Special Topics Forum:

Use of Data in Integrated Behavioral Health Care

TEAM UP FOR CHILDREN

Transforming and
Expanding
Access to
Mental Health Care in

Urban
Pediatrics

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- *Jess Rosenberg, MPH*
- *Charlotte Vieira, MPH*

Disclosure and Acknowledgements

The presenters do not have anything to disclose regarding commercial interests and do not plan on discussing unlabeled/investigational uses of a commercial product.

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Agenda

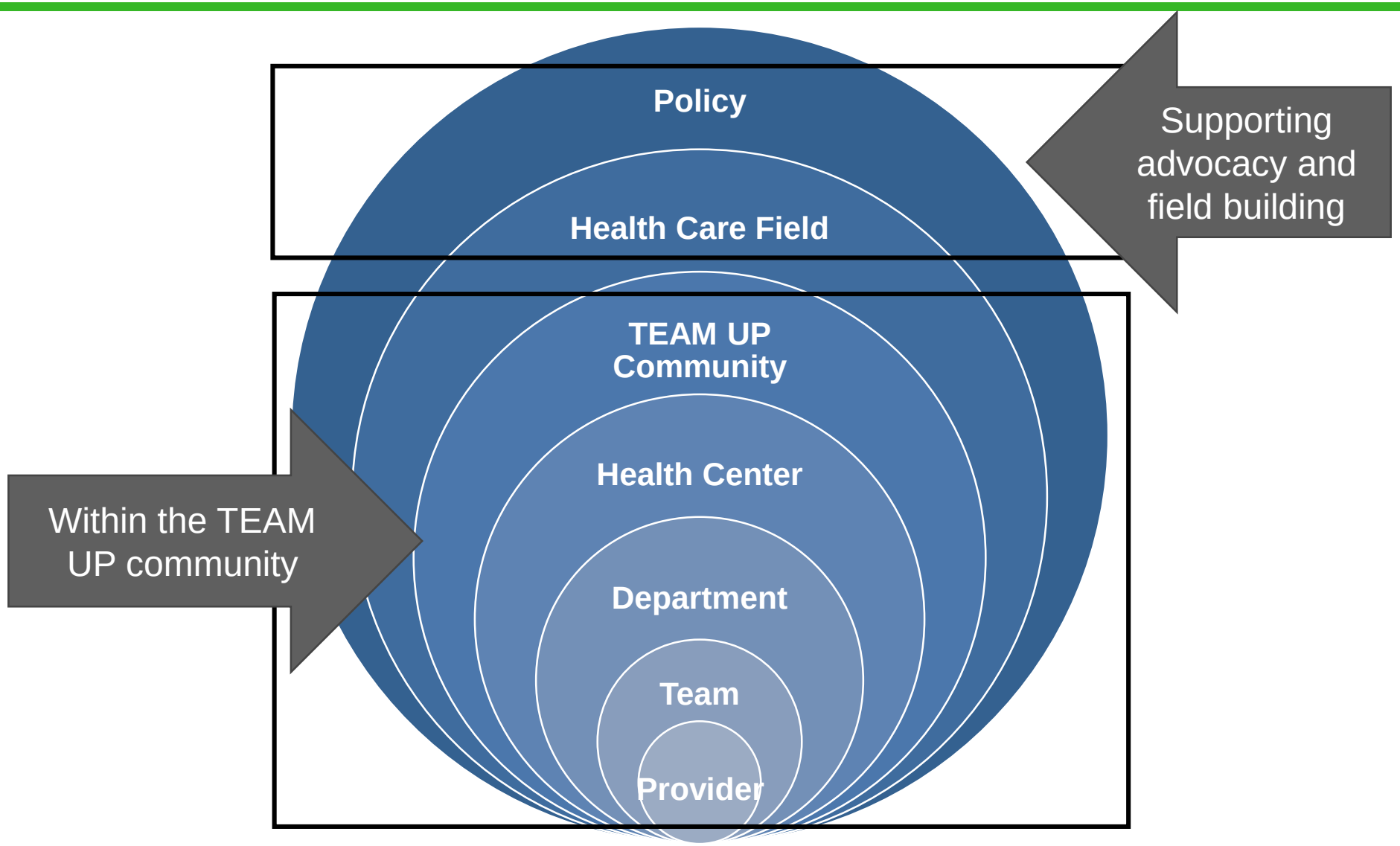
- Share how we think about data in TEAM UP
- Discuss opportunities for furthering our work with the new BH Plans
- Gather input on ways we can support your work and leverage data

Logistics

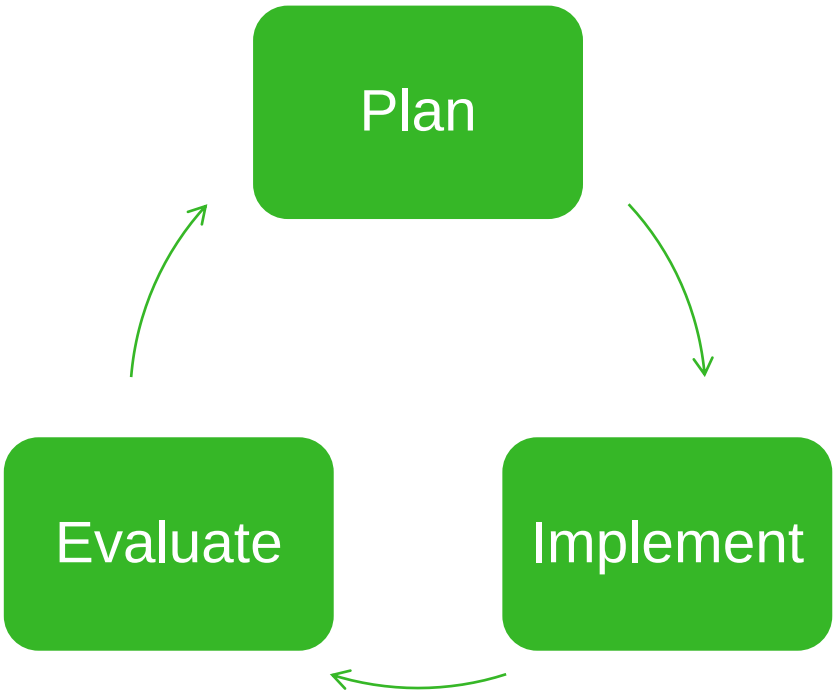
- ✓ Please add your CHC to your Zoom ID and if you would like, your preferred pronouns.
- ✓ Please remember to mute if you are not speaking.
- ✓ Feel free to use the chat function for ongoing comments and questions. We will keep a record.
- ✓ Do what you need to take care of yourself throughout the session.
- ✓ Being on camera makes for a more interactive experience together!
- ✓ Put a note in the chat if you are stepping away, and thanks.

This training (and all future trainings) will be recorded.

How are data used within TEAM UP?



Implementation & Improvement within the TU Community



- **Adopt new strategies and care delivery methods** to serve patients
- **Monitor patterns** in how patients are receiving care
- **Evaluate process** to see if it is running smoothly
- **Engage** entire care team to understand how process is working and where we can improve
- **Put improvements into action** and start the cycle again

Goal to enhance patient care, improve health of patients, and support the care team!

Example: Get children & adolescents engaged in BH care

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Goal: **Get children and adolescents engaged in BH care**

Step 1: Identify need by screening for BH and SDoH concerns during well-child visits

Step 2: Ensure access with warm handoff (WHO) from PCPs to BHCs and CHW/FPs

Step 3: BHCs and CHW/FPs engage patients in care

TEAM UP Data Reports are produced monthly and available on the TEAM UP website: http://teamupforchildren.org/evaluation

Example: Get children & adolescents engaged in BH care

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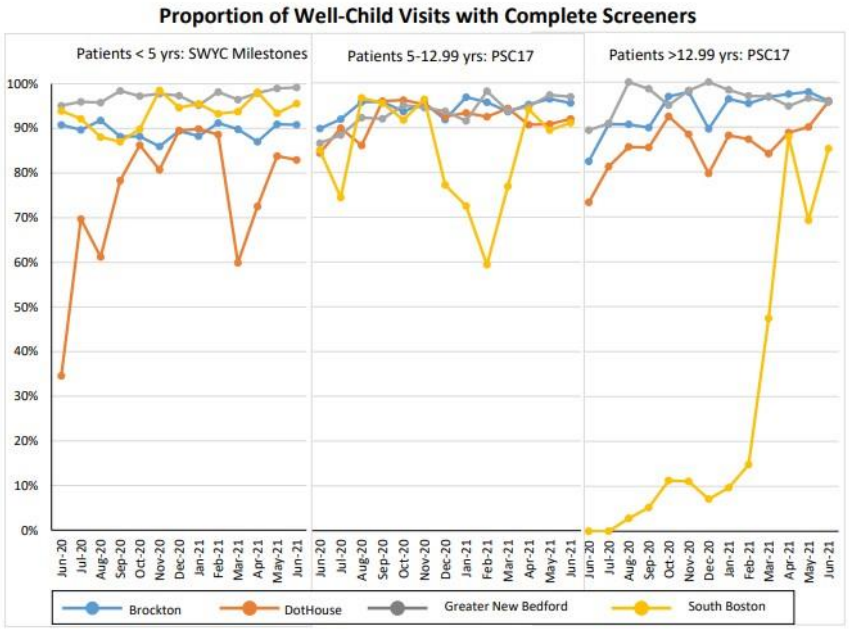
Step 1: **Identify need by screening for BH and SDoH concerns during well-child visits**

How do we know if this is working?

Track the percentage of visits where the screener was completed

If % is low, explore reasons and barriers with care team members

Plan ways to improve screening (e.g., EHR system change, additional clinical training, solve survey burden, etc…)



Example: Get children & adolescents engaged in BH care

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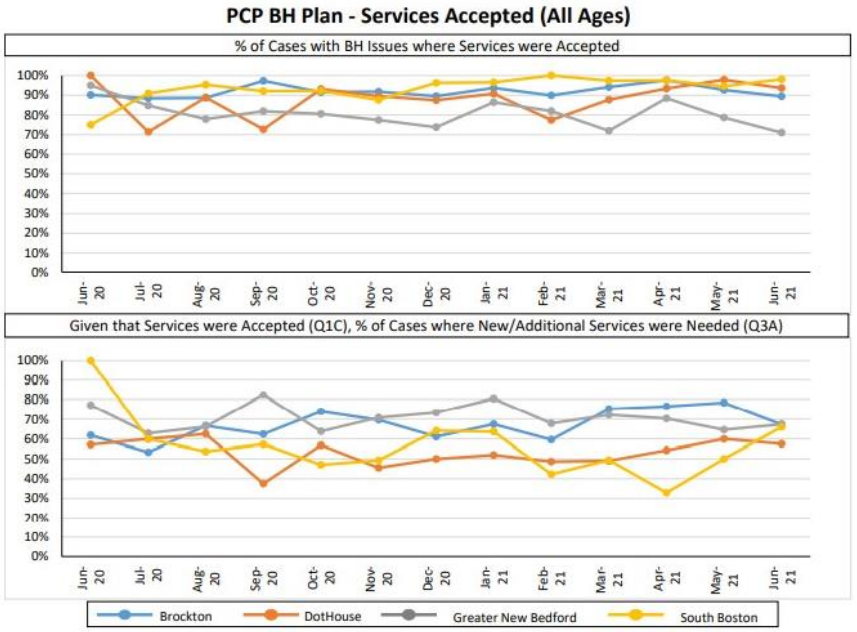
Step 2:

Ensure access with WHO from PCPs to BHCs and CHW/FPs

Look at percentage of completed BH Plans

Use BH Plan data to track WHOs Compare to screening results to see if those with identified concerns get WHO to BHC or CHW/FP

Explore findings with care team to understand if there are opportunities to improve WHO process



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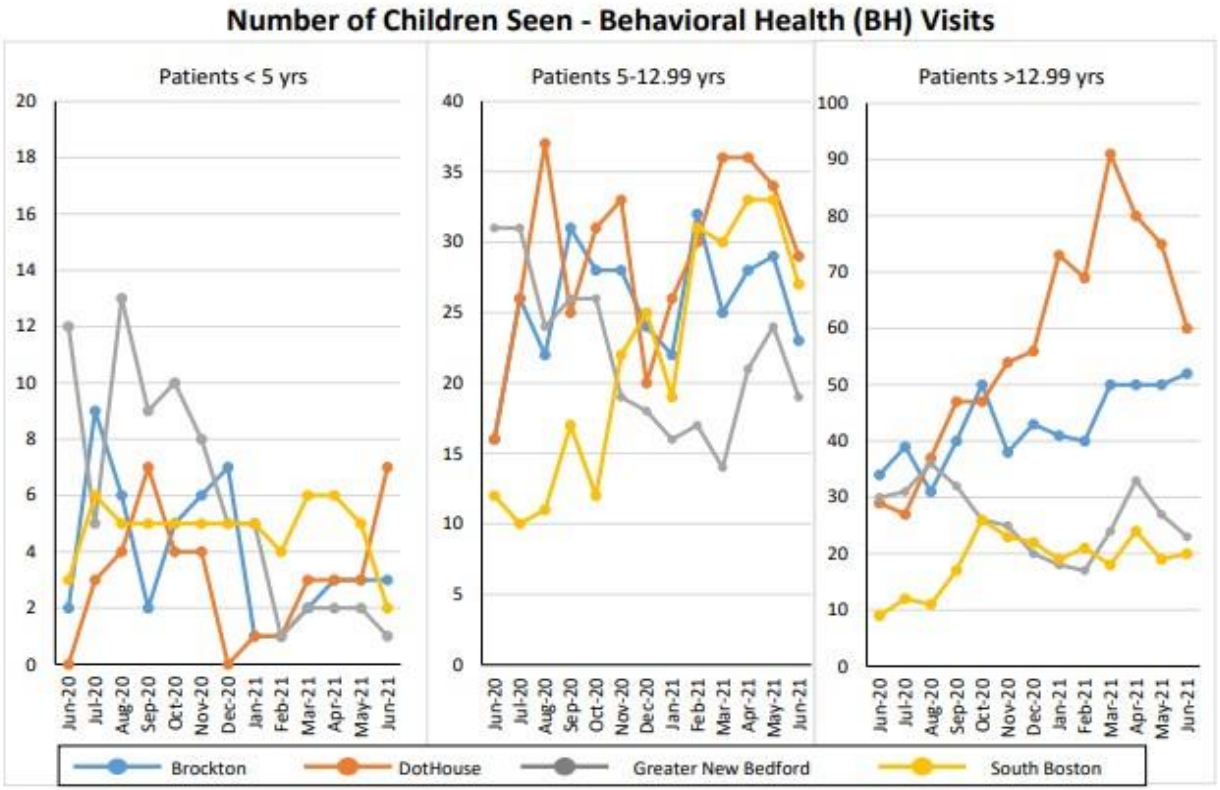
Step 3: BHCs and CHW/FPs engage patients in care

Track the number of BH visits and see if they increase over time.



Note: As of 4/29/21, these graphs represent the unique number of children who had a BH visit. Our team has fully certified that the above data are correct. We are still working with Greater New Bedford to incorporate their first 3 month's worth of BH data.

Building on engagement: What happens next?

Once you get patients in BH Care, what happens next?

What happens at the visit? What interventions are utilized? Screeners?

Are patients/families staying engaged in care? (e.g., coming back for multiple visits?)

Are symptoms improving? (PSC-17 and PHQ-9) Are patients who need more intensive care getting referred? Are other social and material needs being addressed? (SDoH data, CHW BH Plan & BHC BH Plan intersections & analyses)

Building on engagement: What happens next?

Data gathered in the BHC and CHW/FP BH Plans will help answer these questions together!

Often CHW/FPs and BHCs do not have the opportunity to document in this way – this means it is more difficult to characterize the nature and intensity of the work

BH Plans allow us to understand a fuller picture of how care in the integrated setting is delivered and how patients are responding to that care

Ideally data can support you individually, collaboration across the team, improvement of care delivery within the dept., and within the TEAM UP community at large

How Data Support the TEAM UP Initiative

Individual	Streamline documentation with a few clicks, better track major components of work over multiple visits
Care team	Communicate patient needs & plan of care across care team to support collaboration
Department	Support process & workflow improvement, changes in care delivery
TEAM UP community	Allow for more shared learning across CHCs, identify opportunities to develop & refine model

How can these data support advocacy and field building?

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Better characterize role of each team member	Support & Expand Team Up Model	Research Contributions	Community Impact
• Increase understanding of unique contributions and expertise • Advocate for commensurate reimbursement	• Support further development of the TEAM UP model to ensure highest quality of care for patients and families at your CHCs, but also future CHCs as TEAM UP expands	• Contribute to the research literature and evidence base for integrated behavioral health care	• Potential to influence and improve behavioral health care for thousands of children, adolescents, and families from underserved and marginalized populations

Discussion

We can make graphs and show numbers. Your help in understanding the context of those numbers and what is happening at your CHCs is extremely important in this process.

- For those of you completing the new BH Plans, what has your experience been like so far?
- What questions do you think the BH Plans can help answer – For you as the person working with the patient? For patient outcomes? For other trends?
- What other questions do you have related to data collection and/or completing the BH Plan?