Leveraging the UPMC-University of Pittsburgh Partnership to Achieve the Triple Aim through New Models of Team-Based Care
UPMC Health Plan
Patient Center Medical Home

Deborah Redmond, PT, MBA, MHA
Vice President
UPMC Health Plan
UPMC Today

- $11 billion global health enterprise
- Ranked #10 Best Hospitals U.S. News & World Report
- 21 hospitals
- Affiliated University of Pittsburgh – ranked #5 in NIH funding
- 3rd largest GME program (1,360 residents)
- 3.6 million outpatient visits
- 2+ million Health Plan members
- 400+ clinical locations
- 65,000 employees
- 3,200 employed physicians and 5,500 affiliated physicians
- International Division - 9 countries
- Altoona Regional Health System newest system
UPMC Recognized for High Quality and Innovation - 2013

2013 U.S. News & World Report Rankings
UPMC Health Plan (484 plans ranked nationally)
  Commercial HMO #1 in Pennsylvania; #11 nationally
  Commercial PPO #1 in Pennsylvania; #48 nationally

UPMC for You (131 plans ranked nationally)
  Medicaid #1 in PA; #15 Nationally

UPMC for Life (405 plans ranked nationally)
  Medicare PPO #1 in WPA; #40 nationally

Community Care
  Behavioral Health MCO #1 Quality in Pennsylvania – 2013 NCQA Rankings - Perfect Score

APA’s 2013 Gold Achievement Award – Community Care

Best Customer Experience Award – April 2013
International Customer Management Institute (ICMI)

National Business Group on Health Platinum Award Award for Best Employers for Healthy Lifestyles

UPMC Center for High-Value Health Care
UPMC Continues to Focus on People, Process and Technology to Unleash the Power of an Integrated System

Right Economic Incentives
- Gainsharing
- Capitation and Bundled Payments
- Care Management Payment
- Performance Payment
- Benefit Designs

Right Clinical Model
- Standardized Protocols & Registries
- Care Transition Programs
- Patient Centered Services
- Chronic Care Management Models
- Lifestyle Coaching & Education

Right Consumer/Patient Supports
- Consumer Incentives
- Transparency: Cost/Quality
- Shared Decision Support Tools

Right Infrastructure
- People
- Process
- Technology

Value Network

Improved Quality and Cost and Patient Experience

UPMC Center for High-Value Health Care
Just Up the Road From One of Our Hospitals . . .
UPMC Health Plan Supports Medical Home Model with Virtual Teams and Community Resources

UPMC Health Plan Virtual Team Support

UPMC Center for High-Value Health Care
UPMC Health Plan 5th Year of Medical Home Transforming Care Delivery

- UPMC Health Plan 422 active sites in Medical Homes
- ~1,000 primary care physicians participating
- Improved care coordination and quality outcomes
- Data and physician report cards drive results
- Integrated primary care and Health Plan coaching teams
- General Internal Medicine developing intensive community based team
Focus on Aligning Financial Incentives

- 2008: PCMH Implement N=6
- 2009: Additional PCMH N=6
- 2010: Exploration of Alternative Payment Methods N=6
- 2011: Implemented Alpha site PHO N=3700 Medicare Advantage
- 2012: Additional N=4
- 2013: 32% Population in “Shared Savings” sites
Medicare – Shared Savings Experience

• **Group 1 – Medicare**
  – Improved Medical Expense Ratio from 92.4% in 2011 to 89.5% in 2012 and 85.2% in 2013
  – Increased Medicare Star Rating from 3.3 in 2012 to 4.3 in 2013

• **Group 1 – Medical Assistance**
  – Improved Medical Expense Ratio from 92.1% in 2012 to 82.3% in 2013
  – Driven by a reduced IP Admits per 1,000 from 167 in 2012 to 137 in 2013

• **Group 2 – Medicare**
  – Improved Medical Expense Ratio from 106.7% in 2011 to 91.9% in 2013
  – Reduced Total Medical Expense PMPM by 20% between 2011 and 2013

• **Group 3 – Medicare**
  – Reduced IP Admits per 1,000 13% from 378 in 2011 to 329 in 2013
  – Reduced ER Visits per 1,000 13% from 355 in 2011 to 308 in 2013

UPMC Center for High-Value Health Care
The Infamous Bottom Line

Note to self...
Get in touch
with Bottom Line!
Care Coordination and Outpatient Follow-up Critical - Medical Homes Focus on Five-Day Follow-up to Help Reduce Readmissions

- 5-day follow-up rates increased 4.6%, from 32% in 2011 to 36% in 2013
- Median number of days to a follow-up visit decreased from 9 days to 7 days
- 30-day readmission rate decreased 1.5%: from 16% to 14% (p=0.000)
- Medicare experienced the largest increase in 5-day follow-up: 32% to 39% (p=0.000)
Changing Payment Model and Providing Clinical and Analytic Support Shows Results in Patient Centered Medical Homes

<table>
<thead>
<tr>
<th>Medicare (HMO, PPO, SNP) CY 2013</th>
<th>2011 Shared Savings MER</th>
<th>2013 Shared Savings MER</th>
<th>2013 STARS Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider A</td>
<td>91.6%</td>
<td>88.5%</td>
<td>4.2</td>
</tr>
<tr>
<td>Primary Care Provider B</td>
<td>92.4%</td>
<td>81.9%</td>
<td>4.3</td>
</tr>
<tr>
<td>Primary Care Provider C</td>
<td>95.2%</td>
<td>88.4%</td>
<td>4.8</td>
</tr>
<tr>
<td>Primary Care Provider D</td>
<td>93.3%</td>
<td>89.7%</td>
<td>4.0</td>
</tr>
<tr>
<td>Primary Care Provider E</td>
<td>89.4%</td>
<td>87.6%</td>
<td>4.1</td>
</tr>
<tr>
<td>Primary Care Provider F</td>
<td>92.1%*</td>
<td>90.0%</td>
<td>4.4</td>
</tr>
<tr>
<td>Rest of Network</td>
<td>92.5%</td>
<td>91.4%</td>
<td>4.2</td>
</tr>
</tbody>
</table>

*Initiated 2012
**The Bottom Line – Impact on Costs**

**Medical Costs**
- Savings is observed without delay in shared savings, after 5 months in PCMH, and up to 12 months when the site is both
- Compared to RON, there is no difference in medical

**Pharmacy Costs**
- Significant savings in Pharmacy without delay in all programs and significantly better than RON

**Total Costs**
- No difference compared to RON, except when site is **PCMH + SS**

**Quality**
- Quality (HEDIS) improves significantly in all programs
Changing Clinical Practice From Cowboys . . .
To Pit Crews
Savings Expectations

- If program started ~6 months ago, no savings
- If program started 12+ months ago, savings = offset
- If program started ~6-12 months ago, ‘prorated’ savings

Program Value = Avoided Costs
What is the impact on Quality?

HEDIS change by percent change in cost

- PCM+SS
- SS only
- PCM only

Quality Increase

Quality Decrease

Lower Cost (More Savings)
Is the Quality Performance Sustainable?

- HEDIS is (more) reliable over time
  - absolute measures w/ similar meanings
Conclusion

• Early adoption is proving successful.
• Payment innovation is imminent.
• Many models/methods are being explored.
• Cannot underestimate time and resources.
• Prediction…this is the way to successfully controlling health care expenditure and improving costs.
Integrating Physical & Behavioral Healthcare: Creating Health Homes

Lyndra J. Bills, MD
Medical Director
Community Care Behavioral Health
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 and Disease Management Programs

• Serving over 750,000 individuals receiving Medical Assistance in 39 counties through a statewide network of over 1,800 providers
New Models of Care Delivery

• New models of care delivery are important for behavioral health:

  – World Health Organization ranks depression, alcohol, and tobacco use among the top causes of disability

  – Individuals may be at higher risk for health conditions due to the psychiatric medications or other medications they are prescribed

  – Individuals who have a serious mental illness (SMI) have a mortality rate that is higher than comparison groups – mostly due to medical conditions, such as cardiovascular disease or diabetes
The Physical Health/Behavioral Health (PH/BH) Link
% of Adults with Health Conditions

People with mental health (MH) conditions: 25% of adult population

68% of adults with mental health conditions have medical conditions

29% of adults with medical conditions have mental health conditions

People with medical conditions: 58% of adult population
## Higher Medical Co-morbidities

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Risk Among Persons with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2-3x higher</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>2-3x higher</td>
</tr>
<tr>
<td>HIV</td>
<td>Higher, but varies</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>5-11x higher</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Higher</td>
</tr>
</tbody>
</table>
Adverse Childhood Experiences Study

- Expanded definition of child maltreatment. Types of adverse experiences surveyed:
  - Sexual abuse
  - Emotional abuse
  - Emotional neglect
  - Physical abuse
  - Physical neglect
  - Substance abuse in home
  - Mental illness in home
  - Incarceration of family member
  - Parental separation or divorce
  - Witness violence against mother
Adult Heart Disease Risk Factors

Risk Factors for Adult Heart Disease are Embedded in Adverse Childhood Experiences

ACEs

Dong et al, 2004
The ACE Score and the Prevalence of Severe Obesity (BMI >35)

ACE Score

Percent Obese (%)
Tobacco Use Statistics

• Cigarette smoking continues to be the leading cause of preventable disease and death in the U.S. 5

• Nearly 1 in 5 adults in U.S. currently smokes 6

• Extensive research shows psychiatric disorders and cigarette smoking are frequently co-morbid 7, 8, 9, 10, 11

• Individuals diagnosed with a current psychiatric disorder smoked 46.3% of all cigarettes consumed in the U.S. 12

• Adults with lifetime depression, anxiety, or major depressive episodes were more likely to be “current smokers, smoke with higher intensity and frequency, have more dependence, and have lower success at quitting” compared to individuals without these psychiatric conditions 13
Key Points About PH/BH Connections

Increased morbidity and mortality associated with serious mental illness (SMI)

Increased morbidity and mortality largely due to preventable medical conditions

- Metabolic disorders, cardiovascular disease
- High prevalence of modifiable risk factors (i.e., obesity, smoking)

Some psychiatric medications contribute to risk
Key Points

Traumatic stress exposure can lead to both mental and medical illness

Established monitoring and treatment guidelines to lower risk are underutilized in SMI populations

Co-morbid substance abuse can increase medical illness
Leading up to a BH Home

• Affordable Care Act definition of a health home

• Medical care management in behavioral health settings
  – Care managers focused on communication and advocacy with physical health providers
  – At 12-month follow-up, 58% in intervention group had received recommended preventive services versus 22% in usual care
  – Improved rates of cardiometabolic monitoring and connection with primary care

• Nurse navigators for patients with SMI
  – Randomized trial
  – Improvements in preventive care
  – Improved cardiac care
  – Improved measure of mental health quality of life
  – Reduced costs
Behavioral Health Home Plus (BHHP)

- Designed to demonstrate the efficacy of care coordination of PH/BH services for individuals with SMI & co-occurring medical conditions

- Developed as collaborative effort with Behavioral Health Alliance of Rural Pennsylvania (BHARP): 23 North Central counties

- Expands on existing knowledge base
  - Strong health care navigator training & technical assistance
  - Embedding medical expertise within behavioral system
  - Self-management strategies for common concerns, such as smoking cessation & exercise
  - Person-directed personal health record

- Initial sites included four rural BH providers
Health Home Team Members

• RN (wellness nurse)
  – Provides clinical consultation/interface with physical health and behavioral health clinicians and member

• Certified peer specialist
  – Assists with engaging member and securing informed consent; if requested, accompanies member to appointments and coaches member to support his/her own advocacy within health care system

• Case manager
  – Provides enhanced case management services accessing and coordinating both physical and behavioral health services and supports
Health Home Team Members

- Primary physical health provider
  - Provides physical health clinical services; has access to behavioral health team services and supports; participates as a member of the team

- Primary behavioral health provider
  - Provides accountability and lead responsibility for managing the health home team, ensuring access to both physical and behavioral health services, collecting data, and tracking outcomes

- Community Care specialized care manager

- Health Plan special needs resources
Role of Community Care

• Analyze and stratify the population

• Standardize the model across behavioral health providers, including training and technical assistance

• Utilization, cost, and outcomes reporting

• Facilitate information exchange and provide notice of key events

• Provide specialized high-risk care management, including pharmacy management, with:
  – Oversight/consultation of person-centered planning
  – Facilitation of data and information sharing with the health home team
Initial Results Are Positive

- Strong engagement by members
- Physical health and wellness concerns become routine part of recovery plan
- Nurses and case managers partner to address physical health concerns
- Became basis for PCORI grant application
Optimizing Behavioral Health Homes by Focusing On Outcomes That Matter Most for Adults with Serious Mental Illness

- Three-year, $1.7 million grant from the Patient-Centered Outcomes Research Institute (PCORI)
- Focus on patient- and provider-directed interventions to address wellness and PH concerns
- Builds on prior work in North Central state option region of Pennsylvania
Unique Opportunity

• Study the effectiveness of wellness interventions for individuals with SMI across 11 Community Mental Health Centers (CMHC) in the North Central and Chester County regions

• Clustered randomized design using mixed methods to examine impact of strategies/interventions on patient-centered outcomes

• Will compare two promising strategies for promoting the health, wellness, and recovery of adults with SMI
Promising Strategies

Provider-Supported Integrated Care

• Uses registered nurses on staff at participating facilities to work with patients on coordinating their care, enhance communication between providers & provide patient wellness support & education

Self-Directed Care

• Service delivery at self-directed facilities to focus on providing tools, education & resources that activate patients to be more informed & effective managers of their health & health care
Implementation Underway

- Training in 2013
- Over 1,100 members enrolled in study
- 11 additional sites implementing BHHP model in 2014
- Using IHI Learning Collaborative Model for implementation with intensive technical assistance from Community Care
- Results in 2016
Evaluation Underway

- **Primary Outcomes**
  - Health status
  - Activation in care
  - Engagement in primary/specialty care

- **Secondary/Exploratory Outcomes**
  - Mental health symptoms, hope, quality of life, medication use, functional status, emergent care, lab monitoring, individual and family satisfaction with care

- **Covariates**
  - Engagement in interventions, social support, severity of mental illness, medical stability, patient demographic and clinical characteristics
Evaluation Components

• Member completed measures
  – Physical and Behavioral Health Status (SF12v2)
  – Patient Activation Measure (PAM)
  – Physical Health Information
  – Survey of Healthcare Experience (PACIC)
  – Hope
  – Sheehan Disability Scale
  – Satisfaction/Quality of Life (QLESQSF)
  – Social Support (ISEL)

• Qualitative interviews
  – Three sets of provider and patient interviews over the course of the evaluation period

• Use of existing claims and administrative data
Learning Collaborative Underway

• Process Aims (target of 80% by November 2014)
  – Completion of the wellness planning tool
  – Established connection between PH and BH providers as evidenced by minimum of two reciprocal contacts
  – Case manager consultation with wellness nurse (Provider-Supported only)
  – Member use of at least one self-management tool (Self-Directed only)

• There is variability in performance on the process aims
  – Consultation is highest performing Process Aim (70%)
Learning Collaborative Underway

- Measuring impact of the intervention on staff and individuals in service through Outcome Aims (target of 80% by November 2014)
  - Behavioral health service providers report high confidence in their ability to assist service users with their physical health and wellness needs
  - Service users rate their BH service provider as highly understanding and respecting of their PH and wellness needs and goals
  - Service users report being highly involved in working with their BH service provider on PH and wellness

- Survey completions by staff and individuals on confidence, respect, and involvement using a 0-10 scale; high ratings = 9 or 10
1st Quarter Progress on Outcomes Aims

- Confidence: 40.0%
- Respect: 79.1%
- Involvement: 42.2%

UPMC Center for High-Value Health Care
References

1. World Health Organization  
   www.who.int/mental_health/management/depression/definition/en/
2. SAMSHA/Thomson Reuters
5. USDHHS, 2004
6. CDCP, 2010a
10. Degenhardt and Hall, 2001
References

11. Grant et al, 2004
12. 2001-2002 National Epidemiologic Survey on Alcohol & Related Conditions
13. 2005-2006 NSDUH
14. SAMSHA/Thomson Reuters
17. “Integrated Behavioral Health Reduces Depression and Anxiety in Primary care Patients, Improving Quality of Life and Reducing Costs” AHRQ


14. Genesys HealthWorks Health Navigator in the Patient Centered Medical Home


Palliative and Supportive Care: InterProfessional Care in Action

Denise Stahl, MSN, ACHPN
Executive Director
UPMC Palliative and Supportive Institute (PSI)
Changes in population demographics, health care economics, and service delivery demand improved professional preparation to support patients and families throughout the experience of serious illness and through end of life.

Core principles of palliative care can be integrated across care settings to effect high quality care throughout the experience of serious illness, while supporting resource and utilization management at the same time.
What are the chances?

- Of dying from sudden death, unexpected cause (MI, accident, etc)?
- Of dying from a life threatening illness with a predictable steady course of decline or a prolonged illness with periods of sudden crisis?
Steady Predictable / Progressive Illness

Decline

Health Status

Time

UPMC Center for High-Value Health Care
Slow Decline with Periods of Sudden / Severe Crisis

Health Status

Crisis

Decline

Death
What do WE want?

- Do we want our physicians to do everything possible to extend life?

- Do we want more time in the hospital?

- If additional treatments offer little possibility of benefit, do we want more invasive care?

- Research suggests that the care we get, is not necessarily the care we want.
What do patients say is most important?

- 52% Improving quality and meaning
- 34% Achieving Relief or Comfort
- 22% Altering the trajectory or illness
- 11% Focus on preparing for dying

(n=215; some chose more than one priority)

Studies have shown...

- ALL patients want vigorous treatment of pain
- ALL patients want relief from worry and anxiety.
- ALL patients want communication about their care over time.
- ALL patients want coordinated care.
- ALL patients want support for family caregivers.
- ALL patients want practical support.
- ALL patients want to feel safe in the health care system.
Shirley’s experience
Lessons from Shirley

• The patient’s medical diagnosis is just one small chapter in the patient/family story.
• The family perspective is essential to understanding the patient’s lived experience of illness.
• The health care team must step back and look at the 75,000 ft view to really assess
• It takes a community of providers and professionals to really meet the needs of the patient and family at large.
• Sometimes the most important on the team is NOT the physician or advanced practice nurse.
• Palliative Care can complement the primary/specialty care team in identifying the patients’ goals and greatest needs.
What is Palliative Care?

“The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anti-cancer treatment.”

W.H.O. 1990
“Palliative care seeks to prevent, relieve, reduce or soothe the symptoms of disease or disorder without effecting a cure... Palliative care in this broad sense is not restricted to those who are dying or those enrolled in hospice programs... It attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them.”

Institute of Medicine 1998
• 2001: Palliative care leaders met to discuss the standardization of palliative care with the goal of improving the quality of care. Revisions made in 2013 (3rd Edition)

• The National Consensus Project (NCP) was formed with representation from the five major palliative care membership and leadership organizations (AAHPM, CAPC, HPNA, NHPCO)

• Goal: to build national consensus around the definition, philosophy, and principles of palliative care
There is no model that fits every organization or institution.

Palliative care delivery must be individually integrated into specific care settings (e.g., hospital, nursing home, assisted living, home care) with attention to the culture of the organization.
Clinical Practice Guidelines for Quality Palliative Care: Domains of Care

- Structure and processes of care
- Physical aspects of care
- Psychosocial and psychiatric aspects of care
- Social aspects of care
- Spiritual, religious, and existential aspects of care
- Cultural aspects of care
- Care of the imminently dying patient
- Ethical and legal aspects of care
Doing this well.....requires a team of the RIGHT professionals with the RIGHT skills at the RIGHT time.......
The Transdisciplinary Palliative Care Team

- Patient and Family
- Physicians
- Advanced Practice Providers
- Nurses
- Social Workers
- Counselors and Psychologists
- Clergy
- Volunteers
- Nutritionists
- Mental Health Professionals
How is the Palliative model of care different?

- Primary goal is relief/prevention of suffering
- Focus of care is patient and family
- Distressing sx treated as they present
- Both measurable and subjective data are valued
- Therapy is indicated if it controls sx and/or relieves suffering
- Care consists of physical, emotional, social, and spiritual dimensions
Quality Palliative Care

• Patient-Centered
• Beneficial/Effective
• Accessible/Equitable
• Knowledge/Evidence Based
• Efficient

• AND... TIMELY???
The Palliative Care Continuum of prior decades

Disease-Modifying Treatment

Palliative Care

Hospice Care

Bereavement Support

Death

Terminal Phase of Illness
A New Model of Palliative Care for Oncology Patients With Advanced Disease; Mazanec, Polly; Daly, Barbara J.; Pitorak, Elizabeth F.; Kane, Donna; Wile, Sally; Wolen, Judith; Journal of Hospice & Palliative Nursing. 11(6):324-331, November/December 2009. doi: 10.1097/NJH.0b013e3181bd03b7
The mission of the UPMC Palliative and Supportive Institute (PSI) is to *ensure high quality, coordinated care for patients with serious illness* by *increasing palliative care capacity and expertise* across the UPMC continuum of care through consistent education, training, and technical assistance for health care professionals who care for persons with serious illness.
Quality of life for all patients and families living with the burden of serious illness will be promoted by attentive symptom management and the commitment that all care will focus on promoting the patient/family’s values.
Palliative care is specialized medical care for people living with serious illness. Palliative care focuses on improving quality of life by providing relief from pain and symptoms, as well as the stress of living with a serious illness. In addition, palliative care works to make sure that the patient’s and family’s values guide the treatment plan. Palliative care is typically provided by a team of doctors, nurses, and other specialists who work with the patient’s other doctors to make sure each patient receives the best possible treatment and care for their illness. Palliative care is available to all patients with serious illness, regardless of age or the stage of the illness. Palliative care does not replace the patient’s traditional medical care, but supplements that care to offer extra help and support for the patient and family along the way.
PSI and Palliative Care in Action

• 11 inpatient consultation teams (MD/NP/SW)
  – Over 20,000 encounters in FY13
  – Improved attention to pain, symptoms, goals of care, pt and family support, discharge planning, end of life care support
  – Decreased hospital mortality
  – Increased hospice utilization in community and increase LOS on hospice
  – Over $15mil in estimated cost savings
  – > 90% patient/family satisfaction with services

• 7 ambulatory care locations (MD/NP)
  – Increased access for real time support of pain and symptom management
  – Decreased unplanned or emergent ER/hospital admissions for symptom support
PSI and Palliative Care in Action

• 4 UPMC SNF CRNP programs
  – Improved attention to pain, symptoms, goals of care, pt and family support, discharge planning, end of life care support
  – Decreased unplanned transfer to acute care and hospital readmission
  – Increased SNF mortality (consistent with pt/family goals)
  – Increased hospice utilization

• Expanding home care programs to supplement traditional home care team with CRNP

• Supplement hospice team for Family Hospice and Palliative Care, Inc. with specialty trained physicians/CRNP staff, and joint education and quality monitoring
The Nature of Suffering and the Goals of Medicine - Eric J. Cassell

“The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick...failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering, but becomes a source of suffering itself.”
Community Care’s School-Based Child Clinical Home (SBCCH)

Judith W. Dogin, MD
Senior Medical Director for Children’s Services
Community Care Behavioral Health
A clinical home implies services are accessible, integrated, comprehensive, and coordinated through a single team/service that provides full clinical interventions and responsibility without fragmentation.
School-Based Child Clinical Home Model Defined

- Collaborative and multi-stakeholder origins
- Voluntary mental health service for children and youth, ages 5-20, and their families
- Team delivered by master’s prepared and licensed lead clinicians and bachelor’s level behavioral health workers
- Based in schools or other child serving settings; services extend into home environment and community
- Comprehensive, 24/7 service, flexibly delivered
- One stop shop for referral and linkage with other needed services
• Team based model
• Family focused and inclusive
• Resiliency based and trauma informed care
• Positive behavior support and intervention tools
• Co-occurring mental health and substance abuse disorders principles and intervention strategies
Team Components

- Licensed Master’s Prepared Clinicians (MHP)
- Experienced Bachelor’s Prepared Workers (BHW)
- Administrative Agency Support
- Consultation to MHPs
Service Components

Clinical Interventions

Case Management

Crisis Intervention

Case Consultation and Training
Guiding Principles

- The team has ongoing accountable responsibility for behavioral and physical health needs for the identified child and his/her family
- The team’s sponsoring provider agency has a clinical and financial structure in place capable of providing stability for team staff members
- Team staff receive training through the Learning Community to capably provide care
- Model fidelity is supported through coaching and case consultation and measured through quality monitoring
- Outcomes monitoring occurs through routine assessment of a child and family’s functioning and satisfaction through analysis of data
Value of Clinical Home

- Greater flexibility and responsiveness with team approach
- Integrated service approach improves care
- Strong communication and collaboration with school staff and integration with school interventions
- Decreased school discipline referrals
- Increased coordination of care with physical health providers
- Improved child and family functioning
Evaluation Questions

- What impact do school-based services have on child/family functioning and child internalizing/externalizing behavior?
- What impact do school-based services have on academic activities including attendance and grades? (in progress)
- What impact do school-based services have on other behavioral health service utilization?
• Child Outcomes Survey (COS) developed with family and provider input
• Measures caregiver report of progress over time in child and family functioning and therapeutic relationship
• Caregiver and teacher report of child behavior measured through the Strength and Difficulties Questionnaire (SDQ)
• Survey results shared and discussed in the clinical session to inform treatment planning and improve quality of care
Diverse Population of Children Served

• Demographics for all children receiving SBCCH Team Service 2009-present
  – 1801 students
  – Majority are boys (71%)
  – 16% are Hispanic
  – 70% European American, 14% African American, 16% other (multi-racial)
  – Ages range from 4 to 19 years old, with a mean age of 9.5 years
  – 41% of children receiving SBCCH were newly identified for mental health services
Child and Family Functioning Improve

Ratings of family (p<.0001) and child functioning (p<.0001) improve significantly over 18 months of service.
High Ratings of Therapeutic Relationship

Caregiver perception of the therapeutic relationship is high and improves over time (p<.001)
Parent (p<.0001) and teacher (p<.0001) report of Total Difficulties improve significantly over 18 months of service.
Learning Collaborative: A New Quality Initiative

- Based on IHI Model
- A regional network of clinical home teams committed to transforming services to achieve a breakthrough quality improvement in:
  - Increasing health care coordination (PH/BH)
  - Increasing family/caregiver confidence in managing their family
- Promotes mutual learning among participants
- Develops infrastructure to sustain improvement
- Spreads new knowledge and improvement to other parts of organization
By December 1, 2014, 100% of youth have documented physical and behavioral health coordination including reciprocal communication between the CCH Team and medical providers via letter, telephone contact, or personal visit 2 times a year for medically-complex youth and 1 time a year for all other youth.
Health Care Coordination Improves in First Quarter

The percent of youth with reciprocal communication around physical health care improves from baseline.
By December 1, 2014, 80% of families report a high level of confidence (rated a 9 or 10) in their ability to manage their family’s wellbeing in the home, as measured by a 10-point confidence question.
The percent of caregivers reporting high levels of confidence in supporting their families’ wellbeing improves from baseline.
Summary

- SBBH is a comprehensive clinically effective team-based service
- Clinical and functional outcomes for children and families are monitored throughout program participation
- A Learning Collaborative Model is used to support spread and fidelity to program model