LEGISLATIVE COMMITTEE MINUTES

SB534

Bill as Introduced

SB 534-FN - AS INTRODUCED

2016 SESSION

16-2932
05/01

SENATE BILL ***534-FN***

AN ACT to implement a system of care for children's behavioral health.

SPONSORS: Sen. Forrester, Dist 2; Sen. Avard, Dist 12; Sen. Carson, Dist 14; Sen. Feltes, Dist 15; Sen. Fuller Clark, Dist 21; Sen. Kelly, Dist 10; Sen. Lasky, Dist 13; Sen. Little, Dist 8; Sen. Morse, Dist 22; Sen. Reagan, Dist 17; Sen. Sanborn, Dist 9; Sen. Stiles, Dist 24; Sen. Watters, Dist 4; Rep. Wallner, Merr. 10; Rep. Rosenwald, Hills. 30; Rep. Kotowski, Merr. 24; Rep. Ladd, Graf. 4

COMMITTEE: Health and Human Services

ANALYSIS

This bill directs the department of health and human services and the department of education to develop a comprehensive system of care for children's behavioral health services. The bill establishes reporting requirements and authorizes the departments to enter into an interagency agreement regarding program implementation.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

16-2932
05/01

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Sixteen

AN ACT to implement a system of care for children's behavioral health.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Findings. The general court finds that:

I. Mental health disorders are the most expensive health conditions in childhood, straining public and private resources. The cost of the most expensive interventions are largely borne by the public sector.

II. Children with serious and complex behavioral health conditions are frequently involved in multiple service systems, creating a risk of expensive duplication of services and reduced effectiveness due to inconsistent approaches to treatment.

III. Serious mental health disorders can result in devastating consequences to children and their families, including dropping out of school, juvenile and criminal justice involvement, low vocational success, inability to live independently, and suicide.

IV. Effective treatment of such disorders at the earliest possible stage reduces total expenditures and makes it more likely that affected children will graduate from high school, become employed, and avoid the need for public benefits.

V. Meaningful family and youth involvement in the planning and delivery of their own services increases effectiveness by building peer supports and leveraging families' strengths and natural supports.

VI. Schools and early childhood programs using multi-tiered system of supports optimize school and student functioning through services supported by the community and parents, positive behavior supports, and data for decision-making.

VII. The Children's Behavioral Health Collaborative, a joint effort of the department of education, the department of health and human services, and more than 50 other entities engaged in children's services, has developed a comprehensive plan for improving the effectiveness, efficiency, and integration of children's behavioral health services in New Hampshire. The collaborative's efforts have been assisted by funding from the federal government, the New Hampshire Charitable Foundation and the Endowment for Health. The resulting plan calls for transitioning to a system of care for children's behavioral health consisting of a coordinated array of services designed to improve cost-effectiveness, avoid duplication, and provide care in the least restrictive environment. Cost-effectiveness in the plan is achieved by decreased use of inpatient and residential services, increased cross-system collaboration, decreased duplication, and improved use of Medicaid.

VIII. Other states have implemented approaches utilizing a system of care, and they have

experienced improvements in the functioning of youth and their families, improvements in systems, improvements in quality of care, and decreased costs for youth with the most serious behavioral health challenges.

2 New Chapter; System of Care for Children's Mental Health. Amend RSA by inserting after chapter 135-E the following new chapter:

CHAPTER 135-F

SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH

135-F:1 Purposes. The purposes of this chapter are to:

I. Increase service effectiveness and improve outcomes for children with behavioral health challenges and their caretakers.

II. Reduce the cost of providing services by leveraging funding sources other than general funds, reducing the need for costly out-of-home placements, and reducing duplication across agencies.

III. Coordinate care for children involved in multiple systems and children at risk of court involvement and out-of-home placement.

135-F:2 Statement of Policy. It is the policy of New Hampshire to implement a system of care model for providing behavioral health services to children in all of the publicly-funded service systems in the state.

135-F:3 Definition; System of Care.

I. In this chapter, "system of care" means an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to New Hampshire children and youth.

II. The system of care is to provide services to all children and youth receiving publicly-funded behavioral health services, including, but not limited to, children and youth in any of the following systems:

(a) Children in need of services under RSA 169-D.

(b) Juvenile delinquency under RSA 169-B.

(c) Child protection under RSA 169-C.

(d) Children with disabilities under RSA 186-C.

(e) Children and youth eligible for services under RSA 135-C.

(f) Children eligible for early intervention pursuant to Part C of the Individuals with Disabilities Education Act and He-M 510.

(g) Children eligible for the child care scholarship program under He-C 6910 due to disability.

III. The system of care shall have the following characteristics:

(a) A comprehensive behavioral health program with a flexible benefit package that includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.

(b) An absence of significant gaps in services and barriers to access services.

(c) Community-based care planning and service delivery, including services and supports for children from birth through early childhood.

(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which places an emphasis on early identification, prevention, and treatment and uses an individualized wraparound approach for children with complex needs.

(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.

(f) An efficient balance of local participation and state-wide administration.

(g) Integration of funding streams.

(h) A performance measurement system for monitoring quality and access.

(i) Accountability for quality, access, and cost.

(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.

(k) Effective identification of youth in need of transition services to adult systems.

135-F:4 Duties of Commissioner of the Department of Health and Human Services. The commissioner of the department of health and human services shall:

I. To the extent possible within existing statutory and budgetary constraints, modify the policies and practices of the department of health and human services to establish a system of care; and

II. Develop a plan for full establishment and maintenance of a system of care. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:

(a) System capacity, including workforce sufficiency.

(b) Federal funding participation, including but not limited to Medicaid waivers and plan amendments.

(c) Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.

(d) Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.

(e) Recommended modifications to law, practice, and policy to prepare for and accommodate the participation of privately funded service providers in the system of care.

(f) Coordination with the plans and activities of the commissioner of the department of education to implement the system of care.

135-F:5 Duties of Commissioner of the Department of Education. The commissioner of the department of education shall:

I. To the extent possible within existing statutory and budgetary constraints, modify the

policies and practices of the department of education to support establishment of a system of care; and

II. Develop a plan for full support and participation of the department of education in the establishment and maintenance of a system of care by the department of health and human services. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:

(a) Development of a multi-tiered system of supports in New Hampshire schools.

(b) System capacity, including workforce sufficiency.

(c) Federal funding participation, including but not limited to Medicaid waivers and plan amendments.

(d) Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.

(e) Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.

(f) Coordination with the plans and activities of the commissioner of the department of health and human services to implement the system of care.

135-F:6 Reporting Requirements. The commissioners of the department of health and human services and the department of education shall issue a joint system of care report on or before December 1 of each year, beginning on December 1, 2016. The report shall be provided to the governor and executive council, the speaker of the house of representatives, the president of the senate, the house and senate finance committees, and the house and senate policy committees with jurisdiction over health and human services and education issues.

I. Beginning in 2016, the report shall address the following:

(a) The total cost of children's behavioral health services.

(b) The extent to which the state's behavioral health service systems are consistent with a system of care.

(c) A description of any actual or planned changes in department policy or practice or developments external to the departments that will affect implementation of a system of care.

(d) Any other available information relevant to progress toward full implementation of a system of care.

II. Beginning in 2017, the report shall also address the following:

(a) A summary of the interagency agreement between the departments required by RSA 135-F:7.

(b) Identification of those actions which will be required to maximize federal and private insurance funding participation in the system of care, along with target dates for completion.

(c) Identification of changes to statutes, administrative rules, policies, practices, and managed care and provider contracts which will be necessary to fully implement the system of care.

(d) Identification of significant gaps in the array of children's behavioral health services, along with a description of plans to close those gaps.

III. Beginning in 2018, the report shall also address the following:

(a) Projections of future demand for services in the system of care.

(b) Identification of shortfalls in workforce sufficiency affecting full implementation of the system of care and plans for addressing those shortfalls.

(c) Identification of specific plan amendments and other changes to the Medicaid system required for full implementation of the system of care and plans for making those changes.

(d) Numbers of children and youth awaiting services in various categories.

IV. Beginning in 2019, the report shall also address the following:

(a) Detailed statistical information regarding children and families serviced, along with demographic characteristics, service need and provision, involvement in service systems, service funding sources, and placement or other site of service provision.

(b) Outcomes, including but not limited to status upon exit from the system of care, measured treatment results, recidivism, and other returns to the service system.

(c) Financial information, including but not limited to measures of cost-effectiveness, comparisons with other states with regard to levels of funding from federal, state, local, and private sources, and cost savings resulting from service coordination and effectiveness.

(d) An assessment of any influences external to the department of health and human services and the department of education, including configuration of the private children's behavioral health care system, which may be affecting establishment of the system of care.

135-F:7 Joint Responsibilities of the Commissioner of the Department of Education and the Commissioner of the Department of Health and Human Services.

I. The commissioner of the department of education and the commissioner of the department of health and human services shall enter into an interagency agreement which supports full implementation of a system of care. The agreement shall be completed no later than December 1, 2017, and shall be amended as necessary and renewed no less frequently than every 2 years. The agreement shall provide for:

(a) Coordination of a delivery system of behavioral health services across the life span of children, youth, and adults with behavioral health needs.

(b) Maximum federal reimbursement and revenue.

(c) Coordination of care and funding among agencies.

(d) Assistance to local education and behavioral health providers, including but not limited to:

(1) Development of model agreements to be utilized by school districts, other education providers, area agencies, community mental health centers, and other entities

participating in the system of care.

(2) Provision of technical assistance to support development of coordinated services by school districts, other education providers, area agencies, community mental health centers, and other entities participating in the system of care.

II. The commissioners may apply for any federal waivers, plan amendments, or other changes or expansion of federal funding mechanisms necessary to implement the provisions of the agreement.

3 Effective Date. This act shall take effect upon its passage.

LBAO
16-2932
1/28/16

SB 534-FN- FISCAL NOTE

AN ACT to implement a system of care for children's behavioral health.

FISCAL IMPACT:

The Departments of Education and Health and Human Services state this bill, **as introduced**, will increase state general fund expenditures by $535,870 in FY 2017, $497,393 in FY 2018, $522,790 in FY 2019, and $549,239 in FY 2020. There will be no impact on county and local expenditures, or on state, county, and local revenue.

METHODOLOGY:

The Department of Education states this bill requires it to partner with the Department of Health and Human Services to develop a comprehensive system of care for children's behavioral health services, consisting of a coordinated array of services designed to improve cost-effectiveness, avoid duplication, and provide care in the least restrictive environment. The bill also establishes reporting requirements relative to the performance of services provided. The Department states it does not currently have a plan in place to provide state comprehensive services to school-age children as required by the bill, and four new positions - one Program Administrator III, two Education Consultants, and one Program Assistant I - will be necessary to implement the bill. The Department projects the cost of these positions as follows:

Administrator III (LG 31)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$62,732	$67,041	$70,181	$73,359
Benefits	$29,507	$31,635	$33,622	$35,719
Other Expenses	$5,350	$350	$350	$350
Position Total:	$97,589	$99,026	$104,153	$109,428

Education Consultant I (LG 26)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$50,583	$53,898	$56,238	$58,676
Benefits	$27,059	$28,986	$30,813	$32,760
Other Expenses	$5,350	$350	$350	$350
Position Total:	$82,992	$83,234	$87,401	$91,786
x Two Positions:	$165,984	$166,468	$174,802	$183,572

Program Assistant I (LG 12)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$28,743	$30,401	$31,649	$32,858
Benefits	$22,659	$24,252	$25,858	$27,558
Other Expenses	$5,350	$350	$350	$350

Position Total:	$56,752	$55,003	$57,857	$60,766
Total Position Costs:	**$320,325**	**$320,497**	**$336,812**	**$353,766**

The Department of Health and Human Services states development of the required plan and compliance with the bill's reporting requirements will require extensive data collection, evaluation, and analysis. The Department anticipates these requirements will require the addition of one Administrator III position and one Planning Analyst/Data Systems position, and projects the costs of these positions as follows:

Administrator III (LG 31)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$62,732	$67,041	$70,181	$73,359
Benefits	$29,507	$31,635	$33,622	$35,719
Other Expenses	$5,350	$350	$350	$350
Position Total:	$97,589	$99,026	$104,153	$109,428

Planning Analyst (LG 24)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$46,391	$49,433	$51,597	$53,898
Benefits	$26,215	$28,087	$29,878	$31,797
Other Expenses	$5,350	$350	$350	$350
Position Total:	$77,956	$77,870	$81,825	$86,045
Total Position Costs:	**$175,545**	**$176,896**	**$185,978**	**$195,473**

In addition to the above position costs, the Department states that it will need to contract for systems analysis and readiness evaluation as required by the legislation, at an estimated cost of $40,000 in FY 2017 only.

This bill does not provide authorization or appropriations for new positions.

CHAPTER 203
SB 534-FN - FINAL VERSION

2016 SESSION

16-2932
05/01

SENATE BILL ***534-FN***

AN ACT to implement a system of care for children's behavioral health.

SPONSORS: Sen. Forrester, Dist 2; Sen. Avard, Dist 12; Sen. Carson, Dist 14; Sen. Feltes, Dist 15; Sen. Fuller Clark, Dist 21; Sen. Kelly, Dist 10; Sen. Lasky, Dist 13; Sen. Little, Dist 8; Sen. Morse, Dist 22; Sen. Reagan, Dist 17; Sen. Sanborn, Dist 9; Sen. Stiles, Dist 24; Sen. Watters, Dist 4; Rep. Wallner, Merr. 10; Rep. Rosenwald, Hills. 30; Rep. Kotowski, Merr. 24; Rep. Ladd, Graf. 4

COMMITTEE: Health and Human Services

ANALYSIS

This bill directs the department of health and human services and the department of education to develop a comprehensive system of care for children's behavioral health services. The bill establishes reporting requirements and authorizes the departments to enter into an interagency agreement regarding program implementation.

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STATE OF NEW HAMPSHIRE

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AN ACT to implement a system of care for children's behavioral health.

Be it Enacted by the Senate and House of Representatives in General Court convened:

203:1 Findings. The general court finds that:

I. Mental health disorders are the most expensive health conditions in childhood, straining public and private resources. The cost of the most expensive interventions are largely borne by the public sector.

II. Children with serious and complex behavioral health conditions are frequently involved in multiple service systems, creating a risk of expensive duplication of services and reduced effectiveness due to inconsistent approaches to treatment.

III. Serious mental health disorders can result in devastating consequences to children and their families, including dropping out of school, juvenile and criminal justice involvement, low vocational success, inability to live independently, and suicide.

IV. Effective treatment of such disorders at the earliest possible stage reduces total expenditures and makes it more likely that affected children will graduate from high school, become employed, and avoid the need for public benefits.

V. Meaningful family and youth involvement in the planning and delivery of their own services increases effectiveness by building peer supports and leveraging families' strengths and natural supports.

VI. Schools and early childhood programs using multi-tiered system of supports optimize school and student functioning through services supported by the community and parents, positive behavior supports, and data for decision-making.

VII. The Children's Behavioral Health Collaborative, a joint effort of the department of education, the department of health and human services, and more than 50 other entities engaged in children's services, has developed a comprehensive plan for improving the effectiveness, efficiency, and integration of children's behavioral health services in New Hampshire. The collaborative's efforts have been assisted by funding from the federal government, the New Hampshire Charitable Foundation and the Endowment for Health. The resulting plan calls for transitioning to a system of care for children's behavioral health consisting of a coordinated array of services designed to improve cost-effectiveness, avoid duplication, and provide care in the least restrictive environment. Cost-effectiveness in the plan is achieved by decreased use of inpatient and residential services, increased cross-system collaboration, decreased duplication, and improved use of Medicaid.

VIII. Other states have implemented approaches utilizing a system of care, and they have experienced improvements in the functioning of youth and their families, improvements in systems, improvements in quality of care, and decreased costs for youth with the most serious behavioral health challenges.

203:2 New Chapter; System of Care for Children's Mental Health. Amend RSA by inserting after chapter 135-E the following new chapter:

CHAPTER 135-F

SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH

135-F:1 Purposes. The purposes of this chapter are to:

I. Increase service effectiveness and improve outcomes for children with behavioral health challenges and their caretakers.

II. Reduce the cost of providing services by leveraging funding sources other than general funds, reducing the need for costly out-of-home placements, and reducing duplication across agencies.

III. Coordinate care for children involved in multiple systems and children at risk of court involvement and out-of-home placement.

135-F:2 Statement of Policy. It is the policy of New Hampshire to implement a system of care model for providing behavioral health services to children in all of the publicly-funded service systems in the state.

135-F:3 Definition; System of Care.

I. In this chapter, "system of care" means an integrated and comprehensive delivery structure for the provision of publicly funded behavioral health services to New Hampshire children and youth.

II. The system of care is to provide services to all children and youth receiving publicly-funded behavioral health services, including, but not limited to, children and youth in any of the following systems:

(a) Children in need of services under RSA 169-D.

(b) Juvenile delinquency under RSA 169-B.

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(d) Children with disabilities under RSA 186-C.

(e) Children and youth eligible for services under RSA 135-C.

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(g) Children eligible for the child care scholarship program under He-C 6910 due to disability.

III. The system of care shall have the following characteristics:

(a) A comprehensive behavioral health program with a flexible benefit package that

includes clinically necessary and appropriate home and community-based treatment services and comprehensive support services in the least restrictive setting.

(b) An absence of significant gaps in services and barriers to access services.

(c) Community-based care planning and service delivery, including services and supports for children from birth through early childhood.

(d) Service planning and implementation based on the needs and preferences of the child or youth and his or her family which places an emphasis on early identification, prevention, and treatment and uses an individualized wraparound approach for children with complex needs.

(e) Services that are family-driven, youth-guided, community-based, and culturally and linguistically competent.

(f) An efficient balance of local participation and state wide administration.

(g) Integration of funding streams.

(h) A performance measurement system for monitoring quality and access.

(i) Accountability for quality, access, and cost.

(j) Comprehensive children and youth behavioral health training for agency and system staff and interested parents and guardians.

(k) Effective identification of youth in need of transition services to adult systems.

135-F:4 Duties of Commissioner of the Department of Health and Human Services. The commissioner of the department of health and human services shall:

I. To the extent possible within existing statutory and budgetary constraints, modify the policies and practices of the department of health and human services to establish a system of care; and

II. Develop a plan for full establishment and maintenance of a system of care. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:

(a) System capacity, including workforce sufficiency.

(b) Federal funding participation, including but not limited to Medicaid waivers and plan amendments.

(c) Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.

(d) Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.

(e) Recommended modifications to law, practice, and policy to prepare for and accommodate the participation of privately funded service providers in the system of care.

(f) Coordination with the plans and activities of the commissioner of the department of education to implement the system of care.

135-F:5 Duties of Commissioner of the Department of Education. The commissioner of the department of education shall:

I. To the extent possible within existing statutory and budgetary constraints, modify the policies and practices of the department of education to support establishment of a system of care; and

II. Develop a plan for full support and participation of the department of education in the establishment and maintenance of a system of care by the department of health and human services. Such plan shall be reviewed and amended annually. It shall include sufficient detail to allow compliance with the reporting requirements of RSA 135-F:6, and shall address at least the following elements:

(a) Development of a multi-tiered system of supports in New Hampshire schools.

(b) System capacity, including workforce sufficiency.

(c) Federal funding participation, including but not limited to Medicaid waivers and plan amendments.

(d) Changes to statutes, administrative rules, and structure of appropriations, and department policy, practice, and structure.

(e) Projections of cost savings from increased service effectiveness and reductions in costly forms of care and use of such savings to close existing gaps in children's behavioral health services.

(f) Coordination with the plans and activities of the commissioner of the department of health and human services to implement the system of care.

135-F:6 Reporting Requirements. The commissioners of the department of health and human services and the department of education shall issue a joint system of care report on or before December 1 of each year, beginning on December 1, 2016. The report shall be provided to the governor and executive council, the speaker of the house of representatives, the president of the senate, the house and senate finance committees, and the house and senate policy committees with jurisdiction over health and human services and education issues.

I. Beginning in 2016, the report shall address the following:

(a) The total cost of children's behavioral health services.

(b) The extent to which the state's behavioral health service systems are consistent with a system of care.

(c) A description of any actual or planned changes in department policy or practice or developments external to the departments that will affect implementation of a system of care.

(d) Any other available information relevant to progress toward full implementation of a system of care.

II. Beginning in 2017, the report shall also address the following:

(a) A summary of the interagency agreement between the departments required by

RSA 135-F:7.

(b) Identification of those actions which will be required to maximize federal and private insurance funding participation in the system of care, along with target dates for completion.

(c) Identification of changes to statutes, administrative rules, policies, practices, and managed care and provider contracts which will be necessary to fully implement the system of care.

(d) Identification of significant gaps in the array of children's behavioral health services, along with a description of plans to close those gaps.

III. Beginning in 2018, the report shall also address the following:

(a) Projections of future demand for services in the system of care.

(b) Identification of shortfalls in workforce sufficiency affecting full implementation of the system of care and plans for addressing those shortfalls.

(c) Identification of specific plan amendments and other changes to the Medicaid system required for full implementation of the system of care and plans for making those changes.

(d) Numbers of children and youth awaiting services in various categories.

IV. Beginning in 2019, the report shall also address the following:

(a) Detailed statistical information regarding children and families serviced, along with demographic characteristics, service need and provision, involvement in service systems, service funding sources, and placement or other site of service provision.

(b) Outcomes, including but not limited to status upon exit from the system of care, measured treatment results, recidivism, and other returns to the service system.

(c) Financial information, including but not limited to measures of cost-effectiveness, comparisons with other states with regard to levels of funding from federal, state, local, and private sources, and cost savings resulting from service coordination and effectiveness.

(d) An assessment of any influences external to the department of health and human services and the department of education, including configuration of the private children's behavioral health care system, which may be affecting establishment of the system of care.

135-F:7 Joint Responsibilities of the Commissioner of the Department of Education and the Commissioner of the Department of Health and Human Services.

I. The commissioner of the department of education and the commissioner of the department of health and human services shall enter into an interagency agreement which supports full implementation of a system of care. The agreement shall be completed no later than December 1, 2017, and shall be amended as necessary and renewed no less frequently than every 2 years. The agreement shall provide for:

(a) Coordination of a delivery system of behavioral health services across the life span of children, youth, and adults with behavioral health needs.

(b) Maximum federal reimbursement and revenue.

(c) Coordination of care and funding among agencies.

(d) Assistance to local education and behavioral health providers, including but not limited to:

(1) Development of model agreements to be utilized by school districts, other education providers, area agencies, community mental health centers, and other entities participating in the system of care.

(2) Provision of technical assistance to support development of coordinated services by school districts, other education providers, area agencies, community mental health centers, and other entities participating in the system of care.

II. The commissioners may apply for any federal waivers, plan amendments, or other changes or expansion of federal funding mechanisms necessary to implement the provisions of the agreement.

203:3 Effective Date. This act shall take effect upon its passage.

Approved: June 6, 2016

Effective Date: June 6, 2016

LBAO
16-2932
Revised 4/4/16

SB 534-FN FISCAL NOTE

AN ACT to implement a system of care for children's behavioral health.

FISCAL IMPACT:

The Department of Health and Human Services states this bill, **as introduced**, will increase state general fund expenditures by $180,710 in FY 2018, $179,606 in FY 2019, and $188,890 in FY 2020. There will be no impact on county and local expenditures, or on state, county, and local revenue.

METHODOLOGY:

The Department of Health and Human Services states this bill requires it to partner with the Department of Education to develop a comprehensive system of care for children's behavioral health services, consisting of a coordinated array of services designed to improve cost-effectiveness, avoid duplication, and provide care in the least restrictive environment. The bill also establishes reporting requirements relative to the performance of services provided. The Department anticipates it will need additional personnel in order to develop the plan and to comply with the bill's ongoing data collection, analysis, and reporting requirements. Specifically, the Department anticipates that beginning in FY 2018, it will need one full-time Administrator III position and one full-time Planning Analyst/Data Systems position, which will have the following fiscal impact:

Administrator III (LG 31)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$0	$63,999	$67,041	$70,181
Benefits	$0	$31,022	$32,990	$35,078
Other Expenses	$0	$5,350	$350	$350
Position Total	$0	$100,371	$100,381	$105,609

Planning Analyst (LG 24)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$0	$47,327	$49,433	$51,597
Benefits	$0	$27,662	$29,442	$31,334
Other Expenses	$0	$5,350	$350	$350
Position Total	$0	$80,339	$79,225	$83,281

Total Position Costs:	**$0**	**$180,710**	**$179,606**	**$188,890**

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The Department of Health and Human Services states this bill, **as introduced**, will increase state general fund expenditures by $180,710 in FY 2018, $179,606 in FY 2019, and $188,890 in FY 2020. There will be no impact on county and local expenditures, or on state, county, and local revenue.

METHODOLOGY:

The Department of Health and Human Services states this bill requires it to partner with the Department of Education to develop a comprehensive system of care for children's behavioral health services, consisting of a coordinated array of services designed to improve cost-effectiveness, avoid duplication, and provide care in the least restrictive environment. The bill also establishes reporting requirements relative to the performance of services provided. The Department anticipates it will need additional personnel in order to develop the plan and to comply with the bill's ongoing data collection, analysis, and reporting requirements. Specifically, the Department anticipates that beginning in FY 2018, it will need one full-time Administrator III position and one full-time Planning Analyst/Data Systems position, which will have the following fiscal impact:

Administrator III (LG 31)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$0	$63,999	$67,041	$70,181
Benefits	$0	$31,022	$32,990	$35,078
Other Expenses	$0	$5,350	$350	$350
Position Total	$0	$100,371	$100,381	$105,609

Planning Analyst (LG 24)	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**
Salary	$0	$47,327	$49,433	$51,597
Benefits	$0	$27,662	$29,442	$31,334
Other Expenses	$0	$5,350	$350	$350
Position Total	$0	$80,339	$79,225	$83,281

Total Position Costs:	**$0**	**$180,710**	**$179,606**	**$188,890**

The Department of Education states this bill will have no fiscal impact, since the Department of Health and Human Services will be the primary coordinator of the requirements contained in the bill.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Andy Sanborn; Chair
Sen Molly Kelly; Vice Chair
Sen Kevin Avard; Member
Sen Sharon Carson; Member
Sen Martha Fuller Clark; Member

Date: February 3, 2016

HEARINGS

Thursday	02/11/2016
(Day)	(Date)

Health and Human Services	LOB 101	1:30 p.m.
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

1:30 p.m.	**SB 530-FN**	relative to volunteer health services.
2:00 p.m.	**SB 516-FN**	relative to preventing violence in health care facilities.
2:45 p.m.	**SB 532-FN**	relative to prior authorization for substance abuse treatment.
3:15 p.m.	**SB 533-FN-A-LOCAL**	relative to drug law enforcement and penalties, insurance coverage for substance use disorders, a statewide drug court grant program, and drug abuse prevention; and making appropriations therefor.
3:45 p.m.	**SB 534-FN**	to implement a system of care for children's behavioral health.

Sponsors:

SB 530-FN

Sen. Forrester	Sen. Morse	Sen. Little	Rep. Spanos
Rep. D. Brown	Rep. Vadney	Rep. Gallagher	

SB 516-FN

Sen. Woodburn	Sen. Soucy	Sen. Hosmer	Sen. Watters
Sen. Kelly	Sen. Lasky	Sen. Feltes	Sen. Fuller Clark
Rep. Shurtleff	Rep. Rosenwald		

SB 532-FN

Sen. Stiles	Sen. Birdsell	Sen. Boutin	Sen. Carson
Sen. Cataldo	Sen. Feltes	Sen. Fuller Clark	Sen. Hosmer
Sen. Kelly	Sen. Lasky	Sen. Little	Sen. Pierce
Sen. Soucy	Sen. Watters	Sen. Woodburn	Rep. Sherman
Rep. J. Ward			

SB 533-FN-A-LOCAL

Sen. Woodburn	Sen. Soucy	Sen. Hosmer	Sen. Kelly
Sen. Fuller Clark	Sen. Lasky	Sen. Watters	Sen. Pierce
Sen. Feltes	Rep. Shurtleff	Rep. Wallner	Rep. Rosenwald
Rep. Sherman			

SB 534-FN

Sen. Forrester	Sen. Avard	Sen. Carson	Sen. Feltes
Sen. Fuller Clark	Sen. Kelly	Sen. Lasky	Sen. Little
Sen. Morse	Sen. Reagan	Sen. Sanborn	Sen. Stiles
Sen. Watters	Rep. Wallner	Rep. Rosenwald	Rep. Kotowski
Rep. Ladd			

Kelly Flathers 271-3091

Andy Sanborn
Chairman

REVISED

SENATE CALENDAR NOTICE
Health and Human Services

Sen Andy Sanborn; Chair
Sen Molly Kelly; Vice Chair
Sen Kevin Avard; Member
Sen Sharon Carson; Member
Sen Martha Fuller Clark; Member

Date: February 3, 2016

HEARINGS

Thursday	02/11/2016
(Day)	(Date)

Health and Human Services	LOB 101	2:00 p.m.
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

2:00 p.m.	**SB 530-FN**	relative to volunteer health services.
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SB 533-FN-A-LOCAL

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Rep. Sherman			

SB 534-FN

Sen. Forrester	Sen. Avard	Sen. Carson	Sen. Feltes
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Sen. Morse	Sen. Reagan	Sen. Sanborn	Sen. Stiles
Sen. Watters	Rep. Wallner	Rep. Rosenwald	Rep. Kotowski
Rep. Ladd			

Kelly Flathers 271-3091

Andy Sanborn
Chairman

REVISED 2/10/16

SENATE CALENDAR NOTICE
Health and Human Services

Sen Andy Sanborn; Chair
Sen Molly Kelly; Vice Chair
Sen Kevin Avard; Member
Sen Sharon Carson; Member
Sen Martha Fuller Clark; Member

Date: February 3, 2016

HEARINGS

Thursday		02/11/2016
(Day)		(Date)
Health and Human Services	SH 100	2:00 p.m.
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

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SB 530-FN

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Rep. Shurtleff	Rep. Rosenwald		

SB 532-FN

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Sen. Cataldo	Sen. Feltes	Sen. Fuller Clark	Sen. Hosmer
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SB 533-FN-A-LOCAL

Sen. Woodburn	Sen. Soucy	Sen. Hosmer	Sen. Kelly
Sen. Fuller Clark	Sen. Lasky	Sen. Watters	Sen. Pierce
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Rep. Sherman			

SB 534-FN

Sen. Forrester	Sen. Avard	Sen. Carson	Sen. Feltes
Sen. Fuller Clark	Sen. Kelly	Sen. Lasky	Sen. Little
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Sen. Watters	Rep. Wallner	Rep. Rosenwald	Rep. Kotowski
Rep. Ladd			

Kelly Flathers 271-3091

Andy Sanborn
Chairman

Senate Health and Human Services Committee

Kelly Flathers 271-3091

SB 534-FN, to implement a system of care for children's behavioral health.

Hearing Date: February 11, 2016

Time Opened: 5:30 p.m. **Time Closed:** 6:15 p.m.

Members of the Committee Present: Senators Sanborn, Kelly, Avard and Fuller Clark

Members of the Committee Absent: Senator Carson

Bill Analysis: This bill directs the department of health and human services and the department of education to develop a comprehensive system of care for children's behavioral health services. The bill establishes reporting requirements and authorizes the departments to enter into an interagency agreement regarding program implementation.

Sponsors:

Sen. Forrester	Sen. Avard	Sen. Carson
Sen. Feltes	Sen. Fuller Clark	Sen. Kelly
Sen. Lasky	Sen. Little	Sen. Morse
Sen. Reagan	Sen. Sanborn	Sen. Stiles
Sen. Watters	Rep. Wallner	Rep. Rosenwald
Rep. Kotowski	Rep. Ladd	

Who supports the bill: Sen. Lasky; Sen. Avard; Sen. Carson; Sen. Forrester; Rep. Schroadter; Sen. Feltes; Paula Minnehan - NHHA; Sen. Fuller Clark; Sen. Watters; MaryAnn Cooney - NH DHHS; Susan Paschell - NH Community Behavioral Health; Kristine Stoddard - Bi-State Primary Care; Tym Rourke - Governor's Commission on Substance Use Disorders; Sen. Kelly; Sen. Morse; Michael Skibbie - Disability Rights Center; Keith Kuenning - C.F.S; Jodie Lubarsky - Seacoast Mental Health Center; Effie Malley - Children's Behavioral Health Collaborative; Mary Steady - NH DOE; Karen Waford - NH Public Health Association; P. Alan Pardy - NH Association of Special Education Administrators; John Dejoie - NH Kids Count; Ken Norton - NAMI NH; Joelle Martin - Preschool Teacher, EC Advocate; Michele Merritt - New Futures; Beth Anne Nichols - MHBG Behavioral Health Advisory Council; Lisa DiMauteni - Parent; Jeff Meyers - NH DHHS; Stuart Trachy - NH Chapter NASW

Summary of testimony presented in support: Senator Forrester (Prime): This approach to children's services is a proven way to improve the lives of children and their families while reducing the use of less effective, restrictive, disruptive, and expensive interventions. You will hear in detail from other witnesses today about the system of care and it's benefits. A system of care provides an organizational framework for service systems and a well-defined philosophy to guide service delivery. That philosophy includes a commitment to an array of home and community based services, care in the least restrictive setting, family and youth involvement, cultural and linguistic competence, cross-system collaboration, care management, and accountability. It works well because a premium is put on the involvement of families and youth in planning their care. This leads to better engagement in treatment and better outcomes. There is a focus on community services over residential treatment, services that are known to be more effective and less costly. Children's services come from multiple systems, so coordination and collaboration is fundamental to getting the best and most cost-effective outcomes. Even when there are enough resources to help a child, everyone benefits when those systems work together. We can be confident that, if we do this right, the state will benefit. Other states have seen reductions in suicide rates, dropout rates, and emergency room visits. Measures of child and family wellbeing go up. The cost of treating the most complex children goes down significantly. In Maine, there was an average decrease in $4,400 in Medicaid costs for children with difficult-to-treat conditions. The bill takes an approach that is designed to gradually move the state toward a full system of care over the next four years. The DOE and the DHHS must modify their approach to see if it can be done within current resources. Over the next few years we can assess our current system and plan for the changes necessary to get us to the point where we are seeing the outcome improvements and cost savings typical from a system of care. This legislation is a result of a years long collaboration of representatives of state agencies, local providers, school districts, and child advocates. They are backed up by national experts and supported by Endowment for Health and NH Charitable Foundation.

Jeff Meyers - Commissioner of the NH Dept. of Health and Human Services: I strongly support this legislation. It's the right thing to do for the state. It is consistent with what the department is moving toward and other programs we are now pursuing, which focus on increasing capacity and the integration of services around behavioral health in NH. Out department submitted a revised fiscal note that eliminates any cost in the current biennium. We can have a conversation about resource needs from this bill in the next budget.

Senator Sanborn: Will it save us money? When and how much?

Jeff Meyers: We have a myriad of programs in NH that touch children's behavioral health. If they are coordinated, over time we would anticipate a reduction in overall cost. There will be resource needs to implement this fully in the next budget. This is complementary to the new Medicaid waiver that's going to be implemented in the state later this year.

Senator Sanborn: Do we really need legislation for this?

Jeff Meyers: It is valuable to communicate the legislature's commitment to this kind of program to the department and the public. The community mental health agreement did not address children's mental health issues in the same way it addressed them for adults. This is the best expression of how we should move forward.

Mary Steady - NH Dept. of Education: I am speaking in support of this legislation. The Department of Education is also removing our fiscal note. Even though there has been a stabilization of drug use in NH, at-risk factors like suicide, cutting, etc. have increased since 2009. 75%-80% of children's mental health treatment occurs within the school system, but we are not currently setup to fully address this. We have created an office at the Department of Education, the Office of Student Wellness, to address these issues on our end. Through this office we have applied for and received several federal grants to help specific schools set up mental health systems. We have also partnered with the Children's Behavioral Health Collaborative. About 50 partners come together every month to address this issue and look at what is happening in the state. We need to address children's health on a multi-tiered system of support. What are we doing for all children, before they enter into any sort of system, to prevent that? How do we identify children being served by multiple systems? This bill will give us that organizational framework we need, such as a shared data system across the DOE and the DHHS. It will also enable us to sustain this work once the federal funds are used.

Senator Avard: What does YBRS stand for?

Mary Steady: YBRS is the Youth Behavior Risk Survey. It is administered at schools.

Michael Skibbie - Disability Rights Center: I am speaking in support of this bill. I have been working closely with the Children's Behavioral Health Collaborative on this project and passed out some relevant materials. 2-5% of children suffer from a serious mental health disorder that causes substantial impairment of function at home, in school, or in the community. These kinds of disorders can have devastating consequences for children and families when not treated effectively. It relates to a lack of vocational success, substance use disorders, involvement with the correctional system, and in some cases, suicide. Most adult mental health disorders begin when people are children. We need to effectively treat these disorders when they first manifest themselves. This can improve outcomes for children and families for a lifetime. ⅔ to ⅘ of children with significant behavioral health disorders do not receive the support they need. At any given time there is an average of 6 children waiting in emergency rooms for inpatient psychiatric care in NH. The DHHS believes that 15 of the ~60 kids now serving sentences at the Sununu Center would be candidates for an inpatient psychiatric facility In NH, we spend about $700 million in special education services. It is common for out-of-district placements and expensive interventions to be linked to behavioral health disorders, as opposed to other learning disabilities. Children's Behavioral Health Collaborative concluded that a system of care is the right response. There are four characteristics of a system of care that illustrate why it works so well: (1) Allows for integration and coordination of services. (2) Puts families in the driver's seat by increasing engagement and success. (3) Ensures there is a continuum

of care available. (4) Puts an emphasis on care outside of institutional settings, which is much less expensive and significantly more effective. The savings go beyond the direct costs. The time is right to take this kind of initiative. We have learned valuable lessons from some programs that are now expiring. This is a gradual and sensible way of getting into this project.

Jodie Lubarski - Seacoast Mental Health Center: I am testifying in strong support of this bill and believe it is both timely and necessary. As a practitioner I have seen firsthand what has been successful and not successful. We have a grassroots effort in Portsmouth called the Portsmouth Resource Connections Team. Our initial goal was to keep track of youth served by multiple agencies and improve coordination. Our second goal soon became prevention. We have been able to invite families into our monthly meetings, listen to their goals, and offer them resources and support. Our small example in Portsmouth represents what this bill intends to do.

Senator Sanborn: How do you get past HIPAA regulations?

Jodie Lubarski: We have memorandum of understanding amongst our agencies that is signed by the executive director at each agency. We also use a release of information that the families consent to.

Effie Malley - Director of the Children's Behavioral Health Collaborative: I am speaking in support of this legislation. It takes an initial step in the state's building of a system of care. This is a milestone following years of work and input from youth, families, providers, state agencies, community organizations, and philanthropic organizations. The Collaborative produced the state's first strategic plan based on what works. We have decades of evidence built by the system of care approach. The plan's overarching goal is commitment to and leadership for a system statewide of coordinated services. It includes action steps that we are already taking to build a system of care. With a system of care approach, more youth will be able to stay with their families and go to their local schools, fewer youth will be in juvenile facilities or in inpatient psychiatric care, fewer youth will visit emergency departments for emotional and behavioral problems, youth who are at risk or experimenting with substances will be identified and will be able to access services in their communities, parents concerned about their toddlers will get referrals to expert providers and care that reflects best practices, more minority and refugee families will be able to access services for their children, families will access intensive home-based services, mobile crisis services, and respite care, all of which will prevent situations from escalating, etc. NH's future prosperity depends on our ability to foster the health and well-being of our next generation. Children's behavioral health is fundamental to their overall health, so it is intrinsically linked to the health of our state.

Ken Norton - Executive Director at the National Alliance on Mental Illness NH: As someone who has a family member poorly served by multiple systems and being a former foster parent, my family and I were not able to navigate the complexities of such a fragmented system. If there had been a system of care for my family, it would have made a large difference with fewer negative outcomes. This was not an isolated

experience. For the past 15 years, reductions in funding has resulted in a lack of clear vision and leadership for mental health in NH. The 10 year blueprint that the state has for mental health is silent about children. More inpatient beds are not the answer; we need comprehensive, community-based, integrated services.

Fiscal Note: See fiscal note dated 1/28/16. An updated fiscal note is pending approval.

Future Action: Ought to Pass

KEF
Date Hearing Report completed: February 12, 2016

Speakers

Senate Health and Human Services Committee: Sign-In Sheet

Date: 02/11/2016 Time: 4:15 PM Public Hearing on SB 534-FN

SB 534-FN to implement a system of care for children's behavioral health.

Name	Representing			Speaking?		
Sen. Bette Lasky	SD #13	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen. Kevin Avard	SD #12	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☐
Sen. Sharon Carson	SD #14	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☐
Sen. Jeanie Forrester	Prime SD #2	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☐
Rep. Adam Robert Schroadter	Rockingham 17	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen. Dan Feltes	SD #15	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Paula Minnehan	NH Hospital Assoc	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen. Fuller Clark	SD #21	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☐
Sen. Watters	4	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
MaryAnn Cooey	NH DHHS	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Susan Paschell	NH Community Behavioral Health	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Kristine Stoddard	Bi-State Primary Care	Support ☒	Oppose ☐	Speaking?	Yes ☐	No ☒
Tom Rourke	Gov Commission on SUD	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Sen. Kelly	#10	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☐
Sen. Morse	SD	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Michael Skibbie	Disability Rights Ctr	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Keith Kuennen	C.F.S.	Support ☑	Oppose ☐	Speaking?	Yes ☐	No ☑
Jodi Hubarsky	Seacoast Mental Health	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐
Ferle Malley	Children's Behav'l Health Collab've	Support ☑	Oppose ☐	Speaking?	Yes ☑	No ☐

Senate Health and Human Services Committee: Sign-In Sheet

Date: 02/11/2016 Time: 4:15 PM Public Hearing on SB 534-FN

SB 534-FN to implement a system of care for children's behavioral health.

Name	Representing	Support	Oppose	Speaking? Yes	Speaking? No
✓ Mary Steady	NHDOE	☒	☐	☒	☐
✓ Karen Welford	NH Public Health Assoc.	☑	☐	☐	☒
✓ P. Alan Pardy	NH Assoc. Spec. Ed. Admin	☑	☐	☐	☑
✓ John DeJoie	NH Kids Count	☒	☐	☐	☒
* Ken Norton	NAMI NH	☑	☐	☑	☐
✓ Joelle Martin	Preschool Teacher / EC Advocate	☑	☐	☐	☒
✓ Michele Merritt	New Futures	☑	☐	☐	☒
✓ Bell Anne Nichols	MHBG - Behavioral Health Adv. Council	☑	☐	☐	☐
✓ Lisa DiMartino	Parent	☑	☐	☐	☐
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Senate Health and Human Services Committee: Sign-In Sheet

Date: 02/11/2016 Time: 4:15 PM Public Hearing on SB 534-FN

SB 534-FN to implement a system of care for children's behavioral health.

Name	Representing	Support / Oppose	Speaking?
✓ Jeff Meyers	DHHS	Support ☑ Oppose ☐	Yes ☑ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐
		Support ☐ Oppose ☐	Yes ☐ No ☐

Senate Health and Human Services Committee: Sign-In Sheet

Date: 02/11/2016 Time: 4:15 PM Public Hearing on SB 534-FN

SB 534-FN to implement a system of care for children's behavioral health.

Name	Representing	Support	Oppose	Speaking? Yes	Speaking? No
Stuart Trachy	NH Chapter – NASW (social workers)	☒	☐	☐	☒
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Testimony

SB 534

NH Children's Behavioral Health Collaborative

Honorable Chairman Andy Sanborn
Senate Health and Human Services Committee
Room 101 Legislative Office Building
33 North State Street
Concord, NH 03301
February 11, 2016

Honorable Chairman Sanborn and Members of the Committee,

I am Effie Malley, the Director of the NH Children's Behavioral Health Collaborative. I am here today to speak in support of Senate Bill 534, which takes an initial step in the state's building a system of care. This legislation represents a milestone in long years of deliberate work by many stakeholders.

The Collaborative is an unprecedented coalition of New Hampshire families and youth, working with individual stakeholders, behavioral health organizations, and youth agencies. The Collaborative produced the state's first strategic plan to transform NH's system of mental health and substance use services so that it provides children and families in need the right care at the right time and in the right place.

The Collaborative's strategic plan is based on what works, specifically giving careful consideration of other states' experience, and the decades of evidence built by the system of care approach. The plan is the result of hundreds of hours of input from youth, families, providers, state agencies, community organizations, and philanthropic organizations. The plan's vision is a system of care that is integrated and comprehensive, and led by families and youth. The plan's overarching goal is to create a commitment to and leadership for a statewide system of coordinated services. The plan includes action steps that families, youth, leaders, providers, and other stakeholders are taking to build a system of care.

Other people here today will talk about the improved outcomes a system of care approach will bring: decreases in youth depression, anxiety, and aggression; decrease in suicide and substance use; improved academics; and stronger families. I want to take a moment to describe what the system of care approach will look like in your communities:

- More youth will be able to stay with their families and go to their local schools
- Fewer youth will be in juvenile facilities or in inpatient psychiatric care
- Fewer youth will visit emergency departments for emotional and behavioral problems
- Youth who are at risk or experimenting with substances will be identified and will be able to access services in their communities
- Parents concerned about their toddlers will get referrals to expert providers and care that reflects best practices

- More minority and refugee families will be able to access services for their children
- Families will access intensive home-based services, mobile crisis services, and respite care, all of which will prevent situations from escalating
- More schools will connect with their community mental health centers and will be able to support all students with behavioral health needs
- More school staff will be trained in mental health first aid and suicide prevention, and be able to participate in family-led wraparound teams

Bottom line: New Hampshire's future prosperity depends on our ability to foster the health and well-being of our next generation. Children's behavioral health is fundamental to their overall health, so is intrinsically linked to the health of our state. Senate Bill 534 lays the groundwork for the behavioral health system our children need. I hope you will join the Collaborative in supporting this truly transformative work.

Thank you for your attention. I am happy to answer any questions that committee members may have.

Sincerely yours,

Effie Malley, Director

ISSUE BRIEF

Return on Investment in Systems of Care for Children With Behavioral Health Challenges

Beth A. Stroul, M.Ed.
Sheila A. Pires, M.P.A.
Simone Boyce, Ph.D.
Anya Krivelyova, M.A.
Christine Walrath, Ph.D.

Published by:

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development

FEBRUARY 2015

Core System of Care Values

- Community Based
- Family Driven, Youth Guided
- Culturally and Linguistically Competent

System of Care Principles

- Broad Array of Effective Services and Supports
- Individualized, Wraparound Practice Approach
- Least Restrictive Setting
- Family and Youth Partnerships
- Service Coordination
- Cross-Agency Collaboration
- Services for Young Children and Their Families
- Services for Youth and Young Adults in Transition to Adulthood
- Linkage With Promotion, Prevention, and Early Identification
- Accountability

The landscape for the organization and financing of behavioral health services for children and adolescents is rapidly shifting in the United States as a result of state and local budgetary pressures, large-scale Medicaid redesign initiatives in states, and opportunities and challenges posed by national health reform. Increasing attention to the importance of behavioral health care within the larger health care arena and among other child-serving systems, such as child welfare and juvenile justice, is also having a substantial impact. State policymakers must make decisions, often quickly, about how to invest public resources for which there are multiple, competing demands. In this context, information on the "return on investment" (ROI) from particular approaches is critical for informing policy and resource decisions. This issue brief highlights ROI information on the system of care approach for children, youth, and young adults with mental health challenges and their families.

Systems of Care

Since the mid-1980s, the Substance Abuse and Mental Health Services Administration (SAMHSA) has invested resources in the development of systems of care for children, youth, and young adults with mental health challenges and their families. Such resources are intended to improve the quality and outcomes of services and control costs. This approach provides an organizational framework for service systems and a well-defined philosophy to guide service delivery. System of care values and principles include a broad array of home- and community-based services and supports, individualized care provided in the least restrictive setting, family and youth involvement, cultural and linguistic competence, cross-system collaboration, care management, and accountability.

In 1993, SAMHSA launched the Comprehensive Community Mental Health Services for Children and Their Families Program, commonly referred to as the "Children's Mental Health Initiative" (CMHI). An extensive national evaluation has provided substantial evidence that systems of care work (Stroul, Goldman, Pires, & Manteuffel, 2012). For example, outcomes for children and youth include decreased behavioral and emotional problems, suicide rates, substance use, and juvenile justice involvement, as well as increased strengths, school attendance and grades, and stability of living situation. In addition, there is also a growing body of evidence indicating that the system of care approach is cost effective and provides an excellent ROI. Data obtained from analyses conducted by states and counties, along with several multi-site studies, demonstrate cost savings both currently and in the future. Cost savings are derived from reduced use of inpatient psychiatric hospitalization, emergency rooms (ERs), residential treatment, and other group care, even when expenditures increase for home- and community-based care and care coordination. Cost savings are also derived from decreased involvement with the juvenile justice system, fewer school failures, and improved family stability, among other positive outcomes. Given these results, SAMHSA has made a commitment to take systems of care

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Michael Skibbie

to scale and is providing resources to states, tribes, territories, and other jurisdictions to support the widespread expansion of the approach.

Return on Investment Analysis

ROI compares the cost of an investment with its benefits, measured in monetary terms. This metric can be easily communicated to different stakeholders—policymakers, funders, administrators, providers, service recipients, and the general public—to explain the value of an investment. In the context of SAMHSA's current focus on expanding systems of care, a project was undertaken to document what is known to date about ROI, specifically cost savings, from systems of care (Stroul, Pires, Boyce, Krivelyova, & Walrath, 2014). Data on resource investment in systems of care was found in the CMHI national evaluation, the evaluation of the Medicaid Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration, the published literature, and from states and communities that have implemented systems of care and conducted their own analyses. The report provides policy-relevant information to guide decisions of policymakers and system leaders on how best to invest resources in mental health services for children and youth.

The systems of care examined share many common characteristics. They serve children and youth with serious and complex mental health conditions. In most cases, they prioritize children who are at high risk for out-of-home placement in restrictive and costly facilities such as inpatient psychiatric hospitals and residential treatment centers. The systems of care include a broad array of home- and community-based services that may include specific evidence-informed interventions. The wraparound practice approach to service planning and care coordination is a common feature among these systems of care and is typically supported by intensive care management with small ratios of care managers to families. All of the systems of care included in the analysis have a specific goal of diverting children from psychiatric inpatient and residential treatment facilities while, at the same time, achieving positive clinical and functional outcomes through the use of effective home- and community-based services. In some cases, the state or community does not use the term "system of care" to describe its intervention, but shares the common characteristics of the approach.

Multi-site studies have documented cost savings related to systems of care. For example, the national evaluation of the CMHI found that children and youth served with the approach were less likely to receive psychiatric inpatient services (ICF International, 2013). From the 6 months prior to intake to the 12-month follow-up, the average cost per child served for inpatient services decreased by 42%. These youth were less likely to visit an ER for behavioral and/or emotional problems and, as a result, the average cost per child for ER visits decreased by 57%. These youth were also less likely to be arrested, with the average cost per child for juvenile arrests decreasing by 38%. Data on other outcomes documented by the national evaluation were "monetized" to derive a financial value (ICF International, 2013). One example is that after 12 months of services in a system of care, 8.6% of youth had dropped out of school, compared with an average of 20% of high school students with mental health challenges nationwide. This result translates into economic gains in average annual earnings and earnings over a lifetime, with an estimated cost savings of 57% per youth.

The evaluation of the PRFT Waiver Demonstration tested the system of care approach, with an array of home- and community-based services and the wraparound process, as an alternative to residential treatment. Across nine states, waiver services cost only 32% of services provided in PRTFs, and there was an annual savings of between $35,000 and $40,000 per child.

States and communities that have implemented the system of care approach have reported changes in service utilization patterns with associated cost savings. Most frequently, these findings represent cost savings resulting from decreased utilization of inpatient and residential treatment services, based on diversion from admission to these facilities, reduced readmissions, and decreased lengths of stay. Reduced rates of out-of-home events of other types were also found, particularly placements in juvenile correction facilities. Reduction in the use of physical health services and visits to ERs also yielded cost savings. In several cases, states have projected cost savings based on the implementation of early intervention services or on future implementation of the system of care approach.

Common Characteristics of the Systems of Care

- Service population of children and youth with serious and complex disorders with priority on those at high risk of out-of-home placement
- Array of home- and community-based treatment services and supports
- Individualized, wraparound approach to service planning and care coordination
- Intensive care management at low ratios
- Goal of diversion and/or return of children from inpatient and residential treatment settings

Highlights of Cost Savings from Systems of Care

Highlights of ROI information are summarized below from two multi-site analyses, three states, and three communities.

Cost Savings Result From

- Decreased use of inpatient psychiatric and residential treatment
- Decreased use of juvenile correction and other out-of-home placements
- Decreased use of physical health services and ERs

MULTI-SITE ANALYSES

Children's Mental Health Initiative (CMHI) National Evaluation *ICF International, 2013*

- Improved outcomes for children served in CMHI-funded systems of care were translated to cost savings that are reflected in the mental health, child welfare, juvenile justice, and education systems, as well as cost benefits to productivity.
- Children and youth were less likely to receive psychiatric inpatient services. From the 6 months prior to intake to the 12-month follow-up, the average cost per child served for inpatient services decreased by 42%. Savings were estimated at more than $37 million when applied to all children served in CMHI-funded systems of care between 2006 and 2013.
- Children and youth were less likely to visit an ER for behavioral and/or emotional problems. From the 6 months prior to intake to the 12-month follow-up, the average cost per child for ER visits decreased by 57%. Savings were estimated at nearly $15 million when applied to all children served in CMHI-funded systems of care between 2008 and 2013.
- Children and youth were less likely to be arrested. From the 6 months prior to intake to the 12-month follow-up, the average cost per child for juvenile arrests decreased by 38%. Savings were estimated at $10.6 million when applied to all children served in CMHI-funded systems of care between 2006 and 2013.
- Children and youth were less likely to repeat a grade. Only 6.3% of children in systems of care for 12 months repeated a grade, compared with 9.6% of American students in the general public. This resulted in a 35% lower cost per child, a potential cost savings of $3.3 million when applied to the 9,244 children aged 14 to 18 enrolled in CMHI-funded systems of care between 2006 and 2013.
- Children and youth were less likely to drop out of school. After 12 months of services, 8.6% of youth had dropped out of school, compared with an average of 20% of high school students with mental health challenges nationwide. This result translates into economic gains in average annual earnings and earnings over a lifetime, with an estimated cost savings of 57% per youth. This result translates into a potential cost savings of over $380 million when extrapolated to all 9,244 youth aged 14 to 18 enrolled in CMHI-funded systems of care between 2006 and 2013.
- Caregivers missed fewer days of work due to caring for their children's mental health conditions. A decline in missed days of work translates into an estimated 39% reduction in the average cost of lost productivity. Of caregivers who were unemployed at intake, 21% reported being employed at the 12-month interview. This result translates into an estimated 21% reduction in the average cost of unemployment due to a child's mental health condition (a reduction of $10,171 in average cost of unemployment per caregiver) for children served in CMHI-funded systems between 2006 and 2013.

Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver Program Evaluation *Urdapilleta et al., 2012; HHS, 2013*

The Centers for Medicare and Medicaid Services (CMS) initiated a Medicaid demonstration waiver program in 2005 to provide and test home- and community-based services for children and youth with serious mental health conditions as an alternative to placement in PRTFs. Nine states participated, adopting the system of care approach with an array of services and supports and the wraparound process, and an evaluation assessed both outcomes and costs.

- Waiver expenditures on services were found to be substantially less than expenditures on services in PRTFs across all grantees and through all waiver years. All states achieved significant savings in the costs of caring for youth with severe emotional disorders.
- For all nine states over the first 3 demonstration years for which cost data were available, there was an average savings of 68%. Waiver services cost only 32% of services provided in PRTFs, with an average per child savings of between $35,500 and $40,000 across the states.

STATE EXAMPLES

Georgia

DiMeo-Ediger, Russ, & Rana, 2012

- When a system of care approach with wraparound was used, there was an 86% decrease in inpatient hospital utilization for youth in the state's PRTF Waiver Demonstration. For non-waiver youth who also had serious and complex mental health conditions and received similar intensive services, inpatient utilization decreased by 89%. There was a 73% decrease in PRTF stays for waiver youth and a 62% decrease for non-waiver youth.
- In FY 2011, the average cost to Medicaid for a youth in a PRTF was $78,406. During involvement in the demonstration, costs declined by 56% to $34,398, an estimated savings of $44,008 annually per youth.
- In FY 2012, the average cost for a youth in a juvenile correction facility was $6,998. During involvement in the demonstration, costs declined by 45% to $3,817, yielding an estimated savings of $3,180 per youth.
- The system of care approach has decreased the percentage of youth experiencing an out-of-home placement event by half—40% to 20%.

Maine: THRIVE System of Care

Yoe, Goan, & Hornby, 2012

- For children and youth served by the trauma-informed system of care, the use of inpatient mental health services decreased by half, from 18% to 9%. Medicaid inpatient hospital costs decreased by approximately $122,000, yielding a savings of 51%.
- Medicaid cost savings of over $450,000 occurred between the period prior to enrolling in the system of care and the period after program involvement, an average savings of $4,436 per child.
- The average cost per child per month was reduced by 30% (from $2,452 in the period prior to enrollment, compared with $1,665 in the period after enrollment, an average monthly savings of $787).
- Costs associated with visits to the ER decreased by 40%.

Oklahoma

Strech, Harris, & Vetter, 2011

A group served with the system of care approach (care management group) was compared with a control group to compare costs for physical health and behavioral health services combined and costs for behavioral health services alone.

Total Charges (Including Inpatient and Outpatient)

- For behavioral health services alone, there was a significantly greater reduction in average total behavioral health charges for the care management group. There was a 41% reduction for the care management group versus a 17% reduction for the control group.
- For behavioral health and medical costs combined, there was a 35% reduction in average total charges for the care management group versus a 15% reduction for the control group.

Inpatient

- For behavioral health services alone, average inpatient charges for the care management group declined by 60% versus a 17% reduction for the control group.
- For behavioral health and medical costs combined, care management also resulted in a 60% reduction in average inpatient charges, compared with a 17% reduction in average inpatient charges for the control group.

Outpatient

- Average outpatient behavioral health charges increased as desired by 19%, suggesting a substitution of community-based services for inpatient care, whereas outpatient days decreased for the control group by 17%.

Total Per Youth Per Month Charges

- For behavioral health alone, care management resulted in savings of $357 per youth per month during the 12-month intervention period, compared with the control group, and $770 per youth per month for the entire 24-month period. These savings were used to project savings for the entire population of 1,943 moderate to high Medicaid utilization youth. It was estimated that the system of care approach as implemented through care management would have achieved a savings over a 1-year period of between $8,334,938 and $18,162,398 if all youth in the study population had received care management.
- For medical and behavioral health services combined, care management resulted in savings of $458 per youth per month during the intervention and savings of $720 per youth per month for the entire 24-month time period, compared with the control group. These savings were used to project savings for the entire population of 1,943 moderate to high Medicaid utilization youth. It was estimated that a savings of between $9,112,402 and $16,777,805 would have been achieved if the entire study population had all received care management over a 1-year period.

COMMUNITY EXAMPLES

California: Los Angeles

Rauso, Ly, Lee, & Jarosz, 2009

- During a follow-up period, youth graduating from a community-based system of care approach with wraparound had significantly fewer subsequent out-of-home placements than youth in a comparison group who graduated from services in a residential treatment setting. As a result, 56% had some type of placement versus 91% of the residential group. Community-based system graduates also experienced significantly fewer days in out-of-home placements.
- Youth who were graduates of the community-based system were more likely to be placed in less restrictive settings, such as with foster parents or relatives (77%), whereas the majority of children in the comparison group (70%) were placed in more restrictive settings.
- The average post-graduation costs for youth served in the community-based system were nearly 60% less than the costs for the comparison group ($10,737 versus $27,383). Placement costs for the residential treatment group were 2.5 times the cost for the group served with the community-based approach.

Massachusetts: Mental Health Services Program for Youth (MHSPY)

Grimes et al., 2011; Grimes & Mullin, 2006

- Data from 1998 to 2002 indicated that the vast majority of days for MHSPY enrollees were spent at home, with an increase over time and a corresponding reduction in hospitalization and out-of-home placements.
- From 1998 to 2002, enrollees' days spent in placements not included in the MHSPY benefit (foster care, residential, group home, detention, jail, secure treatment, and boot camp) were reduced by 50%.
- A study found that intervention youth were consistently maintained in least restrictive settings, with over 88% of days spent at home.
- The intervention group used lower intensity services and had substantially lower claims expense than matched counterparts in "usual care." The average total costs of MHSPY (including medical, mental health, and wraparound care coordination costs) were far below costs for the comparison group. The MHSPY costs were 50% to 60% less than the costs of serving youth in more restrictive settings (that did not include the costs of medical or wraparound services included in MHSPY's costs).
- Total per member per month claims expense (including pediatric inpatient, ambulatory pediatric, ER, pharmacy, and inpatient and outpatient mental health) was less than half for the intervention group than claims for the matched group in usual care ($761 per youth per month versus $1,573 per youth per month). For example, claims were 32% lower for ER use and 73% lower for inpatient psychiatric services.
- The intervention group was more psychiatrically impaired than the comparison group, suggesting that these findings may underestimate the actual cost savings from the system of care.

Wraparound Milwaukee

Kamradt, 2013; Kamradt, Gilbertson, & Jefferson, 2008

- From 1996 to 2012, Wraparound Milwaukee reduced the use of psychiatric hospitalization for Milwaukee County youth from an average of 5,000 days annually to less than 200 days per year (a 96% decline). Placements in residential treatment centers declined from 375 in 1996 to approximately 90 in 2012 (an 87% decline).
- Since its inception, Wraparound Milwaukee has reduced costs by more than 50% (from over $8,000 per child per month to about $3,450 per child per month). Declines in costs are attributed to reduced utilization of inpatient and residential treatment. For example, the percentage of Wraparound Milwaukee enrollees using residential treatment declined between 2010 and 2012 from 25% to 17%.
- Data from 2012 documented that Wraparound Milwaukee is less expensive than placement in residential and inpatient settings. Costs of residential treatment were estimated at $9,460 and inpatient services at $39,100 per child per month (or $8,400 for a 7-day stay), compared with the $3,200 per child per month cost of Wraparound Milwaukee.
- Nearly every youth at risk of juvenile correctional placement is enrolled in Wraparound Milwaukee; 80% have a diagnosed mental health condition. The average number of youth in correctional facilities from Milwaukee County declined from 250 in 2007 to 142 in 2012; consequently, costs to the county for juvenile correctional placements declined by 37%, nearly $9 million in savings.
- Estimates of costs avoided by Milwaukee County since the inception of Wraparound Milwaukee in 1996 were calculated. When Wraparound Milwaukee was initiated, there was an average of 337 youth placed in residential treatment centers. Factoring in modest increases in the number of youth placed and cost increases resulted in a projection of potential expenditures by child welfare and juvenile justice agencies of $85 million from 1996 to 2012 without Wraparound Milwaukee. With Wraparound Milwaukee's system of care, placement costs were only $10 million in 2012, representing a cost avoidance of about $75 million.

Conclusion

Given the importance of understanding the business case for investing in the system of care approach, it is important to build capacity in states and other jurisdictions to collect and analyze ROI information. This ROI information should be timely, policy-relevant, and easy to interpret and apply to immediate decisions about resource allocation. However, calculating return on investment is not without challenges. These include:

- *Obtaining the resources and expertise needed for ROI analyses*—Allocating the needed time, money, and skilled staff to conduct ROI analyses, particularly with more complex methods
- *Obtaining data from multiple sources*—Gathering data to capture cost savings across systems (e.g., costs saved by juvenile justice when placements in correctional facilities are decreased due to increased use of community-based treatment), Medicaid claims data, internal MIS system data, etc.
- *Determining the cost implications of changes in service utilization*—Translating changes in service utilization patterns into the impact on expenditures (e.g., decreased utilization of inpatient and residential treatment)
- *Monetizing benefits from systems of care*—Quantifying specific, important outcomes in systems of care that typically are not assigned monetary values
- *Assessing short-term and long-term costs*—Exploring both immediate and longer term cost implications associated with the system of care approach

To address these challenges and produce needed cost information, it is recommended that materials and technical assistance be provided to strengthen the capacity of states and communities to produce and use return on investment data related to systems of care. Widespread dissemination of available information on return on investment is recommended, with a particular emphasis on state Medicaid agencies and policymakers across the multiple child-serving agencies that share responsibility for financing and providing children's behavioral health services.

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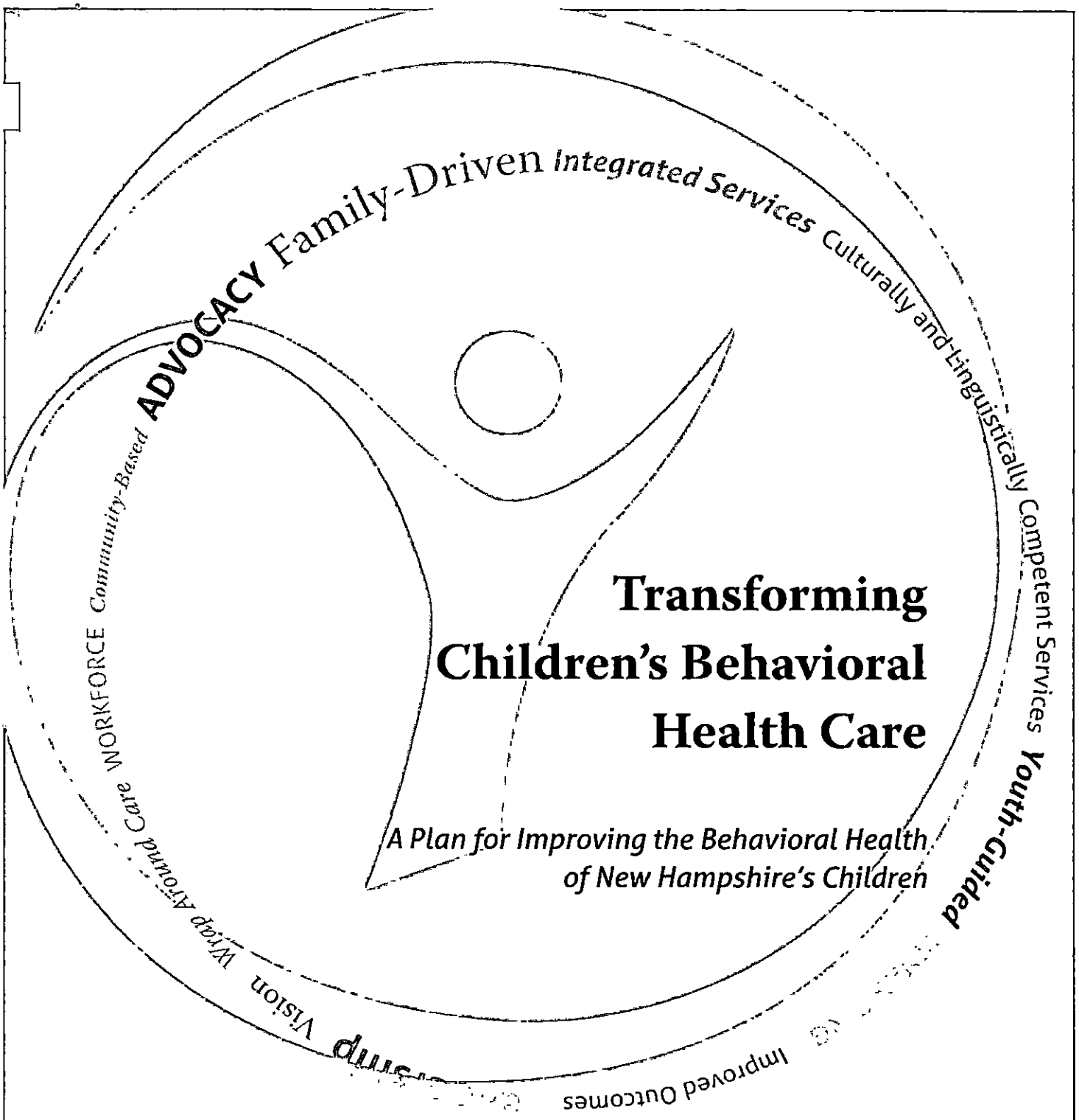


Transforming Children's Behavioral Health Care

A Plan for Improving the Behavioral Health of New Hampshire's Children

Executive Summary

The New Hampshire Children's Behavioral Health Collaborative – 2013

SB534-FN Michael Skibbie

"And how are the children?"

– Traditional Masai tribal greeting

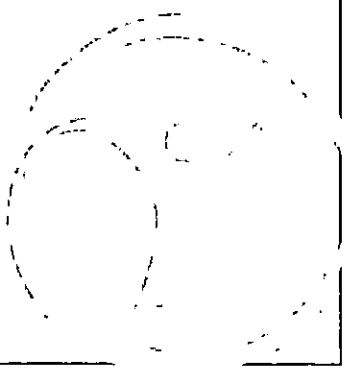
Protecting and promoting children's behavioral health is a fundamental investment in a child's future. Early behavioral health conditions have long-term implications that range from school success to future wage earnings to a sense of well-being and overall health. Behavioral health, which refers to mental health and substance use conditions, is a measure of well-being that is as complex as the human brain itself. Understanding and serving this complex inter-relationship between the body, behavior and emotion is particularly challenging with children. The patterns of experience mapped by the brain continue to influence the child's development for the rest of his or her life, impacting his or her long-term health and well-being[1].

As a society and as a state, it is our responsibility as leaders and professionals to ensure that we are supporting the healthy social and emotional development of New Hampshire's future citizens and leaders. We must meet their behavioral health needs with highly effective services and supports that provide significant long-term positive outcomes for children, youth and their families.

It is this responsibility that led to the establishment of the New Hampshire Children's Behavioral Health Collaborative (the Collaborative) in November of 2010. This unprecedented coalition of over 50 organizations came together to study the current landscape of children and families and the existing behavioral health systems, services and supports. Following the best practice approach known as System of Care, the Collaborative developed a plan to build an integrated and comprehensive service delivery structure that is family-driven, youth-guided, community-based and culturally and linguistically competent.

This publication establishes the state's first documented plan for such an integrated and comprehensive system of behavioral health care for our state's children and youth, presenting the action steps families, youth, leaders, professionals and other stakeholders will take to achieve an effective System of Care for the next generation.

The Institute of Medicine refers to the term **'behavioral health'** as including mental health and substance use conditions and recognizes that behavioral health care has several characteristics that challenge its effectiveness, such as separate care delivery systems and a less developed quality assurance infrastructure.[2]



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WHERE WE ARE NOW

The first step to developing a plan for a better system of care for children's behavioral health is to understand where we a now. The Collaborative reviewed data from many sources to appreciate how children and families are being currently served and supported. This informed the Collaborative's priorities for a transformation of the service delivery system for behavioral health promotion, early intervention, treatment and supports.

OUR CHILDREN

One in five of preschoolers through teens have an emotional disorder that impacts their daily functioning at home, in school or in their community.[3] Of those children receiving mental health services, approximately 43% are diagnosed with a co-occurring alcohol or drug use disorder. Similarly, of adolescents in New Hampshire alcohol or drug treatment programs, 2/3 of males and 4/5 of females have a co-occurring mental health disorder.[4] On any given day, over 250 New Hampshire children are living and receiving care in an in-state residential placement or treatment facility outside of their home community.[5]

FAMILIES

Families also bear significant and uncounted responsibilities and expenses in supporting their children's well-being. Families report frustration with what they describe as fragmented and uncoordinated systems, often likening their experiences with current systems for children's behavioral health to being "lost in a maze." Families also describe a lack of opportunities to voice their child's strengths and needs.[6]

LOCAL SCHOOLS

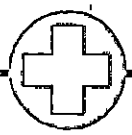
Schools already play a central role in providing mental health services to New Hampshire's children, some working with community-based providers and federal aid programs to support students. Schools often see behavioral health needs at early ages and stages and reach out to families and community-based services. While New Hampshire has one of the lowest high school dropout rates in the country, New Hampshire's school suspension rates are nearly twice the national rate, and students with emotional disabilities are suspended at higher rates than other students.[7] New Hampshire's rates of regular alcohol and marijuana use among 12 to 17 year olds are also some of the highest in the country.[8]

WHERE WE ARE NOW

The assessment of state and community efforts and resources to provide behavioral health care to New Hampshire children reinforced that behavioral health care happens in many places and in many ways, but that gaps in services and in coordination of those services can compromise effective care and outcomes.

PRIMARY CARE

Primary care providers play a substantial role in treating children and youth with behavioral health disorders, with most childhood psychiatric medications prescribed by pediatricians. Although they are often stretched to capacity with monitoring and caring for the physical health of children, the frequency of well-child checkups and the relationships many families develop with their primary care professional provides an opportunity to identify behavioral health concerns earlier and coordinate services and supports.



COMMUNITY BASED PROVIDERS

Children's behavioral health needs are served by a range of community-based providers, including the state's ten community mental health centers that serve more than half of children with serious emotional health disorders. These centers and other provider agencies have been increasingly financially under-resourced in recent years, with notable gaps in services, including adolescent substance abuse and co-occurring disorder treatment. Community mental health centers now handle approximately 10,000 children with increasingly complex needs, a number that has remained constant for the past three years, despite significant budget reductions.[9]

BEHAVIORAL HEALTH EXPENDITURES

Expenditures for children's mental health services are paid for primarily by Medicaid, child protection, juvenile justice, local school districts, the state's Catastrophic Aid Program and private insurance, systems that do their best to serve the complex and long-range needs of over 50,000 children with diagnosable behavioral health needs. There is little formal coordination between the various systems receiving state and local funding to provide behavioral health services to children or between the public systems and private insurance.[10]

What is a system of care approach?

A System of Care is a behavioral health care approach that relies on a coordinated network of effective community-based services and supports with a broad array of individualized services which help children and youth to function better at home, in school, in the community, and throughout life. This evidence-based approach has been found to decrease caregiver strain, increase stability in living arrangements, increase school performance and attendance, and expand the service array.[11]

SHARING A VISION

Moving from Multiple Systems to an Integrated System of Care

Transforming New Hampshire's current behavioral health care services and supports into to one integrated, comprehensive system of care requires shared values and principles, a commitment to evidence-based and evidence-informed practice, and collaborative action from all stakeholders, establishing a common ground from which to build, with children and families actively participating in the transformation.

SHARED VALUES

The Children's Behavioral Health Care System will be

- Family driven, youth guided
- Community-based
- Culturally and linguistically competent

GUIDING PRINCIPLES

The Children's Behavioral Health Care System will involve

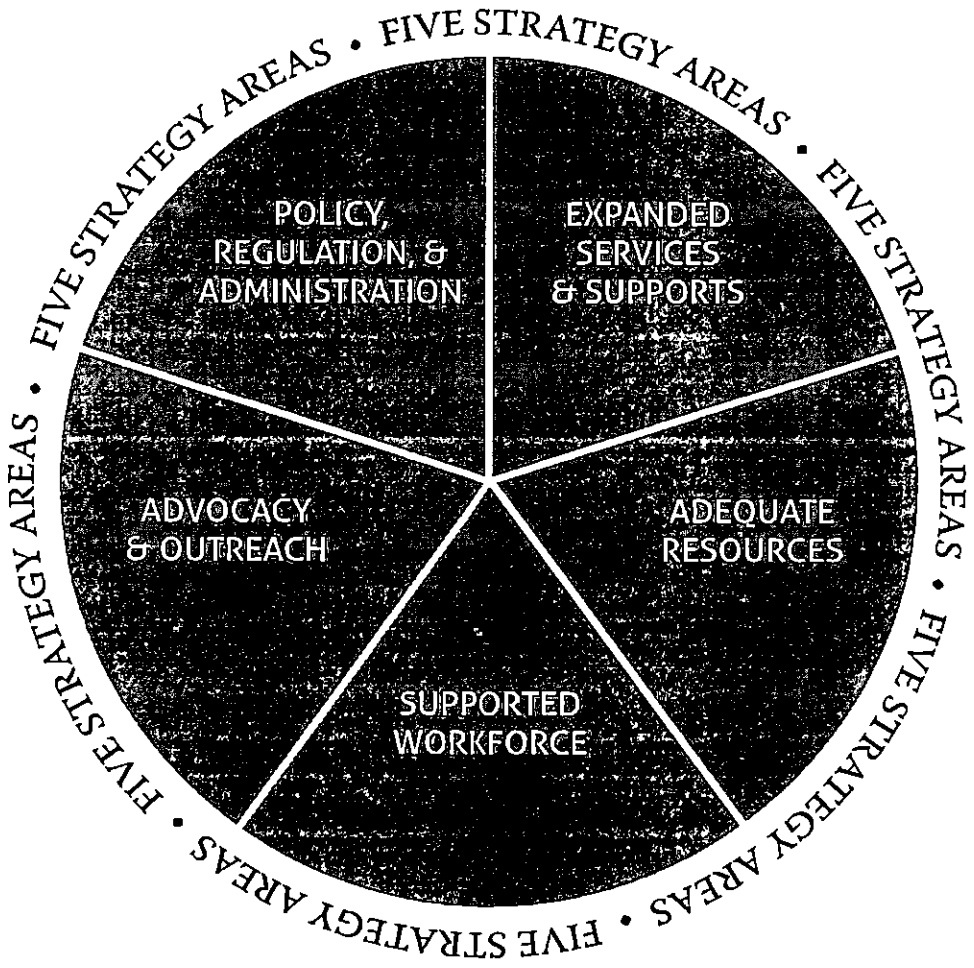
- Effective, evidence-informed services
- Individualized, wraparound service planning
- Least restrictive environments
- Youth and families as full partners in services and policies
- Integrated care
- Care management for service coordination
- Developmentally appropriate services
- Prevention, early identification & intervention
- Promoting advocacy and protecting rights
- Focus on accountability and quality
- Non-discrimination

The changes and improvements recommended within this plan's goals must be realized at the system level, at the service level, and at the environmental level to support transformation. For example, a policy change at the system level can lead to a wider array of services and supports available at the service level, while advocacy and media efforts can reduce stigma within a child's environment, encouraging more access to services.

These multiple levels of coordinated action are present in the goals and strategies for a transformed and improved system of care for children and their families.

BUILDING TOGETHER

Changing such a complex system of services and supports for a complex constellation of disorders and needs will not be simple, straightforward or quick. The goals for the state's transformation plan were established within five strategy areas recommended by the federal Center for Mental Health Services.[12]



"When my child is struggling mentally it seems like his entire body is breaking down."

"I honestly think it's about time that mental health issues were treated just like a cold or a broken bone [but] mental health issues still carry a stigma"

"If your mental health is suffering the rest of your life will be suffering"

Family focus group participants sharing their experiences with the current behavioral health care system[13]

TRANSFORMATION GOALS

The Collaborative's planning process focused on each System of Care strategy area and analyzed the policy, service array, financing, workforce, advocacy and other changes that would be needed to address each goal in the Plan. A more detailed matrix of sub-strategies and action items for each of the goals and five strategy areas can be found at www.NH4Youth.org.

This planning method established nine core goals that will move New Hampshire toward a System of Change approach and that underscore the effective leadership, bold policy change, adequate financing, strong workforce, mobilized advocates, and the strong voice of children and families that will be drivers of change and improvement for our next generation.

When parents of children with behavioral health conditions were asked what quality care meant to them, one shared that it was care that was **"not driven by money, but need."**[14]

Align child-serving systems toward common goals and outcomes

- Developing a state-level leadership and management body to maintain focus, commitment and action
- Conducting joint trainings, technical assistance and coaching on System of Care values and principles
- Developing agreements among agencies and organizations to braid financing in support of integrated, collaborative, and evidence-informed care

Implement family-driven, youth-guided, culturally and linguistically competent services and systems

- Increasing family and youth involvement at the policy and systems level
- Increasing family and youth involvement in the planning and delivery of their services
- Implementing peer-to-peer support services for families and youth
- Increasing the cultural and linguistic competency of children's behavioral health services, thereby reducing disparities

Improve services and outcomes for children and youth with serious and complex behavioral health needs and their families

- Creating an entity that serves as a centralized and accountability hub for managing services, costs, care, and improved outcomes, particularly those who are involved in multiple state systems
- Developing individualized care through fidelity to a wrap-around approach to service planning and care for high-need children and their families
- Broadening the array of available services and supports, such as respite care, mobile crisis units, substance use prevention, early intervention and treatment, family and youth peer supports, and other specialized services for children in key transition periods

Wraparound is intensive, individualized care planning that engages children and youth with complex needs and their families, considering strengths and assets in tailoring care.[15]

Realign financing streams to better invest resources for behavioral health services and supports for children, youth and families

- Coordinating and redirecting financing streams to support a broader array of effective, coordinated home and community-based services and supports for high need children and their families
- Incorporating children's behavioral health provisions, structures and services into the state's Medicaid/Managed Care System

"It would be so helpful to make one phone call to see what services are available."[16]

–Wolfeboro area parent

Create a sustainable infrastructure to provide on-going training in the System of Care approach, effective services, and other workforce development strategies

- Incorporating both pre-service and in-service training in evidence-based, evidence-informed and promising practices within higher education and credentialing, licensing and certification requirements
- Making available training topics relative to this plan, such as cultural and linguistic competence, co-occurring mental health and substance use disorders, and System of Care principles

"[I got] tired of hearing [my child] is too young to diagnose".[17]

– Claremont area parent

Identify emotional and behavioral health challenges and needs at earlier ages and at earlier stages

- Increasing early identification and intervention strategies
- Implementing an evidence-based multi-tiered system of supports within schools state-wide to address student behavioral health needs, improving educational outcomes

Maximize opportunities for integration of mental health and substance use prevention, intervention, and treatment with primary care

- Increasing and systematizing the use of evidence-based screening within primary care, emergency services and other child-serving systems
- Implementing an approach that supports primary care physicians, nurse practitioners and other providers in expanding their knowledge relative to prescribing psychiatric medications, such as access to specialty consultation

National Standards on Culturally and Linguistically Appropriate Services (CLAS) can serve as a standard for transformation activities.[18]

Measure outcomes of implementing improved services that are family-driven, youth-guided and culturally and linguistically competent

- Adopting a common and culturally and linguistically competent behavioral health assessment tool across multiple systems and focusing on positive outcomes and improvement and that establishes and implements clear eligibility and evaluation criteria for different social-emotional needs across multiple child-serving systems
- Developing the ability to share and track culturally and linguistically competent service data across child-serving systems
- Increasing awareness of the role of data collection and use among children, youth and families

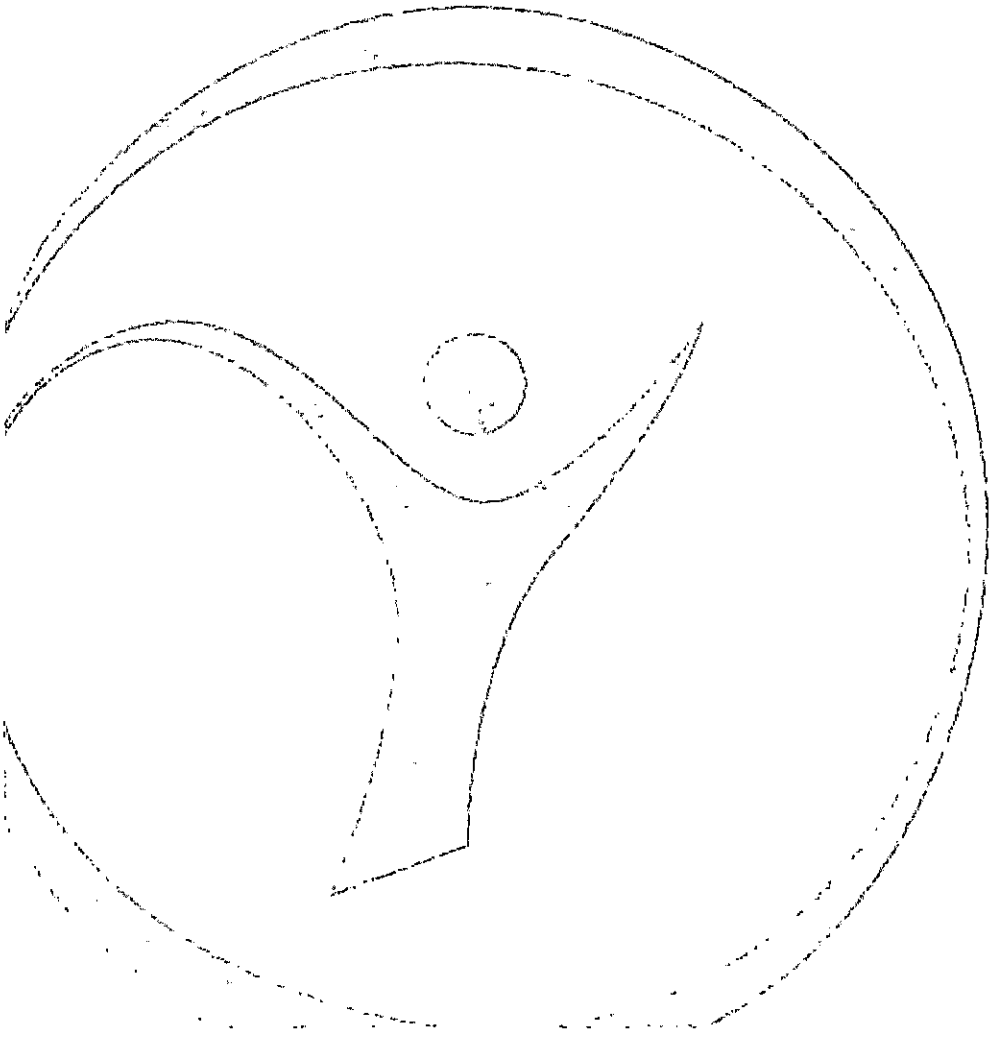
Maximize support for implementing family-driven, youth-guided, culturally and linguistcally competent systems and services

- Use strategic marketing and a range of other communication strategies to increase knowledge, influence decision-making, and generate support for an expanding and improving a family-driven, youth-guided and culturally and linguistically competent system of care

NH Children's Behavioral Health Collaborative

ABOUT THE COLLABORATIVE

The New Hampshire Children's Behavioral Health Collaborative first convened in November of 2010 through a joint initiative of the Endowment for Health and the New Hampshire Charitable Foundation to study and respond to the strengths and challenges of meeting the behavioral health needs of New Hampshire's children and youth. The Collaborative has expanded its membership and technical expertise to ensure a robust assessment of existing systems, best practice research, assets and limitations as well as the needs and hopes of those served by the existing systems of care. The vision of the membership is to cultivate and sustain an integrated, comprehensive children's behavioral health system for the Granite State.



PARTNERS AND CONTRIBUTORS

ARCH of the Upper Valley
Autism Society of New Hampshire
Bi-State Primary Care Association
Center for Life Management
Child and Family Services
Child Health Services
Children's Alliance of New Hampshire
Community Bridges
Coos Family Support Project
Dartmouth-Hitchcock, Children's Hospital at Dartmouth
DDG Consulting
Disabilities Rights Center
Early Learning New Hampshire
Easter Seals New Hampshire
Endowment for Health
Families in Transition
Foundation for Healthy Communities
Friends of Recovery – New Hampshire
Geisel School of Medicine at Dartmouth
Granite State Children's Alliance
Granite State Federation of Families for Children's Mental Health
Greater Nashua Mental Health Center
National Alliance on Mental Illness New Hampshire
National Association of Social Workers – New Hampshire
New Futures
New Hampshire Alcohol & Drug Abuse Counselors Association
New Hampshire Alcohol & Other Drug Service Providers Association
New Hampshire Association of Infant Mental Health
New Hampshire Association of Marriage and Family Therapy
New Hampshire Association of Special Education Administrators
New Hampshire Center for Excellence
New Hampshire Charitable Foundation
New Hampshire Children's Lobby
New Hampshire Children's Trust
New Hampshire Coalition Against Domestic & Sexual Violence
New Hampshire Community Behavioral Health Association
New Hampshire Council on Autism Spectrum Disorders
New Hampshire Department of Education
New Hampshire Department of Health & Human Services
New Hampshire Family Voices
New Hampshire Legal Assistance
New Hampshire Medical Society
New Hampshire Partners in Service
New Hampshire Pediatric Society
New Hampshire Psychiatric Society
New Hampshire Psychological Association
New Hampshire Residential Provider Network
New Hampshire School Administrators Association
New Hampshire School Nurses' Association
New Hampshire Suicide Prevention Council
NFI North
Parent Information Center
Phoenix House
School Administrative Unit 39
School Administrative Unit 46
School Administrative Unit 81
School Administrative Unit 90
University of New Hampshire Institute on Disability

The Collaborative is further supported by funding and technical assistance from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), and technical expertise from the National Technical Assistance Center for Children's Mental Health (NTAC) at Georgetown University's Center for Child and Human Development.

The Collaborative wishes to recognize and thank the many youth, family members, community members, and leaders across the state who participated in focus groups and contributed their input and guidance to the development of the underlying values, concepts, and strategies of this document. The shared commitment of all who are stepping forward will help guide, build and strengthen a transformed children's behavioral health system for our state.

[1] Raver, C. C. (2002, December). Emotions matter: Making the case for the role of young children's emotional development for early school readiness (Social Policy Report, Vo. 26, No. 3). Ann Arbor, MI: Society for Research in Child Development.

[2] *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC: The National Academies Press, 2006. Retrieved from http://www.iom.edu/Reports/2005/Improving-the-Quality-of-Health-Care-for-Mental-and-Substance-Use-Conditions-Quality-Chasm-Series.aspx#sthash.q88QHCsk.dpuf

[3] Department of Health and Human Services (US); Rockville (MD): Department of Health and Human Services. Mental health: a report of the Surgeon General. 1999

[4] *Reclaiming Our Future, A Pathway for Treating Co-Occurring Mental Health and Substance Use Disorders in New Hampshire's Adolescents and Young Adults,* National Alliance on Mental Illness -New Hampshire, 2009. http://www.naminh.org/uploads/docs/NAMIReclaimingOurFuture.pdf

[5] *Residential Placement Report*, New Hampshire Department of Health and Human Services Internal Report, January 2013

[6] *Collecting Family Voices on Children's Mental Health. NH Children's Mental Health Focus Group Project* Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[7] *Mental Health Services in New Hampshire's Schools.* NH Center for Public Policy Studies Report, April 2009

[8] U.S. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

[9] NH DHHS Block Grant Proposal, 2011

[10] *Mental Health Services in New Hampshire's Schools.* NH Center for Public Policy Studies Report, April 2009

[11] Stroul, B.A., & Friedman, R. M. (2011). *Issue brief: Strategies for expanding the system of care approach.* Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. Retrieved from http://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf

[12] Ibid

[13] *Collecting Family Voices on Children's Mental Health.* NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

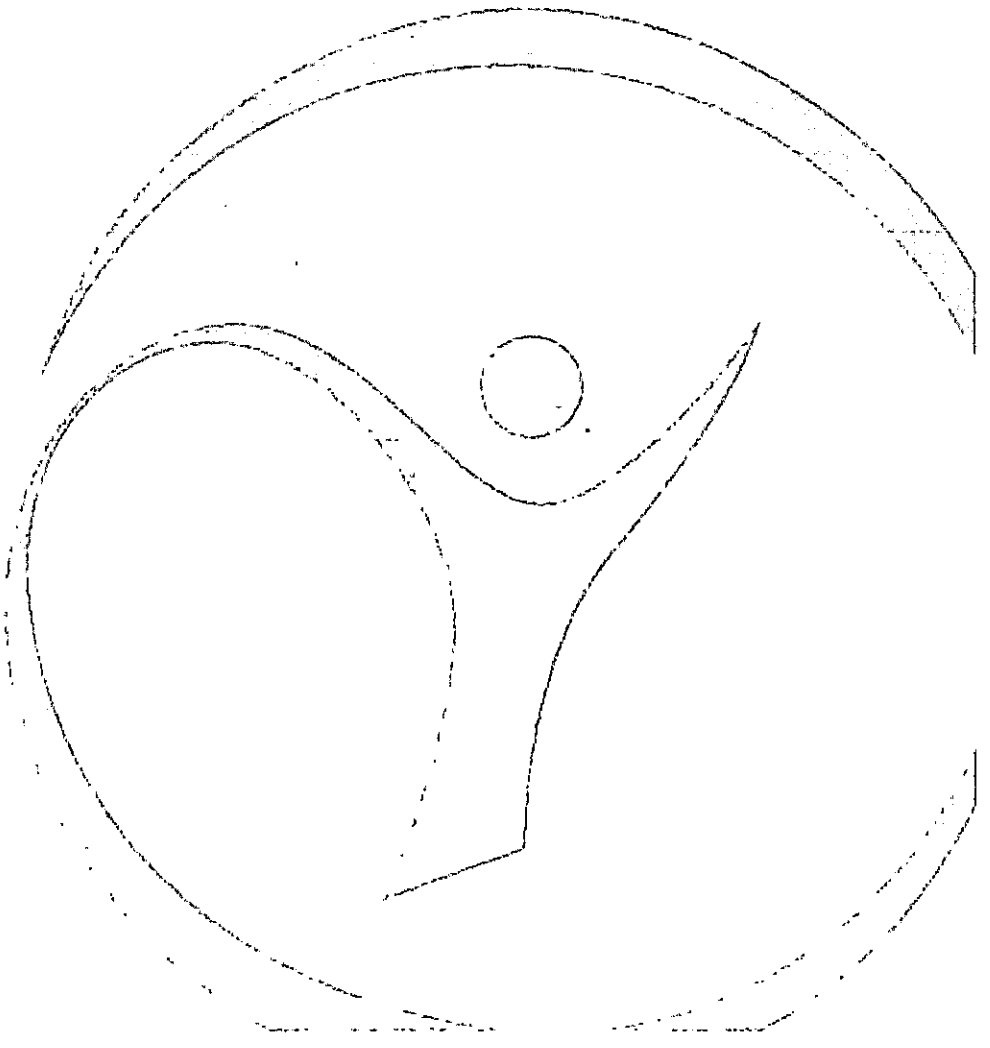
[14] *Collecting Family Voices on Children's Mental Health.* NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

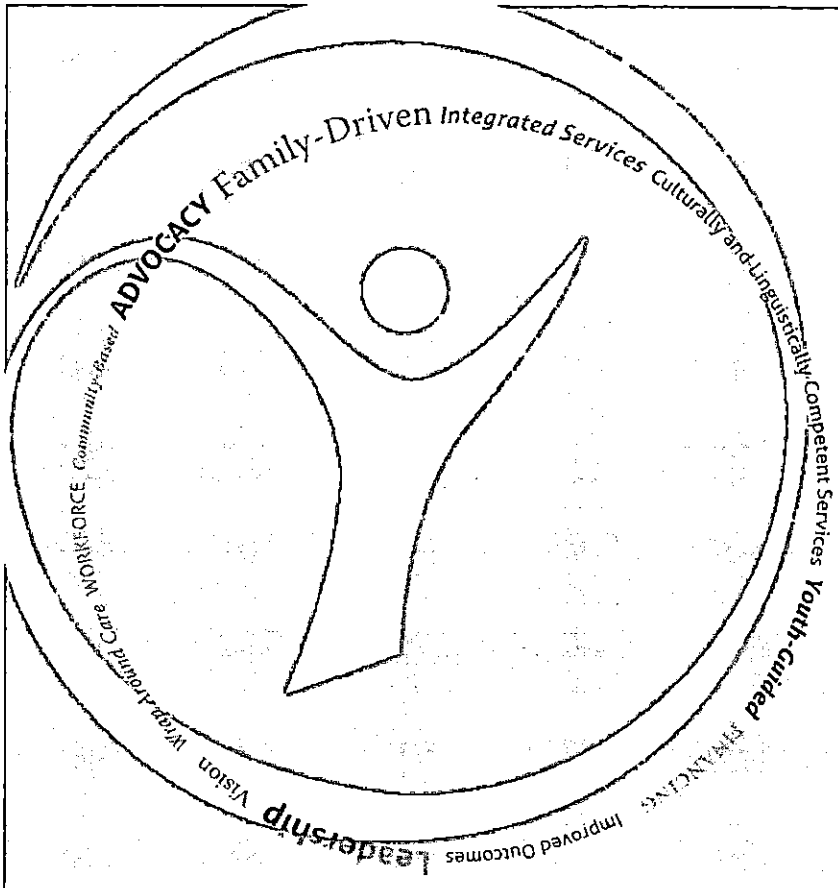
[15] *Bruns, E. J. & Walker, J. S. (2010). The wrap-around process: An overview of implemen-tation essentials. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative.*

[16] *Collecting Family Voices on Children's Mental Health.* NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[17] *Collecting Family Voices on Children's Mental Health.* NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[18] National CLAS Standards available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15




ADVOCACY Family-Driven Integrated Services Culturally and Linguistically Competent Services Youth-Guided
Improved Outcomes
Leadership Vision
Wrap-Around Care WORKFORCE Community-Based

Timeline of DHHS/DOE reporting requirements under Senate Bill 534 (new RSA section 135-F:6)

a. December 2016:
    i. Determine total cost of children's behavioral health services
    ii. Identify to what extent current system conforms with system of care principles
    iii. Describe actual or planned changes in department policy or practice or developments external to the departments that will affect implementation

b. December 2017:
    i. Summary of the interagency agreement between the departments required by the bill
    ii. Identification of actions required to maximize federal and private insurance funding participation
    iii. Identification of changes to statutes, administrative rules, policies, practices, and managed care and provider contracts which will be necessary to fully implement the system of care
    iv. Identification of significant gaps in the array of children's behavioral health services, along with a description of plans to close those gaps

c. December 2018:
    i. Projections of future demand for services
    ii. Identification of shortfalls in workforce and plans for addressing those shortfalls
    iii. Identification of specific plan amendments and other changes to Medicaid required for full implementation and plans for making those changes
    iv. Numbers of children and youth awaiting services in various categories

d. December 2019:
    i. Detailed statistical information regarding children and families serviced, along with demographic characteristics, service need and provision, involvement in service systems, service funding sources, and placement or other site of service
    ii. Outcomes, including but not limited to status upon exit from the system of care, measured treatment results, recidivism, etc.
    iii. Financial information, including cost-effectiveness, comparisons with other states, and cost savings
    iv. Assessment of any influences external to the departments which may be affecting establishment of the system of care.

SB 534-FN Michael Skibbie

SB534

NEW HAMPSHIRE
PUBLIC HEALTH ASSOCIATION
Improving Health, Preventing Disease, Reducing Costs for All

4 Park Street, 4th Floor
Concord, NH 03301
603.228.2983 | info@nhpha.org
www.nhpha.org

TO: Chairman Andy Sanborn and Members of the Health and Human Services Committee

DATE: February 11, 2016

RE: SB534 Testimony

My name is Karen Welford. I am a Teaching Lecturer at Plymouth State University, a former Director of the Family Resource Center in Laconia and a member of the Public Policy Committee of the New Hampshire Public Health Association. The NH Public Health Association is a private statewide membership organization composed of health care and public health professionals. For the last 25 years, the New Hampshire Public Health Association has brought together members who share a common goal of making sure that all of New Hampshire citizens live, learn, work and play in safe and healthy environments. I am here today, on behalf of our individual and organizational members, to state our strong support for SB534, directing the Department of Health and Human Services and the Department of Education to develop a comprehensive system of care for children's behavioral health services.

"Mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being. One way to ensure that our health system meets children's mental health needs is to move toward a community health system that balances health promotion, ... prevention, early detection and universal access to care".[i]

Public health's mission is to create the conditions within which people can be healthy. It is the art and science of preventing disease, prolonging life and promoting physical and mental health and efficiency through organized community efforts. As the approach to children's mental health continues to evolve, the recent public health successes in the area of children's physical/medical health provide compelling evidence that a public health approach is the next logical step for children's mental health.[ii]

The evidence-based framework, called system of care, is designed to pull together disparate service entities into one organized coherent approach. Utilizing the public health approach, the NH Children's Behavioral Collaborative emphasizes the promotion of mental health as well of the prevention of and intervention for mental illness. This framework supports a change of thinking from the traditional individually-focused deficit driven mental health intervention to a whole population, strength-based approach. Extensive research shows that the system of care approach is a smarter investment that brings better outcomes for youth, as well as their families and communities

NHPHA's position on Child Health and Safety "supports...health care and injury prevention efforts for children to enable them to develop to their full potential."[iii] SB534 is a giant step forward in enabling New Hampshire's children to develop to their full potential and is supported by the New Hampshire Public Health Association.

---

[i] US Department of Health and Human Services. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, 2002. Available at: http://www.surgeongeneral.gov/topics/cmh/childreport.html. Accessed on November 14, 2008.

[ii] Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). *A Public Health Approach to Children's Mental Health: A Conceptual Framework: Expanded Executive Summary*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Public Health Approach to Children's Mental Health: A Conceptual Framework

[iii] NHPHA position statement on Child Health and Safety. Available at http://nhpha.org/images/nhpha/Policy_Stuff_2015/REVISED_Policies/Child_Health_and_Safety_2013.pdf

APHA
AMERICAN PUBLIC HEALTH ASSOCIATION
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SB534

NAMI New Hampshire
National Alliance on Mental Illness

Honorable Chairman Andy Sanborn
Senate Health and Human Services Committee
Room 101 Legislative Office Building
North State Street, Concord, NH 03301

February 11, 2016

Honorable Chairman Sanborn, and Committee Members,

My name is Kenneth Norton and I serve as the Executive Director of NAMI NH, the National Alliance on Mental Illness. I am also here today to speak personally as a family member and former foster parent about the challenges my family has faced attempting to access children's behavioral health services. The lack of a coordinated approach between our family member's school, community mental health center, and other service providers negatively impacted our family/family member emotionally, economically and socially, and contributed to what started as a mental health condition becoming a co-occurring substance use disorder. Our families experience was that a system that was clearly fragmented resulted in negative outcomes including out of state residential placement, homelessness and ultimately repeated incarceration. Sadly, my work at NAMI NH with other families of children with serious emotional disorders informs me that my family's experience is not unique. Therefore, personally and on behalf of NAMI NH, I am here today to speak in support of SB 534 to establish a system of care for children's behavioral health. I believe that if such a system had been in place, my family's experience and the outcomes we experienced would likely have been much more positive.

By way of background regarding children's mental health services, it is important to note several key contextual issues which have contributed to the need for this bill. Over the past fifteen years, changes within the Department of Health and Human Services organizational structure such as altering mental health services from a "Division" to a "Bureau" as well as downgrading and leaving vacant key positions, have had an adverse impact on the Department's vision and leadership in the area of mental health in general, and children's services in particular. The Children's Mental Health Director Position has been vacant for at least seven of the past eight years. The road map for rebuilding New Hampshire's mental health system "Addressing the Critical Mental Health Needs of NH's Citizens" issued in 2008, and more commonly referred to as the "ten year plan" is silent about children's mental health. Likewise, the Mental Health Agreement resulting from the Federal Class Action suit, only applies to the adult mental health system. All of these have combined to create a vacuum regarding strategic planning and vision for Children's Behavioral Health Services in NH.

The NH Children's Behavioral Health Collaborative was created out of this vacuum and after studying efforts in other states, identified the success other states were having implementing the System of Care model as the most effective strategy for transforming children's behavioral health services in NH. .

Perhaps the most compelling indicator of the need for this bill is that yesterday thirteen children were being boarded in emergency departments throughout our state waiting for an inpatient psychiatric bed. This practice is wrong medically, legally, ethically, economically and morally and can be frightening, traumatizing and unnecessarily delays needed intervention and treatment for children and their families. However, opening more inpatient beds is not the solution to this problem, the solution will come from what is outlined in this bill: establishing an *integrated community based system of care* through a coordinated approach between the Department of Health and Human Services, the Department of Education and private providers.

I strongly urge you to vote SB 534 as ought to pass

I am happy to answer any questions which you have.

Sincerely,

Kenneth Norton LICSW
Executive Director

SB534

New Hampshire State Behavioral Health Advisory Council

Candace Cole-McCrae, Chair
603-652-7594
snowyowl@metrocast.net

Allen Penrod, Vice Chair
603-345-1559
allen@be-like-water.com

February 4, 2016

Senator Andy Sanborn
Senate Health and Human Services Committee
New Hampshire Senate
33 North State Street
Concord NH 03301

Re: SB 534 – An Act to implement a system of care for children's behavioral health

Dear Mr. Chairman and Members of the Committee,

The NH Behavioral Health Advisory Council (NH-BHAC) advises the State Mental Health Authority (the NH-DHHS Bureau of Behavioral Health) on priorities for the federal Mental Health Block Grant. The Council, whose members includes consumers and family members of people with mental health challenges, has identified the need for a state plan for early identification and services for children's mental health.

This letter expresses the Council's recommendation of SB 534. This proposed legislation is a policy priority of the NH Children's Behavioral Health Collaborative (CBHC). It advances the goals in the CBHC strategic plan, released in 2013, which is supported by the NH-BHAC.

SB 534 seeks to transform NH's system of mental health services providing children and families the ability to easily and efficiently navigate a challenging network of treatment. The legislation's purpose is to take a first step in building a system of care for children and youth with behavioral health challenges. In an effort to remove silos, we ask that the committee integrate the administration for this system across departments.

The System of Care approach is supported by extensive national research that demonstrates an improved return on investment and cost effectiveness for States. More importantly, the approach is effective for children and youth with mental health challenges, decreasing suicidal behavior, substance use, juvenile justice involvement, and improving academics. In other states, the system of care approach has seen a reduction in expenses to the state.

New Hampshire is ready: this bill calls for inter-agency agreements to be formed to ensure that the system develops.

Thank you for the opportunity to voice our support.

Respectfully,

Candace Cole-McCrea, PsyD
Chair

Allen Penrod, M-LADC
Vice-Chair

cc: NH-BHAC
Michele Harlan, Director, NH-DHHS Bureau of Behavioral Health
Beth Anne Nichols, MHBG State Planner, NH-DHHS Bureau of Behavioral Health

SB 534

NASW

National Association of Social Workers - NH Chapter

Senator Andy Sanborn
Senate Health and Human Services Committee
New Hampshire Senate
33 North State Street
Concord NH 03301

February 8, 2016

Re: Senate Bill 534 – An Act to implement a system of care for children's behavioral health

Dear Mr. Chairman and Members of the Committee,

My name is Lynn Stanley and I am the executive director of the NH Chapter of the National Association of Social Workers. I am writing to express the support of NH NASW for Senate Bill 534.

Comprehensively addressing the mental health needs of New Hampshire's children is paramount to the health and well-being of our families and communities. When children do not receive the care and services they need, there is a cumulative social and economic impact. Senate Bill 534 provides a roadmap to significant positive change to NH's system of mental health services.

This legislation is a policy priority of the NH Children's Behavioral Health Collaborative, of which the NH NASW is a member. SB534 advances the goals in the CBHC strategic plan, released in 2013. This legislation starts building a system of care for youth with mental health and substance use challenges.

The system of care approach is supported by extensive national research that demonstrates excellent return on investment and cost effectiveness. More importantly, the approach is effective for children and youth with mental health challenges, decreasing suicidal behavior, substance use, and juvenile justice involvement and improving academics.

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. Our children with mental health issues are one of our most vulnerable populations, which is the primary reason the NH NASW is supporting this legislation.

Thank you for the opportunity to voice our support.

Sincerely,

Lynn Stanley, LICSW
Executive Director, NH NASW

4 Chenell Dr., Ste. 103, Concord, NH 03301 • Tel: (603) 226-7135 • E-mail: naswnh@worldpath.net • Fax: (603) 228-3836

SB534

New Hampshire
Association of Special Education
Administrators INC

RE: SB 534

TO: Senate Health and Human Services Committee

Date: February 11, 2016

Senator Sanborn and Members of the Committee:

My name is P. Alan Pardy, and I am the Executive Director of the NH Association of Special Education Administrators.
We are a professional association of just under 200 members, statewide, all of whom manage special education programs and services in both public and private schools.

I am here in support of SB 534, to establish a coordinated system of care for children's behavioral health.
As a former special education director, I am very familiar with the many issues that arise when children become involved in the courts when they also have special education needs. This combination of being involved in both education and court systems can create stress for families, confusion over responsibilities, and, occasionally, a fragmented delivery of services.
SB 534 offers a well-thought-out plan for coordinating the responsibilities and services of both the Department of Education and the Department of Health and Human Services.
I hope you will give serious consideration to supporting SB 534.

Sincerely,

Dr. P. Alan Pardy
Executive Director
NHASEA

2 Pillsbury Street
Suite 500A
Concord, NH 03301
603-224-7555
info@nhasea.org

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Thursday, February 11, 2016

THE COMMITTEE ON Health and Human Services

to which was referred **SB 534-FN**

AN ACT to implement a system of care for children's behavioral health.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS

BY A VOTE OF: 4-0

Senator Molly Kelly
For the Committee

Kelly Flathers 271-3091

HEALTH AND HUMAN SERVICES

SB 534-FN, to implement a system of care for children's behavioral health.
Ought to Pass, Vote 4-0.
Senator Molly Kelly for the committee.

Docket of SB534

Docket Abbreviations

Bill Title: to implement a system of care for children's behavioral health.

Official Docket of **SB534**:

Date	Body	Description
2/1/2016	S	**Introduced** 01/21/2016 and Referred to Health and Human Services; **SJ 3**
2/10/2016	S	===ROOM CHANGE=== Hearing: 02/11/2016, Room 100, SH, 04:15 pm; **SC5**
2/17/2016	S	Committee Report: Ought to Pass, 03/03/2016; **SC7**
3/3/2016	S	Special Order SB 534 to after the Committee on Education, Without Objection, MA
3/3/2016	S	**Ought to Pass**: MA, VV; OT3rdg; 03/03/2016; **SJ 7**
3/15/2016	H	Introduced 03/10/2016 and referred to Health, Human Services and Elderly Affairs **HJ 25** P. 118
3/22/2016	H	==RECESSED== Public Hearing: 03/29/2016 03:15 PM LOB 205
3/30/2016	H	==CONTINUED== Public Hearing: 04/05/2016 10:00 AM LOB 205
4/19/2016	H	Executive Session: 04/19/2016 10:00 AM LOB 205
4/21/2016	H	Committee Report: Ought to Pass for 05/11/2016 (Vote 18-0; RC) **HC 29** P. 25
5/11/2016	H	**Ought to Pass**: MA **RC** 197-99 05/11/2016 **HJ 38** P. 102
5/23/2016	H	Enrolled 05/19/2016
5/23/2016	S	Enrolled (In recess 05/19/2016); **SJ 19**
6/13/2016	S	Signed by the Governor on 06/06/2016; Chapter 0203; Effective 06/06/2016

NH House	NH Senate

Other Referrals

SB 534

COMMITTEE REPORT FILE INVENTORY

__X__ ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

__X__ **DOCKET (Submit only the latest docket found in Bill Status)**

__X__ **COMMITTEE REPORT**

__X__ **CALENDAR NOTICE**

__X__ **HEARING REPORT**

__X__ **PREPARED TESTIMONY AND OTHER SUBMISSIONS HANDED IN AT THE PUBLIC HEARING**

_____

__X__ **SIGN-UP SHEET(S)**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

____ - AMENDMENT # _____ ____ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

__X__ AS INTRODUCED ____ AS AMENDED BY THE HOUSE

__X__ FINAL VERSION ____ AS AMENDED BY THE SENATE

__X__ **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

amended fiscal note 4/4/16

PLEASE INCLUDE THE COMMITTEE OF CONFERENCE REPORT HERE IF IT IS SIGNED BY ALL.

DATE DELIVERED TO SENATE CLERK

7/27/16

BY:

Kelly Klathens

COMMITTEE AIDE