Promoting Triple P as a Norm in Pediatric Practice

Through NC Project LAUNCH, Whole Person Integrated Care, and NC Partners' System of Care Expansion Grant

HFCC 2018 – Martha Kaufman on behalf of
NC Partners Behavioral Health Management

NC Project LAUNCH/s Family Centered Medical Home Model (2012-2015)

- Public health approach
- For children 0-8 and their families
- Improving systems that serve young children to promote physical, social, cognitive & emotional growth
- Grantee - NC DPH/Women & Children's Branch
- Local implementation site - Alamance County (Lead Agency – Department of Public Health) 1/2012- 9/2015
- 55 SAMHSA-funded sites

NC Project LAUNCH

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Medical Home

- Primary care that is accessible, continuous, comprehensive family-centered, coordinated, compassionate & culturally effective
- For all children and youth, including children & youth with special health care needs

Family-Centered Care

- Recognizes vital role of families in health & well-being of children
- Emotional, social, & developmental support are integral components of health
- Respects child's/ family's innate strengths
- Health care is opportunity to build on strengths, support families in care-giving & decision-making
- Includes screening, assessment, referral

Family-Centered Medical Home

- An approach, not just a place
- Pediatric care team works in partnership with child & family to assure medical & non-medical needs are met
- Helps the family access, coordinate, & understand specialty care, educational services, family support, other community services to promote overall health of child & family

American Academy of Pediatrics

Prevention & Promotion & Intervention

1. Promotion – Stay Positive Campaign
2. Screenings: Child Social-Emotional Development & Parental Depression
3. Integration of behavioral health and support with Primary Care
3. Home Visiting
4. Early Childhood MH Consultation
5. Family Strengthening

FCMH

Triple P
Positive Parenting Program
for every parent

NC LAUNCH FCMH Sites

Burlington Pediatrics

- 3 locations
- 27 medical staff
- Annual served = 3,000
- Medicaid ~ 60%
- ECMH Team

  Start Date – July 2012

Kernodle Pediatrics

- 1 location
- 7 medical staff
- Annual served = 1,500
- Medicaid ~ 60%
- ECMH Team

  Start Date – October 2012

FCMH Flow Chart

WELL CHILD VISITS

Family-Centered Medical Home

Pediatrician

Nurse

Warm handoff

ECMH TEAM

Triple P Positive Parenting Program for every parent

Health Promotion & Prevention

Social – Emotional Screening

Family Priorities

SUPPORT & ASSISTANCE

Family Centered Health Navigator

- Engagement & partnership
- Peer support
- Assess/address Social Determinants
- Care coordination
- School-based support
- Lactation Counseling

Triple P Positive Parenting Program for every parent

Early Childhood MH Specialist

- Child development education
- Assess/address behavioral health needs
- Evaluation
- School-based support
- Brief Interventions
- Clinical referrals

Comprehensive & Family-Centered

Necessary components

- Information on child development and parenting
- Ready access to support
- Early identification of risks & needs

Destigmatized parenting assistance

- Triple P/Stay Positive
- Routine health settings
- Community Peer Parent of CSHN

Pro-active Engagement & Support

- Meeting the family where they are
- Identification of most pressing needs
- Identification/promotion of strengths
- Rapid, effective, empowering parenting techniques

Universal screening – child/parent

Comprehensive & Family-Centered

Necessary components:

- Information and referral
- Behavioral Health Treatment
- Medical Home

Action – Warm Hand-off

- Active partnering, solution-finding, modeling/support/coaching to recruit and access priority resources (Social Determinants)
- Suite of parenting/family support services per actual need/preference (TP 3, 4) – on site, in home/community , by phone - prn
- Assessment, psycho-social/clinical evaluations, short-term treatment (CBT, TF-CBT, PCIT, etc.)
- School-based support
- Responsive & accessible community-based services (Home Visiting Consortium)

Follow-up and On-going availability @ Med Home

- Phone check-ins, home visits
- Full-time, on-site

II. Project LAUNCH NC - Sample Brochure

(Perth Design Group, Burlington NC)

Do You Worry About Your Child's:

- ✔ Development?
- ✔ Eating or Sleeping Patterns?
- ✔ Temper Tantrums?
- ✔ Learning Ability in School?
- ✔ Behavior?

If you answered YES to any of these, then we can help!

Project LAUNCH serves children birth to age 8 and their families. We work to promote the wellness of young children and provide health professionals who work with your family to:

- Provide emotional support, discipline strategies, positive parent approaches and outreach to resources
- Help create an understanding of how child-serving agencies work
- Provide further assessment of your child to determine what support services can help

See reverse for more information

PROJECT LAUNCH
helping children soar

Project LAUNCH services are available at:

Burlington Pediatrics
530 West Webb Avenue
Burlington, NC 27217
(336) 228-6316

Kernodle Clinic Pediatrics
908 S. Williamson Avenue
Elon, NC 27244
(336) 538-2416

Do you have concerns about...?

_____ Discipline or behavior concerns
Emotional support
_____ Tantrums
_____ Hyperactivity
_____ Sleep issues
_____ Feeding/eating issues
_____ Learning
_____ Child care needs
_____ Child care behavior concerns
_____ Food
_____ Housing
_____ Utilities
_____ Transportation
_____ Clothing
_____ Employment
_____ Lack of insurance

Name_____

Child's Name_____

What would be the best way to contact you?

Phone _____

Time of day_____

Text Message _____

Email_____

Please return this form to your nurse.

PROJECT LAUNCH
helping children soar

Whole Person Integrated Care

Developing a Common Language & Approach to promote Positive Parenting for all families of children 0-8

Social Services	Public Schools	Home Visiting	Health Depart-ment	Law Enforce-ment	Family/ Comm	MH Provider	Primary Care	Hospital
Child Welfare	• Social Work • Nursing • E C	• P for C • CDSA • Exchange • Club • EI Centro	• Child Health • CC4C • WIC • Ctr Preg • Dental • H. Resources	Community Policing Officers	• Family & Community members • Burlington Housing Authority	Institute for Family Centered Services/ MH Provider	• Pediatric P. Care (2) • Family Practice • FQHC	• Pediatric • Rehab • H Resources

Triple P Level 3 PC ~ 170; Level 4 = 5
Seminar = 20; Discussion Group = 15

Promoting positive social-emotional health & reducing risks for social-emotional challenges for young children & their families across early-child care, service & educational settings through *Positive Parenting Program approaches* ***& consistently active linkages with their Medical Home***

Family Centered Medical Home

Triple P 3/PC

Triple P 3/PC

Triple P 3/PC

Triple P 3/PC

Triple P 3/PC

Whole Person Integrated Care

Alamance County Health Department

EveryWhere.EveryDay.EveryBody.

"TRIPLE P TRAINED PEDIATRICIANS

All of our pediatricians are Triple P trained. "Triple P" stands for Positive Parenting Program. This program is a parenting program intended to help parents manage their children's behavior and form a stronger, happier family unit. With this program, children are raised to become confident individuals. The idea is not to tell parents *how* to parent, but to provide them with strategies that they can use in their own household based on their own personal values and needs.

The Triple P program is international. Ongoing research about the effectiveness of the program has been done for 30 years, and 230 trials have been conducted around the world. The parenting solutions provided are proven to be effective in almost any culture or family."

"HOW IS TRIPLE P TRAINING RELATED TO PEDIATRICIANS?

Although the Triple P program is a parenting program, pediatricians can go through training as well. This allows a pediatrician to effectively provide parenting advice to the families of their child patients. This is useful if a pediatrician recognizes a behavioral or social concern related to a child's development.

The training for a pediatrician lasts 1-4 days, depending on what level the pediatrician has chosen based on his or her practice and patient needs. The training is skills-based. Triple-P trained pediatricians are tested on problem solving, consultations, and presenting."

Impact: More Comprehensive Care

Before LAUNCH/Baseline	With LAUNCH
Neither practice had access to on-site resources to provide family support, home visiting, school-based assistance, clinical services, psychoeducation or mental health/developmental assessments.	With the on-site Early Childhood Mental Health Teams, the practice and patients/families of the practice gained an array of family support and treatment resources.
	• The Burlington Peds ECMH Team received 962 referrals. • The Kernodle Clinic Peds ECMH Team received 605 referrals • Burlington Pediatrics received National Committee for Quality Assurance (NCQA) Level 3 Accreditation as a Family Centered Medical Home

Families Return for Care

- Families use the teams as an ongoing, periodic resource to address emerging concerns (88% of Burlington Peds and 82% of Kernodle Clinic families returned to the teams for more services after a 3-mo. or longer period of no services)
- Moreover, families who initially declined services from the teams come back and receive services (70% at Burlington Peds and 88% at Kernodle Clinic)
  - Families like having easy access to the teams within their pediatrician's office and will go to them for services when they need them
  - The ECMH teams are becoming more entrenched as a 'normative service' in the practices

Feedback from Practitioners

- Physicians feel less pressured to handle behavioral and social-emotional issues in the 10 minutes they have to address a patient's concerns and feel they can practice medicine again
- Doctors are confident that "families will be taken care of and taken care of well"
- Procedurally, it is much easier to make referrals for social/emotional concerns – the process is faster, more personable and efficient
- The Team took pressure off clinic staff by handling families' social/emotional concerns
- The Team helps decrease barriers for families in accessing community services by helping families fill out the necessary paperwork together Follow up on referral outcomes is now possible
- The team's knowledge and expertise around parenting issues and incorporation of Triple P is a great addition to the practice

Feedback from Families

- It helped my family with issues with both children not just the one.
- This is a wonderful program!! The therapist was very supportive and helped me get my daughter back into OT. This program is very helpful to parents and is very beneficial to the community.
- Our child has shown a tremendous improvement since the start of this service. The most helpful part of the services was the one-on-one attention our child received
- Every pediatrician's office should have program like this.
- Just knowing that I do have someone I can talk to without judgment. The phone calls to let me know that y'all care. Thanks so much.
- So great to have help; very friendly staff. So nice not to feel alone in this situation. The most helpful thing was the guidance and positive parenting help

PARTNERS
Improving Lives. Strengthening Communities.

- 2 Community health homes
- 5 Integrated care centers
- Medicaid Savings $

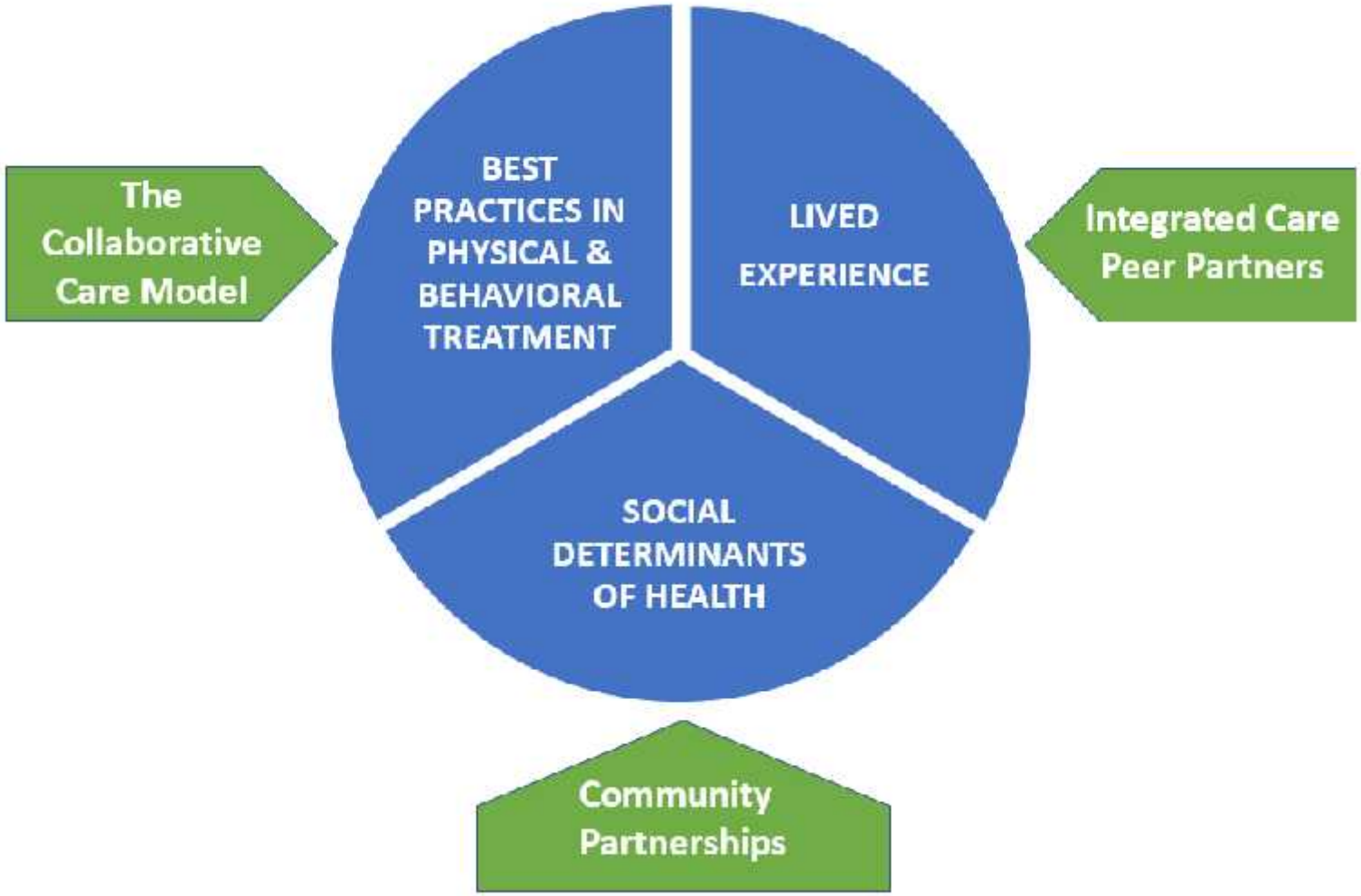
- SOC Expansion Grant $
- 2 + Primary Care Practices

Whole Person Integrated Care
Partners | Improving Lives. Strengthening Communities.
www.PartnersBHM.org

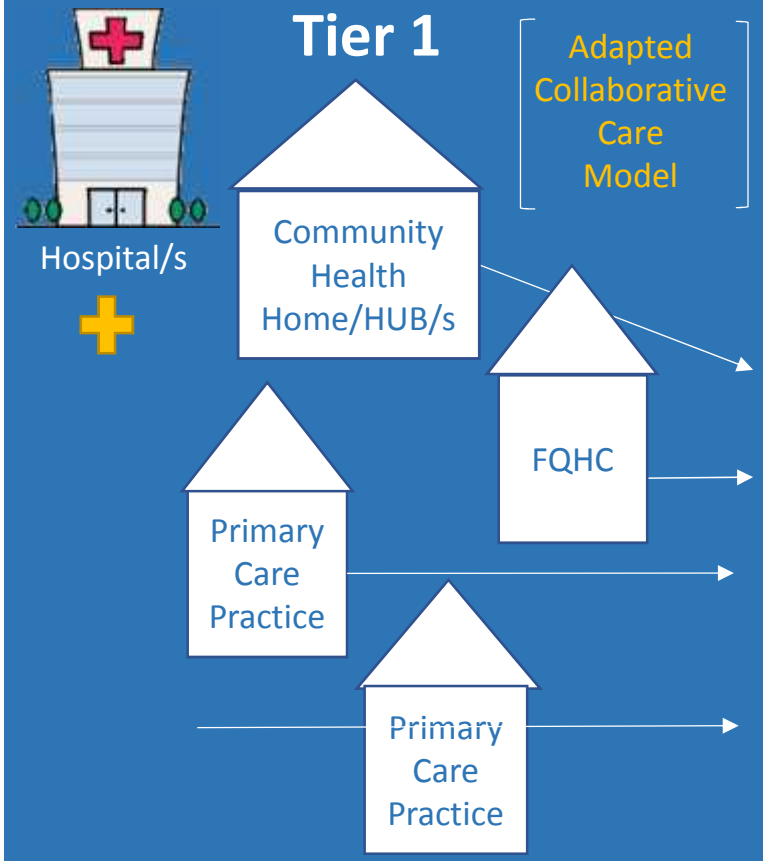
Whole Person Integrated Care (WPIC)

- An innovative model that focuses on helping people become & stay healthy—rather than focusing more narrowly on "managing" diseases or conditions;
- Includes, but is not limited to strategies such as integrated care, which has typically focused on integration of healthcare services (hospital, primary care, & specialty services such as behavioral health); and,
- Expands the concept of integration beyond the health sector to include the broad range of services & approaches now known to positively & negatively impact overall health, reduce health disparities & optimize public & private resources.

Whole Person Integrated Care



INFRASTRUCTURE TO ADVANCE, SUPPORT & SUSTAIN THE WHOLE PERSON INTEGRATED CARE MODEL



Tier 2

A community forum guided by the Collective Impact model:

- ✓ PBHM, local provider network, agencies, organizations, Tier 1 reps, etc.
- ✓ 1 forum per county
- ✓ Involve, Support & Sustain Tier 1 partners
  - Communication
  - Referral network
  - SDOH resources
  - Feedback loops
  - Population Data Feed to ID gaps
  - Outcomes reporting
  - Peer learning, TA

Tier 3

General public,
The ~ 85% we are not reaching (penetration rate)

Local Government
Businesses
Foundations/investors

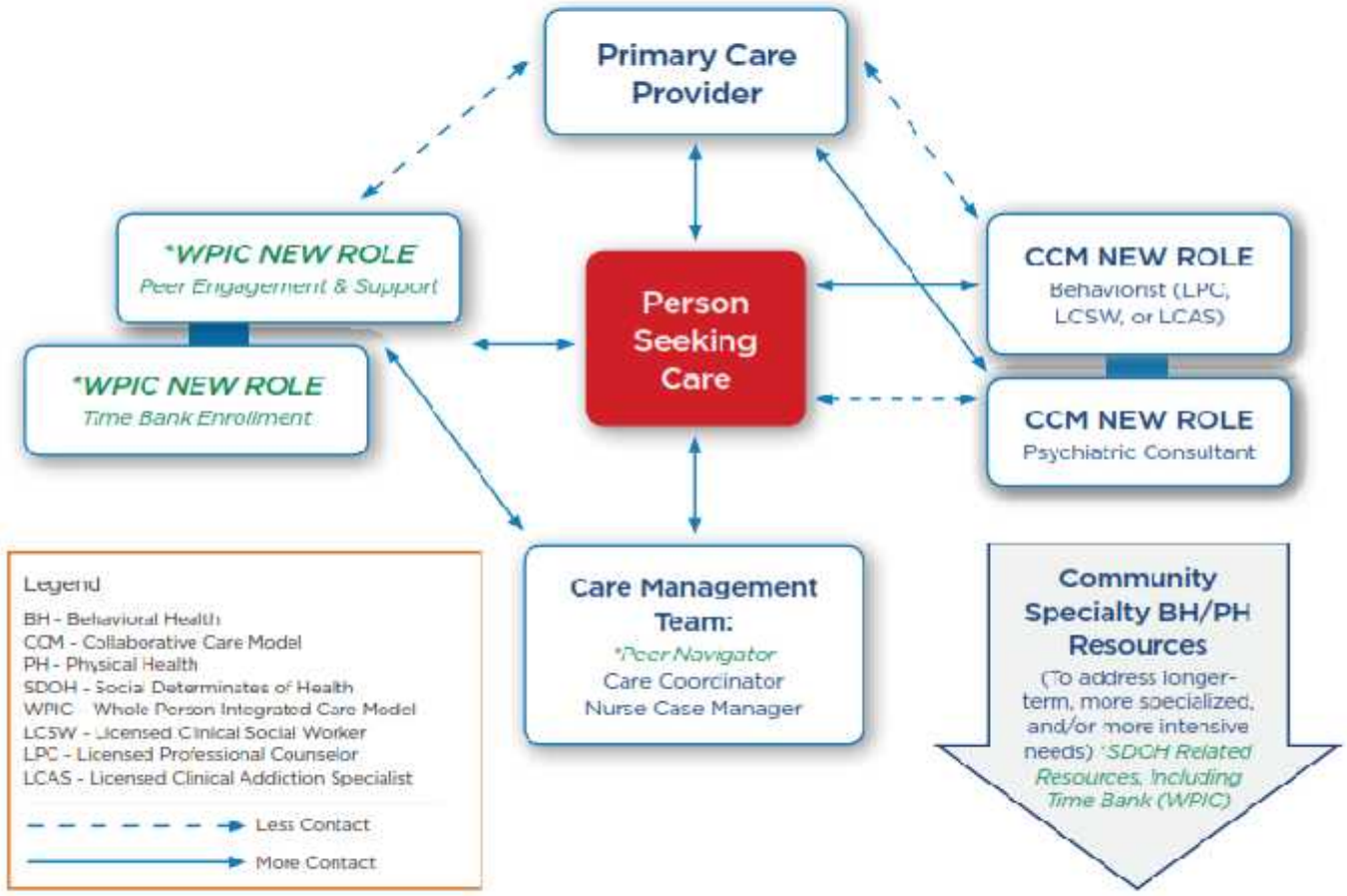
SDOH resources via a Community Time Bank

PR/Social Marketing
Population health
Health promotion
Outreach
Etc.

COMMUN ITY HEALTH NETWORK

Whole Person Integrated Care

Figure 1. Adapted Collaborative Care Team Structure



*Green italics denote functions adapted from the original Collaborative Care Model

Adapted from the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Institute Collaborative Care Model (CCM).

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Principles of Effective Integrated Health Care

1. **Patient-Centered Team Care / Collaborative Care**
   Primary care and behavioral health providers collaborate effectively using shared care plans. It's important to remember that colocation does NOT mean collaboration, although it can.

2. **Population-Based Care**
   Care team shares a defined group of patients tracked in a registry to ensure no one "falls through the cracks." Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

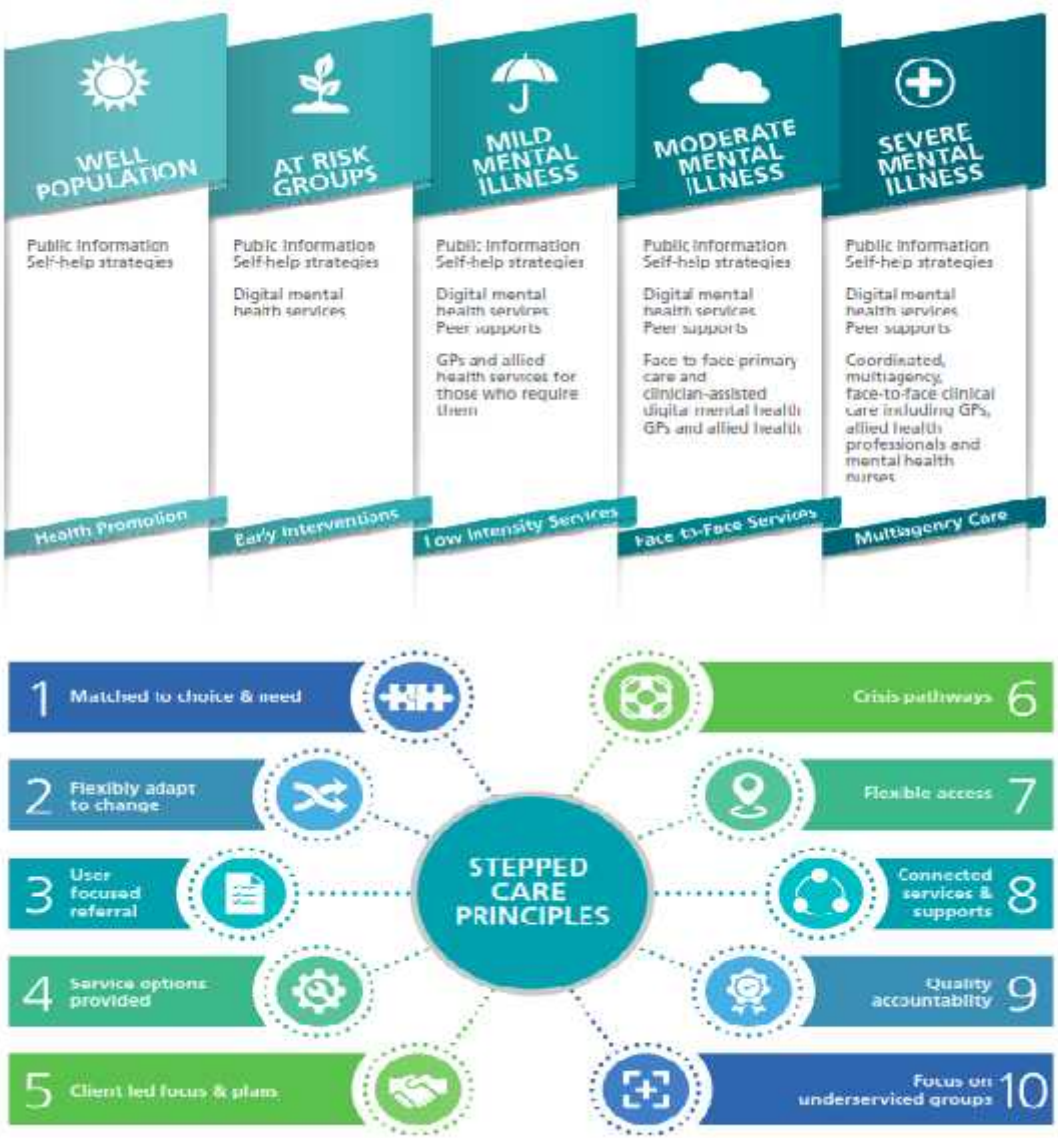
3. **Measurement-Based Treatment to Target**
   Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

4. **Evidence-Based Care**
   Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

5. **Accountable Care**
   Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Incorporates the Stepped Care Model

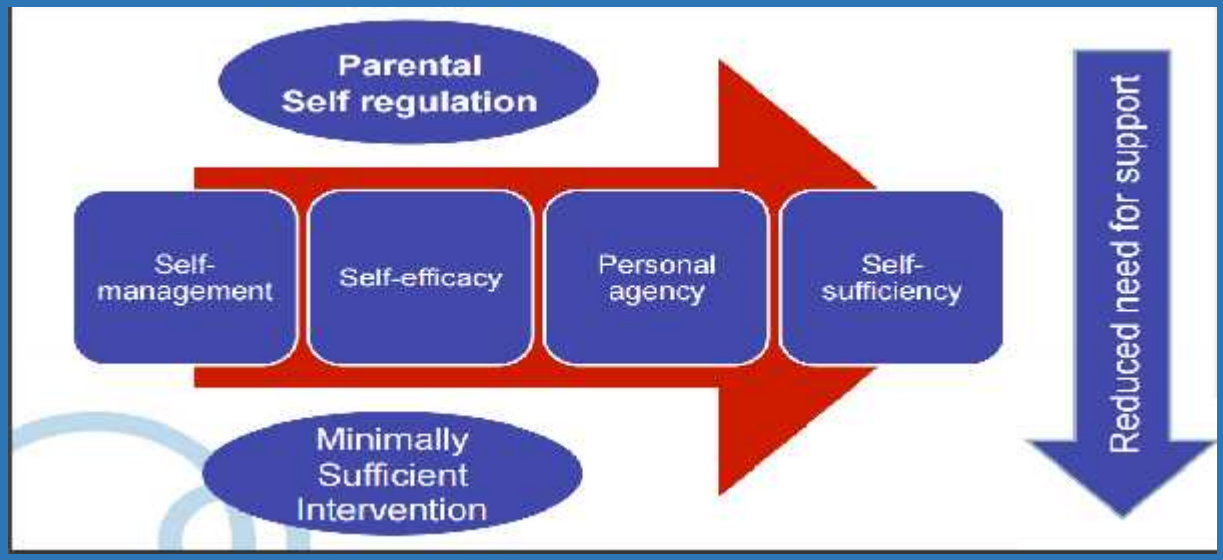
STEPPED CARE MODEL & PRINCIPLES



Collaborative Care/ Stepped Care + Triple P =

Complementary Models for Integrated Care

Triple P: Masterclass Promoting self regulation Matthew R Sanders, PhD Parenting and Family Support Centre University of Queensland February 2013 HFCC2013, Los Angeles, CA



Flow of Care in PCP

WELL CHILD VISITS

Pediatrician

Nurse

Warm handoff

2-Person Team

Triple P – for every parent

Health Promotion & Prevention

Social – Emotional Screening

Youth/ Family Priorities

Triple P – for every parent

Family Health Navigator

- Engagement & partnership
- Peer support
- Assess/address Social Determinants
- Care coordination
- School-based support

Behaviorist

- Psycho-Ed
- Assess/address behavioral health needs
- Evaluation (CANS)
- School-based support
- Brief Interventions
- Clinical referrals

Model/s: Collaborative Care/Teamlet

Whole Person Integrated Care

For more information on Partners Behavioral Health Management's Whole Person Integrated Care Model

Contact Allison Gosda, Partners Integrated Care Director: AGosda@partnersbhm.org