Children's Behavioral Health Collaborative

Partnering to Improve Behavioral Health Outcomes for Children & Families in Palm Beach County

Presentation to PBC Citizen's Advisory Committee

June 9, 2016

Children's Behavioral Health Collaborative

Collaborative Purpose

The Children's Behavioral Health Collaborative (CBHC) was formed to help build healthy communities through a seamless, accessible, and recovery oriented system of care for children and their families in need of behavioral health services throughout Palm Beach County.

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Development of CBHC

In response to the County FAA proposal, key leaders from Boys Town South Florida, Center for Child Counseling, Families First of Palm Beach County, NAMI of PBC, and FAU Community Health Center developed the Children's Behavioral Health Collaborative (CBHC) to improve the system of care for children experiencing mental health concerns. With Boys Town as the lead, a request was submitted to the County, earning the highest scores and recommendations from the review team. The Board of County Commissioners approved funding for the CBHC on July 22, 2014, with the contract starting October 1, 2014.

Additional funding has been secured from the Quantum Foundation and PBC's Youth Services Department.

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Overview of Core Partners

Participating Agencies and Primary Roles:

- **Boys Town** – Care Coordination Services
- **Center For Child Counseling** – Individual, Family, and Group Therapy
- **Families First** – Individual, Family, and Group Therapy
- **Florida Atlantic University's Community Health Center** – Psychiatric Assessment, Medication Management, and Health Services
- **National Alliance on Mental Illness- PBC** – Peer Support, Family Education and Support, Functional Skills training, Advocacy and Outreach

Note: 975 children served (assessed/opened, triaged) since 10/1/2014

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Year 1 Report --Evaluation of the *Children's Behavioral Health Collaborative, Palm Beach County, FL*

JUNE 9, 2016- PRESENTATION TO PBC CITIZEN'S ADVISORY COMMITTEE

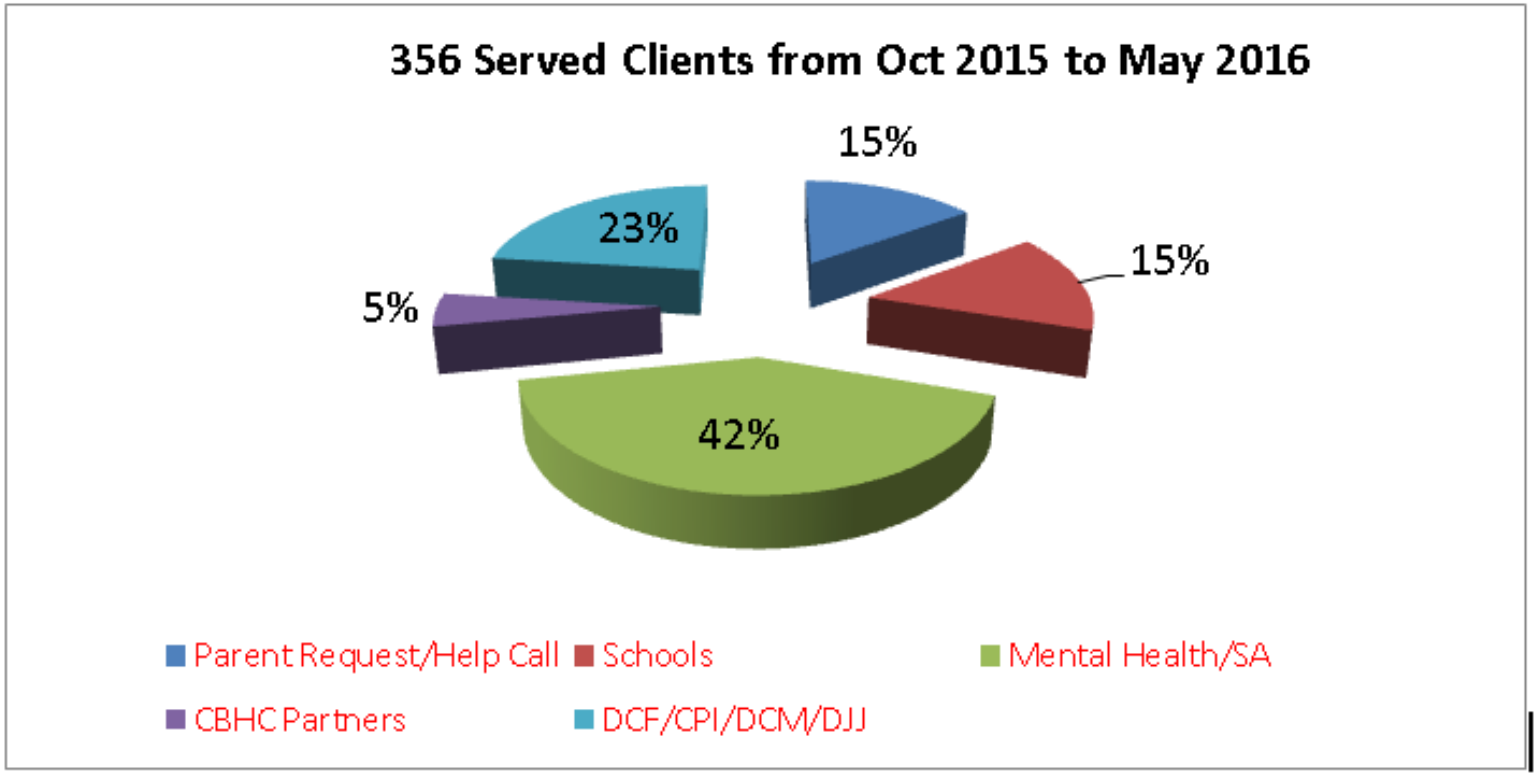
EVALUATORS: JONI WILLIAMS SPLETT, PH.D., UNIVERSITY OF FLORIDA, AND MARK WEIST, PH.D., UNIVERSITY OF SOUTH CAROLINA

CBHC Goals

For families and youth with challenging emotional/behavioral problems:

- Make it easier to get help
- Provide services at school, in home, and in the community
- Ensure access to an array of services
- Enhance family voice and choice
- Improve communication and collaboration
- Empower effective systems navigation

PBC Served Clients- Referral Sources



Evaluation Overview

May 1, 2015 through April 30, 2017

Focus on about 600 cases receiving care coordination between 10.1.14 and around 1.31.17

Interim reports (December, 2015; June 2016; October/November 2016)

Final report March, 2017 (in time for application for the next funding cycle)

Mix of qualitative and quantitative analyses

Assessment as intervention and focus on ongoing quality improvement

Situating the work here in relation to other work in Florida and in relation to national developments in systems of care

Definitions and Abbreviations

Abbreviation	Full Name	Definition
CBHC (ALL)	Children's Behavioral Health Collaborative	Inclusive of ALL clients receiving care coordination services from Boys Town South Florida (BT)
PBC	Palm Beach County	The primary funder, PBC Financial Assisted Agency
SEFBHN	Southeast Florida Behavioral Health Network	Inclusive of all clients who received services funded by BNET and/or SEFBHN at any time during their stay
MEDICAID	Medicaid	Inclusive of all clients who received services funded by CENPATICO, CMS, HLTHE/WELC, HUMANA, MCC, MEDICAID, WELLCARE and/or MOLINA at any time during their stay

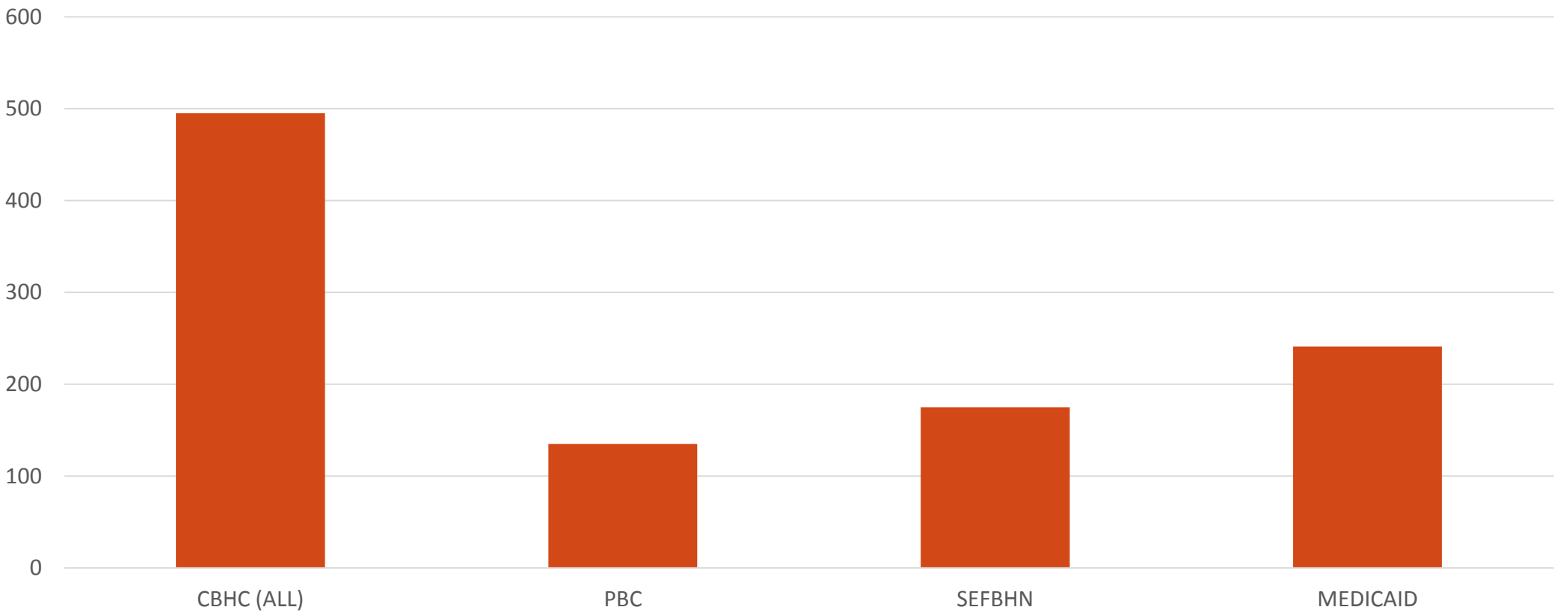
Year 1 Evaluation Overview

- Includes admitted children from 10.1.14 to 3.31.16

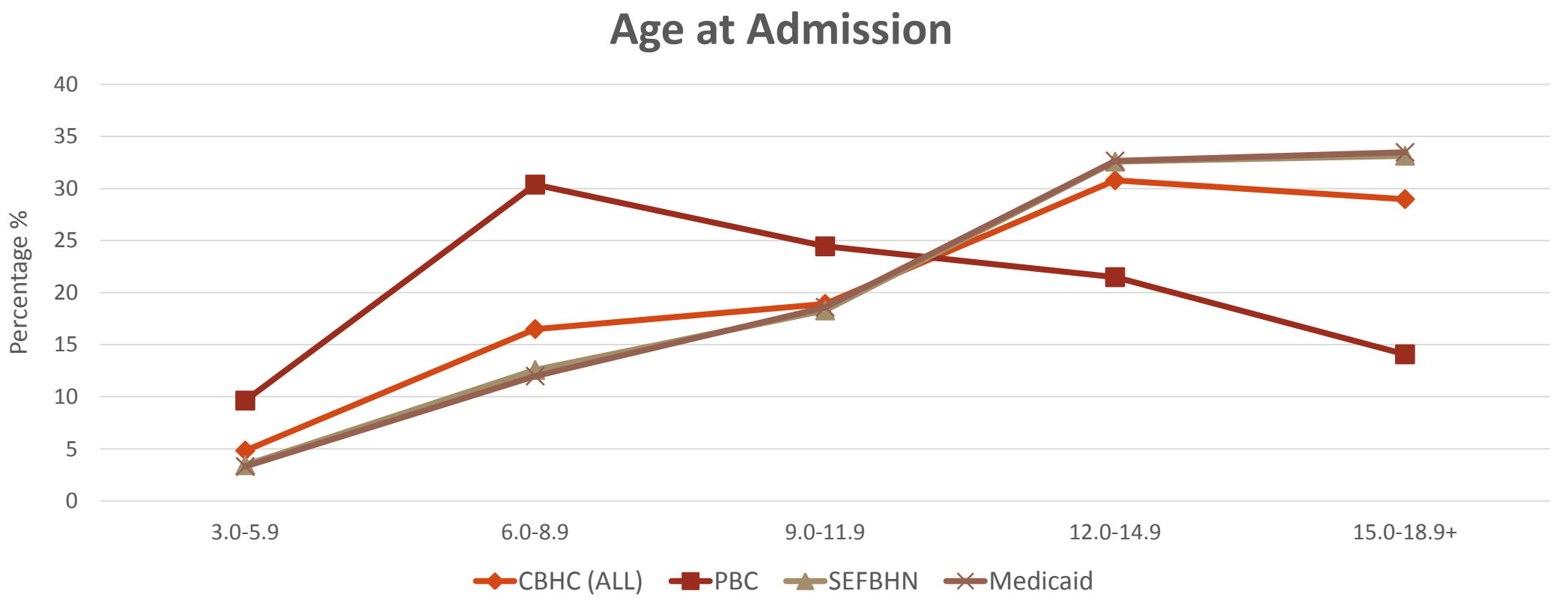
- Client demographic, educational, diagnostic, and case characteristics
- Latency and point of service entry
- Length of service provision and types of services provided
- Medication usage
- Assessment of outcomes: Children's Functional Assessment Rating Scale and Pediatric Symptom Checklist
- Case studies using school records

In later slides, * indicates significant differences between funding source

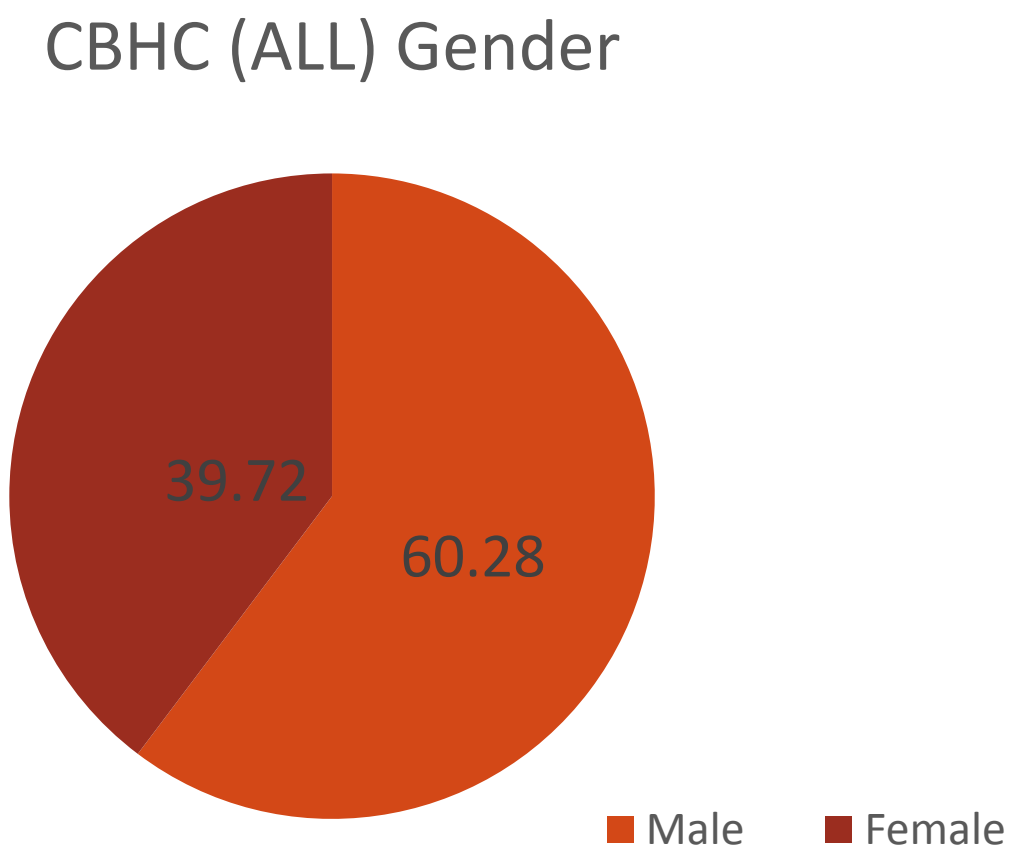
Number of Clients by Funding Source



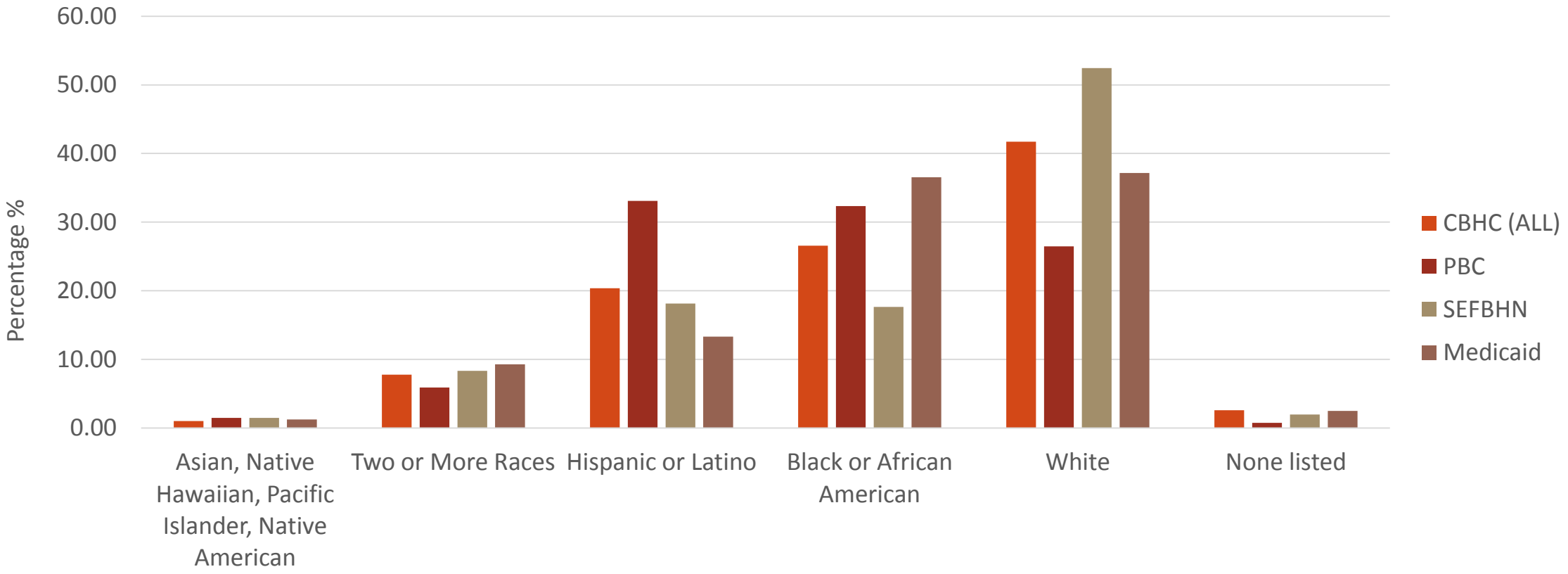
Client Demographics: Age at Admission Group by Contract*



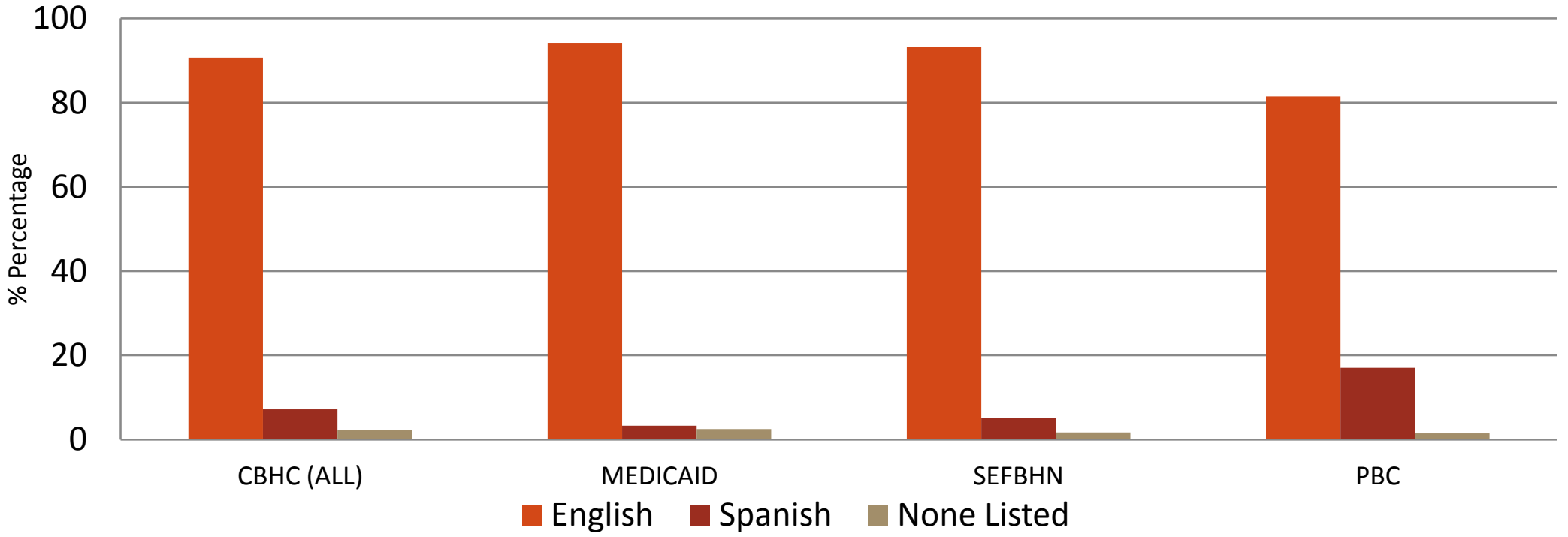
Client Demographics: Gender



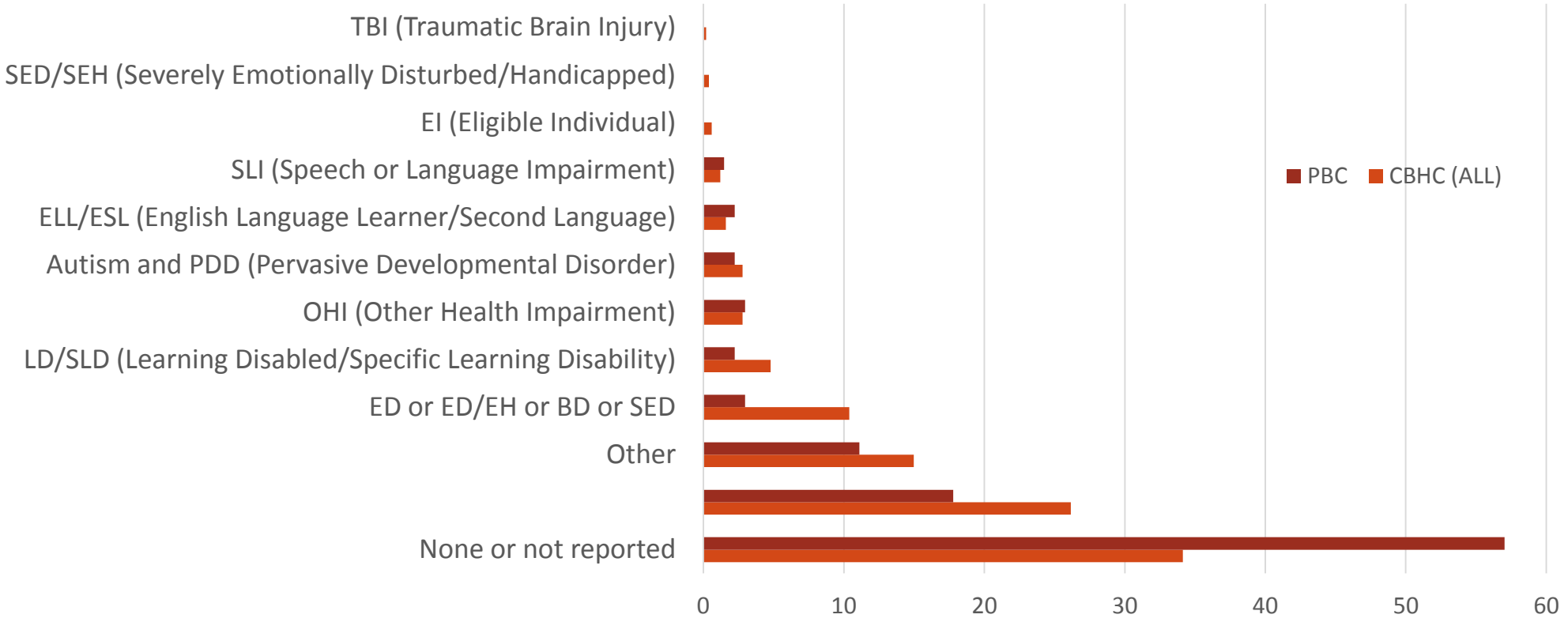
Client Demographics: Race by Contract*



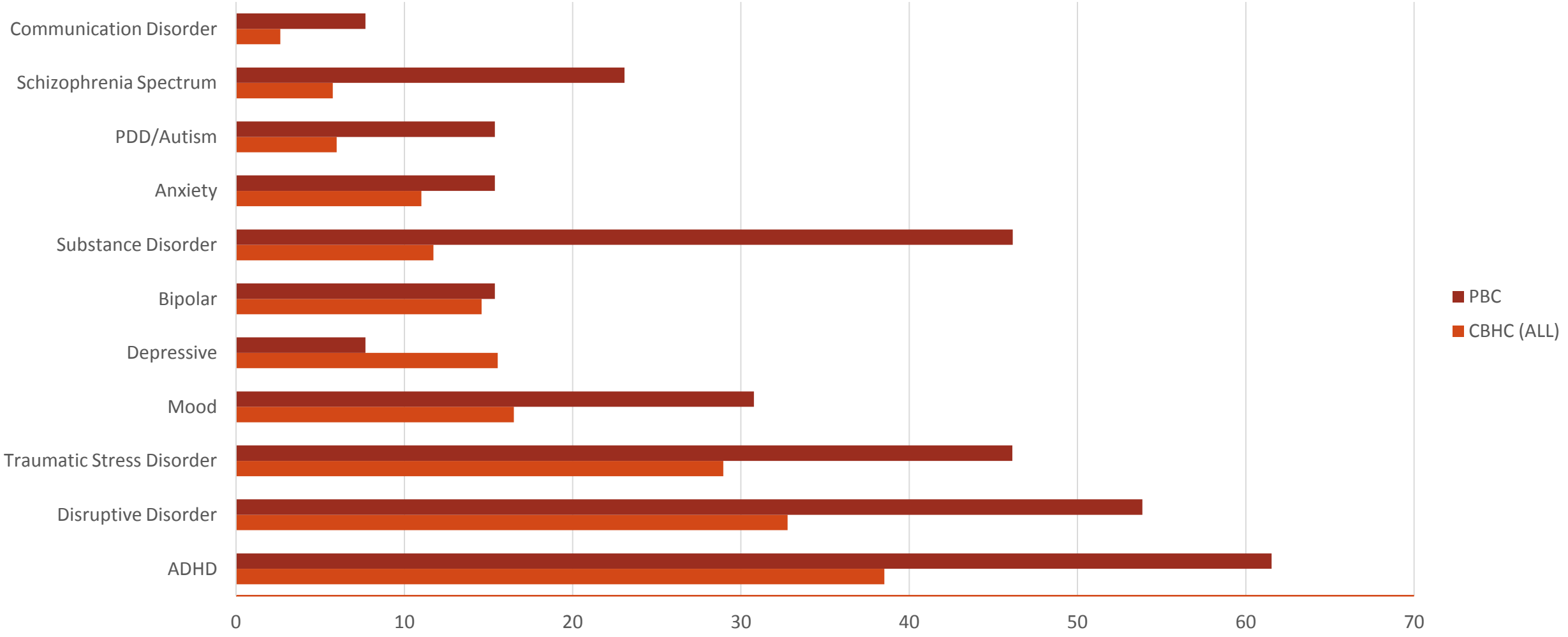
Client Demographics: Language by Contract*



Client Demographics: Educational Classification



Types of Presenting Problems: Diagnostic Categories



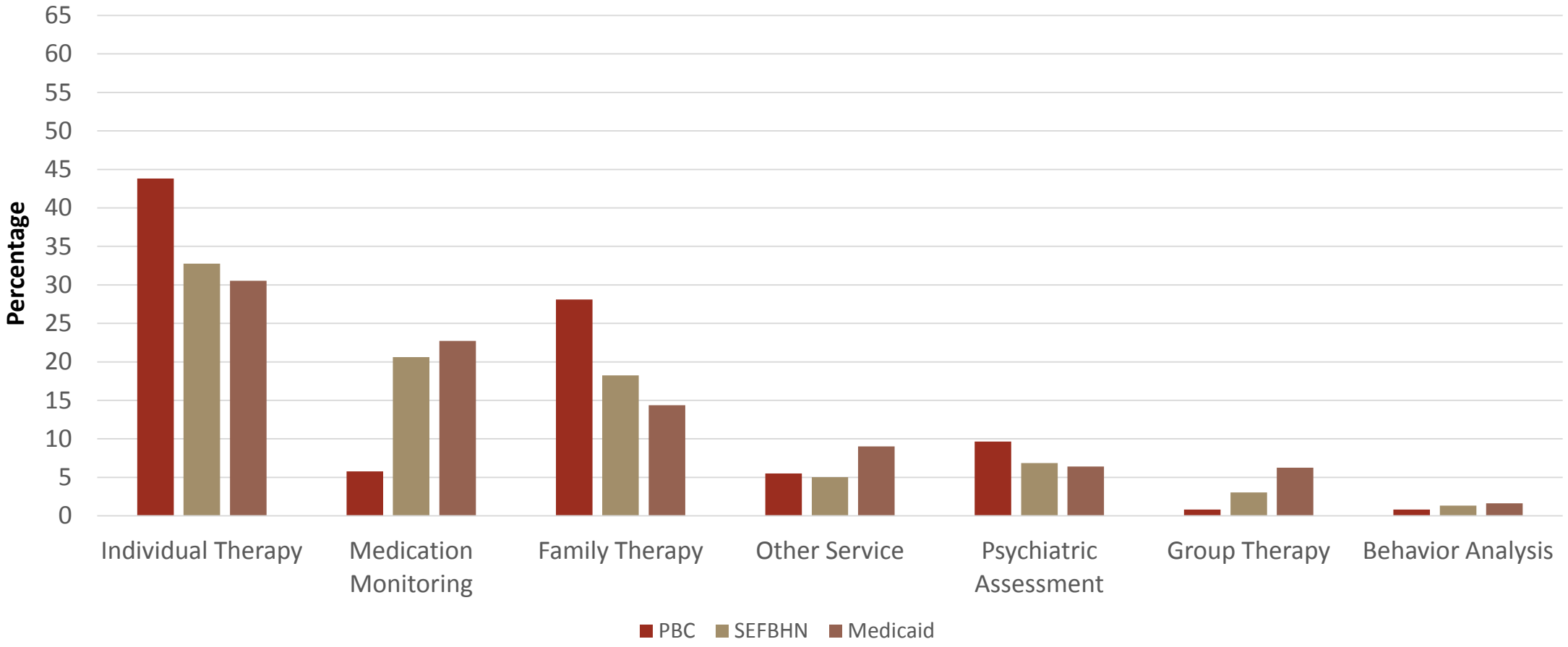
Latency of Service Provision from External Providers after Referral*

	Mean (Months)	Mean # of Days (Days)	Std. Deviation (Months)	Median (Months)
CBHC (ALL)	0.25	7.4 days	0.51	0.00
PBC	0.21	6.2 days	0.32	0.00
MEDICAID	0.28	8.4 days	0.57	0.00
SEFBHN	0.21	6.2 days	0.45	0.00

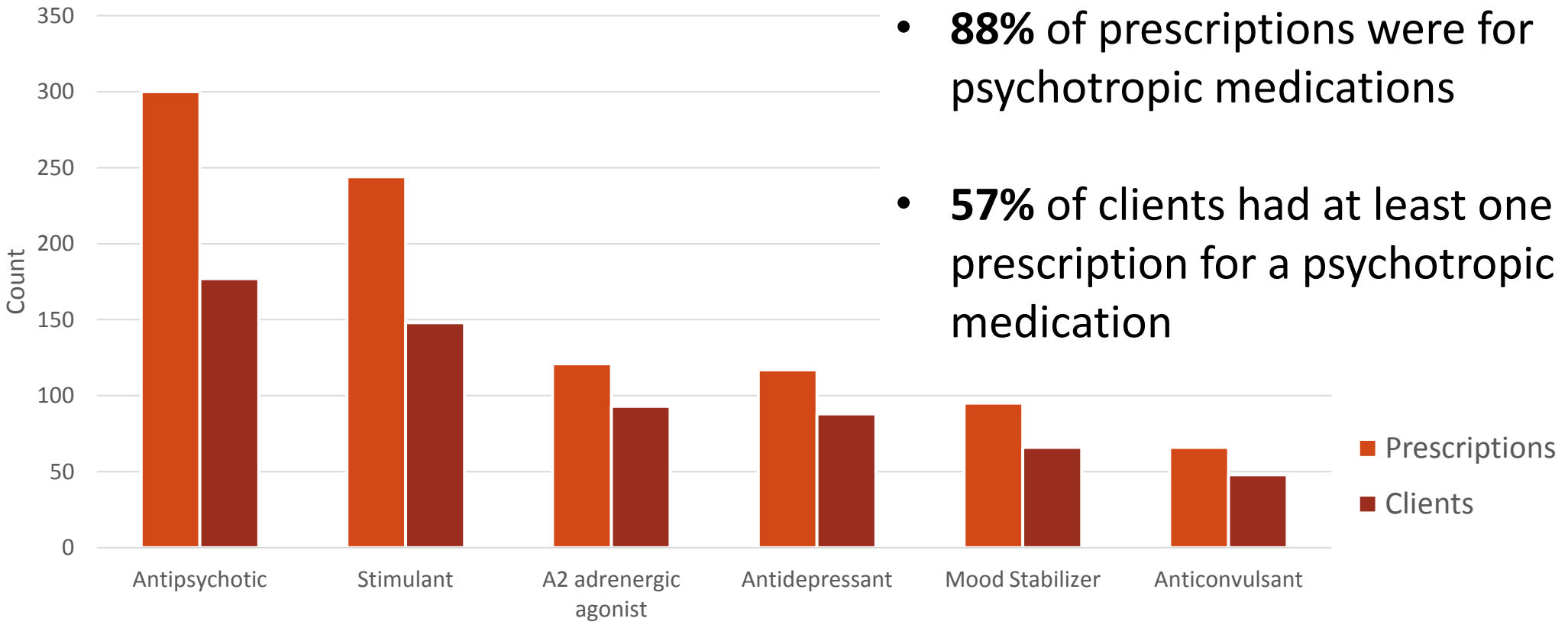
Length of Service for Discharged Clients (Months) by Contract*

	Mean	Std. Deviation	Median	Minimum	Maximum
CBHC (ALL)	5.74	3.81	5.10	0.17	17.40
PBC	7.19	3.57	6.77	0.57	16.97
MEDICAID	5.07	3.67	4.20	0.17	16.40
SEFBHN	5.47	3.92	4.35	0.17	17.40

Types of Services – Percent of all Services Funded by Contract*

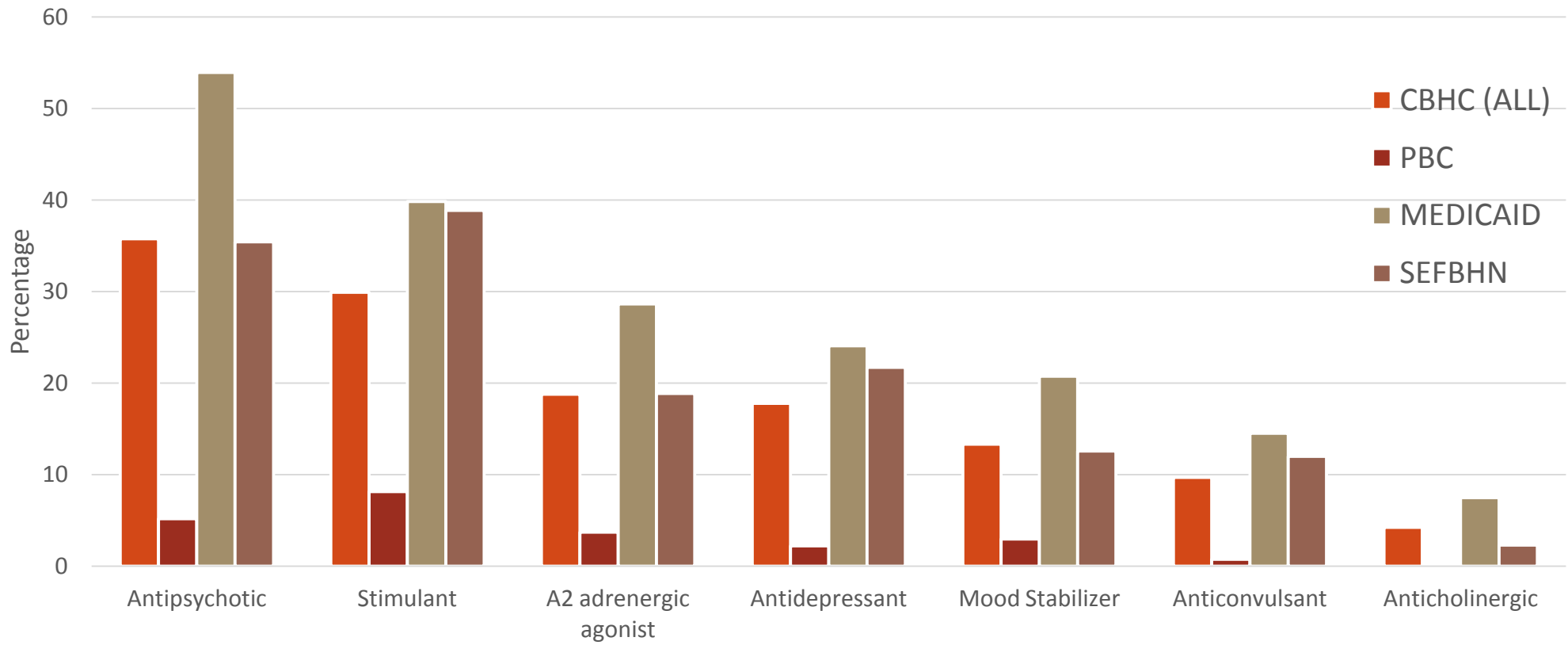


Medication Prescriptions for CBHC (ALL) Clients



- **88%** of prescriptions were for psychotropic medications
- **57%** of clients had at least one prescription for a psychotropic medication

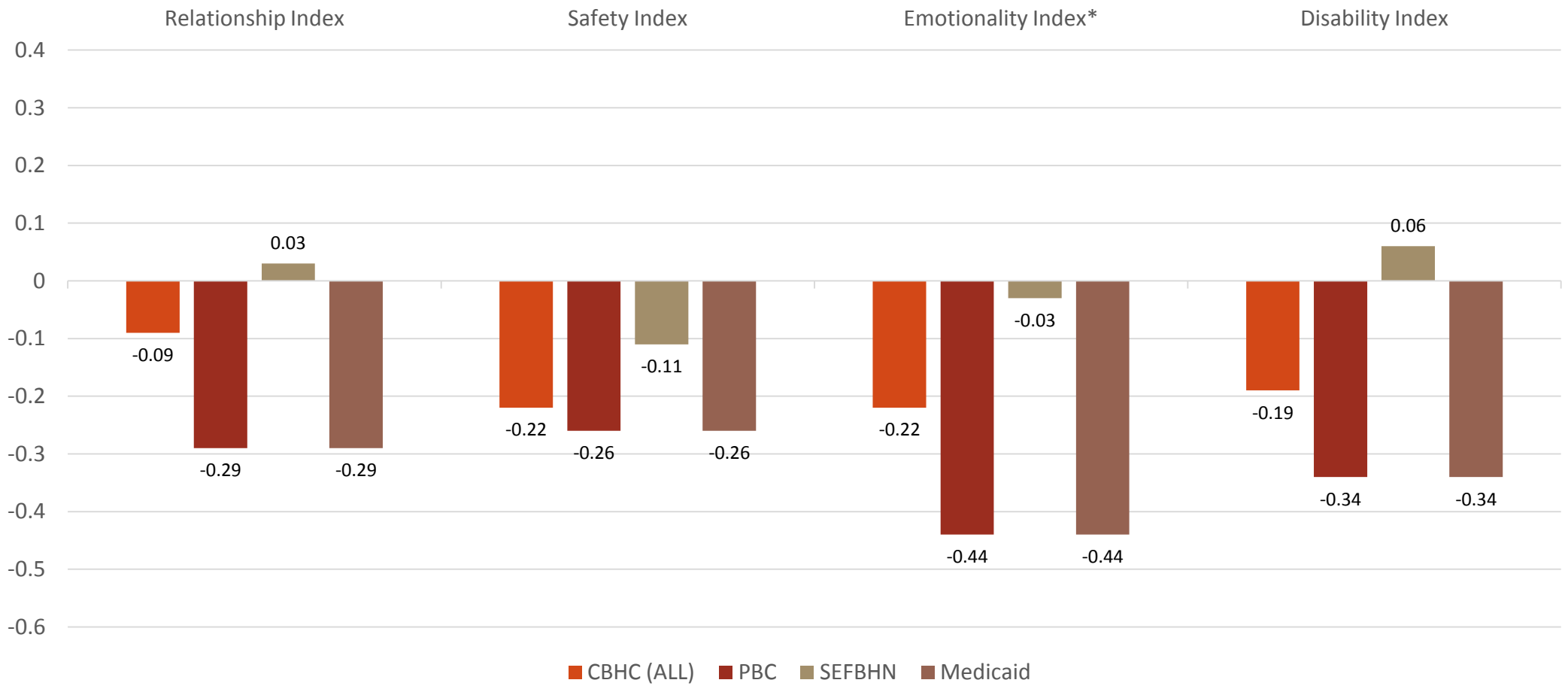
Percent of Unique Clients on Medication by Contract



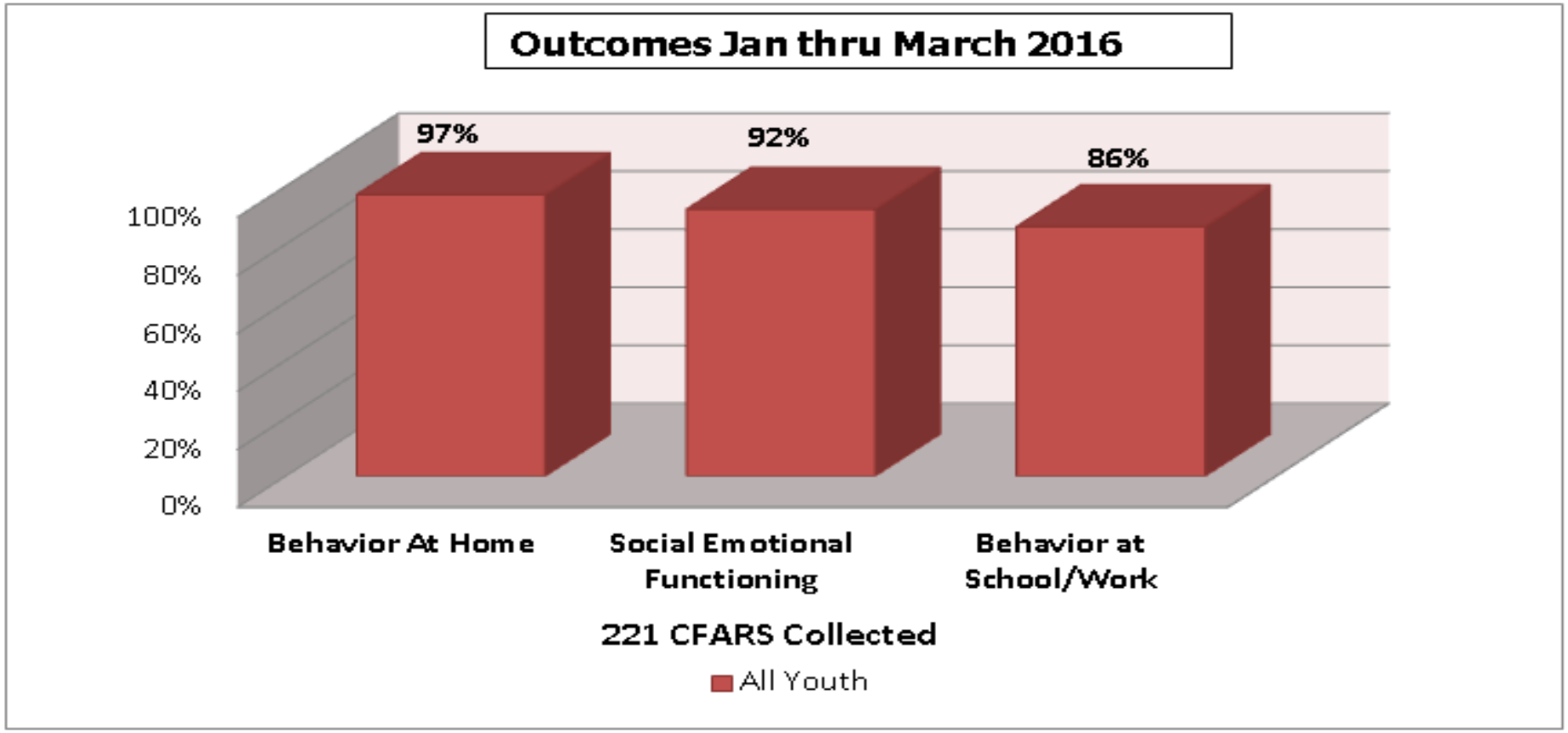
Children's Functional Assessment Rating Scale -- Index Scores

Relationships	Safety
Hyperactivity Work or School Interpersonal Relationships Cognitive Performance Behavior in the Home Danger to Others	Socio-Legal Substance Use Security Management Needs Danger to Self
Emotionality	**Disability**
Anxiety Traumatic Stress Depression	Activities of Daily Living Functioning Medical/Physical Thought Process

CFARS: Change from Intake to Discharge by FIRST Funder*



PBC Outcomes- CFARS



Evaluating Psychosocial Outcomes

Adopted Pediatric Symptom Checklist – Parent and Youth Self Report

Developed online administration via Qualtrics

- County grant awarded January 25 and Qualtrics contract signed February 29

Started March 1, 2016

34 parent-report forms, and 28 student report forms collected at intake

5 parent report forms collected at 3-month follow-up

Pediatric Symptom Checklist

34 valid parent report intake assessments

Total Score Mean = 35

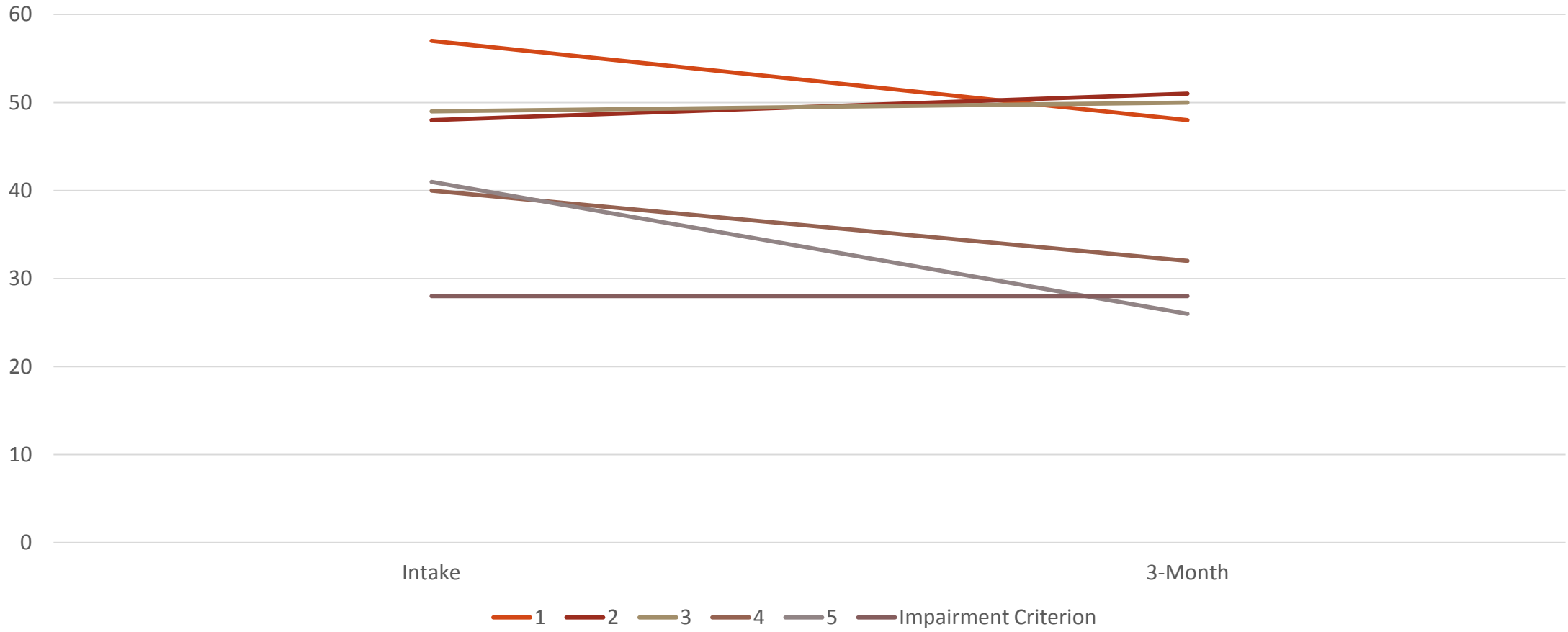
- Minimum = 7, Maximum = 57
- 26 of 34 (76.5%) meet impairment criterion (Total Score ≥28)

28 valid youth self-report intake assessments

Total Score Mean = 29.86

- Minimum = 9, Maximum = 47
- 14 of 28 (50%) meet impairment criterion (Total Score ≥30)

Treatment Progress: Parent Report



Exploring school record variables for some cases

Five students with school record data

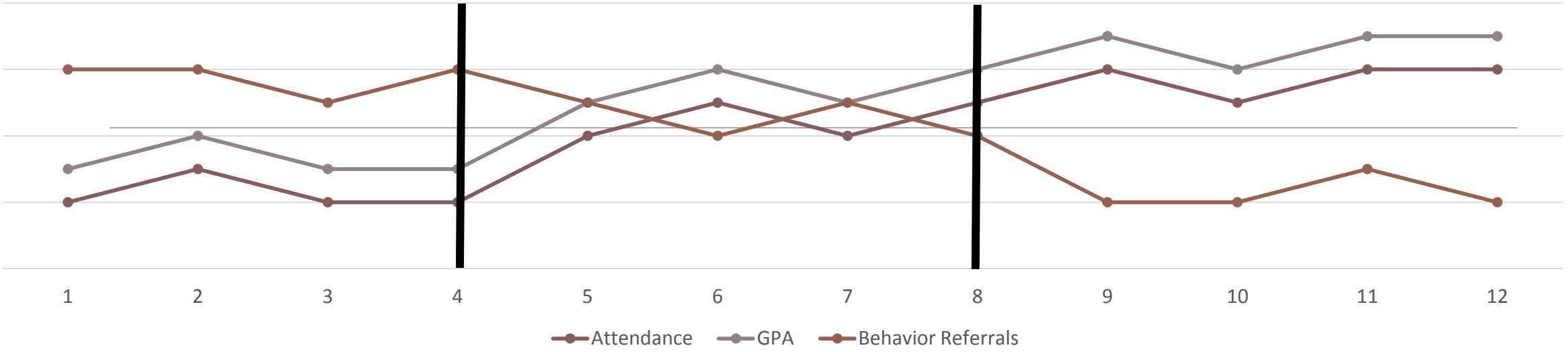
Variability in school record data and other information available

- Absences and tardies best available data

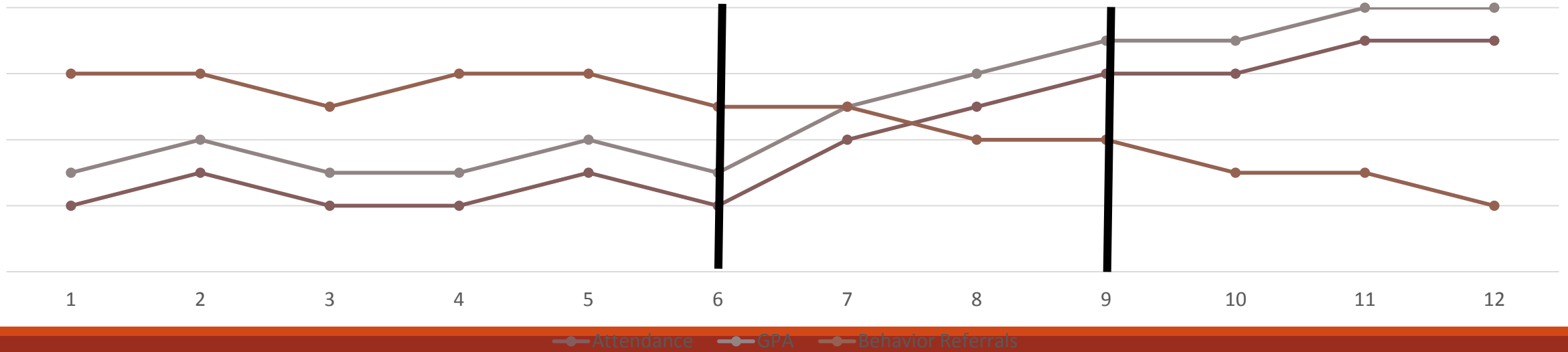
Goals

- Attain deeper understanding of presenting problems and what happens with individual children
- Children are regularly being seen in schools- need to incorporate this data into evaluation
- Determine trends in relation to functioning before, during and after intervention

MADE UP EXAMPLES, Student A:



Student B:



CONCLUSIONS

Continuing evidence for strong collaboration and commitment to helping these youth

County funded cases:

- Earlier age of admission and greater diversity on language and race/ethnicity
- Serving children and youth with diverse diagnostic presentations
- Associated with longer length of services

Individual therapy is primary service approach, along with care coordination

Greater than half the sample on psychotropic medication, 36% on antipsychotics

- 5% County funded on antipsychotics, 54% Medicaid funded cases on antipsychotics

CONCLUSIONS 2

Positive change from intake to discharge on CFARS for all service funding types

Pediatric Symptom Checklist is usable, documenting impairment (76% of sample based on parent report) and in small number of initial cases (5) showing improvement in the right direction

School record data are complex, and more work is needed on case studies

NEED FOR SYSTEMATIC REVIEW AND FOLLOW-UP ACTION FOR ALL CASES SEEN SO FAR:

For example -- medication status and appropriateness of intervention, diagnostic labels and their appropriateness, quality of care in relation to dose and evidence-based practices received

PILOTING OF PROCESS FOR NEW CASE FORMULATIONS/TREATMENT PLANS