TEAM UP
FOR CHILDREN

Transforming and
Expanding
Access to
Mental Health Care in

Urban
Pediatrics

Grantmakers in Health Webinar: Building an Integrated Behavioral Health Workforce for Children and Families

April 14, 2022

Overview of TEAM UP Initiative

TEAM UP's mission statement affirms the Initiative's intent to promote behavioral health as a social justice issue

TEAM UP Mission Statement

TEAM UP for Children is grounded in the belief that access to services to promote behavioral health and family strengthening is a social justice issue.

The Initiative seeks to meet the needs of community members that have experienced multiple challenges in their home countries or local communities, from trauma and racism to poverty and violence.

It builds upon the strength of community health centers as anchoring, culturally competent institutions that share this mission, and that have come together to develop a sustainable, adaptable, and replicable model of integrated health care.

TEAM UP builds the capacity of local community health centers to deliver integrated pediatric behavioral health care

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Our Vision

All children and families will live within a community that fosters and promotes physical and behavioral health, wellness, and resilience

Our Aim

To promote positive child health and well-being through innovation and consistent delivery of evidence-based integrated behavioral health care

Target Population

Children, and their families, seeking care at participating TEAM UP federally-qualified community health centers

What Is TEAM UP

- Eight-year, $22M+ initiative that **builds the capacity of seven local community health centers** to deliver high quality, evidence-informed **integrated behavioral health care** to children and families

- Expands access to care by **integrating behavioral health clinicians (BHCs)** and **community health workers (CHWs)** into pediatric and family medicine teams to provide comprehensive behavioral health services as part of routine primary care

- Focuses on **improving early identification** of behavioral health problems and providing a **full spectrum of preventative and treatment services** to children and families

Key Partners

- **Community Health Centers**: Brockton, Codman Square, Dimock, DotHouse, Greater New Bedford, Lowell, South Boston
- **Boston Medical Center**
- **Health Care For All**
- **Center for the Study of Social Policy**

The current TEAM UP model has been developed through two phases of co-creation with seven health centers across Eastern Massachusetts

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Phase I:
Pilot
2015

- Model Development
- Implementation
- Initial Dissemination

Codman Square Health Center

- 6,080 total peds patients
- 89% Black, 9% Latinx
- TEAM UP clinical team: 3 BHCs & 4 CHWs

THE DIMOCK CENTER

- 3,440 total peds patients
- 63% Black, 50% Latinx
- TEAM UP clinical team: 3 BHCs & 2 CHWs

LOWELL COMM HEALTH CENTER

- 10,550 total peds patients
- 32% Latinx, 27% Asian, high % of best served in language other than English
- TEAM UP clinical team: 3 BHCs & 3 CHWs

Phase II:
Scale-Up
2019

- Implementation
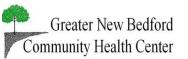- Model Growth
- Dissemination & Spread

Brockton Neighborhood Health Center

- 7,774 total peds patients
- 70% Black, 12% Latinx, high % of undocumented immigrants
- TEAM UP clinical team: 6 BHCs & 4 CHWs

DotHouse Health
We keep you well

- 5,985 total peds patients
- 35% Asian, 35% Black
- TEAM UP clinical team: 3.5 BHCs & 3 CHWs

Greater New Bedford Community Health Center

- 4,560 total peds patients
- 66% Hispanic, 30% White, high % of undocumented immigrants
- TEAM UP clinical team: 3 BHCs & 3 CHWs

SOUTH BOSTON COMMUNITY HEALTH CENTER

- 2,513 total peds patients
- 60% White, 12% Black, high rate of substance use disorders
- TEAM UP clinical team: 2 BHCs & 2 CHWs

Phase II expanded the TEAM UP community with four new health centers and two new partners with an eye towards scale and spread

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Cohort 1: Evaluate long-term program sustainability & outcomes; mentor Cohort 2
- Codman Square Health Center
- The Dimock Center
- Lowell Community Health Center

Extend funding to original TEAM UP CHCs

Spread TEAM UP to four new CHCs

Cohort 2: Validate model in new settings; refine TEAM UP toolbox; respond to demand for TEAM UP
- Brockton Neighborhood Health Center
- DotHouse Health
- Greater New Bedford Health Center
- South Boston Health Center

Phase II Objectives

Partnerships: Advance sustainability, scale, and spread
- **Health Care For All:** Advocating for sustainability of integrated pediatric behavioral health care
- **Center for the Study of Social Policy:** Creating a case study to describe the Initiative's efforts to develop, implement, sustain, and replicate TEAM UP's approach

Engage an external advocacy & case study partners

Advance model implementation and evaluation

Implementation & Evaluation Support: Guide model adoption, adaption, and evaluation
- **Boston Medical Center:** Leading the Learning Community to provide clinical training, practice transformation support, and evaluation

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This TEAM UP Transformation model was co-developed with Cohort 1 health centers. It is currently being implemented by Cohort 2 health centers

TRANSFORM CARE

STRENGTHEN FAMILIES
- Augment support during the prenatal-postpartum transition
- Promote strength-based parenting and access to early childhood education

ENHANCE SCREENING
- Screen for social, developmental, and behavioral issues
- Screen for parental concerns and social determinants of health

ENSURE ACCESS
- Address material needs and identify emerging behavioral issues
- Engage families in comprehensive, integrated care
- Build population health strategies and refine clinical workflows

BRIDGE CONNECTIONS
- Navigate families to Early Intervention and community-based services
- Provide innovative pathways to specialists

TRANSFORM

STRENGTHEN FOUNDATIONS

SHIFT THE CULTURE
- Fully commit to transformation
- Engage leaders and empower champions
- Involve families and the community
- Identify health disparities and promote equitable access to care

READY THE ENVIRONMENT
- Optimize revenue and prepare for sustainability
- Fortify EMR and reporting systems
- Prepare the physical space
- Foster a trauma-forward, culturally-responsive environment

BUILD THE TEAM
- Augment staffing and establish new roles on the care team
- Grow evidence-based knowledge and clinical skills
- Collaborate in a team-based approach to care

STRENGTHEN

TEAM UP provides clinical training and practice transformation support through the Learning Community

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CREATE A LEARNING COMMUNITY

CLINICAL TRAINING
- Develop skills in the core competencies of pediatric integrated behavioral health care
- Provide role-focused support for new and existing care team members

PRACTICE TRANSFORMATION
- Utilize a data-driven quality improvement framework to promote long-term sustainability
- Share learnings, celebrate successes, and disseminate results

CREATE

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The TEAM UP Learning Community

Learning Community Objectives

CLINICAL TRAINING

- Develop skills in the core competencies of pediatric integrated behavioral health care
- Provide role-focused support for new and existing care team members

- Expand knowledge in core areas of pediatric behavioral health

- Discuss cases with specialists and build capacity and content expertise

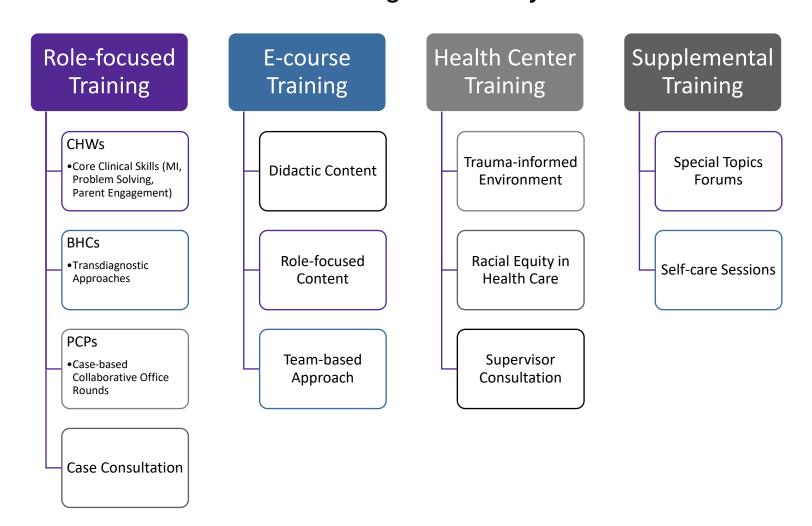- Apply new skills to think through clinical processes as a team

PRACTICE TRANSFORMATION

- Utilize a data-driven quality improvement framework to promote long-term sustainability
- Share learnings, celebrate successes, and disseminate results

- Implement and improve new clinical workflows for integrated behavioral health

- Engage in systems change to enable operational support for new care delivery models

- Innovate, share learning, and build the field through model development and dissemination
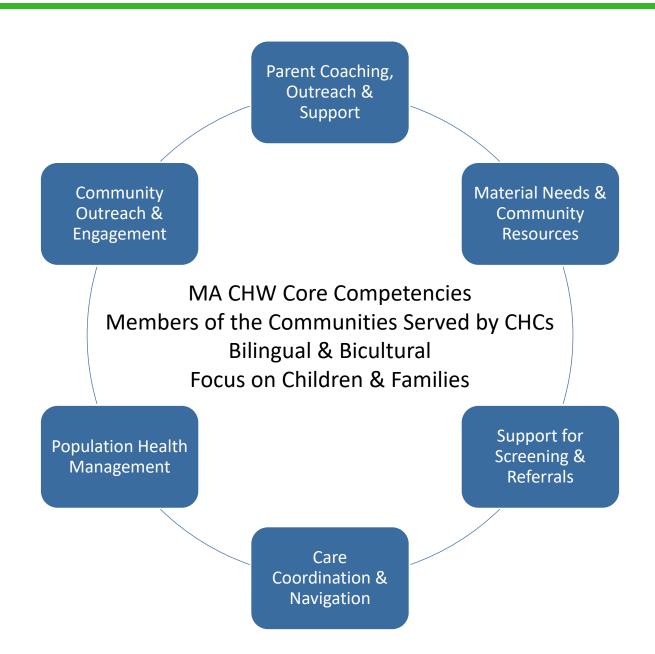
Clinical Training for Family Partners & CHWs, BHCs, and PCPs

If you are a CHW, a BHC, or a PCP at a TEAM UP health center, here's what you receive in clinical training over two years

Role-focused Training

CHWs
- Core Clinical Skills (MI, Problem Solving, Parent Engagement)

BHCs
- Transdiagnostic Approaches

PCPs
- Case-based Collaborative Office Rounds

Case Consultation

E-course Training

Didactic Content

Role-focused Content

Team-based Approach

Health Center Training

Trauma-informed Environment

Racial Equity in Health Care

Supervisor Consultation

Supplemental Training

Special Topics Forums

Self-care Sessions

Family Partner/Community Health Worker Scope of Work

What TEAM UP Is Learning

TEAM UP's evaluation continues to track changes in identification of behavioral health issues, access to care, cost, and child and provider outcomes

1. Improved Identification of Child Behavioral Health Issues?

2. Increased Receipt of Evidence-informed Behavioral Health Services for Children?

Data Source: Electronic medical record Data monthly about *every* pediatric encounter

Includes ICD codes; psychotropic medications; item-level screening and BH plans from PCPs, BHCs, and CHWs

3. Improved Child Outcomes Including Reduction in ED Visits and Hospitalizations, and Increases in On-site Behavioral Health Care?

4. Reduced Medical Expenditures/Cost Savings?

Data Source: MA All-Payer Claims Dataset (APCD)*

Includes data on children at TEAM UP sites and matched controls, regardless of health insurance

5. Change in Pediatric Providers' Perceived Level of Integration, Burnout/Professional Fulfillment, and Confidence Assessing and Treating Child Behavioral Health Conditions Over Time?

Data Source: Surveys of providers and staff at three time points

Includes measures on Level of Integration; Mental Health Practice Readiness Inventory; Maslach Burnout Inventory and Areas of Work Survey; Assessment of comfort with diagnosing and managing various BH conditions

* CHIA stopped work on APCD data when they redirected efforts to other state COVID-19 data needs. Our analysis of Cohort 2 APCD data is currently paused until the state resumes APCD data availability.
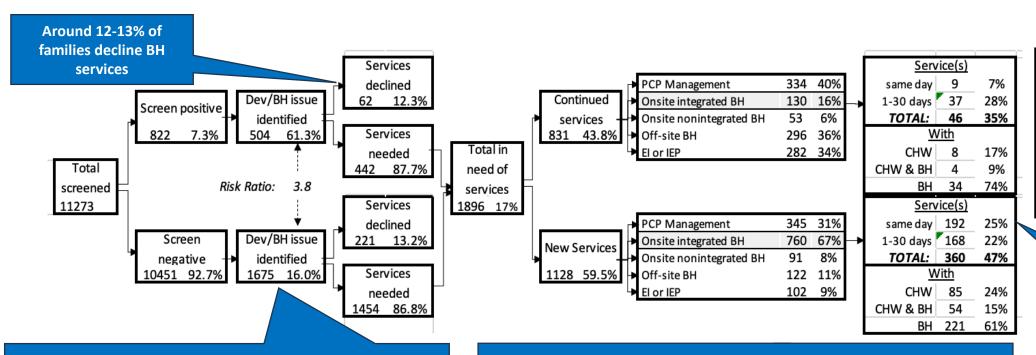
Highlights from TEAM UP Cohort 1 Study – recently published in *Pediatrics**

- **Screening for social, emotional, and behavioral issues was completed at over 80% of well-child visits** across age groups, which is significantly greater than the highest reported estimate of the statewide average (74%) as well as the long-term average reported by the State's BH initiative (67.5%)

- **Children who received warm handoffs were more likely to complete an additional behavioral health visit** as compared to routine internal referral. Because a warm handoff includes an immediate visit, children with warm handoffs receive two behavioral health visits before children with routine internal referrals receive one behavioral health visit

- There was a **significant decline in polypharmacy** from 9.5% at the beginning of the project to 5.7% by the end

- Children who received new diagnoses of ADHD after implementation of TEAM UP **were more likely to have a follow-up contact with a clinician within 30 days of diagnosis** (62.9% vs 78.3%)

*Sheldrick, R.C., Bair-Merritt, M., Durham, M.P., Rosenberg, J., Tamene, M., Bonacci, C., Daftary, G., Tang, M.H., Sengupta, N., Morris, A., Feinberg, E. Integrating pediatric universal behavioral health care at federally qualified health centers. *Pediatrics.* 2022;149(4):e2021051822

Cohort 2 is using new data visualization tools to track how children are identified with a behavioral health issue and receive services

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Early findings show **continued strong results in identifying behavioral health (BH) issues and ensuring prompt access to BH services,** even through the challenges brought by the pandemic

Around 12-13% of families decline BH services

Total screened 11273		

Screen positive 822 7.3% → Dev/BH issue identified 504 61.3%

Screen negative 10451 92.7% → Dev/BH issue identified 1675 16.0%

Risk Ratio: 3.8

Services declined 62 12.3%

Services needed 442 87.7%

Services declined 221 13.2%

Services needed 1454 86.8%

Total in need of services 1896 17%

Continued services 831 43.8%

PCP Management	334	40%
Onsite integrated BH	130	16%
Onsite nonintegrated BH	53	6%
Off-site BH	296	36%
EI or IEP	282	34%

New Services 1128 59.5%

PCP Management	345	31%
Onsite integrated BH	760	67%
Onsite nonintegrated BH	91	8%
Off-site BH	122	11%
EI or IEP	102	9%

Service(s)		
same day	9	7%
1-30 days	37	28%
TOTAL:	**46**	**35%**
With		
CHW	8	17%
CHW & BH	4	9%
BH	34	74%

Service(s)		
same day	192	25%
1-30 days	168	22%
TOTAL:	**360**	**47%**
With		
CHW	85	24%
CHW & BH	54	15%
BH	221	61%

This tool presents data on PSC-17 screening & PCP's plan of care for children ages 5-18 years

Data collected from 6/1/20 – 8/31/21

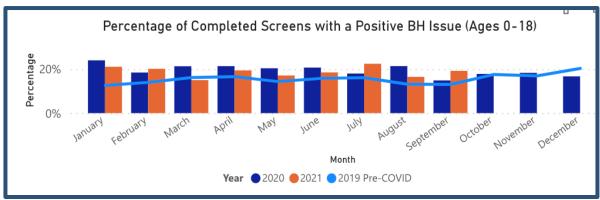A positive screen is highly correlated with being identified with a BH Issue; however, **most children identified with a BH issue screen negative***
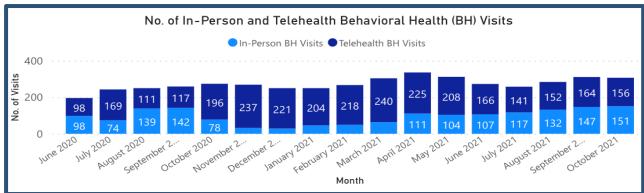
In this example, 11,273 children were screened; 504 children who were identified with a BH issue screened positive; 1675 children who were identified with a BH issue screened negative

* This finding replicates prior findings published by Karen Hacker

The **most common key BH issues** for each age group are:
- Under 5 years: developmental concern; social/material need; family stress
- 5-13 years: developmental concern; hyperactivity/inattention; anxiety
- 13-18 years: depression; anxiety; hyperactivity/inattention

Most children in need of new BH services are **referred to the integrated care team** and are seen on the same day; more children are **referred to the integrated BHC and the CHW**

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TEAM UP's new public interactive dashboard provides real-time data on screening, receipt of behavioral health services by telehealth, and SDOH needs during the pandemic
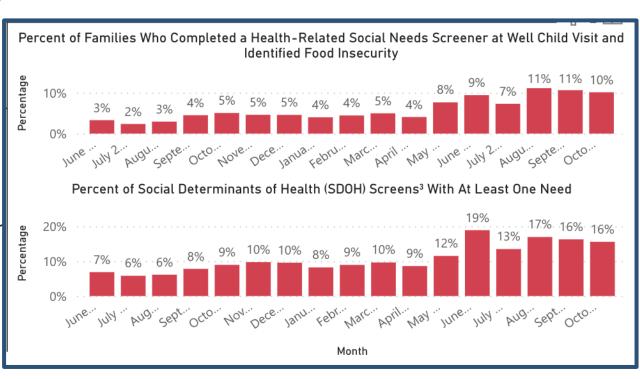
Percentage of Completed Screens with a Positive BH Issue (Ages 0-18)

Percentage — 20%, 0%

Month: January, February, March, April, May, June, July, August, September, October, November, December

Year: 2020, 2021, 2019 Pre-COVID

No. of In-Person and Telehealth Behavioral Health (BH) Visits

In-Person BH Visits • Telehealth BH Visits

No. of Visits — 400, 200, 0

Month	Telehealth	In-Person
June 2020	98	98
July 2020	169	74
August 2020	111	139
September 2...	117	142
October 2020	196	78
November 2...	237	
December 2...	221	
January 2021	204	
February 2021	218	
March 2021	240	
April 2021	225	111
May 2021	208	104
June 2021	166	107
July 2021	141	117
August 2021	152	132
September 2...	164	147
October 2021	156	151

The percent of **positive screens for BH issues has been higher virtually every month throughout the pandemic** when compared to pre-pandemic levels

This graph from Cohort 1 shows the percentage completed screeners that were positive pre-COVID and now

During the pandemic, telehealth became a consistent delivery platform for BH visits, accounting for **more than 50% of visits from October 2020-June 2021 at Cohort 2 CHCs**, at which point the proportion of telehealth and in-person visits became approximately equal

Percent of Families Who Completed a Health-Related Social Needs Screener at Well Child Visit and Identified Food Insecurity

Percentage — 10%, 0%

June 3%, July 2%, Augu 3%, Septe 4%, Octo 5%, Nove 5%, Dece 5%, Janu 4%, Febru 4%, Mar 5%, April 4%, May 8%, June 9%, July 7%, Augu 11%, Septe 11%, Octo 10%

Percent of Social Determinants of Health (SDOH) Screens[3] With At Least One Need

Percentage — 20%, 10%, 0%

June 7%, July 6%, Aug 6%, Sept 8%, Octo 9%, Nov 10%, Dec 10%, Janu 8%, Febr 9%, Mar 10%, April 9%, May 12%, June 19%, July 13%, Aug 17%, Sept 16%, Octo 16%

Month

There has been a **notable increase in SDOH needs and food insecurity** identified between June and October 2021 at Cohort 2 CHCs; one possible explanation is the marked increase in inflation since April 2021
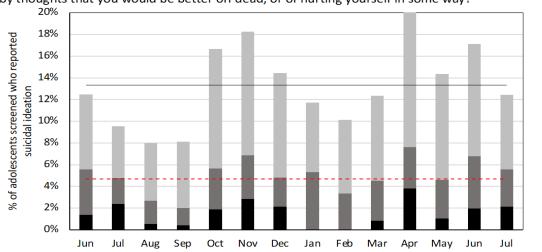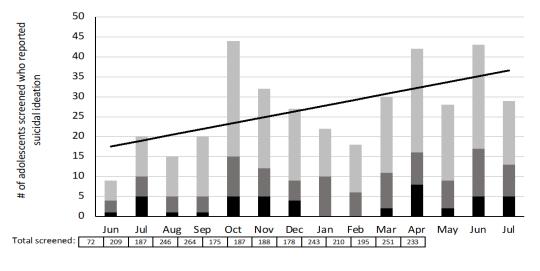
Screening for suicidal ideation in TEAM UP (Cohort 2)

Question posed to adolescents: Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?

The average % of adolescents reporting any suicidal ideation at Cohort 2 CHCs during the pandemic is more than 2x the national average

This is a benchmark of the national average before COVID (NHANES Study 2017-2018)

Over time, more children are reporting suicidal ideation

Total screened: 72 | 209 | 187 | 246 | 264 | 175 | 187 | 188 | 178 | 243 | 210 | 195 | 251 | 233

Legend: ■ Nearly every day ■ More than half the days ■ Several days — trend over time

<u>Note</u>. Data do not include adolescent who reported "not at all" or were not screened, for example because they presented with a behavioral health crisis; for NHANES (2017-2018), see: https://wwwn.cdc.gov/Nchs/Nhanes/limited_access/DPQY_J_R.htm

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TEAM UP's Cohort Study suggests improved child outcomes coincident with behavioral health care at Cohort 1 health centers

Highlights from TEAM UP Cohort Study*

- TEAM UP's Cohort Study **included 60 children, ages 6-12, with a behavioral health issue** for which they were receiving care at the health center; parents surveyed at baseline and then at 6 and 12 months

- There was **improvement in children's behavioral symptoms, health-related quality of life, and school-related functional outcomes** over 12 months

- Improvements in behavioral symptoms and health-related quality of life were associated with **improvements in school-related functional outcomes** over time

- The assessments reported here offer a much **richer clinical picture than is available through EMR or claims data alone**

- Findings are consistent with the hypothesis that **the evidence-based treatments offered through TEAM UP were effective**, although the effect of other confounders, maturation, and regression to the mean cannot be ruled out

*These findings are excerpted from the currently embargoed Cohort Study report. Please do not share or disseminate.

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Highlights from TEAM UP Claims Analysis Study* and Statewide Pediatric Behavioral Health Claims Analysis**

- Using data from a Massachusetts Medicaid managed care plan (2014-2017) an analysis was conducted to look at the **impact of TEAM UP on health care utilization and costs**

  - After 1.5 years of implementation, TEAM UP was associated with a **relative increase in the rate of primary care visits**, driven by children with a mental health diagnosis at baseline, but **no change in rates of ED visits, inpatient admissions, or other outpatient visits**

  - Even with increased rates of primary care, there was **no significant change in avoidable health care utilization or cost** at TEAM UP health centers 1.5 years into implementation

- Using CHIA data (2013-2017), a supplemental analysis of BH-related ED visits for all children across the state revealed that **BH and all-cause ED visits decreased from 2013-2017 with young adults** (18-21) **experiencing the largest declines in BH-related (63% decrease) and all-cause (61% decrease) ED visits,** and ED visits declining across most diagnostic subgroups, autism spectrum disorder and suicidal-related diagnoses excepted

*Cole MB, Qin Q, Sheldrick RC, Morley DS, Bair-Merritt MH. The effects of integrating behavioral health into primary care for low-income children. Health Serv Res. 2019;54:1203–1213. https://doi.org/10.1111/1475-6773.13230

**These findings are excerpted from a currently embargoed manuscript. Please do not share or disseminate.

Cohort 1 staff reported perceived benefits associated with the TEAM UP model, and we are tracking provider and staff burnout and professional fulfillment for Cohort 2

Highlights from TEAM UP Cohort 1 and Cohort 2 Studies of Provider Burnout

- Results from qualitative interviews conducted with Cohort 1 demonstrated that the TEAM UP model of integrated BH care was **associated with perceived greater interdisciplinary collaboration and communication, and enhanced provider wellness***

- We added the Maslach Burnout Inventory to staff surveys for Cohort 2, and at baseline, **PCPs reported higher levels of burnout** in comparison to their BHC and CHW colleagues

- Compared to national estimates among physicians and psychologists, **Cohort 2 PCPs and BHCs reported lower levels of burnout**, while personal accomplishment was similar

- While we collected the baseline Cohort 2 provider burnout data prior to the onset of the pandemic, **we have recently collected these data at mid-point, and will again at the end of the implementation period**

*Fong, H., Tamene, M., Morley, D. S., Morris, A., Estela, M. G., Singerman, A., & Bair-Merritt, M. H. (2019). Perceptions of the Implementation of Pediatric Behavioral Health Integration in 3 Community Health Centers. Clinical Pediatrics. 2019 Oct;58(11-12):1201-1211. https://doi.org/10.1177/0009922819867454

Grantmakers in Health Webinar
April 14, 2022

Amy Rosenthal
arosenthal@hcfama.org

Health Care For All

Direct Service: Free consumer HelpLine

Policy: Advocacy and coalitions

Community: Outreach and organizing

www.hcfama.org

Health Care For All (HCFA) advocates for health justice in Massachusetts by working to promote health equity and ensure coverage and access for all.

Window of opportunity

1115 Medicaid Waiver

MassHealth 1115 Medicaid Waiver renewal process

Lays out parameters and federal funding for state Medicaid program

Drafted by state Medicaid program and negotiated with Centers for Medicare and Medicaid (CMS)

Provides federal flexibility for state Medicaid program to test innovations that support the goals of the Medicaid program, including improving health care outcomes and reducing costs

Current waiver effective until June 30, 2022

Key Provisions in 1115 Waiver Proposal

Specific focus on pediatric care, behavioral health & primary care

New primary care payment structure ("sub-capitation")
- Prioritizes team-based integrated care
- Child & family-specific competencies

Focus on Social Determinants of Health screening and support
- Increased funding for SDOH program
- Family-based nutrition supports

New health equity data and accountability program
- Data collection & stratification (race, ethnicity, language, etc.)
- Accountability and incentives for reducing disparities

HCFA 1115 Waiver Advocacy

1. Strategic partnerships

2. Appointed to all three EOHHS stakeholder workgroups

3. Extensive written comments during public comment opportunties

4. Conducted research and drafted policy memos

5. Regular check-ins with senior MassHealth policy staff

6. 1:1 meetings with MassHealth and EOHHS leadership

7. Meetings with Congressional delegation & CMS

Why should advocacy be included?

- Promote program sustainability

- Support systemic change

- Elevate under-represented voices

- Provide clinicians with tools to make change and support programs