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
Lehigh-Capital Region
Northeast Region

North Central Region: County

Community Care Office

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• 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, youth & child’s choice

• Respect family’s culture & traditions & how that influences life priorities & choices

• Support collaborative learning process between family & CSBBH team

• Engage families across all generations

• 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

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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

- Clinical Interventions
- Case Management
- Crisis Intervention
- Case Consultation & Training for educational staff

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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
  – 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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Person Responsible</th>
<th>Child Clinical Home Milestones</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mary</td>
<td>Identify coach Who will serve as coach for your CCH team(s)?</td>
<td>11/01/2013</td>
</tr>
<tr>
<td></td>
<td>Mary</td>
<td>Processes in place for coach to serve and be informed of activities in the LC How will your identified coach interact with the LC?</td>
<td>11/05/2013</td>
</tr>
<tr>
<td></td>
<td>John</td>
<td>Coach support of LC How will your identified coach support and reinforce activities of the LC?</td>
<td>11/10/2013</td>
</tr>
<tr>
<td></td>
<td>Susan</td>
<td>Identify members of the Quality Improvement Team Who will comprise the Quality Improvement team (QIT) to carry out the Learning Collaborative?</td>
<td>11/01/2013</td>
</tr>
<tr>
<td></td>
<td>Jane</td>
<td>Program Director</td>
<td>11/01/2013</td>
</tr>
<tr>
<td></td>
<td>Peter</td>
<td>Upper level management with access to executive leadership to support the Learning Collaborative effort</td>
<td>11/01/2013</td>
</tr>
<tr>
<td></td>
<td>Mary</td>
<td>A quality assurance or improvement staff who can support data collection and analysis</td>
<td>11/01/2013</td>
</tr>
<tr>
<td></td>
<td>Mrs. Jones</td>
<td>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</td>
<td>11/20/2013</td>
</tr>
<tr>
<td></td>
<td>Susan</td>
<td>QIT Operations When will the QIT meet? Has a regular schedule of meetings been established?</td>
<td>11/10/2013</td>
</tr>
<tr>
<td></td>
<td>Susan</td>
<td>Which members of the QIT will participate on the monthly calls?</td>
<td>11/10/2013</td>
</tr>
<tr>
<td></td>
<td>Jane</td>
<td>Executive Commitment Have you reviewed the Executive Leadership Pledge with your CEO and submitted a signed version by November 15th to Kate Nicholson?</td>
<td>11/02/2013</td>
</tr>
<tr>
<td></td>
<td>Jane</td>
<td>Have your clinical and quality improvement leadership reviewed, signed and submitted the Leadership Team Pledge to Kate Nicholson by November 15th?</td>
<td>11/02/2013</td>
</tr>
</tbody>
</table>

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)
Hint: Display data in tables and graphs to make change over time easier to observe
Process Aim Optional Worksheet

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:

<table>
<thead>
<tr>
<th>Name/ID</th>
<th>1st Date of Coordination</th>
<th>2nd Date of Coordination</th>
<th>3rd Date of Coordination (optional)</th>
<th>Timely</th>
<th>Timely</th>
<th>Timely</th>
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</thead>
<tbody>
<tr>
<td>Katy P.</td>
<td>06/01/2012</td>
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<td></td>
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<tr>
<td>Mariah C.</td>
<td></td>
<td>03/01/2013</td>
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<td>Jay Z.</td>
<td>02/01/2013</td>
<td>03/01/2013</td>
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<tr>
<td>Mick J.</td>
<td>02/01/2013</td>
<td>06/01/2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James T.</td>
<td>12/10/2012</td>
<td>06/01/2013</td>
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<tr>
<td>Taylor S.</td>
<td>12/01/2012</td>
<td>12/01/2013</td>
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### Process Aim Optional Worksheet

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:**

<table>
<thead>
<tr>
<th>Name/ID</th>
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<th>2nd Date of Coordination (optional)</th>
<th>In Service?</th>
<th>Timely</th>
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<td>Robert P.</td>
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<td>Christina A.</td>
<td>05/01/2011</td>
<td>05/01/2012</td>
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<td>Miley C.</td>
<td>09/01/2013</td>
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<tr>
<td>Kenny C.</td>
<td>01/01/2013</td>
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<td>Yes</td>
<td>0</td>
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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

<table>
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<tr>
<th>Observation Number</th>
<th>Value</th>
<th>Median</th>
<th>Meets Goal</th>
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<td>386</td>
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</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0.0</td>
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Median: 6.0
% Meeting Goal: 24.0

Confidence

% Meeting Goal

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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

Act → Plan

Plan → Do

Do → Study

Study → Act
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

<table>
<thead>
<tr>
<th>BEGIN DATE:</th>
<th>DATE COMPLETED:</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>MILESTONE:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## 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
Outcome Aim Progress

Pre: 59.6%
Q1: 66.3%
Q2: 70.1%
Q3: 74.2%
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 psychototropic 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!

Diane Lyle  |  lyledl@ccbh.com

Shari Hutchison  |  hutchisons@ccbh.com