe emotional disturbance. Meeting that goal required bringing together a variety of agencies that are providing services to these children. Children’s Village grew out of long-standing relationships between agencies serving CSHCN in the Yakima Valley. Under the leadership of a major hospital, the Village put together a capital campaign which drew upon community resources to fund a new center to serve CSHCN. The success of the capital campaign indicates that key organizations with strong reputations in a community may be able to mobilize private financial resources for a population that elicits a great deal of community concern.

None of the three organizations were able to get all agencies that provided services for their target population to be full partners during project development. For a variety of reasons, certain organizations were unable to commit financial and organizational resources. However, the efforts were able to move ahead because there was a critical mass of organizations who were able to make solid commitments. While full cooperation of relevant organizations is an ideal, creating a new effort to provide integrated services requires a willingness to move ahead when support is gained from key organizations, rather than every organization.

All of the model programs recognized the frustration of parents who must deal with multiple service systems. Children’s Village took this further and obtained direct parental input during the program planning stages. One of the results was the creation of a drop-in child care center for siblings of CSHCN. While some of those involved with planning saw this as a luxury, parents who were interviewed indicate it is one of the Village’s most helpful features. Direct parental involvement in program planning represents an opportunity to develop services that may be overlooked by other groups.

# Building and Maintaining Relationships. Relationships between organizations and individuals within and outside the model programs are key to the ability to provide integrated services. Sometimes this involves relationships among providers within an organization. At Metropolitan Hospital Center in New York City, providers have found that services are most effective when pediatric staff and mental health staff work together to deliver appropriate services. Similarly, providers from different organizations within Children’s Village teach each other various methods for providing more effective therapies. In other cases, key relationships involve the model program and other organizations. The Center for the Vulnerable Child has a mutually beneficial relationship with the local Head Start agency, which allows CVC case managers the opportunity to offer services at Head Start and enables the Head Start agency to meet its requirement to provide developmental and cognitive screening. The Community Resources Manager who works with the Dawn project plays a key
role in developing the network of individuals and agencies from the community who provide services to Dawn clients.

One of the main ways that relationships involving the model projects are built and maintained for Dawn, MHSPY, and Children’s Village is through the use of multi-level inter-agency forums where decisions are made and information shared. One of the factors that was identified as crucial to managing interagency relationships is having high-level administrative officials with the power to commit resources serve on the committees or other bodies responsible for major management decisions. While having high-level administrators endorse these programs is a necessary condition for providing and maintaining integrated services, that alone is not sufficient. The willingness to commit time and effort to the projects also needs to be developed among direct service managers and direct services staff. This is generally done through a variety of committees and task forces that serve to address issues that come up while services are provided. These groups facilitate the development of relationships among staff at a variety of different levels and also provide a forum for obtaining their feedback about program operations.

Involving and Serving Families. One of the most important relationships that an integrated service provider needs to develop is with the families that receive services. The projects visited for this study use a variety of mechanisms for working with families. All of the groups except the Metropolitan Hospital Center pediatric clinic, which is embedded in a much larger organization, provide for a parental role on governing committees, advisory groups or similar bodies. All of the sites have processes designed to involve families in decision-making at various levels of treatment. While their success at fostering family involvement has varied based on factors such as reasons for referral and the cultural background of the families served, the importance of families as partners is widely recognized.

A number of the programs have helped develop parental support organizations. One of the initial goals set by the Dawn Project was the fostering and formation of a parent support organization. That goal was met and the parent organization has broadened to include parents of children with severe emotional disorders who are not being served by Dawn. The parent support organization continues to provide input on the administration of Dawn and also has taken on a broader advocacy role with all the organizations in the county that serve children with SED. Children’s Village and Massachusetts MHSPY both make use of parent partners who can offer support to families with children receiving treatment. Both programs also sponsor social events that offer families, including the siblings of children with special needs, the opportunity to get to know other families in similar situations. Parent support groups can combine an opportunity for social support with an educational component, such as the monthly parent groups organized by the care coordinator at Metropolitan
Hospital Center. The staff at Children’s Village have found that parent groups play an especially important role for Latino families, because the provider community has a shortage of Latino staff. The bilingual parent coordinator plays a key role in reaching out to the Spanish-speaking community and connecting parents to services available at the Village and elsewhere.

Clearly, developing community relationships is important for programs that seek to integrate mental and physical health care, as children with special needs are often involved with multiple service providers who operate within a number of different agencies and organizations. However, the structures, missions, and goals of these various agencies are not always compatible, presenting a significant challenge for program administrators. In the Massachusetts MHSPY project, for example, while all of the partner agencies agree on the essential goal of the program—to integrate care for high-risk children in the hope of preventing future catastrophe—their perspectives on this goal can differ widely. This is illustrated by the Massachusetts Department of Youth Services’ view that the MHSPY model is essentially a preventive one and thus often irrelevant to the population for which they are responsible, while the Massachusetts Department of Public Health sees MHSPY as providing a treatment service, and thus outside its mandate of population-based prevention.

The study sites commonly experienced challenges building relationships with certain key partners, such as local school systems. Schools are crucial not only for school-age children, but often for pre-school children who are eligible for early intervention services. The decentralized oversight of school systems presents challenges for organizations trying to integrate their services with schools. Programs may have to deal with multiple school districts and with special education staff within individual schools. State departments of education are useful partners, but as the Dawn and Massachusetts MHSPY projects found, even when the state department was involved in the project, relationships had to be nurtured with individual school districts to make integration of services work. However, schools may be wary of these partnerships for fiscal reasons, as they may fear being financially responsible for services provided by partner agencies.
Two other types of agencies pose special challenges for some of the study sites and will likely do so for similar programs. These are the child protective services system and the juvenile justice system. Any program that focuses on children with SED is likely to need to develop relationships with child protective services and juvenile justice. Even those organizations that focus primarily on physical illness will often find themselves serving a considerable number of children involved with the child protective services system. These agencies represent challenges because their primary mission may clash with the goals of projects that seek to provide children with integrated health care.

The first priority of a child protection agency is the safety of children. Parents may see these agencies as a threat because they can remove children from the home, so any program that works with both parents and child protective services must be careful not to alienate parents. Child protective caseworkers may also be reluctant to share responsibility for a case because of concerns about their own liability. The child protection agency that works with the MHSPY program found that some workers simply are not well suited for the type of collaborative effort required in the program.

Juvenile justice agencies also have distinct cultures and missions that may conflict with a program seeking to provide integrated health services. The ultimate authority of a case referred through juvenile justice rests with the courts. The Dawn Program found that clients referred through the court system were becoming abruptly ineligible for Dawn when judges closed cases. Both Massachusetts MHSPY staff and individuals from the juvenile justice agency indicated that the programs often have difficulty meshing their cultures; MHSPY takes a strength-based approach which focuses on the progress the client is making, but the juvenile justice agency may have to threaten punitive actions because program participants are still engaged in behavior that constitutes a violation of their parole conditions.

The programs studied here are addressing the challenges of working with diverse agencies through a variety of methods.
Maintaining the Commitment of High-Level Administrators. The programs studied recognize the need to maintain the commitment of high-level administrators, such as by involving them as key decision-makers and working to ensure that the program meets their own agency’s needs. Massachusetts MHSPY staff stressed the importance of maintaining the involvement of the various agencies’ administrators, in particular their financial commitment, not only because the funds are needed for operations but because without that commitment the program is likely to slip down the agency’s priority scale. Individuals involved with Dawn and Children’s Village also stressed the importance of maintaining the involvement of high-level administrators. Any effort that involves multiple agencies or organizations will likely require constant efforts at maintenance of relationships. Even when a program appears to be working well, there may be a temptation for an agency or organization to pull back resources from a cooperative effort and use them internally. Program managers need to pay attention to the concerns of participating agencies and try to address them whenever feasible. Administrators also need to give their own staff the time to participate in collaborative efforts, even in cases when billing hours may present a challenge.

Becoming Fluent in Other Organizational Cultures. Relationships between agencies, organizations, and individuals work best when there is a shared understanding of the strengths and constraints that different participants bring to the process. At Metropolitan Hospital Center, cooperation worked best with pediatric and mental health providers who had a clear understanding of what kind of problems warranted a mental health referral and what kind were best dealt with by other units. Massachusetts MHSPY assigned Care Managers to be liaisons at service offices of other agencies because it helped them build relationships and understand the type of work done by workers for other agencies. MHSPY and Children’s Village have staff who are familiar with the process of developing Individualized Education Plans (IEPs) for special education children, thus helping the programs work with school districts. This type of cross-training is made easier by co-location of staff, but as shown in the case of MHSPY can also be encouraged through out-stationing some staff. Once again administrative support for this type of sharing is important to its success.

Focusing on Outcomes Relevant to Participating Organizations. How can organizations maintain strong relationships when there are budget and other organizational pressures that work to undermine them? One very useful strategy is to make sure that outcomes are measured which are important to each participating agency. Measuring outcomes is an especially important strategy for programs that seek to integrate services across agencies. The program that was probably furthest along in this respect was the MHSPY program. However, even for MHSPY the main outcomes being measured have to do with the child’s functional status. While this is clearly crucial, the program director found
herself having to put together special analyses focused on measures of special concern to partner agencies (e.g., lost school days for the education system, avoidance of re-arrest for the juvenile justice system) in order to maintain their support. A program that focuses on such outcomes from the beginning may have an easier time maintaining the cooperation of partners.

All of the programs have struggled with the challenge of building relationships within the community and with other agencies. While the strategies discussed here have not been implemented by all of the study projects, they do provide a sampling of some ways in which community support can be built and cooperation between organizations can be fostered. Individuals interviewed for this study universally recognize the importance of cooperation, but they also make it clear that maintaining and expanding productive cooperation is an ongoing task that cannot be ignored.

2. Shared Financing

A major product of these interagency relationships is the development of strategies to jointly fund integrated services. As discussed in Section II, the study projects relied on a variety of funding sources, including foundation and government grants, Medicaid reimbursement, and discretionary funds from a variety of state agencies. In addition, the five projects offer examples of a range of payment strategies, as described below.

Grant Funding for Salaries. The Center for the Vulnerable Child in Oakland derives the majority of its funding from Federal, county, and foundation grants, and uses these grants to support the salaries of its staff. The project does not currently receive reimbursement from third-party payers for services, although negotiations are under way with Medi-Cal for payment for mental health services provided by care coordinators. Other projects also use grant funding for specific services; Children’s Village in Yakima uses Title V grant funds to support its CSHCN specialty clinics, and the Metropolitan Hospital Center project uses a Maternal and Child Health Bureau Special Projects of Regional and National Significance grant to support its care coordinator.

Fee-for-Service Reimbursement. The providers at Children’s Village in Yakima and Metropolitan Hospital Center in New York bill their clients’ insurers on a fee-for-service basis. In most cases, the payer is the state Medicaid program. In New York, many of these clients are enrolled in Medicaid managed

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care plans, but the providers themselves do not receive capitated payments and are not at risk. Likewise, in Yakima, mental health services are financed on a capitated basis through a Regional Service Network (RSN) which is administered by Greater Columbia Behavioral Health. This organization has three service providers under contract, all of which are involved with Children’s Village, and which bill the RSN on a fee-for-service basis.

# Partial Capitation. The Dawn Project in Indianapolis developed a capitation rate to be paid to Choices, the non-profit managed care organization formed by the county’s community mental health centers to serve Dawn clients. The rate of $4,130 per member per month covers residential treatment as well as other community-based mental health and support services (e.g., mentoring) not covered by insurers. Physical health services and care coordination, especially for the large portion of Dawn clients who have Medicaid coverage, are generally not paid for out of the capitated rate. Providers of these services are reimbursed on a fee-for-service basis by Medicaid or other third-party payers.

# Full Capitation. The Massachusetts MHSPY project receives a capitated payment that covers all medical, mental health, and support services for enrolled children, with the sole exception of residential treatment services, which are rarely included in managed care capitation payments. The capitation payment of $3,283 is paid to the managed care organization in which the program’s clients are required to enroll.

Many of these payment mechanisms require the use of a variety of sources of funding, including reimbursement by Medicaid or other payers, foundation grants, and funds from state and local agencies. These disparate funding sources may be combined in a variety of ways, as described below.

# Patchwork Funding. As described above, the New York, Oakland, and Yakima projects use funding from a variety of government agencies, foundations, and third-party payers to support the various functions and services of their projects. However, these disparate funders do not coordinate with each other in any way.

# Braided Funding. This term may be used to describe how the Dawn Project combines funds from the Department of Mental Health, the Department of Education, and the Marion County Office of Families and Children. While DMH contributes a small amount toward the capitation rate for all enrollees, the majority of the payment comes from either the Department of Education or the Marion County Office of Family and Children, depending on the source of the referral into the program. Therefore, while the program’s total budget reflects a
combination of funds from all three agencies, the funds themselves still follow individual clients.

### Blended Funding

The Massachusetts MHSPY project represents a more complete blending of funding across agencies. In this case, the state Departments of Medical Assistance, Mental Health, Education, Social Services, and Youth Services each contribute to the total pool of funds from which the capitation payments to Neighborhood Health Plan are drawn. While the agencies do not contribute equal amounts, their funds are not connected to the specific clients nor to the number of clients they refer to the program.

The Massachusetts MHSPY program’s financing structure comes the closest to representing fully integrated funding; however, developing and sustaining this structure has been challenging. The program’s approach to blending funds is based on the assumption that the benefits of the program in coordination of services and prevention of out-of-home placement would accrue to the partner agencies regardless of the number of children they refer, as all MHSPY clients are involved with multiple service systems. Despite the potential benefit of combined funding, however, the creation of this financing structure was no simple task. Even with the best intentions, state agencies are not always able to make budget allocations that are not for the purchase of specific services; to contribute to this project, each agency needed to find a source of discretionary funds that could justifiably be used for this project. This was easier for some agencies than for others, and some of the partners are now struggling to justify their continued participation. In addition, the state Medicaid agency had a particular challenge in designing the project so that it did not seem to be a sole-source contract with one managed care plan and could receive approval from the Health Care Financing Administration. Because of these issues, the planning phase of the MHSPY project took nearly a year and a half.

Another critical financing issue that came up in many of the study sites was the role of managed care in financing the programs and overseeing program services. In the two MHSPY programs, managed care organizations were closely involved in the design and implementation of the programs. In both of these sites, staff extolled the benefits of managed care: under their capitated systems, care coordinators have the flexibility to provide services and supports not typically covered by Medicaid or other insurers, and they have the authority to approve services
for payment. In addition, they have found that managed care facilitates coordination, as a variety of providers have access to common records and may be located in the same building, allowing for ease of communication and information-sharing.

However, in the sites in which managed care plans were not included in the project team, these systems caused nearly insurmountable problems. Several sites noted that the payers that they rely on will only reimburse for one service for each enrollee on any one day; therefore, when a group of providers convene for case conferences, only one of them can bill for their time. Without a source of payment, providers find it difficult to conduct coordination activities. The makeup of managed care networks can cause difficulties as well, as primary care providers or care coordinators may refer families to the best qualified or most convenient providers, who may not be in their plans’ provider networks. Finally, system-wide carve-outs of mental health services, such as that used in California’s Medi-Cal managed care system, can pose a barrier to care coordination and information-sharing.

Based on these findings, it appears that the inclusion of managed care organizations (MCOs) in the planning and oversight of service integration efforts is critical to the success of these efforts in a managed care environment. Involvement of MCOs facilitates not only integrated funding but also coordinated care and shared information. It is also evident that system-wide mental health carve-outs pose a significant barrier to information-sharing and service integration.

In addition, the experience of the case study sites emphasizes the importance of maximizing Medicaid reimbursement for medical, mental health, and care coordination services. Given the challenge of securing and sustaining grant funds and discretionary allocations from other state and local agencies, it is important that providers be reimbursed for as many services as possible so as to devote limited funds from other sources to those services that Medicaid or other payers do not cover.

3. Co-location
Co-location of mental and physical health care providers has proven to be an extremely effective agent for integrating mental and physical health services. The strategy not only improves access and saves time for patients through “one-stop shopping” mechanisms, but it also allows for increased information sharing and cross-training between providers. Staff members can make direct referrals to each other and can also be in continuous communication regarding clients’ progress. This contributes to more comprehensive health care for patients, especially CSHCN, who often have critical and simultaneous physical and mental health needs. Service providers with different backgrounds and training can also observe and learn from each other and, in turn, become more knowledgeable practitioners. Furthermore, co-location of mental and physical health services may also assist in reducing the stigma associated with the use of mental health services because it normalizes mental health care as an entity parallel to physical health care. Given its many direct benefits, the influential report *Mental Health: A Report of the Surgeon General* recommends co-location of mental health services with a host of other service systems (e.g., education, primary care, welfare, juvenile justice, substance abuse treatment) as a step toward the goal of eliminating racial/ethnic and socioeconomic disparities in access to mental health care services (U.S. Department of Health and Human Services, 1999).

In the five case study sites, almost all of the programs made some attempt to co-locate mental and physical health services, but the Metropolitan Hospital Center Center in New York City, MHSPY program in Massachusetts, and Children’s Village in Yakima appeared most successful in implementing this strategy. Their co-location efforts, described by their respective service settings, are summarized briefly below.

# Co-location in a Hospital Setting. Metropolitan Hospital Center, a large, inner-city public hospital, integrates care for CSHCN through linkages between its Child Developmental Clinic, CSHCN Specialty Clinic, Department of Pediatrics, and Department of Child and Adolescent Psychiatry. The Developmental Clinic, which is conducted in tandem with the Specialty Clinic for CSHCN, provides targeted mental/behavioral, developmental consultation, and care coordination activities for children who need more intensive care than what would normally be available through the general pediatric clinic, the CSHCN Clinic, or the community-based provider. (Both the Developmental and CSHCN Clinics are housed within the general pediatric unit of MHC; the
Developmental Clinic was initiated by an MHC developmental pediatrician, who saw the need to provide integrated physical, developmental, and behavioral services within the context of a general pediatric unit. The clinic was organized with the collaboration of both pediatric and mental health staff within the hospital, with the core team comprising a developmental pediatrician, a pediatric psychologist, a care coordinator, and a registered nurse. In addition, available on the pediatric service to staff and families using the Developmental and CSHCN Specialty Clinics are the half-time services of a child psychologist and a child psychiatrist. Often, treatment is conducted jointly by the Developmental Clinic and the mental health staff when the child has significant mental health and developmental needs. Without a doubt, the co-location of pediatric and mental health staff within this setting expedites the integration of services. Staff members acknowledged the importance of mental health and pediatric providers being physically available to each other for the care of CSHCN, which allows for immediate on-site consultation and facilitates the development of an accepting relationship between the pediatric and mental health staff that is essential to the development of trust and respect and leads to a shared understanding of the needs of the child and the family.

Co-location in a Managed Care Setting. The Massachusetts MHSPY project offers an example of how care may be co-located in a managed care setting. As described earlier, MHSPY is a collaborative project of the Massachusetts Departments of Education, Mental Health, Social Services, and Youth Services, the Division of Medical Assistance, the school systems of Cambridge and Somerville, and Harvard Pilgrim Health Care, a managed care organization. Its goal is to provide integrated medical, mental health, family support, and wrap-around services for children with severe emotional disturbance within a Medicaid managed care system. Once enrolled in the managed care plan, a child may continue to see his or her existing pediatrician (if the pediatrician is within the managed care network) or may switch to a pediatrician within Harvard Vanguard Medical Associates, the medical group that is formally affiliated with Harvard Pilgrim Health Care. Harvard Vanguard houses care managers, pediatricians, and mental health specialists in one central location. Care managers involved in the MHSPY program report that communication, sharing of records, and coordination are simpler when the child is seen at Harvard Vanguard; because they are located in the same physical space, care managers and pediatricians can meet informally to discuss cases, and because they share administrative systems, the care managers can see patients’ records easily and can relay messages to their doctors promptly.

Co-location in a Multi-Service Center. Co-location was a driving force behind the development of Children’s Village, which houses several service delivery agencies serving CSHCN. To create Children’s Village, several agencies joined together to plan for a new building where they could share resources, collaborate in the provision of care, and coordinate efforts on behalf of children and
families. A truly unique and comprehensive model, the Village provides family resource coordination, medical care, occupational and physical therapy, speech and language services, pediatric specialty clinics, mental health services, dental care, family support services, a health information center, child care, and education services. Within this setting, co-location has been highly advantageous for both agency staff and patients alike. The staff report an increased understanding and respect for the expertise of others, creating high levels of trust and confidence and enabling staff to make referrals that are in line with the needs of clients and the agencies’ strengths. Patients report a greater willingness to ask questions and seek consultations from mental health providers than if a referral and a trip to another office were required. Since its inception, families of CSHCN agree that Children’s Village has made it much easier to access services and has clearly improved the quality of their lives.

Together, these programs demonstrate the advantages of co-locating mental and physical health services, among other specialized services, in integrating care. Although each of the three programs are housed in unique environments, they have succeeded in improving access to and utilization of mental and physical health services, increasing information sharing between providers, and facilitating the provision of comprehensive care.

Nonetheless, while co-location of services may act as a major catalyst for integrating services, it is not without its share of challenges. A major obstacle in co-location involves the different “cultures” present in mental health and physical health environments, as well as in agencies with different missions. At Metropolitan Hospital Center, providers noted that pediatric training emphasizes the treatment of physical conditions without sufficiently recognizing behavioral/developmental issues as significant concerns, whereas mental health training does not usually include an emphasis on the behavioral, developmental, or mental health effects of living with a chronic health condition or disability. The hospital staff recommended joint mental health and pediatric training sessions through opportunities such as grand rounds to better understand each other’s issues and speak the language of each other’s fields. The various service partners of Children’s Village have been able to conquer the challenge of working with different agencies’ agendas by agreeing from the beginning of their partnership that none of the agencies give up anything, including their name, their culture, or their program.
autonomy, a policy that has allowed the partners to forge productive relationships while also maintaining their distinct identities.

4. Care Coordination

In many programs designed to assist CSHCN in accessing the range of services needed by the child and family, care coordination, sometimes referred to as case management, is employed as a strategy to reach that goal. While different definitions of these terms exist (Zimmerman, Schwalberg, Gallagher et al., 2000), care coordination may be distinguished from case management in that, whereas case management is typically reliant on a medical model and focused on a patient’s health care needs, care coordination programs generally use a broader social service model that addresses a full range of medical and social support services and which, in the managed care context, includes the coordination of services offered within and outside the managed care plan (Rosenbach and Young, 2000). Whether the term care coordination or case management is used, however, the responsibilities of the care coordinator/case manager determine the scope and breadth of the coordination activities.

In all five case study sites, care coordination was a central strategy for ensuring that a holistic approach was taken in addressing each child’s needs. Furthermore, the sites’ approaches were consistent with the broad definition of care coordination described above; that is, all were carried out with the aim of facilitating access to the broad range of medical, psychological, support, and other services needed by the clients and their families and, in the case of the two managed care-based programs (Dawn and Massachusetts MHSPY), the scope of coordinated services was not limited to those services covered by the plan.

Despite the similarity in these programs with regard to their overall goal, the five sites used varying approaches with respect to their care coordination activities. As a result of the different environments in which they operate, each of the projects chose to implement staffing models and roles appropriate to their own situations (see Table III-2). For example, in the two hospital-based settings (Metropolitan Hospital Center and the Center for the Vulnerable Child [CVC]), care coordinators provide a bridge between primary and specialty services within the
hospital, as well as between hospital-based care and services available in the community. In addition, in the case of CVC, the highly-trained care coordinators also serve as therapists for clients in need of counseling because of the severe shortage of mental health providers in Oakland. In Children’s Village, the freestanding service center for CSHCN, family resource coordinators help families to identify which of the many services offered within the multi-service center are appropriate for their child and to develop a plan to ensure that the family is linked with the appropriate resources within and beyond the center. In all three of these cases, care coordinators may carry caseloads of dozens of children each.

The two managed care-based sites, Massachusetts MHSPY and Dawn, offer a much more intensive model of care coordination than the other three programs. In these sites, where programs are designed specifically to care for children with serious emotional disturbance, care coordinators work closely with a small number of clients and their families, and in concert with client-focused teams including professionals and non-professionals important in that client’s life, to identify and address the client’s needs. Furthermore, the design of the Massachusetts MHSPY and Dawn programs includes a central role for care coordinators in the management of clinical and fiscal resources covered by their respective capitated rates. In both cases, care coordinators are responsible for not only for identifying services to be included in the care plans but also authorizing payment for these services. Thus, whereas the care coordinators in the other three sites identify service needs but don’t necessarily have any role in approving payment for these services, the care coordinators in the MHSPY and Dawn models have the authority to ensure that needed services will, in fact, be paid for.

Payment for care coordinators’ time and salaries is also an important consideration given the difficulty of paying for services to coordinate care for CSHCN. The two hospital-based sites rely on grant funding for their care coordinator positions and one (CVC) is pursuing Medicaid
### Table III-2.
Care Coordination Approaches

<table>
<thead>
<tr>
<th>Site</th>
<th>Caseloads</th>
<th>Care Coordinator Roles</th>
<th>Financing for Care Coordinator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan Hospital Center</td>
<td>100 children</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The Center for the Vulnerable Child (based in Oakland Children’s Hospital)</td>
<td>60 children</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Children’s Village</td>
<td>40 children &lt; age 3, 50-125 children &gt; age 3</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Massachusetts Mental Health Services Program for Youth (MHSPY)</td>
<td>6-8 children</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Dawn Project (MHSPY)</td>
<td>8-10 children</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Metropolitan Hospital Center has one care coordinator position focused on CSHCN funded with this grant.

**The Center for the Vulnerable Child (CVC) is currently pursuing the possibility of receiving Medicaid reimbursement for case managers’ time spent in providing direct mental health services to clients. MHSPY’s Medicaid reimbursement is based upon the assumption that case managers are providing direct mental health services to their clients 50 percent of their time.

Reimbursement for its care coordinators’ time due to their dual role as therapists. Medicaid is already an established source of care coordination funding for the two more recently established managed care-based sites. MHSPY draws down Medicaid funding through Medicaid’s contribution to the capitated rate paid to the plan to cover all services needed by MHSPY clients. For the majority of Dawn’s clients who have Medicaid coverage, the Community Mental Health Centers who make up the managed care organization and provide the service coordination bill Medicaid directly (for clients who are not Medicaid eligible, payment is drawn from the capitated rate paid by the supporting agencies, which do not include
Medicaid). Children’s Village supports its family resource coordinators through state and Federal funding streams that support services for CSHCN, including Title V/MCH funds and IDEA Part C. Thus, while the long-term prospects for ongoing grant funding to support the care coordination services in the hospital-based sites is unclear, the other three sites have been more successful in folding funding for care coordination into their approaches for financing the broader range of services needed by their clients.

Regardless of the funding mechanisms, all five sites place families at the center of their care coordination efforts, with the approach of doing “whatever it takes” to address families’ needs, a common characteristic of the different projects. Furthermore, the projects tend to share the philosophy that it is important to focus on each family’s strengths and resources in developing strategies to address their needs. In the Dawn and Massachusetts MHSPY projects, a structured approach for identifying each family’s strengths in numerous domains (e.g., daily living, health/medical, and psychological/emotional) is an integral aspect of care planning, as is the inclusion of non-professionals such as mentors, family members, and clergy on teams that work with the family and care coordinator in developing and implementing care plans. The Dawn and Massachusetts MHSPY projects are also distinguished from the other sites by their low caseloads, which allow a level of intensity in working with each family that is not realistic in most other agencies or service delivery settings. For example, in the busy and financially-pressed setting of Metropolitan Hospital Center, the amount of time that the one care coordinator devoted to CSHCN can spend with each family is obviously limited. In cases like this, it becomes more important that care coordination functions be shared among staff working with families of CSHCN rather than limited only to persons with the job title of “care coordinator.” Even more importantly, efforts at the systems level to further develop an infrastructure that supports integration would reduce the need for client-level care coordination services.

5. Information Sharing
The sharing of information between agencies and providers who serve the same clients is a fundamental strategy for promoting the integration of mental and physical health care services. The five projects utilize a variety of approaches for sharing information, ranging from informal sharing facilitated by a common service delivery location to the development of specialized information systems.

# Informal Information Sharing. An important way to share information is having the opportunity to interact and share information informally, as often occurs when providers are co-located. A pediatrician interviewed at the Massachusetts MHSPY project indicated that, while he did not have time to work directly with the care coordinators for MHSPY, on a number of occasions he found out about special issues involving a particular case through conversations in hallways and parking lots. Various providers at Children’s Village mentioned that the availability of mental health specialists at the Village brought major benefits; if a pediatrician, occupational, or speech therapist has a problem with a particular case that they think may be related to a behavioral health issue, they feel comfortable discussing it with the behavioral health specialists who then might make some suggestions or offer to sit in on a session with the client.

# Sharing Records Among Providers at the Same Location. The projects that are located in organizations that provide both physical and mental health care have important advantages for sharing information. For example, Massachusetts MHSPY participants are all enrolled in the same managed care organization and this makes it much easier to share records. In addition, while care coordinators at CVC face challenges in obtaining records from outside mental health providers, they are able to easily access records of treatments that occur within their parent organization, Children’s Hospital. Finally, a common pediatric chart available to both physical and mental health providers at Metropolitan Hospital Center allows providers to make decisions that take into account treatment the child is receiving from other providers.

# Building a Case History. Both of the MHSPY programs (Massachusetts and Dawn) have an enrollment process that requires staff to compile records from the various agencies that have been involved with families that are new to the program. This often involves an elaborate process, since most of the families have had contacts with multiple agencies. The public health nurse for Indian Health Services in Yakima invests a great deal of time and energy trying to build case histories for children referred to the Fetal Alcohol Syndrome/Fetal Alcohol Effects Specialty Clinic at Children’s Village. She interviews family members and attempts to locate and interview the child’s birth mother with the goal of obtaining the most complete picture possible of the child’s history.
Specialized Information Systems. Dawn and Children’s Village have created specialized information systems to share case information among different agencies and providers. Dawn is able to use an online management information system developed for a project funded under the same grant. This system allows service coordinators to input data about their clients in a central place and for the team to obtain real-time information, including assessment results, the services authorized in the service coordination plan, and the costs of these services. The data are shared with partners to inform them about the return they are getting for their investments. Children’s Village uses a common electronic chart which is shared by providers from the different agencies. Parents can request and obtain a “lock-out” that limits which staff can see parts of a child’s record. The main flaw with the system was that it often duplicated records kept by the home agencies of providers. The Village was in the process of rethinking its system and was discussing creating a revised system with the goal of minimizing the requirements for duplicate entry and the risk of having two incomplete records because information is not entered at both sites.

These approaches reflect a range of possible strategies for improving information sharing among providers serving the same clients. However, all of the programs face challenges regarding information sharing. For example, CVC staff in Oakland indicate that they face difficulties obtaining mental health records for clients because of strict confidentiality laws in California; these problems occur even when a family gives them permission to access a child’s records. Even when confidentiality is not a barrier to access, it is a challenging task to compile and maintain a comprehensive record of the range of services provided to each client from multiple providers and agencies.

C. Integrating Along a Continuum

In addition to looking across sites to identify common strategies for improving integration of physical and mental health services for CSHCN, researchers also sought to assess where along the coordination/collaboration/integration continuum the sites fell with respect to their use of these strategies. As described in Section II, researchers conceptualized integration of services as a continuum that also includes coordination and collaboration of services, with different factors influencing the ability of organizations and agencies to provide services that are coordinated, collaborative, or integrated. The use of the continuum construct is intended to serve as a tool for teasing out the different levels of coordination that are possible and the types
of approaches that may be most feasible and appropriate in different situations, not to imply
that one level of coordination/collaboration/integration is inherently better than another.

In studying the five sites, it seems clear that the setting in which services are delivered is a
primary factor in determining what types of approaches are taken to foster more coordination of
services for clients. Although each uses various strategies to facilitate this integration (which
may themselves be described as either coordinated, collaborated, or integrated), the overarching
approaches in the five sites may be described as falling along the continuum as shown in Figure
III-1 and discussed below:

**Figure III-1.**
Placement of Study Sites Along Continuum

<table>
<thead>
<tr>
<th>Metropolitan Hospital</th>
<th>Center for the Vulnerable Child</th>
<th>Children’s Village</th>
<th>Dawn</th>
<th>Massachusetts MHSPY</th>
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</tr>
<tr>
<td>Coordination</td>
<td>Collaboration</td>
<td>Integration</td>
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# Coordination. Of the five study sites, Metropolitan Hospital Center most
closely fits the coordination construct presented earlier; that is, it generally
operates independently from other agencies and organizations serving the same
clients but works with them to exchange information and conduct activities in
such a way as to benefit the client. For example, pediatricians in Metropolitan
Hospital Center’s Special Needs Clinic request information every three months
from schools for children with behavioral/developmental problems, with a
variable level of additional contact with the school depending on the school
staff. This coordinated approach appears to be the most feasible one for a multi-
faceted clinically-driven setting such as a public hospital, where efforts to
coordinate services are often necessarily layered on top of existing and often
complex clinical, financial, and bureaucratic arrangements.

The Center for the Vulnerable Child may be placed on the continuum between
coordination and collaboration. While it, too, largely operates independently
from other organizations, its central focus on coordinating a broad range of
services needed by children and families at-risk for homelessness, along with its larger case management staff, allows for a greater concentration of resources to be devoted to linking clients to resources outside of the hospital setting. For example, CVC case managers work with schools to develop IEPs for clients, participate in attendance review board meetings, and meet regularly with teachers to discuss students’ progress. As with Metropolitan Hospital Center, such interactions serve to inform care planning decisions and to share information for the school’s management plan for the child. In both cases, however, the very different structures and priorities between a public hospital (or a program based in a public hospital, as is CVC) and outside agencies and organizations has challenged efforts to develop more collaborative or integrated relationships; thus, this level of coordination is the approach that is most feasible for these organizations, at least at this time.

Collaboration. The relationship between the partners participating in Yakima’s Children’s Village most closely meets the definition of collaboration set out earlier in this report; that is, two or more entities operating independently who share a common objective (at the client or agency level) and are engaged in one or more aspects of joint planning, delivery, or management of services. Children’s Village was designed not as a new organization but rather as a philosophical and physical entity where agencies caring for CSHCN can co-locate and work together to plan and deliver comprehensive care. While each participating agency retains its name, culture, and program autonomy, each also benefits from a shared commitment to providing more integrated care. For example, at the agency level, partners participate in committees and task forces to address shared challenges and maximize the potential of the Village. Clients benefit from the reduced need to provide duplicate information to partners using the Village’s shared information system and staff ability, enhanced through the experience of working alongside their colleagues from other agencies, to make appropriate referrals and to learn new techniques for addressing client needs. This collaborative model responds particularly well to the needs of a community like Yakima with many resources for CSHCN and agencies that are interested in working together for the benefit of the client, but without significantly altering the structure and culture of their own programs.

Integration. The definition of integration used in this study involves two or more independent entities mixing or blending together into a unified whole some aspect(s) of the planning, financing, delivery or management of services. The Massachusetts MHSPY project most closely fits this definition, as this project brought together a diverse set of agencies and organizations together to develop a new system of care for children with serious emotional disturbance. The Dawn Project (also funded initially with a MHSPY grant from the RWJ Foundation) was similarly designed, but because it involves a more limited set of partners and services, would be placed between collaboration and integration on the continuum. The integrated approach used by these sites reflects the
unique settings in which they were designed; that is, grant funding was provided specifically for the purpose of developing a more holistic and integrated service delivery approach for a targeted subgroup of CSHCN. While the results of these efforts are certainly compelling, the level of required resources limits the settings in which such an approach is likely to be feasible.

In addition to considering the overarching approaches of the five sites, the continuum may also be applied to the different strategies discussed in this report. For example, one of the key strategies noted in this report for improving integration between physical and mental health systems of care is shared financing. The study sites include financing strategies that fall along different points on the continuum, as discussed in the following two examples:

# Integrated Financing. The Massachusetts MHSPY project has successfully blended funding streams from its partner agencies to support the delivery of services to eligible clients. Under this financing arrangement, partners’ financial contributions are pooled into one pot and paid to the managed care organization responsible for serving program participants in the form of a monthly capitated rate.

# Collaborative Financing. The Dawn Project has also brought together various funding streams to support the delivery of services to targeted clients. However, rather than being pooled into one pot for use by any client, funding links are maintained between the clients and the referring agency. That is, the agencies funding the bulk of the project only pay the capitated rate for children referred by their own agencies. Thus, Dawn has “braided” the funding streams in such a way that each agency is able to participate in the new system of care.

Finally, the continuum highlights the particularly critical role of managed care with regard to efforts to integrate physical and mental health services. In cases where managed care is involved as a central partner in the effort to better coordinate services and is involved from the beginning of these efforts, integration was achieved, as in the Massachusetts MHSPY project. However, when managed care is an outsider to the process, particularly as a payer, managed care can be a barrier to integration. This has been the case, for example, in Metropolitan Hospital Center, where efforts to better integrate care for children being seen by the hospital’s pediatric and mental health units have been frustrated by managed care plans that do not
include both units in their provider networks. These examples illustrate the potential value of involving managed care as a partner in efforts to better integrate children’s services.

IV. Conclusions and Recommendations

This final section summarizes the findings of the case studies with respect to the factors that facilitate and hinder integration between physical and mental health services and systems. It concludes with recommendations for enhancing integration between these systems of care.

A. Factors that Facilitate Integration

The study sites were frequently successful in facilitating coordination, collaboration, and integration of systems and services on both the state and local levels. On the systems level, the sites found that strong interagency relationships form the backbone of efforts to integrate services for high-risk children. These relationships may exist on the state level, as in the Massachusetts MHSPY program, or on the local level, as in the Yakima Children’s Village; in either case, the ongoing commitment of people in a range of agencies who have the authority to commit their programs’ resources was consistently noted as critical to the continuing success of the projects.

Essential to the development and sustenance of these interagency relationships is the involvement of a dedicated leader who can attract support and resources, motivate people, and solve problems. However, it is equally important that a project not become dependent on the commitment of a particular person; if a project is to be sustainable and replicable, it cannot be premised on the leadership of someone who is perceived to be superhuman. While it may be a difficult job, it must be one that an ordinary person can do.

A third element of successful integration on the systems level is the strategic organizational location of the project. The study sites were based in a range of types of agencies, including hospitals, managed care organizations, and a multi-service center. In each case, however, the
administrative home of the project was an agency that had the ability to draw resources together and could serve as the focal point for interagency coordination.

With these system-level structures—effective interagency relationships, a strong leader, and a strategic organizational home—in place, the study sites were able to go on to develop the structures that facilitate service integration on the local level. These include the following:

# The Ability to Make Co-location Work. While locating a variety of services in a single location is a logical starting point, simply sharing space does not guarantee integration of services. Several sites, particularly those in New York City and Yakima, were able to take advantage of a shared location to institute screening, referral, and information-sharing mechanisms that support the coordination and integration of services.

# Sharing Record-keeping. Access to information about common clients is essential to service coordination, but confidentiality restrictions and administrative barriers can make this a significant challenge. To overcome these barriers, the study sites have put in place a number of mechanisms, including systems for receiving permission to share records at enrollment (in the Massachusetts MHSPY program), the use of “shadow records” (in Oakland), and the use of common electronic charts (in Yakima’s Children’s Village) to assure that all providers have the information they need to provide comprehensive care to their patients.

# Family Involvement. Most of the study sites found that involving parents, both as clients and as advisors to their programs, serves to improve the quality of service integration. The Dawn Project’s use of family members as mentors, its inclusion of family representatives on the project’s guiding consortium, and the project’s development of a family support group exemplify the range of roles that family members can play in an integrated service system.

# A Focus on Outcomes. Finally, the sustainability of service integration programs depends on the projects’ ability to demonstrate the success of their efforts in improving mental and physical health outcomes for high-risk children. Measuring the effect of service integration on the health status of the child and the family as well as on expenditures for services is challenging but essential to maintaining the participation of agency partners and assuring consistent financial and political support.

Finally, a common feature of all of the study sites was the dedication of staff at all levels. Their flexibility and determination to do whatever is necessary to help their clients, and their
commitment to a holistic approach to the needs of children and families, is essential to making service integration work.

B. Barriers to Integration

The sites explored under this study have faced, and continue to deal with, numerous obstacles in their efforts to integrate a comprehensive array of services for their clients. The quest to improve integration between physical and mental health services in particular is frustrated by numerous challenges. Three key challenges operating at both the system and local levels shared by the study sites are discussed below:

# Separation of Mental and Physical Health Care Systems. The challenge of integration is exacerbated by the ingrained separation of services and systems for mental and physical health care. Pediatricians and mental health providers are typically trained in their own distinct fields, often without exposure to the perspectives, experiences, and expectations of their counterparts in the physical and mental health arenas. This separation often continues in the practice setting where, as in Metropolitan Hospital Center in New York City, pediatric and mental health units are structurally and organizationally distinct. These factors make it difficult for pediatric providers to encourage the appropriate utilization of mental health services by their clients, as well as for mental health providers to understand and address the issues faced by CSHCN and their families.

# Challenges to Building Effective Interagency and Interdisciplinary Partnerships. In order to be successful at serving CSHCN, the sites recognized the need to build strong relationships among the agencies that are important in their clients’ lives. Building strong partnerships with certain key agencies has proven, however, to be very challenging to the study sites. Even when they managed to obtain the commitment of different agencies to the overarching goal of more integrated care, the challenge of developing policies, procedures, and financing approaches that are acceptable to agencies with often conflicting philosophies and priorities is a very challenging task. The sites faced particular difficulties in working with child protective services and juvenile justice agencies, as well as local school districts, as a result of their unique mandates.

Just as agencies have their own cultures which are sometimes difficult to mesh, so too do different disciplines of providers working with CSHCN. Pediatricians, therapists, social workers, mental health providers, and other types of providers have different training and practice experiences which contribute to their different philosophies and approaches to patient care. These differing outlooks and expectations can hinder efforts to promote integration
between providers of different disciplines, just as efforts to build partnerships among different agencies can be hindered by the challenge of melding their different cultures. An added factor challenging efforts to promote partnerships among providers of different disciplines, especially pediatricians and mental health providers, is the inadequate capacity of children’s mental health providers. Even pediatricians who are interested in taking a more proactive approach to identifying mental health needs in their clients will likely be unwilling to do so if there are not enough mental health providers to whom to refer these clients.

# Financial Barriers. Fundamental to any program’s success is the capacity to finance its efforts. However, as demonstrated in all of the study sites, existing financing structures are not set up to promote the integrated delivery of services and, in fact, often impede it. This study highlights the critical nature of seed money in funding the complex and time-consuming process of launching and sustaining integration efforts, funds which the study sites typically obtained in the form of grants. At the practice level, reimbursement structures hinder the ability of pediatric providers to consult and engage in joint planning with their patients’ other individual (e.g., mental health counselor) and institutional (e.g., school) providers. For example, time spent for case conferencing may not be billable, and mental health counseling is often not a covered service if a child does not have a psychiatric diagnosis, although mental health issues may be aggravating a medical condition. At the broader level, while blending funds from different sources is a very promising approach to improving service integration, the experiences of the Massachusetts MHSPY and Dawn projects confirm the complexity and challenge of achieving such a goal.

C. Recommendations

Building upon the findings of this study, this final section proposes numerous recommendations to address the barriers to integration of physical and mental health services for children. In each category, recommendations are included for action at the Federal and state levels as well as the community or program level. These recommendations, which were developed with substantial input from the study’s advisory group, are summarized in Table IV-1 and discussed in turn below.

1. Recommendations to Address the Separation Between Physical and Mental Health Care Systems
The ingrained separation of physical and mental health service delivery systems was identified as a significant barrier to the delivery of integrated services. However, steps can be taken at both the Federal/state and community/program levels to help build structures that tie these systems together more closely for the benefit of CSHCN.

Federal/State-Level Recommendations:

# Increase collaboration between the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration to support the development of comprehensive systems of care for children. At the Federal level, the Health Resources and Services Administration, in which the Maternal and Child Health Bureau resides, is the lead agency on developing systems of care for CSHCN, and SAMHSA is the lead agency on systems of care for addressing mental health needs. Collaboration on the Federal level between these agencies, and cross-training between these agencies, is essential for establishing a framework for integration between physical and mental health systems at all system levels. The Maternal and Child Health Bureau and SAMHSA have recently made important strides in this area through their joint efforts to promote and fund integrated physical,
<table>
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<tr>
<th>Barrier to Integration</th>
<th>Federal/ State-Level Recommendations</th>
<th>Community/ Program-Level Recommendations</th>
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<tr>
<td>Separation of mental and physical health care systems.</td>
<td>Increase collaboration between HRSA and SAMHSA to support the development of comprehensive systems of care for children. Enhance the role of State Title V/MCH agencies in fostering systems development activities encompassing mental health issues. Under managed care arrangements, develop structures to facilitate the delivery of integrated services.</td>
<td>Support pediatricians’ capacity to identify and address patients’ mental and behavioral health needs. Provide opportunities for cross-training of providers specializing in physical and mental health. Co-locate physical and mental health providers in a shared service delivery environment. Establish systems for sharing information among children’s physical and mental health providers. Support holistic care coordination approaches. Involve families in program design and oversight.</td>
</tr>
<tr>
<td>Challenges to building effective interagency and interdisciplinary partnerships</td>
<td>Improve coordination among Federal and state agencies addressing children’s needs. Increase the supply of mental health providers. Enhance managed care plans’ capacity to provide children’s mental health services. Broadly disseminate lessons from successful integration efforts. Promote the availability of technical assistance to support integration efforts.</td>
<td>Utilize data to foster a community-wide sense of responsibility for the care of CSHCN and to promote collaboration. Identify a designated community group to lead efforts to improve integration. Recognize emerging leaders. Identify and measure evaluation indicators that are relevant to different partners. Provide opportunities for cross-agency interaction, education, and relationship building. Provide training in children’s mental health to the continuum of professionals working with children.</td>
</tr>
<tr>
<td>Financial barriers</td>
<td>Create opportunities for shared financing arrangements to support the delivery of integrated services and systems. Establish reimbursement structures that support integration.</td>
<td>Explore opportunities for maximizing funds. Involve managed care entities in a range of efforts to improve integration. Assess and address the parity of mental health benefits. Identify discretionary funds for gap-filling services.</td>
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In FY 2000, the Center for Substance Abuse Prevention within SAMHSA and the Maternal and Child Health Bureau jointly funded eight, two-year planning grant projects. The Maternal and Child Health Bureau funded an additional seven grants in FY 2001 and will continue to work with SAMHSA to ensure that the first eight grantees receive implementation funds in FY 2002.

Enhance the role of State Title V/MCH agencies in fostering systems development activities encompassing mental health issues. The Federal Maternal and Child Health Bureau’s definition of CSHCN is an inclusive one encompassing children with both physical and mental/behavioral health needs. However, State Title V agency activities and programs have typically focused heavily on children with chronic physical disabilities, as reflected in the types of clinical services traditionally funded by Title V/CSHCN programs. While limited budgets have traditionally curtailed Title V agencies’ role in funding mental health services, Title V agencies are well positioned to focus attention on mental health as a critical child health systems issue. Title V agencies can assume a leadership role in working with a diverse array of partners to ensure that mental health needs are addressed as part of a comprehensive systems development agenda.

Under managed care arrangements, develop structures to facilitate the delivery of integrated services. In public and private systems alike, the nation has witnessed a trend toward carving out mental health services from managed care plans’ responsibility. This trend raises the issue of how carve-out arrangements affect the capacity of managed care plans to deliver integrated mental and physical health care services. While coordinating physical and behavioral health care services has been found to be a challenge under both carve-out and integrated designs (Stroul, Pires, and Armstrong, 1997), this study highlights the benefits that an integrated design can offer over mental health carve-out arrangements. Under the Massachusetts MHSPY program, the HMO plan was responsible for delivering both physical and mental health services to its child clients with serious emotional needs, and staff were able to contact providers and assure that patients were seen quickly and to share client records easily among providers. These structural factors were seen as critical to the delivery of integrated care. This model also included a broad range of physical, mental health, and support service benefits to address its clients’ needs, which

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² In FY 2000, the Center for Substance Abuse Prevention within SAMHSA and the Maternal and Child Health Bureau jointly funded eight, two-year planning grant projects. The Maternal and Child Health Bureau funded an additional seven grants in FY 2001 and will continue to work with SAMHSA to ensure that the first eight grantees receive implementation funds in FY 2002.
also facilitated integration of care. The experience of this integrated model can be contrasted with that of the Center for the Vulnerable Child in Oakland, which operates under California’s Medi-Cal mental health carve-out, which key informants consistently identified as a barrier to the delivery of integrated physical and mental health care to high-risk children in that community. While this study illustrates the promise of integrated arrangements as an overall structure that can facilitate integration between physical and mental health care, strategies to facilitate integration are necessary in both integrated and carve-out managed care arrangements.

Community/Program-Level Recommendations:

# Support pediatricians’ capacity to identify and address patients’ mental and behavioral health needs. The ability of pediatricians to offer a comprehensive medical home to their patients is dependent on their ability to recognize and address their patients’ varied health care needs. The use of a simple screening tool in pediatric practices, especially one that can be completed by parents or administered by a nurse (rather than physicians who are already severely limited in the time they can spend with each client), can help to institutionalize the practice of addressing mental/behavioral problems and make it easier for parents to raise these issues. This approach is used successfully in one of the case study sites, Metropolitan Hospital Center, which routinely asks parents of children seen in its pediatric clinic to complete a simple screening form used to assist in the assessment of the behavioral/developmental needs of clients. Clients identified as having an actual or potential problem are referred to child development and mental health specialists within the hospital’s broad pediatric practice for follow-up assessment and care. The availability of specialists to which refer clients with identified needs is certainly an important factor in providers’ willingness to proactively identify mental health issues in their clients. In addition to including developmental/behavioral specialists on staff, affording pediatricians access to mental health specialists by telephone for consultation (a step suggested in Williams, 1993) and providing them with additional training in mental/behavioral health issues are other steps that can be taken to bolster pediatricians’ capacity to address their clients’ mental/behavioral health needs.

# Provide opportunities for cross-training of providers specializing in physical and mental health. Although physical health and mental health are integrally related, the manner in which providers are trained and the settings in which they practice typically focus on one or the other of these as distinct areas of expertise.

3In the general managed care marketplace, however, such comprehensive benefits are not the norm. A study by the Bazelon Center (1999) found that mental health carve-outs generally include a much broader array of mental health services than do integrated models.
Providers interviewed under this study indicated that pediatric training emphasizes the treatment of physical conditions without sufficiently recognizing the role of behavioral/developmental concerns, while the training of mental health professionals usually does not include an emphasis on the behavioral, developmental, or mental health effects of living with a chronic medical condition or disability. Providing opportunities for cross-training of providers specializing in physical or mental health is a critical strategy for helping providers to get “a foot in both worlds” and, as a result, better understand and address the needs of their clients. For example, mental health providers could gain expertise in the issues facing CSHCN by including a rotation in a children’s hospital or special needs clinic as part of their training. Similarly, pediatric training could be enhanced by including practical experience in a setting that provides mental health assessments and interventions to children and their families.

# Co-locate physical and mental health providers in a shared service delivery environment. Co-location offers tremendous opportunities for building a more integrated system of care. In particular, it is an excellent strategy for promoting cross training of physical and mental health providers. It is also a strategy for facilitating cooperation among providers from different disciplines to address common goals, such as information sharing and pooling resources. In Yakima’s Children’s Village, a multi-service center for CSHCN and their families, co-location has been successfully used to create an environment in which different types of providers learn from each other and, in the process, become better at their own specialty. The partners in Children’s Village have also taken advantage of the opportunity of being co-located to address other systems issues; for example, they have blended funds to pay for shared services, including drop-in child care for siblings of patients, created a task force to better manage the large number of mental health referrals made to the Village, and succeeded in developing a common electronic chart shared by providers from the different partner agencies.

# Establish systems for sharing information among children’s physical and mental health providers. In order for clients to receive integrated care from their multiple providers, it is essential that structures be established to foster communication between these providers. While information sharing can be facilitated through informal mechanisms, such as co-location of mental and physical health providers, more formal structures for sharing information among providers are needed to move this important goal higher on the service integration agenda. Collaboration between physical and mental health providers should be undertaken to identify the types of information needed by both types of providers and the structures through which this information will be shared. Managed care administrators, and providers working within a managed care system, have an excellent opportunity to identify the types of information, and means for sharing it, that would benefit care provided to enrollees within their
managed care system. While establishing mechanisms to share mental health records is complicated by client confidentiality concerns, the experiences of the study sites demonstrate that steps can be taken to further the goal of information sharing while addressing this challenge. Both Metropolitan Hospital Center and Children’s Village use a common pediatric chart to which both physical and mental health providers have access; the chart used by Children’s Village is electronic and allows parents to determine which staff can obtain access to the chart.

Support holistic care coordination approaches. Care coordination is a fundamental component of many programs serving CSHCN and of all of the five programs explored under this study. Several facets of a holistic care coordination approach can support the delivery of integrated care. These include addressing the broad spectrum of clients’ needs, being driven by goals identified by the family, and giving care coordinators the authority to authorize the payment of services. This type of care coordination model is used by the Dawn and Massachusetts MHSPY projects, in which care coordinators work closely with a small number of families to identify and address clients’ strengths and needs in an array of areas—including those related to medical care, psychological counseling, social activities, and housing—and, based on these, develop a care plan that will help families achieve their identified goals. In addition, because they are housed and paid by managed care organizations, these care coordinators have the responsibility of authorizing payment for services included in the care plans. By placing this authority with the people with the most client contact, rather than with uninvolved preauthorization personnel, these projects are facilitating informed decisionmaking about the best use of plan dollars to improve client functioning.

The delivery of holistic care coordination also involves the creation of linkages and the reduction in duplicative activities between care coordinators of different agencies/programs serving the same clients. Furthermore, efforts to develop linkages between programs, agencies, and services at the systems level is an important strategy for reducing the need for intensive care coordination at the client level; in addition to working with clients, the Massachusetts MHSPY project care coordinators also serve as liaisons to partner agencies to train agency staff about the MHSPY project and to identify how the program can serve agency needs.

Involve families in program design and oversight. Parents of CSHCN are critical partners in efforts to design, implement, and oversee programs striving to deliver integrated services. Their focus on getting their children’s needs met, regardless of which sector of the health care system that help comes from, offers the critical perspective that it is the outcome—improved child health and functioning—that all partners can and should be working together to achieve. The study sites all have processes designed to obtain family input into program
policies and operations. For example, half of the advisory group membership of Oakland’s Center for the Vulnerable Child is made up of families currently or formerly served by the center. The Dawn Project fostered the creation of a parent support group which provides ongoing feedback to project administrators and whose role has broadened to include a county-wide advocacy role on behalf of children with serious emotional disturbance.

2. Recommendations to Build Effective Interagency and Interdisciplinary Partnerships

Another important challenge to the integration of physical and mental health services is the difficulty of establishing effective partnerships among the different agencies serving CSHCN, as well as among the various providers working with CSHCN and their families. The following recommendations suggest ways to strengthen interagency and interdisciplinary partnerships toward the goal of delivering more integrated care.

Federal/State-Level Recommendations:

# Improve coordination among Federal and state agencies addressing children’s needs. A broad array of agencies are responsible for addressing children’s needs, and it is imperative that agencies targeting the same populations, while pursuing their respective agendas, also work together to identify and address common goals. A model for Federal collaboration may be found in the Federal Interagency Coordinating Council, which works to ensure the delivery of coordinated services to young children with developmental disabilities and their families and includes representation from the Federal Departments of Education, Health and Human Services (DHHS), Agriculture, Interior, and Defense, as well as the Social Security Administration. Within DHHS, there is representation from an array of agencies, including SAMHSA, the National Institute of Mental Health, the Maternal and Child Health Bureau, and the Children’s Bureau. The inclusion of partners from an array of areas affecting children’s health and welfare is a critical means for educating partners about one another’s goals and activities, for identifying shared goals and areas for potential collaboration, and for collectively envisioning and implementing improved systems of care through the development of joint initiatives. Collaboration at the Federal and state levels is critical to support integration at the community level among the many agencies working to improve child and family health, including but not limited to agencies addressing public health, social services, juvenile justice, mental health, and child care.
# Increase the supply of mental health providers. As the national consciousness is raised about the importance of identifying the many children in need of mental health services, efforts also need to be focused on increasing the nation’s capacity to ensure that the supply of mental health providers is adequate to meet that need. The experiences of the study sites and the broader perspective brought to the development of these recommendations by the study’s expert advisory group indicate that a serious shortage of children’s mental health providers exists; providers who can serve culturally and linguistically diverse communities and who can work with young children are in particularly short supply. Due to the difficulty of accessing mental health services for their clients in the Oakland area, especially those with public insurance (few providers participate in Medi-Cal due to low reimbursement rates), the care coordinators in the Center for the Vulnerable Child (who are master’s-level social workers) often provide therapeutic counseling themselves. Action on the Federal level that would focus attention on increasing provider supply could include the addition of a requirement by the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) that state Medicaid programs assess the adequacy of their state’s mental health provider supply and clients’ access to mental health services and, when found to be inadequate, develop a state plan for addressing the situation. Attention by the Health Resources and Services Administration’s Bureau of Health Professions to the supply of mental health providers would also be an important step on the Federal level for addressing this critical systems issue. On the state level, Medicaid programs, as well as other insurance plans, should assess their policies regarding the types of providers eligible for reimbursement for child mental health services; support for services delivered by clinicians other than psychiatrists will be an important component of efforts to address the national shortage of child psychiatrists.

# Enhance managed care plans’ capacity to provide children’s mental health services. Given the shortage of mental health providers and the predominance of managed care in the health care system today, special attention is needed to ensuring that managed care plans have the capacity to identify and meet the mental/behavioral health needs of their young enrollees. This task involves ensuring that plans enroll an adequate number of qualified mental health providers within their networks, and that these providers deliver a high quality of care. Monitoring of these efforts is also important. An important new source of data for measuring plan enrollees’ access to mental health counseling is the CAHPS module on CSHCN, a tool for assessing plans’ delivery of services to CSHCN which includes a question exploring access to these services.

# Broadly disseminate lessons from successful integration efforts. A great deal of attention has been focused in recent years on developing and strengthening integrated systems of care. For example, the Dawn Project explored under this study is one of several communities funded by SAMHSA’s
Center for Mental Health Services to support community efforts to build integrated systems of care for children with serious emotional disturbances and their families. In order for these types of initiatives, involving significant investments of financial and human resources, as well as smaller-scale efforts, to have their fullest impact, lessons from these experiences must be shared broadly. The responsibility for sharing lessons from integration experiences is one that can and should be carried by public and private agencies alike; foundations, Federal agencies, managed care entities, and community organizations all have experiences in fostering the delivery of integrated services that could benefit others working toward similar goals. A broad array of target audiences should be targeted for dissemination efforts; indeed, reaching out to non-traditional partners to share integration lessons can itself be a bridge toward strengthening system ties. Potential audiences may include Federal and state agencies addressing children’s needs, national associations, Technical Advisory Groups (TAGs) advising Medicaid officials and other public administrators, journal audiences, provider organizations, and family advocates.

Promote the availability of technical assistance to support integration efforts. Technical assistance is a critical step in the process of systems development. At each stage in the systems development process, from needs assessment to planning to evaluation and monitoring, communities and programs often require assistance in structuring and carrying out activities. Therefore, support of technical assistance resources is a critical function of funding agencies. The Federal government does, in fact, support a broad range of technical assistance efforts related to systems integration. The Health Resources and Services Administration and the Centers for Medicare and Medicaid Services, for example, support CompCare, an initiative to strengthen quality systems of care for children and adolescents in each of the 50 states and DC. However, despite significant outreach to state agencies, these and other TA resources are often not fully utilized by the intended audiences, thus pointing to the importance of ongoing promotion of their availability. One mode of TA that can be particularly valuable and could be further supported is peer-to-peer assistance, when a representative from a site or program offers insights gained from their own experience in accomplishing a similar goal.

Community/ Program-Level Recommendations:
Utilize data to foster a community-wide sense of responsibility for the care of CSHCN and to promote collaboration. Developing a more integrated system of care for CSHCN is a goal that is clearly most likely to be achieved if there is a broad foundation of community support and involvement. To develop a broad-based sense of responsibility for the community’s CSHCN, and to enlist partners’ commitment to integration efforts, data about the overlapping nature of client populations can be a powerful force. One of the key factors in developing and solidifying the interagency partnerships underlying the Dawn Project was data showing the large degree of overlap in the client populations served by the different agencies, data which led to the binding philosophy that a new service delivery and financing approach would be the best way of meeting the needs of their shared clients. Up-front identification of the benefits of integration to children and families and to the individual systems partners is also critical to the implementation of successful integration efforts.

Identify a designated community group to lead efforts to improve integration. Only with conscious attention by the various agencies and organizations serving children will services become more integrated in a community. The study findings support the importance of having a broad-based community body that serves as a central organizing entity for the promotion of integration. Whether this is a body created for this purpose or an existing body that assumes this function, it is likely to be most effective if it is inclusive of the range of stakeholders in the community’s child health system and if it carries out an assessment of the existing and needed resources upon which to build its strategies for improving systems of care. A community group of this nature can provide an excellent forum through which partners can get to know one another and through which opportunities for coordination, collaboration, and integration activities among partners can be identified and addressed.

Recognize emerging leaders. Another factor that is essential to the development and sustenance of strong community relationships is the involvement of one or more dedicated leaders. Leadership characteristics include being able to attract support and resources, motivate people, solve problems, and maintain momentum toward the accomplishment of goals despite the inevitable obstacles that will be encountered. The success of the Dawn Project in establishing its shared financing structure, for example, may be credited to the members of the Dawn Project’s core leadership group who, when they determined that a fully blended financing approach was not feasible, identified an alternative arrangement to bring together funds from the partner agencies to support flexible services to Dawn clients. Both at the outset of an initiative to promote integration and over time, it is important for members to consider how various partners may develop their leadership skills (e.g., by participating in leadership skills training) and assume leadership roles, and to recognize the importance of remaining flexible in considering who may be suitable for critical leadership roles.
Identify and measure evaluation indicators that are relevant to different partners. A critical lesson from this study is the importance of identifying and measuring evaluation indicators that are meaningful to the various stakeholders. The Massachusetts MHSPY project, for example, identified indicators related to child functioning that were relevant to the various partners, but even then still required the project director to put together special analyses focused on measures of special concern to partner agencies (e.g., lost school days for the education system, avoidance of re-arrest for the juvenile justice system) in order to maintain their support. Taking the time, especially at the outset of a new initiative, to identify indicators that are meaningful to multiple partners and which demonstrate the return they are getting for their investments in relevant terms, is a critical tool for obtaining and maintaining their financial and other means of support.

Provide opportunities for cross-agency interaction, education, and relationship building. The ability of agencies to come together to better serve their shared clients and the community at large depends on their understanding of each other’s roles, organizational cultures, and goals. Therefore, opportunities to promote interaction, education, and shared planning among staff of child-serving agencies are essential. Multi-level interagency forums are a strategy used by Children’s Village, Dawn, and Massachusetts MHSPY to share information and make decisions and, more broadly, to build relationships across agencies. While the commitment of high-level administrators was noted as an essential element for managing interagency relationships, opportunities to build relationships between staff at a variety of levels are also critical. For instance, task forces can provide a valuable forum for direct service managers and service providers from different agencies to discuss service delivery approaches and strategies for improving them.

Provide training in children’s mental health to the continuum of professionals working with children. The shortage of children’s mental health professions requires that communities think creatively about ways to ensure that children’s mental health needs are identified and addressed. As noted earlier, the Center for the Vulnerable Child, for example, responded to Oakland’s shortage of providers by having its own care coordinators provide counseling services to its clients. Other persons interacting on a daily basis with children, including teachers, special education staff, child care providers, and social service providers, among others, could also be trained to help to identify and address children’s mental/behavioral health needs. Empowered with knowledge about normal and abnormal behavior in children, for example, child care providers and teachers can be bolstered in their ability to identify children in need of mental/behavioral health assessments. Furthermore, they can provide critical insight for pediatricians and other providers developing and implementing treatment plans for CSHCN and should be considered critical partners in the care of children.
3. Recommendations to Support Financing of Integration

The third essential area for action to improve integration of physical and mental health services relates to financing. As discussed earlier, existing financing structures are not set up to promote the integrated delivery of services and, in fact, often impede it. This final set of recommendations identifies steps to support financing that facilitates integration.

Federal/State-Level Recommendations:

# Create opportunities for shared financing arrangements to support the delivery of integrated services and systems. To support the delivery of integrated services, efforts are needed to facilitate the pooling of funding across programs and agencies. Funds flowing from Federal to state agencies allocated for a defined scope of services (e.g., substance abuse treatment) and with requirements that expenditures for these services be tracked and reported accordingly hinder the ability of agencies to work together to establish more comprehensive service delivery approaches. The establishment at the Federal level of a set of common goals for which funds from a number of agencies could be used to address would be an example of how flexibility might be increased. At the same time, pressure is needed from the state level to push the issue higher on the Federal agenda; state agencies should actively seek to establish shared funding arrangements with their counterparts interested in creating more integrated systems of care. Mechanisms must be developed to assure fiscal accountability and, at the same time, allow for the development of creative financial structures to promote services integration. Similarly, just as more flexibility is needed around the use of Federal funds by state agencies, so must states be supportive of community-level efforts to pool funding for the purpose of better integrating services.

# Establish reimbursement structures that support integration. A major barrier to integration identified by this study is insurance billing structures that limit the ability of providers to work together to serve shared clients and for services to be delivered flexibly. Providers at Metropolitan Hospital Center, for example, noted that staff time needed for case conferencing to develop and monitor treatment plans may not be billable; while CPT codes for case conferencing exist, insurers typically restrict the number of providers that can bill for a client’s care on the same day. Insurance plans that cover mental/behavioral health counseling only for clients with a psychiatric diagnosis also fail to recognize the link between physical and mental health and hinder the delivery of holistic care, especially for children for whom providers may be reluctant to label with a psychiatric diagnosis. Creative approaches are needed to develop reimbursement structures that support integration. For example, to
encourage provider involvement in service coordination meetings, Dawn offers to reimburse providers from its capitated rate for the time at these meetings. Other strategies that insurers could adopt include allowing for a defined number of hours to be billed for case conferencing for an individual client, or per day. While these strategies would promote integration broadly, attention is also needed to establish reimbursement structures that focus specifically on the delivery of more integrated physical and mental health care. For example, rather than only reimbursing mental health providers for in-person visits with patients, insurers could reimburse mental health professionals for telephone consultations with pediatricians, a convenient but relatively inexpensive approach for fostering the capacity of general practitioners to address their young client’s mental health needs.

Community/Program-Level Recommendations:

# Explore opportunities for maximizing funds. Within each community, numerous agencies and programs fund a range of services for CSHCN and their families. Given the multiple needs of CSHCN, it is likely that a significant proportion of any one agency’s clients may also be clients of another agency or program. Furthermore, some of these clients may be receiving duplicative services, such as care coordination, from these different providers. Given the limited resource base that communities typically have to fund children’s services, it is critical that efforts be made to identify and reduce duplication among child-serving agencies and programs; in the case of care coordination, for example, by allowing one agency to take the lead on delivering this service.

Another step that can be taken toward the goal of maximizing existing resources is to assess if existing services or activities are eligible for Federal matching funds. Many services delivered to CSHCN are potentially reimbursable by Medicaid and/or the State Children’s Health Insurance Program, both of which offer opportunities to stretch local dollars by drawing down Federal matching funds. At the time this study was conducted, the Center for the Vulnerable Child was pursuing the possibility of receiving Medicaid match for the mental health services delivered by its social work-trained care coordinators. The Massachusetts MHSPY project, on the other hand, made Medicaid reimbursement a major focus of its financing strategy from the outset.

# Involve managed care entities in a range of efforts to improve integration. As primary financiers of health care services in many communities, managed care plans have considerable influence in how health care systems operate. Therefore, managed care entities are critical partners in efforts to improve integration in any community with a managed care presence. This lesson was highlighted by the case study findings. Providers at Metropolitan Hospital Center, whose efforts to deliver integrated care did not involve partnerships with managed care plans, identified managed care as a serious obstacle to delivering
integrated care, particularly for children enrolled in plans that contract with the pediatric clinic but not the psychiatric unit. On the contrary, officials of Massachusetts MHSPY and Dawn, projects in which managed care entities were central partners in the design and execution of the integration effort, identified managed care as a primary factor in the success of their projects.

# Assess and address the parity of mental health benefits. An important function of a community coalition addressing integration issues between physical and mental health services and systems is to work to ensure that mental health services are available to its citizens, in particular by continuing the national effort to implement mental health parity. While the Mental Health Parity Act of 1996 has helped to address discrepancies in coverage between mental health and other types of health services, mental health service coverage remains inadequate for many people. The General Accounting Office reported in 2000 that, while most (but not all) employers they surveyed reported to be in compliance with Federal law by establishing parity in mental health and medical/surgical annual and lifetime dollar limits, many have also made changes that have made their mental health benefits more restrictive than that for other medical and surgical benefits, such as by reducing the number of hospital days or outpatient visits for mental health (GAO, 2000). For publicly insured children, low Medicaid reimbursement rates for mental health care hinder access to services, as reported by informants interviewed for this study and by national organizations (National Association of Children’s Hospitals and Related Institutions, 2001). Efforts to assess the adequacy of mental health coverage policies, for the largest employers in an area, for example, as well as to develop strategies for addressing coverage gaps, can be an important part of community efforts to improve access to comprehensive and integrated health care services.

# Identify discretionary funds for gap-filling services. Given the current limitations in funding for integrated physical and mental health services, an important measure to address in the immediate future is the identification of discretionary funds that can be flexibly used for gap-filling services. The study sites that obtained capitated funds to deliver services to CSHCN noted the flexibility of capitation as a major benefit of this financing arrangement, as it allows plans to fund services and equipment not typically funded by insurance programs. The Dawn project, for example, includes “discretionary services” as one of seven categories of services that may be authorized by the care coordinators and which includes clothing, transportation, and monitoring equipment for use by parents of children with serious emotional disturbance, among other items and services. For programs not reimbursed through capitation, identification of another flexible funding source can help to address critical client needs that, if not addressed, can seriously interfere with their ability to follow through with their care plan.
This study has identified an array of recommendations to improve integration between physical and mental health services for CSHCN and which further the goals identified by the Maternal and Child Health Bureau for an optimal system of care for CSHCN discussed in the introductory section. For example, the study’s recommendations to establish reimbursement structures that facilitate integration among providers serving the same clients address the goal to provide all children with coordinated and comprehensive care within a medical home. The study’s recommendation that communities continue to work for the goal of parity in mental health benefits addresses the goal related to the adequacy of public and private health insurance. The goal to ensure that all children will be screened for special health care needs can be furthered by efforts recommended by this study to support pediatricians’ capacity to identify and address patients’ mental/behavioral health needs as well as by providing training in child mental health to non-physician professionals working with children. The study’s conclusion that integrated managed care structures, rather than those that carve out mental health services from other services, facilitate the delivery of integrated physical and mental health services relates to the goal of organizing services in ways that families can use them easily. Finally, the goal of having families of CSHCN partner in decision-making at all levels is supported by the study’s recommendation to involve families in the design and oversight of integration efforts. In sum, by addressing these and the other recommendations identified by this study, important progress can be made toward achieving the Maternal and Child Health Bureau goals to develop an optimal system of care for CSHCN.
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