

HRSA/MCHB 2007 FEDERAL/STATE PARTNERSHIP MEETING

Building Blocks for Promising Practice Models

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Health: A Partnership between Title V and SAMHSA

JEFFREY G. LOBAS: Well, thank you. Well, let me--I want to first, before I get into my slides, thank a couple of people. I want to thank Cassie for her recognition, and this is a very innovative program and an opportunity, and for all those gentle calls about, you know, "We haven't gone through bio yet. We haven't got your slides yet." And so thank you.

I want to thank David Heppel because this is really been a really neat project and program, and I think it has potential for the country. And I remember that you organized the meeting at SAMHSA for me to go into a presentation to the crew there, and I think that made a huge difference. And I want to thank Gary Lippe who has been my partner in Iowa with this, because without him, I don't think any of this would've occurred, and I think we're doing some great things.

Okay, so you have to see Ben and Kate again. So, these are my kids, and I show them all the time. So, this is--apparently the slides are about the stress I have to go through, because I--after the board meeting in (inaudible) in Park City, I took them to a store and I'd lost them. I was--where the heck are they? And then, I found them on this cow, so. And you can see Ben is talking to Kate trying to

figure out how do we get this cow out of this store?

But I also as you know, I present pictures of my kids because they are pretty symbolic for me, and I think Susan cited at her--in one of her meetings. They said pediatricians really don't help--place can't do this in that culture of mental health, and too often, and I'm sure seeing this in this project, we want to divide kids up into emotional and physical. But you know, Ben and Kate come with a body and a soul, and a mind and a heart, and emotions, and they're whole kids and we need to approach them holistically.

It's really striking some of the first meetings Gary and I had with our community group. I stood up, and we were presenting, and somebody actually stood up and said, "Well, Dr. Lobas, you're a physician from the University for--so obviously, you don't care about people." You know, and then I was like, "Whoa." So, and--but that was the amount of distrust, is--was amazing. It was palpable in medical people providers, and that was the last time I put MD on my placard, the last time I wore a tie in a meeting, and it's going a lot better and it's been a trust building process.

But there's a lot of inherent distrust within these various cultures, and I'll talk a little bit about that later. Now, Bonnie gave most of my talk so I can run through these slides real quickly. So Child Health Specialty Clinics is the Title V and SAMHSA for special needs kids where we're funded through a lot of different

sources and housed at the University of Iowa. I had to put this in for Peter. I remember 10 years ago, I was sitting in Kansas City and there was this guy telling stories about his treks, who I didn't know, and there it was, my life for the next 10 years, the famous pyramid. And I do this for Peter, but partly--part of what I've had to do is educate another culture about Title V.

Our mission is to serve children with special healthcare needs and community-based study, but what's most important is, and give you a little flavor of our program, we're actually well positioned in the State of Iowa. We have regional centers throughout that we really are a platform to do a lot of innovative public health programs.

The area--the green area that says, O1, this is about the area that this SAMHSA project is, there are actually going to be four new sites in that area, and each of our regional centers have a satellite plants, so we really are spread well out. We use telehealth a lot so--and each one of these sites are here. We do a number of clinical programs. We do lots of programs, family-to-family support, we do birth-to-five, the mental health project is called The Integrated Evaluation and Planning Clinics. We do autism, we do telehealth, we do medical home.

But let me tell my story of—well, dealing with mental health. I came to Iowa in 1997, and one of the first things I did is a—is a need assessment, even though I had--what's untold to by MCHB, I did it and needs assessment. I went to every

regional center, met with community leaders, and what became clear was, especially from primary care, mental health needs of children were the number one need that wasn't being met. Oral was up there, but at that time, mental health were hugely unreserved, and pediatricians and family physicians were really struggling.

That led to us talking a lot about it, which led to Department of--and Human Services and Health to bring a consultant group and to do a future search looking at on how do we solve this problem, and that led to, well, my first white paper that I was involved with to the legislature in the governor and nothing happened. And then we had another group that met a few years later that was put together by the governor's office and we've got another white paper out of it and nothing happened. And I--and over those first five years, I sat on four, five adviser groups that wrote papers about the cry and need for mental health and nothing happened. The political will wasn't there. So we took part of our budget, and we said, "Hey, I'm--we're tired of this." So we put--took \$300,000. We set in the Creston area, which is in Southwest Iowa. We're going to try something. We're going to try build a model that we think makes sense and works, and maybe, we can show somebody that there's a better way to do it.

And that led to a relationship with Magellan Behavioral Health and they actually funded all of our centers to get telehealth equipment and paid for our first psychiatrist, and that led to a statewide implementation and further funding from

Magellan, which has allowed us to implement this project throughout our--all of our regional centers. One interesting thing, we've had some improvements in funding, now, we--for every child we're seeing in the telehealth system, we're getting paid a per-patient-per-month fee for the care coordination by Magellan.

Then that led to the state and the commission be informed. They'll look at children's mental health issues, which was where I met Gary, and that was this oversight committee and we had meeting after meeting after meeting, and it didn't seem like anything was happening. And Gary and I were sitting next to each other going, "Should we quit?" And then we started talking, "So why don't we try to do something different?" So, we got together, and it was much more complex than this, and we ended up writing this System of Care Grant in the northeast part of the state. And Gary will talk more about that.

But let me talk about some of the stuff we did in Creston. It was aimed as a--evaluation of our whole program, but we've looked at the--we've tried to really research that delivery model and then hopefully, our statewide implementation on a spread strategy with a very collaborative approach. We look--we did it very rigorously. We had focus groups. We did structured interviews. We did outcome research. We looked at our flow and time studies within our clinics and satisfaction surveys, and the interesting thing is we looked at our system. Overall in all our centers we saw about 2,300 kids and the diagnosis were 93 percent of the kids we see in our clinics were behavioral mental health. And these are the

worst of the worse. These are co-morbid kids, kids that either just got out of institution, or they probably need to be in an institution, kids that have been warehoused in schools, and we saw a wide gamut of these.

As Bonnie was saying, we approached this with a very structured model, which was the multi-disciplinary team, enhanced care coordination, child psychiatry, guidelines, et cetera. We've worked with Magellan to develop our guidelines. Our enhanced care coordination, which I think was important part of it really looked at a wide array of giving children services, but we didn't have our fund for wraparound services though.

And the data was amazing, after a couple of years in this relatively small project, we used an instrument called the CANS, the Child (inaudible) and Adolescent Needs and Strength Assessment. It looks at a number of domains, symptomatology, strengths, functioning, et cetera. And if you look here under usual care, with the control or historic control model, the natural history of most of these conditions were that these families did horrible. These kids did badly. The families blew up.

Under the--our intervention, in almost every domain, and although it was a small sample, it was statistically significant, these kids in these families did much better, and their problem was just really symptoms. They improved by at least four percent or under usual care, they usually got worse by 30 percent, under

functioning we improved by 24 percent, whereas the normal natural history was they got worse by 18 percent. So this was staggering, but it told us we made a difference. So that led us to talking with Magellan and talking with the state and we started implementing--hired another psychiatrist.

What we found with this data was that when we com--that these kids were more often abused, they more often had inpatient care. What happened in Creston was referral pattern's changed once they knew we were there. The Mental Health Center is when they'd get a child with a problem, they'd come to Child Health Specialty Clinics. So we found we had a sicker and sicker group as we saw more and more, and that's what I'm expecting we're going to see in the northeast part of the state too.

What we found is that our group of kids compared when you looked at other groups, it compared to the New York System of Mental Health, which were more inpatient or they--intensive case management. So this was a very sick group that we are keeping at home. So what we found is our multi-disciplinary team, works, it's effective, care coordination was important, standardized approach, triage was important, telehealth really was a valuable tool, and the idea of using clinical guidelines really enhanced our care.

We also found there's great variability in our regional centers and--but that we felt this was very cost-effective approach to doing this. We also knew there was a

high-level of unmet need. Iowa has 22 child psychiatrists in the whole state. Now we have two of them in our program and they're seeing kids all over the state in any given day through telehealth.

So we developed a standardized--we concluded we needed a standardized approach. We needed availability—a multi-disciplinary teams. We needed to use a standardized triage and try to standardize as much as we could our approach. The challenges we still had was we had inadequate resources. We had long waiting lists. We had waiting lists. We'd get a referral be three to six months sometime before we can see them.

What we--when we did our implementation statewide we were down to probably three to six weeks, but what we're finding is that's growing again as people learn about us now we get more and more referrals. There weren't services available in most communities and I think that's where the SAMHSA project has really helped us. We couldn't offer 24/7 emergency in crisis intervention. We couldn't offer wraparound services, social marketing and outreach, to get to the hard and difficult populations was also an issue, which we hadn't addressed.

So the evolution of this was, as I said, the oversight committee where Gary and I started talking, we had lots of discussions between CHSC and BHS and SAMHSA. We developed a proposal and ended up being awarded this--the System of Care Grant, which I think has really allowed us to do a lot more in the

state in the northeast part of the state. We are opening four sites in a 10-county region. We're trying to add a care coordination to it.

So just quickly, I'll run through our motto where multi-disciplinary teams in the middle, and a lot of what they're supposed to do is outreach. We call it—we use a lot of--and since we have so much ocean space there, we used nautical terms like lighthouse and navigators in Iowa.

The navigator teams are team of three people, a nurse, a social worker and a parent that's really aimed at both outreach and care coordination. Our clinic motto, I talked about before, and then we really try to standardize this with a feedback. We've been monitoring feedback after a care plan. But what we're trying to add in the community is connections with sub special and primary care at its core. And then what we're trying to add our community-based wraparound services, and then we're trying to--we're going to build an emergency and crisis management system, and hopefully, will all of these will have quality insurance and evaluation as an integral part of it.

So we've done a lot with this project. I'm excited about the future. We've, kind of, proven that actually these two cultures can work together, and we're seeing some of the toughest of the tough kids. And then, to me, this is a very exciting model, which I think we could all take and emulate to some degree in our states working with our colleagues from SAMHSA. So, Gary.