Alternative payment model to meet the needs of stakeholders in a community & school-based behavioral health service

September 30, 2016 | 1:55-2:55 PM

COMMUNITY CARE
Behavioral Health Organization

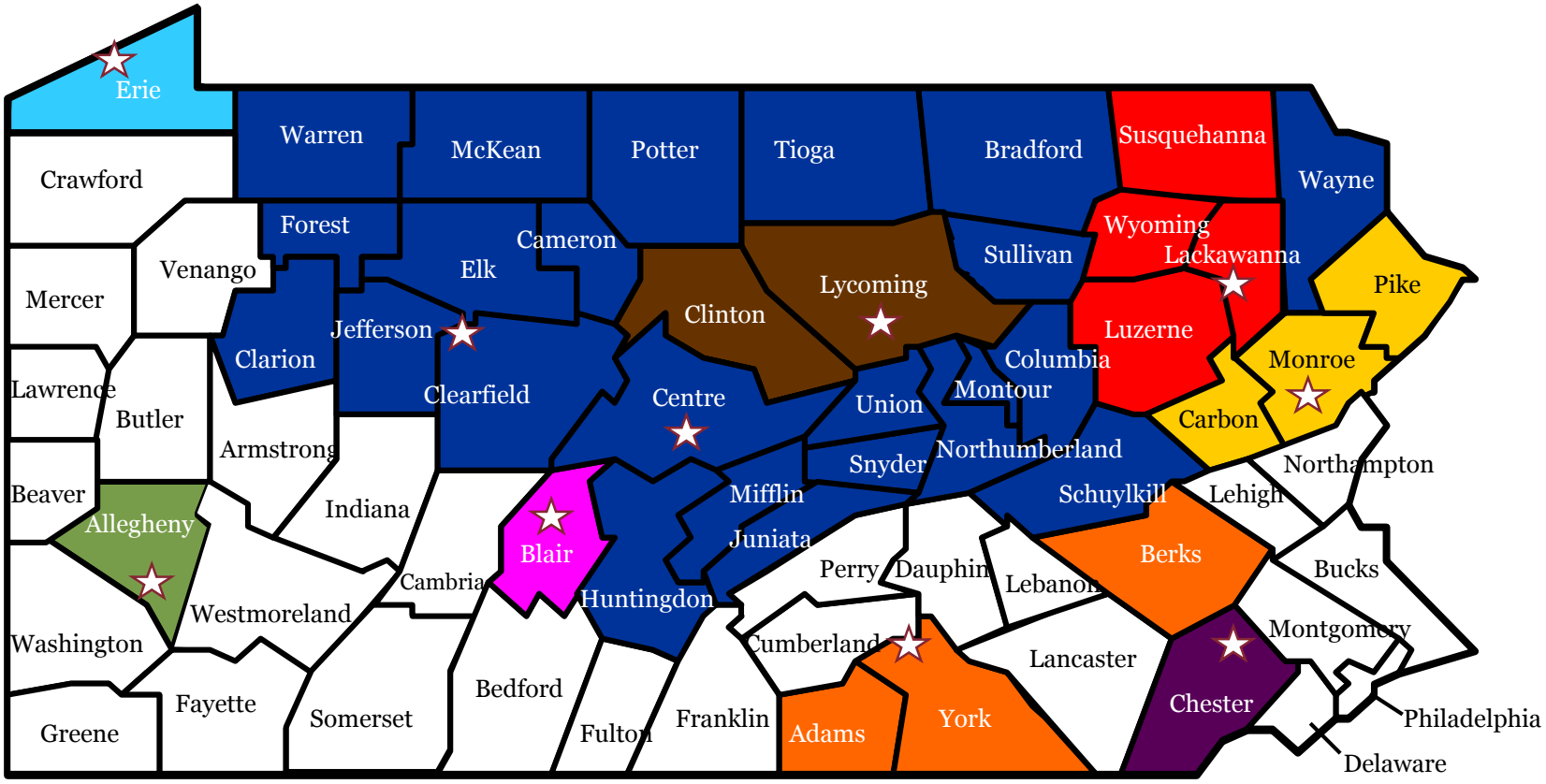
Learning Objectives

- Differentiate among payment models used to support publically-funded services
- Describe process and outcome measures that can be used to motivate value—high quality care for lower cost
- Compare school-based program outcomes before and after implementation of an alternative payment structure

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

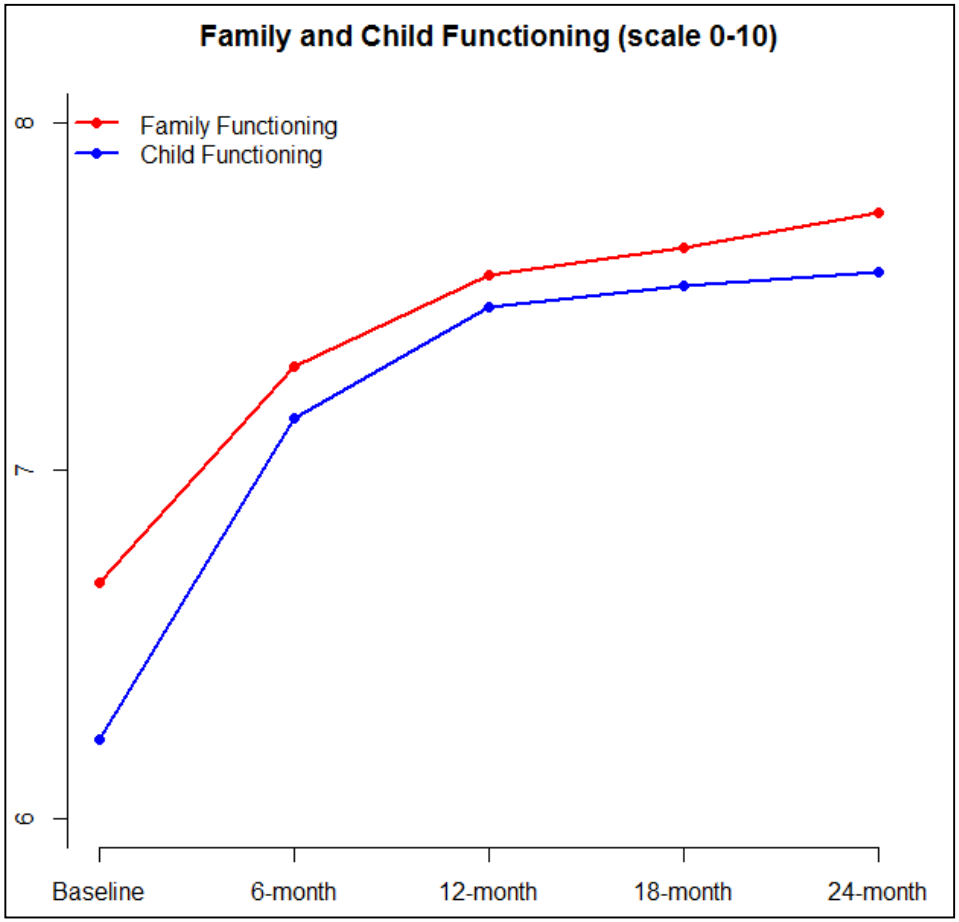
- Flexibly delivered support as needed
- Any team member works with the child & family
- Focus on skill acquisition/generalization
- Assessment within 48 hours of referral
- Services start within 21 days
- Risk of out-of-home placement not required
- Previous failed services not required
- Not time-limited
- 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

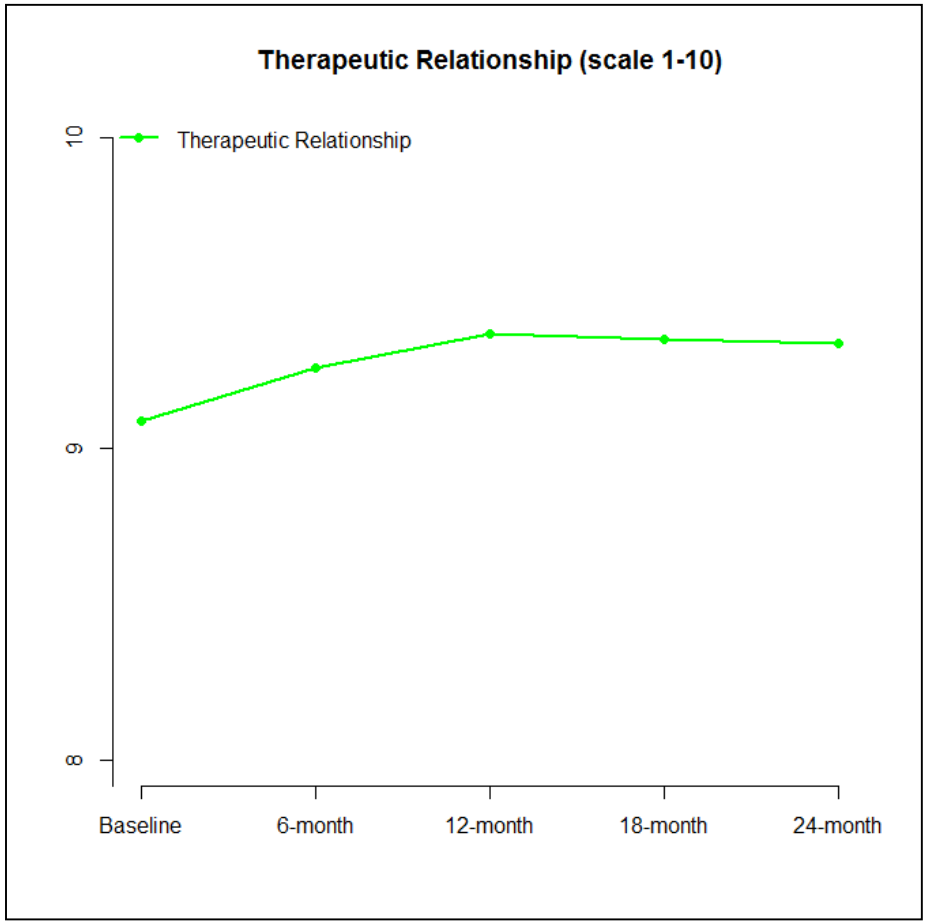
- BHW – bachelor's + 2 years experience
- MHP – master's degree + licensed
- Foundational model principles & framework
- Family-focused
- Services are comprehensive & coordinated
- Crisis mandated 24/7
- Community Care orientation/training for teams
- Outcomes study integral
- Child Outcomes Survey (COS)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

The Child Outcomes Survey (COS)

- The COS measures caregiver report of child and family functioning and therapeutic relationship
- The COS is completed by the caregiver monthly
- Results from the COS are available immediately upon completion and are shared with families to promote discussion and aid in treatment planning
- The COS was developed by providers, families, and staff at Community Care



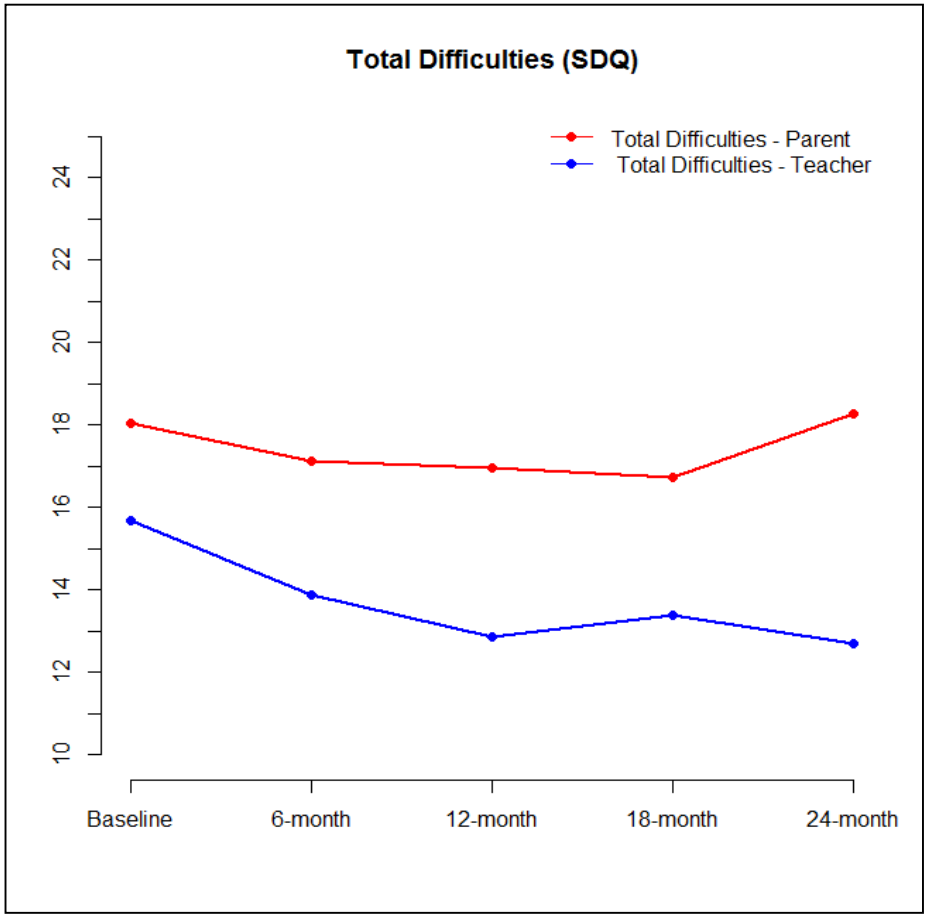
- There was a significant increase in family functioning over time (p<.0001)
- There was a significant increase in child functioning over time (p<.0001)



- There was a significant improvement in therapeutic relationship over time (p<.0001)

Strengths & Difficulties Questionnaire

- The SDQ measures caregiver and teacher report of child behavior
- The SDQ contains 4 sub-scales for difficulties: emotional symptoms, hyperactivity, peer problems, and conduct problems, which are then summed up for a total difficulties scale; the SDQ also contains one strength-based sub-scale, pro-social behaviors
- The SDQ is completed by the caregiver and teacher quarterly
- Parents have significantly higher ($p<.0001$) average ratings of difficulties compared to teachers' ratings
- Overall, there was a significant improvement in parent ($p=.006$) and teacher ($p<.0001$) reported total difficulties scores over time; however, parents' report of total difficulties showed an increase from 18 to 24 months



- Generally, total difficulties decline over 18-24 months; parent reported difficulties remain stable at 24 months

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)

Alternative Payment Models

- Fee for service (FFS)
  - Negotiated rate paid per unit of care
  - Billed units result in revenue
  - Encourages high volume
- Value based payment (VBP)
  - Negotiated rate paid per individual or program
  - Caseload or other criteria established
  - Incentive or additional payment made based on meeting quality standards

CSBBH Value Based Payment

- Agreed upon program budget
- 90% paid monthly as a retainer (10% withhold)
- 10% earned for meeting minimum average caseloads
- 5% earned for meeting quality standards

Quality Indicators of the VBP

- Initiation within 24 hours of referral
- Comprehensive assessment within 48 hours
- 30% of Master's level health professional's time tied to direct service to the family
- Completion of outcome assessments
- Maintenance of staff

Evaluation of the VBP

- Seven CSBBH providers
- Impact on service delivery
  - All paid monthly retainer
  - 5 of 7 met minimum average caseloads
  - All paid 5% “bonus” for quality standards
  - Result payment of 95-105% of budget

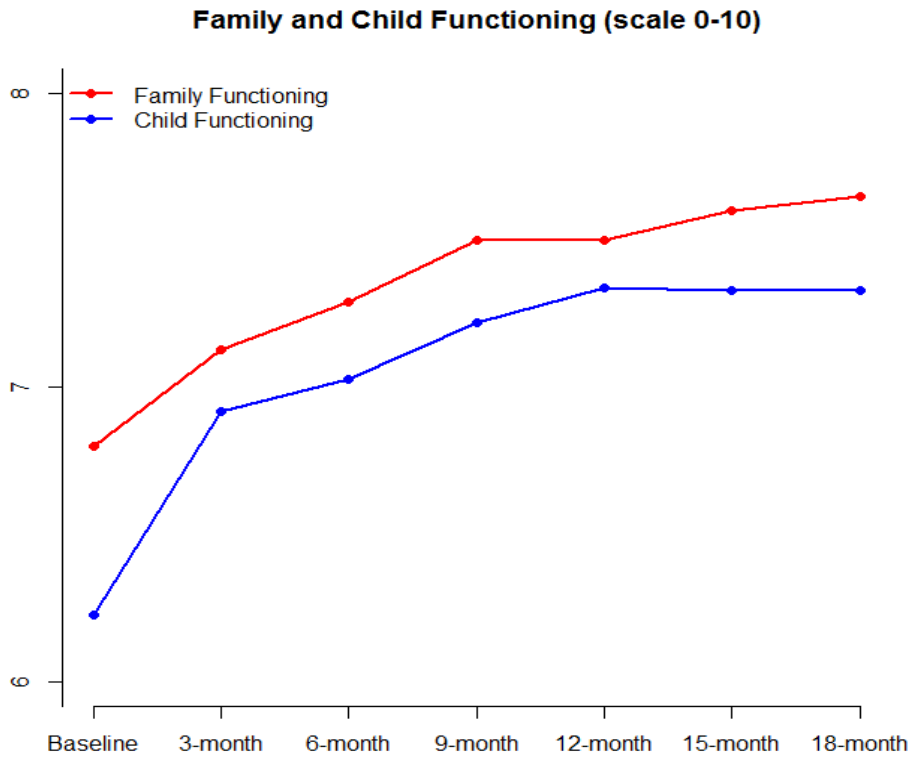
Evaluation of the VBP

- For 7 providers, youth monitored over 18 months pre and post initiation of the VBP
  - Enrollment increased
  - Substantial drop in units of service received per child (23% decrease)

	Pre	Post
Average Units	1304	1003
Average Children	291	521

Evaluation of the VBP

Family and child functioning improved significantly over time for both groups (aggregate shown)



Evaluation of the VBP

Average ratings of caregiver report of therapeutic alliance was significantly higher during the VBP ($p<.001$)

	Pre	Post
Average Rating	8.92 ± 1.43	9.25 ± 1.20

Factors to consider in a VBP

- Routine reporting of metrics included in the VBP is important and uses resources
- Baseline methodology is important (1 yr v. 3 yr look-back); inclusion of stakeholders
- Metrics should have a positive impact on the youth and service
  - Process measures may not be enough
- Withholds put providers at risk
- All or none v. “gate and ladder” approaches
- Cost savings may not be achieved, nor may they be the goal

Thank you!

Shari Hutchison | *hutchisons@ccbh.com*

Diane Lyle | *lyledl@ccbh.com*