Stitching it Together: Approaches to Coordinating Behavioral Health and Physical Health Care for Youth

September 29, 2016 | 9:45-10:45 AM

COMMUNITY CARE
Behavioral Health Organization

Learning Objectives

- Identify two approaches to support the integration of physical and behavioral health care

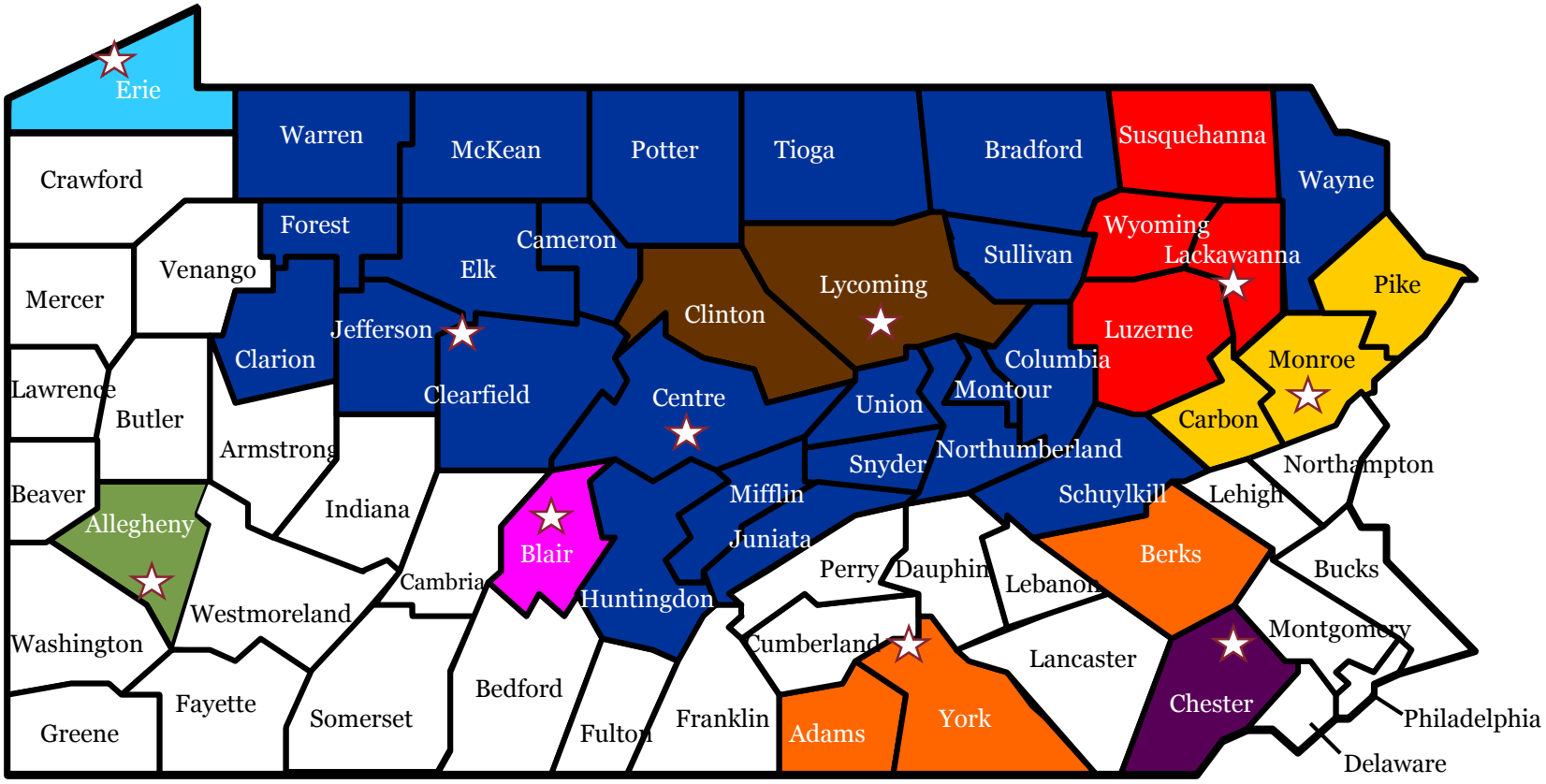
- Describe a Learning Collaborative approach that fosters a collaborative environment to improve and sustain integrated care

- Cite three wellness and health focused strategies associated with a Behavioral Health Home

About Community Care

- Behavioral health managed care company founded in 1996; part of UPMC and headquartered in Pittsburgh
- Federally tax exempt non-profit 501(c)(3)
- Major focus is publicly-funded behavioral health care services; currently doing business in PA and NY
- Licensed as a Risk-Assuming PPO in PA; NCQA-Accredited Quality Program
- Serving approximately 950,000 individuals receiving Medical Assistance in 39 counties through a statewide network of over 1,800 providers

HealthChoices Regions Served



Southwest Region	Southeast Region	North Central Region: County
Lehigh-Capital Region	North Central Region: County	North Central Region: County
Northeast Region	North Central Region: County	North Central Region: State

☆ Community Care Office

CSBBH

- Community & School Based Behavioral Health (CSBBH) is:
  - An innovative service
  - Created by Community Care
  - A single team behavioral health home/service
  - For children, youth & their families
  - Accessible, comprehensive & coordinated
  - Clinical intervention without fragmentation

CSBBH Team Commitments

- Support wellness of entire family
- Include parents/caregivers in all decision making about treatment planning & service delivery
- Appreciate family's reality & experience, & any reservations about making change
- Respect family's culture & traditions & how that influences life priorities & choices
- Engage families across all generations
- Respect family, youth & child's choice
- Support collaborative learning process between family & CSBBH team
- Help families develop resilience & mastery over trauma for future challenges
- Build bridge between family & school, other child-serving entities, community & natural supports
- Believe in family's hope, independence, self-sufficiency & ability to help themselves

CSBBH – Origins

- Started in NE PA in 2009

- Developed from the recommendations of county mental health officials, family members, providers, educators, advocates, & Community Care leadership

CSBBH – Design

- Stakeholder concerns:
  - Increasing student behavioral health needs
  - Existing behavioral health services ineffective
  - Classrooms with multiple mental health personnel (TSS)
  - Poor communication among partners/caregivers
  - Inadequate supports for placement changes

CSBBH Teams

- Located within schools, home & community
- Staffed by Behavioral Health Workers (BHW) – bachelor's – & Mental Health Professional (MHP) – master's
- Are a single point of accountability (behavioral health home)
- Serve children ages 5 to 20 years who:
  - Demonstrate a serious emotional or behavioral disturbance
  - Have problems with school, home & community settings
  - Meet criteria for medical necessity as defined by the state Medicaid program
- Work with multiple partners for referral & treatment

CSBBH 2016

46 Teams

Serving over 1,500 Youth &Families

30 School Districts/ 81 buildings

16 Counties in 5 Contracts

14 Provider Organizations

The CSBBH Model – Distinctions

- A Children's Health Rehabilitation Service Exception Program (BSC/MT/TSS & RTF)
- Collaborative origins – Community Care, providers, educational system, families, county & state partners, advocates
- Developed to address problems with other services
- A team-based, 24/7 *comprehensive* service delivered by MHPs & BHWs with clinical supervision & ongoing evaluation
- Delivered in partnership with families, youth, and schools

The CSBBH Model – Distinctions

- CSBBH is a therapeutic model:
  - Based where the child or youth is – at school, home & community
  - Allied with the family & school in the design & delivery of therapy
  - Delivered *flexibly* in all settings
  - Focused on *whole child* & entire *family wellness*
  - Provides *individualized services, responsive to the intensity & varying needs* of child/youth & families

CSBBH Model Foundations

- CASSP & System of Care principles
- Family systems theory & interventions
- Resiliency/recovery principles & supports
- Evidence-based practices
  - Trauma-informed care
  - SWPBIS – School Wide Positive Behavioral Interventions & Supports/school climate
  - Clinical models including CBT & DBT
- Identification of co-occurring mental health & substance use disorders & needed interventions for entire family
- Coordination with physical health providers

Service Components – the 4 Cs

Youth Eligible for CSBBH Team

- Child/youth ages 5-20 & their families
- Community Care member or MA FFS child/youth
- Diagnosis of serious emotional and/or behavioral disturbance that is impacting functioning at school, home, and/or community
- Internalizing or externalizing behaviors
- Problem school behaviors not required

Youth Eligible for CSBBH Team

- Evaluation & ISPT agreement for this level of care
- Attends a school with a CSBBH Team, in regular education or special education, or in a home or alternative placement coordinated by this school
- Previous MH services or new MH referral
- Step down, or diversion from, more restrictive MH LOC or educational placement
- ASD diagnosis – case-by-case decision

CSBBH

- Flexibly delivered support as needed
- Any team member works with the child & family
- Focus on skill acquisition/generalization
- Assessment within 48 hours of referral
- Services start within 21 days
- Risk of out-of-home placement not required
- Previous failed services not required
- Not time-limited
- 60/40 team/not required
- Contract with school for mutual commitments including co-location in the school & collaboration expectations for all students
- Flexible therapeutic interventions can occur in the school setting including 1 to 1 and group

Staffing & Delivery

- BHW – bachelor's + 2 years experience
- MHP – master's degree + licensed
- Foundational model principles & framework
- Family-focused
- Services are comprehensive & coordinated
- Crisis mandated 24/7
- Community Care orientation/training for teams
- Outcomes study integral
- Child Outcomes Survey (COS) (Family)
- Strengths & Difficulties Questionnaire (SDQ-P), (Family & School)
- School Satisfaction Survey
- NEW – Fidelity Family Survey

CSBBH Team Service Goals

- Helps the child build skills to cope & function in the school
- Provides support to the child to avoid any restrictive interventions & placements (e.g., detentions, suspensions, alternative schools, out-of-home placements)
- Meets the child's & family's needs to do well at home & in the school & community
- Leads to improved outcomes that are meaningful for the child (e.g., has friends, hobbies, successes in school)
- Results in better partnership for the child's benefit by supporting communication between the school & the family
- Has positively influenced the school's culture (school feels safe & welcoming to students, staff & families)

Behavioral Health Home

- Comprehensive model responsive to calls for coordinated care (Affordable Care Act)
- Enhance capacity of behavioral health providers to empower individuals to manage physical wellness
- Community and behavioral health centers serve as a “health home”
  - Primary care, prevention, wellness activities
- Can CSBBH Teams serve as a health home?

Behavioral Health Home Components

- Coordination with primary care and other specialists
- Coordination with community resources
- Staff trained as wellness coaches
  - Peggy Swarbrick's eight domains of wellness
  - Adopted by SAMHSA
  - http://www.samhsa.gov/wellness-initiative
  - Establish wellness goals
- Family participation encouraged

CSBBH

- Support of CSBBH service and implementation of Behavioral Health Home concepts through a learning collaborative (LC)
- Focus on physical and behavioral health coordination and improving overall wellness
- Shift in team roles

CSBBH Learning Collaborative

- 10 provider organizations; 19 school districts; 27 teams
- 12-month participation and commitment
- Oversight and support from Community Care

Hint: Set a firm time frame to start and end the measurement period of the learning collaborative

What is a learning collaborative?

Structured approach for change

Adopt best practices in multiple settings

Uses adult learning principles & techniques

Time-limited learning process

Shared learning & collaboration

The Breakthrough Series

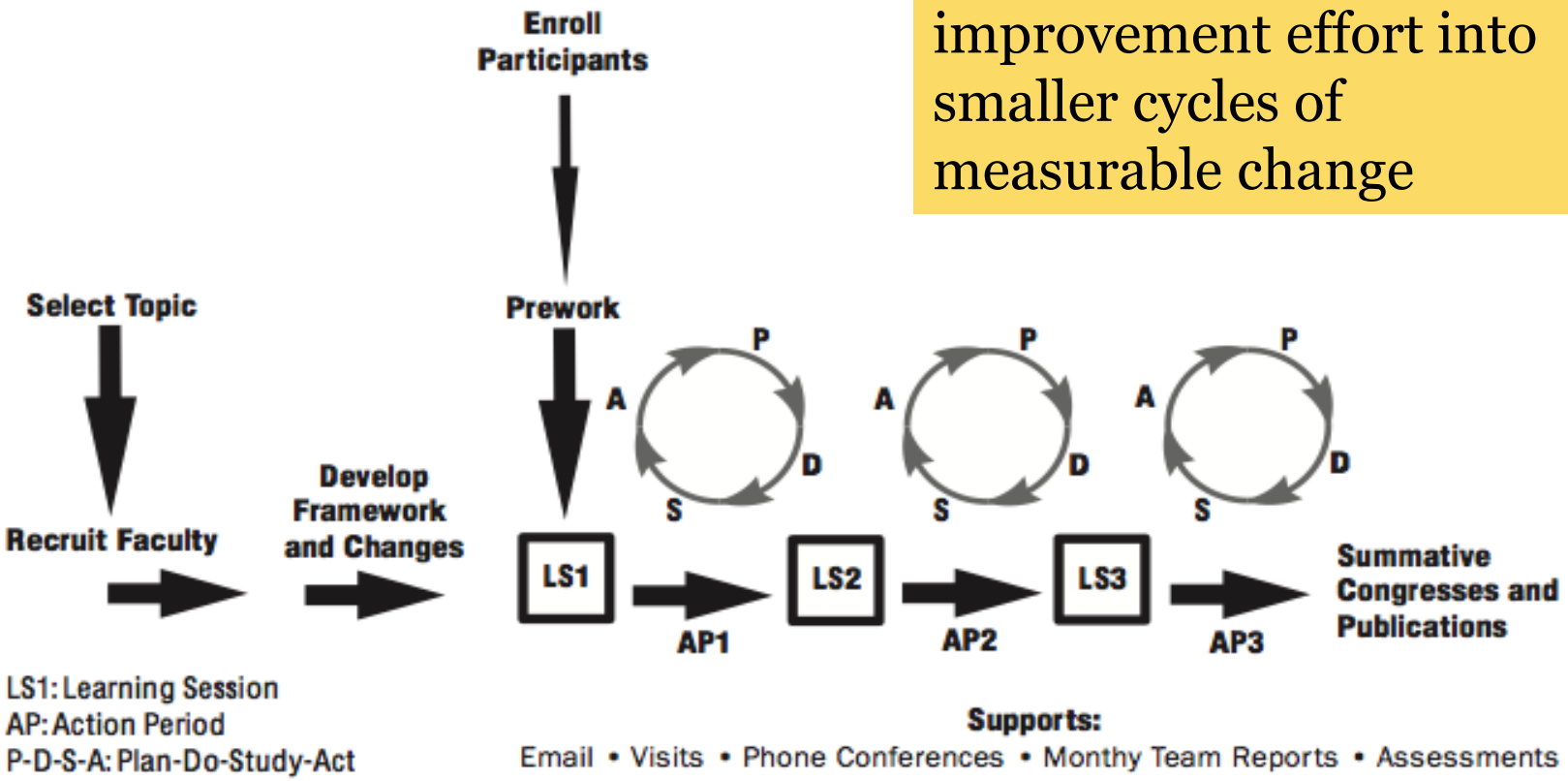
- For articles and information about the learning collaborative model and quality improvement efforts, visit:
  - http://www.ihi.org

Why use the IHI model?

- Proven quality improvement record
- Supports skill development of clinical home staff
- Promotes mutual learning among participants
- Increases use of data to inform decisions and practice
- Develops infrastructure to sustain improvement
- Spreads new knowledge and improvement to other parts of organization

IHI Model and Structure

Hint: Break the quality improvement effort into smaller cycles of measurable change



Learning Collaborative Personnel

- Quality Improvement Team (QIT)
  - Upper Level Administrator
  - Clinical Supervisor
  - Quality Assurance
  - Individuals in Recovery and Families

Learning Collaborative Milestones

Stage	Person Responsible	Child Clinical Home Milestones	Date Completed
START		**Milestone 1: Coaching Structure**	
	Mary	**Identify coach** Who will serve as coach for your CCH team(s)?	11/01/2013
	Mary	**Processes in place for coach to serve and be informed of activities in the LC** How will your identified coach interact with the LC?	11/05/2013
	John	**Coach support of LC** How will your identified coach support and reinforce activities of the LC?	11/10/2013
		Milestone 2: Organizational Commitment	
	Susan	**Identify members of the Quality Improvement Team** Who will comprise the Quality Improvement team (QIT) to carry out the Learning Collaborative?	11/01/2013
	Jane	Program Director	11/01/2013
	Peter	Upper level management with access to executive leadership to support the Learning Collaborative effort	11/01/2013
	Mary	A quality assurance or improvement staff who can support data collection and analysis	11/01/2013
	Mrs. Jones	A family representative, preferably a family whose child received CCH Team Services, or if not available, a family whose child has received behavioral health services currently or in the past	11/20/2013
	Susan	**QIT Operations** When will the QIT meet? Has a regular schedule of meetings been established?	11/10/2013
	Susan	Which members of the QIT will participate on the monthly calls?	11/10/2013
	Jane	**Executive Commitment** Have you reviewed the Executive Leadership Pledge with your CEO and submitted a signed version by November 15th to Kate Nicholson?	11/02/2013
	Jane	Have your clinical and quality improvement leadership reviewed, signed and submitted the Leadership Team Pledge to Kate Nicholson by November 15th?	11/02/2013
		Milestone 3: Staff are fully aware of the LC implementation	
		Educate staff about the Clinical Home Principles	

Learning Collaborative Process Aim

- Process Aim: health care coordination
  - By December 1, 2014, 100% of youth have documented physical and behavioral health coordination twice a year for medically-complex youth and once a year for all other youth

Hint: The Process Aim helps you monitor an *activity* important in the delivery of the new or improved practice

Process Aim Defined

- **Health coordination:** reciprocal communication between the CSBBH Team and medical providers via letter, telephone contact, or personal visit

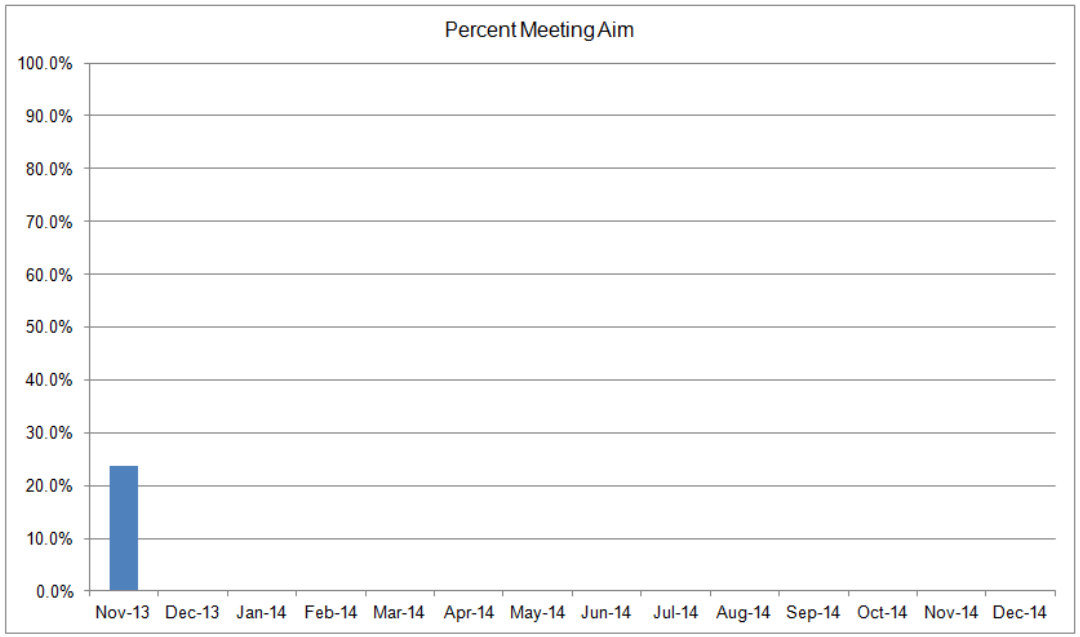
- **Timeliness:** two documented coordination efforts for medically-complex youth should not be within 90 days

- **Medically-complex youth:** a youth with a mental or physical health condition that requires either ongoing medical monitoring (2 or more visits to a physical health practitioner in past 6 months) or medication (antibiotics and medications for acute infections excluded)

Process Aim

Process Aim:	Health Care Coordination											
	Nov-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
1. Number of medically complex youth:	25											
2. Number of medically complex youth w/ timely coordination:	6											
3. Number of non-medically complex youth:	38											
. Number of non-medically complex youth w/ timely coordination:	9											
5. Percent meeting Process Aim (Goal)	23.8%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Hint: Display data in tables and graphs to make change over time easier to observe



Process Aim Optional Worksheet

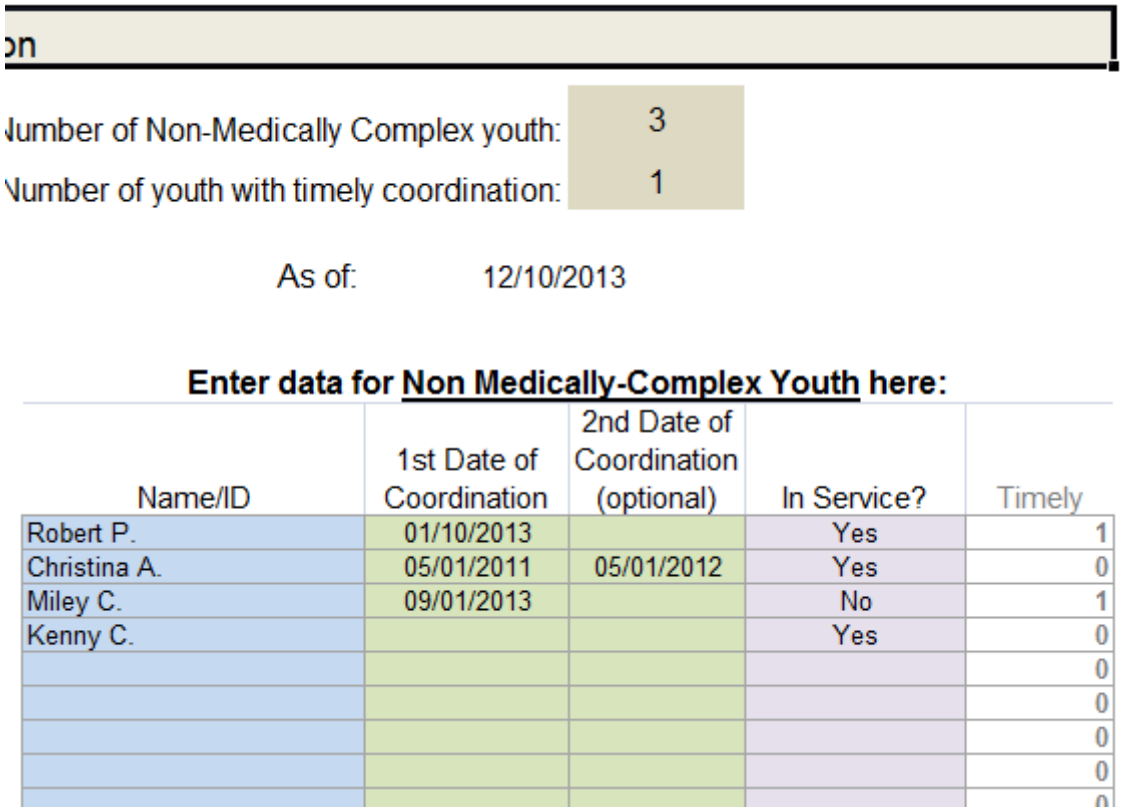
Health Care Coordinati

Number of Medically Complex youth:	6
Number of youth with timely coordination :	2
As of:	12/10/2013

Enter data for Medically-Complex Youth here:

Name/ID	1st Date of Coordination	2nd Date of Coordination	3rd Date of Coordination (optional)	In Service?	Timely	Timely	Timely
Katy P.				Yes	0	0	0
Mariah C.	06/01/2012			Yes	0	0	0
Jay Z.	02/01/2013	03/01/2013		Yes	1	0	0
Mick J.	02/01/2013	06/01/2013		Yes	1	1	0
James T.	12/10/2012	06/01/2013		Yes	1	1	0
Taylor S.	12/01/2012	12/01/2013		Yes	0	1	0
					0	0	0
					0	0	0
					0	0	0

Process Aim Optional Worksheet



on

Number of Non-Medically Complex youth:	3
Number of youth with timely coordination:	1

As of: 12/10/2013

Enter data for Non Medically-Complex Youth here:

Name/ID	1st Date of Coordination	2nd Date of Coordination (optional)	In Service?	Timely
Robert P.	01/10/2013		Yes	1
Christina A.	05/01/2011	05/01/2012	Yes	0
Miley C.	09/01/2013		No	1
Kenny C.			Yes	0
				0
				0
				0
				0
				0

Learning Collaborative Outcome Aim

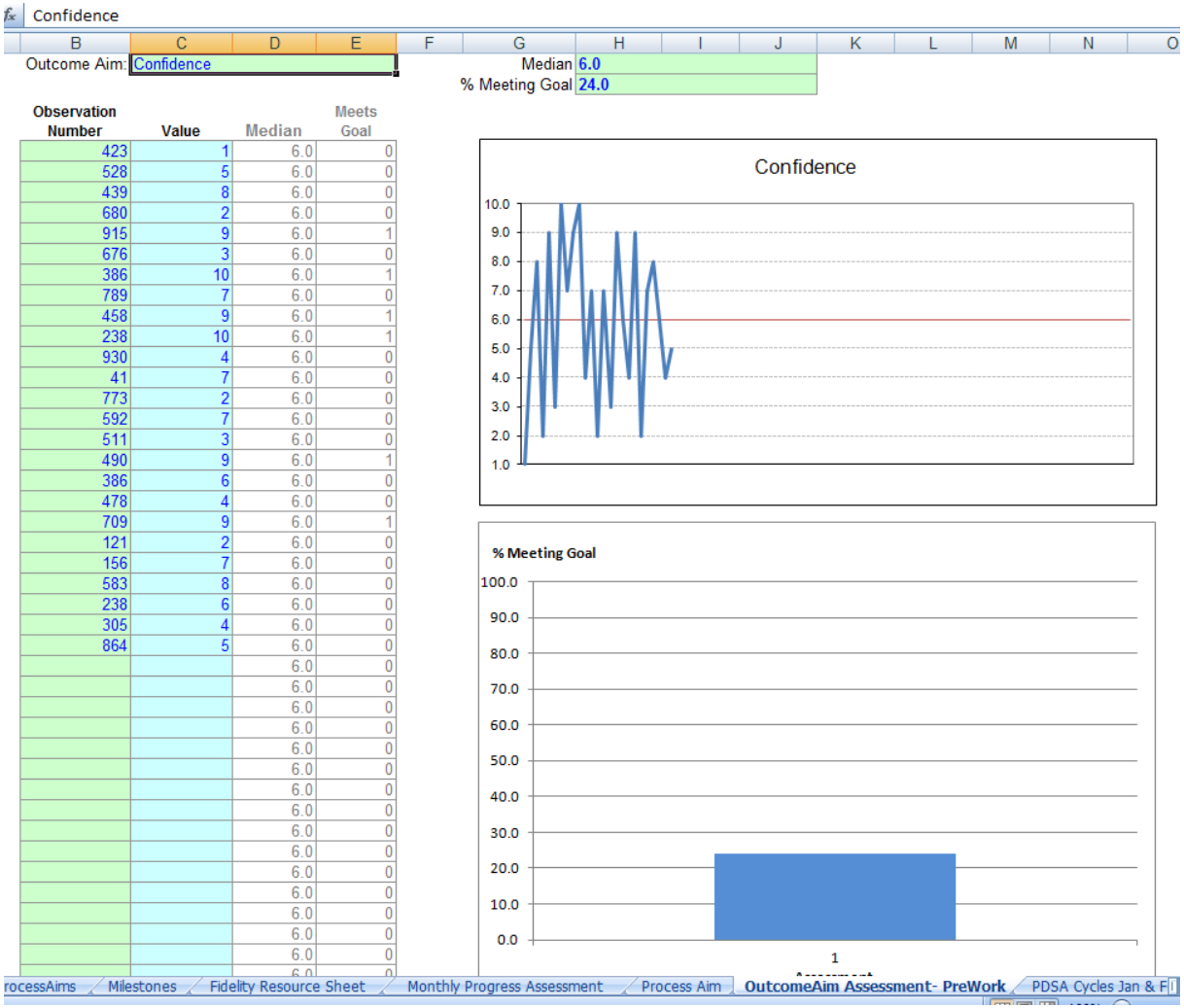
- Outcome Aim: managing family well-being in the home
  - By December 1, 2014, 80% of families report a high level of confidence in their ability to manage their family's well-being in the home

Hint: The Outcome Aim helps you monitor the *impact* of the new or improved practice on individuals

Outcome Aim Defined

- Confidence question: How confident are you in your ability to manage your family's well-being in the home? (1=very low confidence to 10=very high confidence)

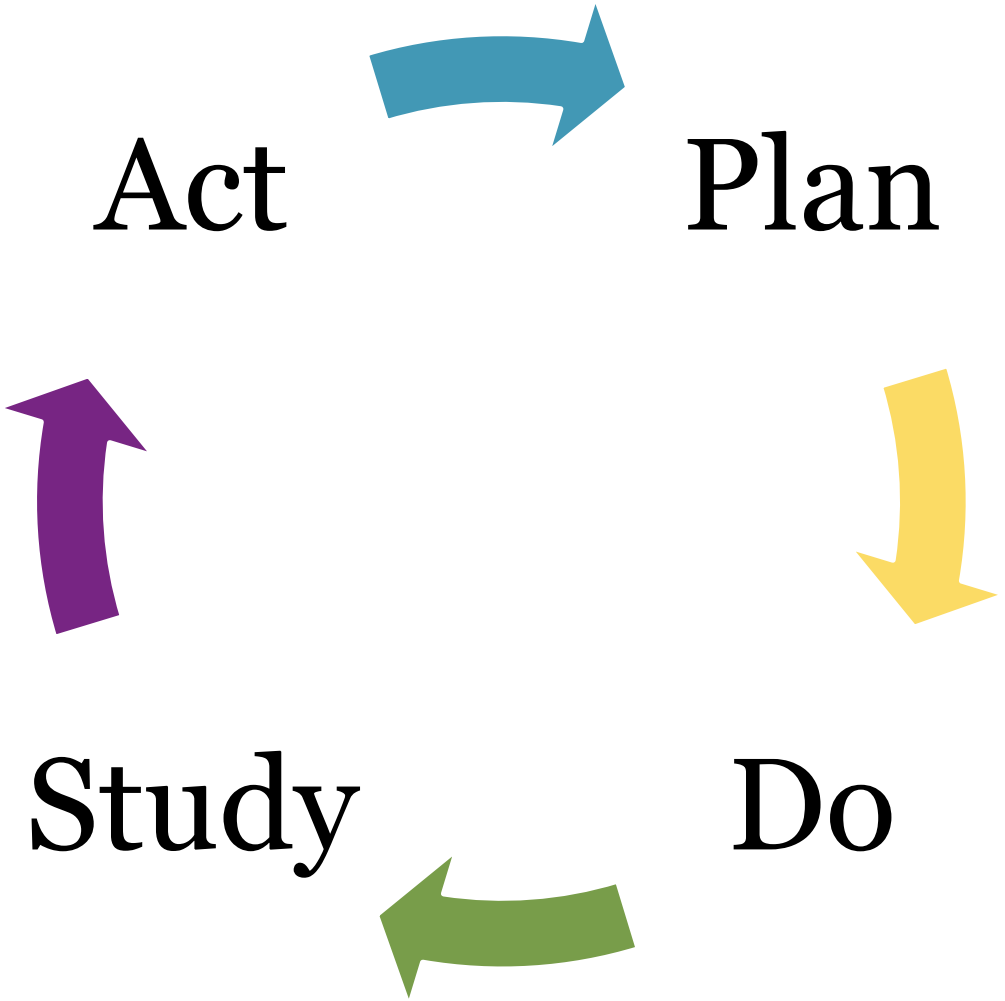
Outcome Aim



What next?

- Establish a process for continuous quality improvement
  - Use information
    - Milestone completion, process and outcome aims
  - Implement a quality improvement activity
  - Seek out feedback and support
    - QIT
    - Monthly regional support calls
    - Learning sessions

Quality Improvement Cycle: PDSA



PDSA Cycle

- Small tests of change
- Conduct one or more each month
- Measure impact of small test of change
- Review data
- Share progress with the collaborative
- Act on results

Hint: Make your PDSA small and focused; have a measurable objective

PDSA Worksheet

BEGIN DATE: **DATE COMPLETED:**

MILESTONE:

PLAN
What is your objective?

What question(s) do you want to answer on this PDSA cycle?

What do you predict will happen?

What is your specific plan?

DO
Did you carry out your plan? □ Yes □ No

Summarize what happened.

STUDY
What did you find out? Compare your observation/data to your predictions and summarize what you learned.

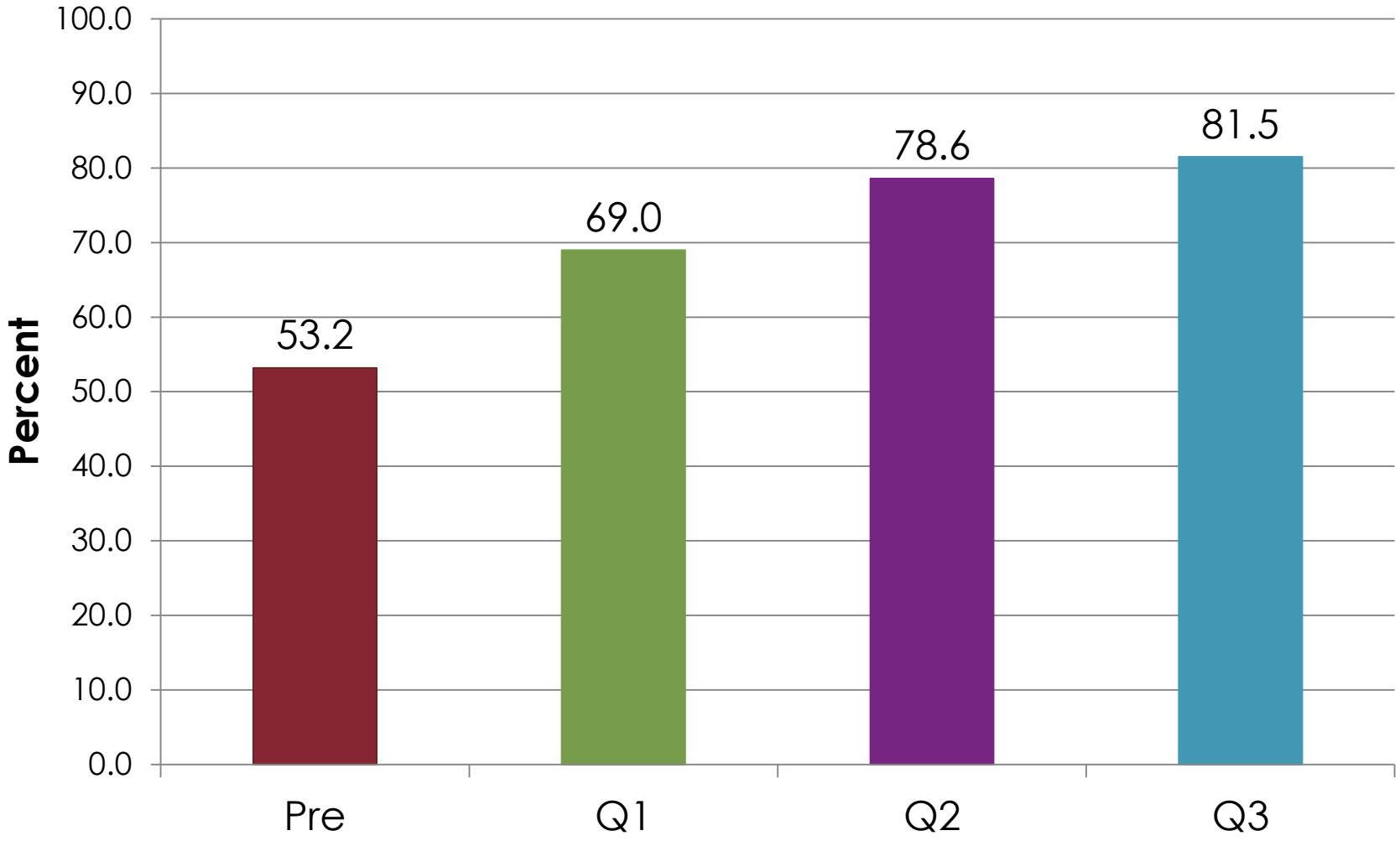
ACT
What is your next logical step?

Learning From Others

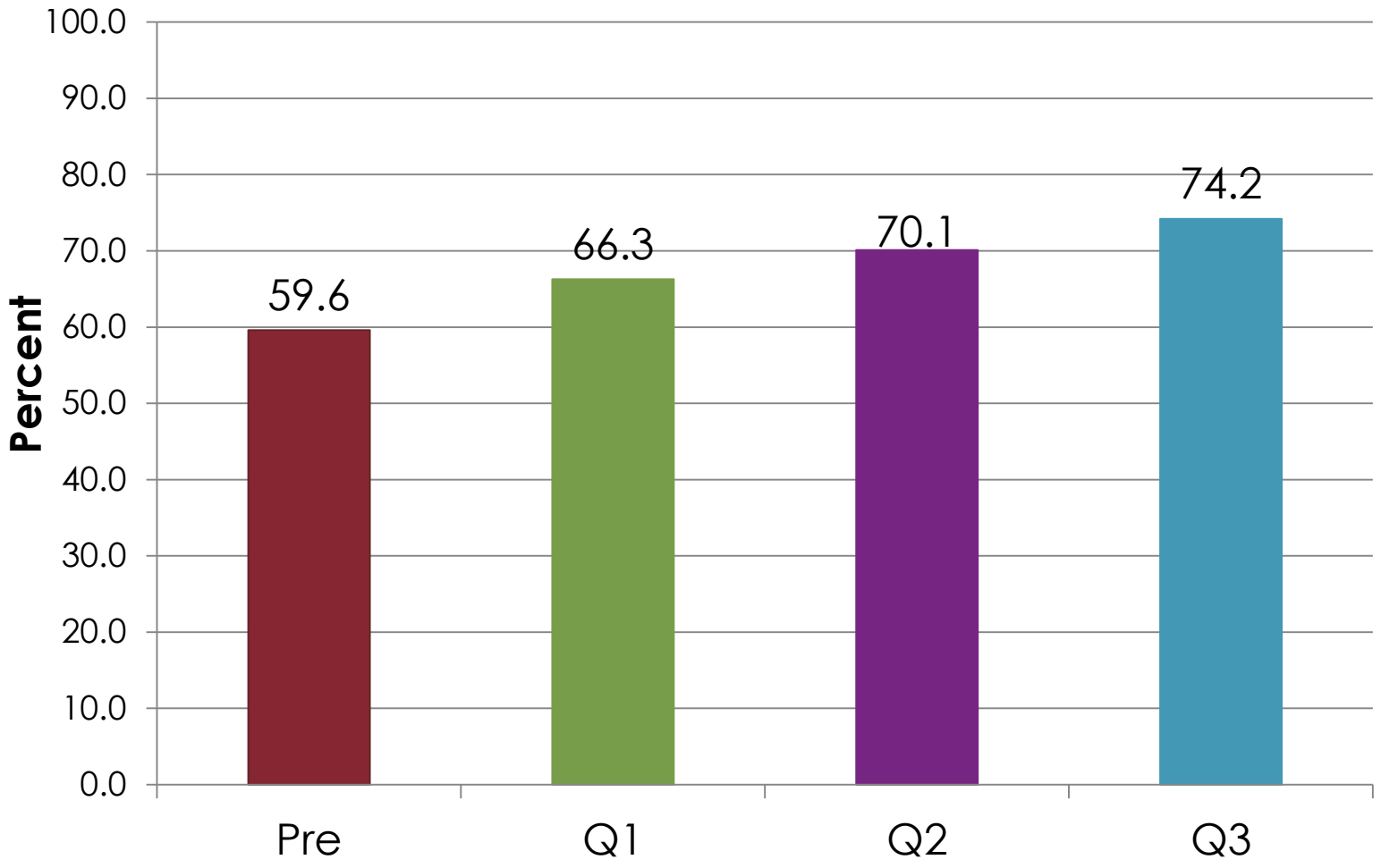
- Monthly webinar support sessions
  - Discussion of aims, milestones, progress, challenges, successes

- Quarterly in person meetings and assistance
  - Storyboard presentations

Process Aim Progress



Outcome Aim Progress



Expansion to Adolescents

- New LC targeted to Adolescents receiving CSBBH and Case Management service
- Empower adolescents to manage their physical wellness (insulin, asthma, diet, activity)
- Focus on provider capacity to facilitate physical assessments
- Rating by youth of confidence in managing wellbeing and feeling involved in wellness planning
- Case consultations

A Provider's Perspective

- Families are receptive to wellness
- PH providers appreciated being contacted
- Necessary elements for success
  - Educating management and Board of Directors
  - Team membership: importance of getting the right people; *family member critical*
  - Regular/consistent meeting times
  - Staff buy in and training; ongoing communication

A Provider's Perspective

- LC resulted in a better understanding of the relationship between physical and behavioral health
- The project provided an opportunity to exchange information so that things were taken more seriously
- We learned better ways to communicate with physical health providers
- The project provided an educational opportunity for family and staff of the benefits of routine health care

Provider Strategies

- Learn the resources in your community, dentists, food banks use the web to find resources, My Plate, etc
- You need to have fun—build activities such as fun walks, cherry picking, fun healthy eating ideas
- Use of agency vans to help youth and families make appointments
- Informational brochures, flu vaccine education, pedometers, better PCP letter, and wellness assessment
- Staff education around language that you use with families
- Hot button issues can be tied back to psychotropic medications and risk which link back to the PCP and why monitoring is important

Provider Strategies

- Bring families together through events, newsletter
- Use a wellness coach
- Get buy-in from staff by talking about the goals of the effort; share data and progress with staff
- Get training in fetal alcohol syndrome, learn about inhalers, insulin injections, etc
- Use the school nurse as a resource
- Remember that progress is being made even if the goal hasn't be fully met
- Drill large tasks down into small, actionable steps
- Maintain the strategies that are working
- Ask the physical health provider for a little bit of information just to open the lines of communication, ex, date of last physical
- Help families problem solve

Provider Challenges

- Hard to collect and organize data over multiple sites
- Wellness is difficult to promote in a crisis driven community
- Parent's main concern is homework, then day-to-day functioning—you need to make wellbeing a priority with families and staff; it's hard to get and keep a parent representative on the QIT
- Understand the mission of the collaboration
- Define roles for members on the QIT
- It's difficult to know how to get started
- Collaboration with physical health providers takes work
- It is difficult to find resources in Spanish

Thank you!

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