

Behavioral Health Integration subgroup

**Tuesday, July 13
10:00 am – Noon**

#	Agenda Items	Notes
•	Integrated behavioral health at Pediatric Associates of Whidbey Island	<p>Marci Bloomquist, Community Health Plan of Washington Elizabeth Westfall, Pediatrics Associates of Whidbey Island <i>See page 4 for slides.</i></p> <ul style="list-style-type: none"> • Prior to Covid, agencies only took patients through walk-in; made warm handoffs difficult; hours did not work for families; turnover was difficult for youth. Not feasible for most families in community. • Just 2 CMHCs in Island County; not taking new clients – workforce shortages. • Collaborative care model – developed by Seattle Children’s using telehealth for psychiatric consultant. Primary contact- BH care manager (telehealth) – motivational interviewing, clinical registry management. Psychiatric consultant – prescribing and consultation. Family involvement. • PAWI: Staffing – psychiatric consultant; BH care coordinator; also, family support advocates; considering a CHW. • Registry developed by Island County Human Services. • Ongoing training through Seattle Children’s care network for FAST program. • Financing gaps: Level of licensure that provider is practicing at – potential problems with billing – they have been using provider codes in these cases; workflow/process for referrals. <p>Q&A:</p> <ul style="list-style-type: none"> • I am curious if there were other differences you have experienced in modifying an adult model to children, youth and their families. <i>Adults’ programs designed for specific issues. Children’s issues often more complex; not always in initial referral. Must adapt for particular patients’ needs. “Hybrid model” – greater flexibility. Expand on tools for measuring symptoms.</i> • Are you delivering services you are not able to bill for? Or are you able to make it fit? <i>Both. Significant amt of patients being discharged from inpatient care do not meet criteria for program but need services since they often need to wait for months for an OP provider. Making regular caring contacts with these youth in the interim; calling and checking in on them – making sure they are still connected with somebody. Care management/touching base with a family – have not been able to bill for. Brief intervention – continuing check-ins re suicide ideation.</i> • CHWs are another strategy for people who are waiting for services. Address needs (resource sharing) and free up the time of the BH navigator. • Role of family advocate? <i>A parent of a patient who is receiving services and has gone through the process themselves. Potential peer support. Currently sort of consultants for the patient/family perspective for resources, etc.</i>

<ul style="list-style-type: none"> • 	<p>Integrated behavioral health: An MCO perspective</p>	<p>Victoria Evans, LICSW, MHP, SUDP –Molina Healthcare <i>See page 14 for slides.</i></p> <ul style="list-style-type: none"> • BH integration slower than anticipated – financial integration more complex and time-intensive – each region different. • Integration – workforce issues; substance use not getting as much attention, often first symptom of MH issues. • Many providers see integration as doing depression screenings. Molina sees anxiety incidence is often higher; and anxiety /depression linked with SU. Not a routine practice with a set cadence for screening; many providers waiting until symptoms appear and then screening. • Screening assessment tool for providers. #1 diagnosis for MH is anxiety. 40% of MH cases have SUD (less so for children and adolescents). 37% had concurrent SU diagnosis. • Moved away from SBIRT model which moves people to specialty care; look at whether they can be served without referring out. <p>Discussion</p> <ul style="list-style-type: none"> • Could we as a group come up with a cost of care model to deliver what we consider to be pediatric integrated care? <i>Vicky – talking about this a part of clinical integration tool with Colette Rush (HCA), ACHs, others. We all acknowledge we need to present something – a strategic plan – recommendation: foundational pieces, then anticipating what we will be asking for next. Something that represents a comprehensive approach – for kids and adults – so we have a large, common voice.</i> • Collaborative care codes really work for clinics that are using this model. VBP – emphasis on adults; may not work well for kids. • Figuring out for PCPs who are already out the door and do not want to rethink. Working with Bree Collaborative – reference re codes to use. Really need financing for care navigators. <p>Action Item</p> <ul style="list-style-type: none"> ➤ Leads to circle back with Vicky’s group.
<ul style="list-style-type: none"> • 	<p>First Approach Skills Training (FAST)</p>	<p>Erin Schoenfelder Gonzalez, Ph.D. - UW Dept. of Psychiatry & Behavioral Medicine/ Seattle Children’s Hospital Nat Jungbluth, Ph.D. – Partnership Access Line/Seattle Children’s Hospital, Help lead the CBT Plus training initiative; Brief intervention work in schools for SMART Center. <i>See page 21 for slides.</i></p> <ul style="list-style-type: none"> • Brief intervention: Up to 30 minutes. • Easily trainable components of EBPs. • See page 26 for primary care adaptations. • Sufficient dose of key ingredients for youth with MH issues. • Pilot – found screening gap; providers not diagnosing depression until it was acute, often too acute for the program. • Part of a stepped care model while waiting to move on to higher level of care. • One stop for lower to medium acuity. • Clinical results good with brief intervention model. • Unanimous family acceptability.

		<ul style="list-style-type: none"> • Losing people when referring outside. Best to do within PCP. • Provided adequate training in 4 hours (pre-pandemic). Bi-weekly video conference calls.
•	Update: Financing BHI in primary care	<p>Tatiana Sarkhosh, Washington Chapter of the American Academy of Pediatrics <i>See page 41 for slides.</i></p> <ul style="list-style-type: none"> • Boston study – highlight – reductions in ER visits.
6.	Closing & next steps	<ul style="list-style-type: none"> • Comment: People working at highest level for credential. Care coordination.

Attendees

Marci Bloomquist, Community Health Plan of Washington (CHPW)
 Rachel Burke, Health Care Authority (HCA)
 Dr. Phyllis Cavens
 Tawnya Christiansen
 Christine Cole
 Devon Connor-Green
 Kahlie Dufresne, Molina Healthcare
 Victoria Evans, Molina Healthcare
 Erin Gonzalez, UW Dept. of Psychiatry & Behavioral Medicine/ Seattle Children’s Hospital
 Leslie Graham
 Libby Hein
 Dr. Bob Hilt, Seattle Children’s Hospital
 Kristin Houser, Parent
 Avreayl Jacobson, King County Behavioral Health and Recovery
 Nat Jungbluth, Partnership Access Line/Seattle Children’s Hospital

Terry Lee, CHPW
 Heidi Nelson
 Liz Perez, CHPW
 Wendy Pringle, HopeSparks
 Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP)
 Shannon Re, Kitsap Children’s Clinic
 Tatiana Sarkhosh, WCAAP
 Noah Seidel, DD Ombuds
 Stephanie Shushan
 Lucas Springstead, HCA
 Mary Stone-Smith, Catholic Community Services of Western Washington
 Elizabeth Westfall, Pediatrics Associates of Whidbey Island
 Howard WH
 Cesar Zatarain, Jr., HCA

Partnerships to Implement Collaborative Care: Pediatric Associates of Whidbey Island (PAWI) Experience Overview

Children's Behavioral Health Integration Subgroup
July 13, 2021



Speakers Introduction

Marci Bloomquist, MS, MHP

North Sound Regional Manager

Community Health Plan of Washington (CHPW)

Elizabeth Westfall, LICSWA

Behavioral Health Care Manager

Pediatric Associates of Whidbey Island (PAWI)

Overview

Why integrate behavioral health? How?



What was and is involved with implementation?
What are the initial results?



Concluding Thoughts



Why integrate Behavioral Health?

Significant behavioral health needs and challenges with access for children

- Island County Behavioral Health needs and gaps identified
 - Limited Community Mental Health Agencies serving youth
 - Rural community with transportation barriers
 - COVID-19 increased need

How was integration organized?

Partnerships to support Collaborative Care Model (CoCM)

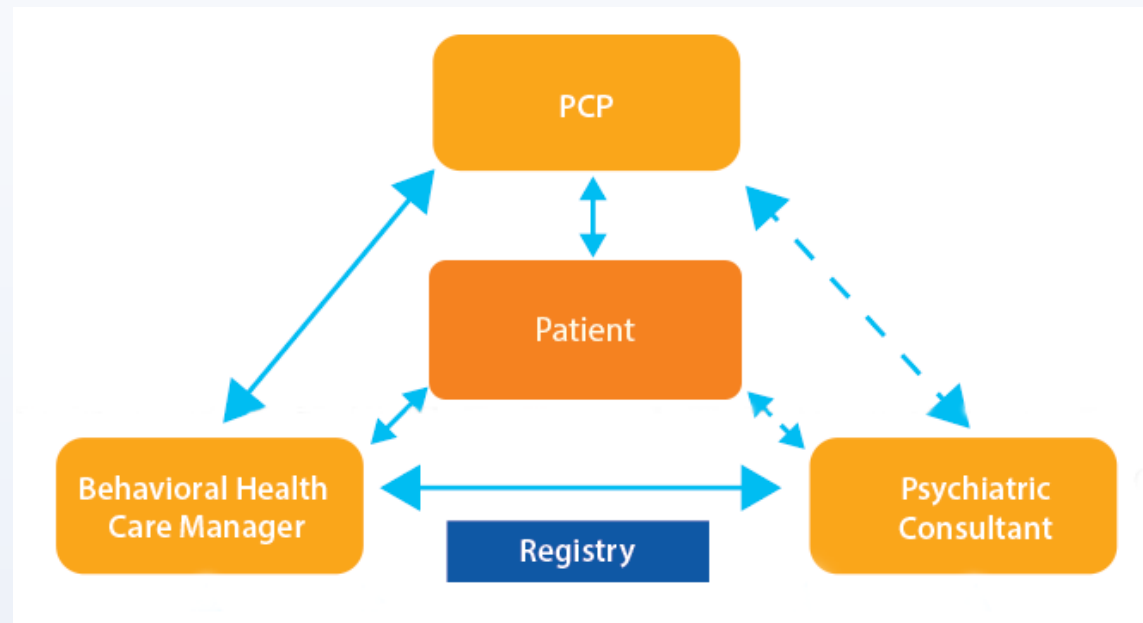
- Initial Partnership with PAWI and Island County and outreach Community Health Plan of Washington; ongoing meetings to support collaboration and monitoring
- Participation in Seattle Children's Care Network (SCCN) Learning Collaborative, with technical support from the UW AIMS Center

Community Health Plan of Washington (CHPW) support

- Provided funding to support initial implementation and outcomes-based payments
- Support for implementation; expertise and experienced with supporting clinics with implementation of CoCM
- Structured Monthly reporting and support for implementation
- Performance Improvement Project to evaluate implementation

Collaborative Care Model in Pediatric Setting

**CoCM
adapted for
pediatric
setting**



**Family Involvement,
as appropriate**

* Model proven effective for diverse populations

Implementation Process

Staffing

Training

Registry
Development

Billing

What are the initial results?

- Success with developing processes and structures for Collaborative Care
 - Staffing – recruited family advocate
- Enrolled patients and successfully treating patients to graduate them from the program
 - Progress to reduce depression and anxiety in a short amount of time
- Billing using Collaborative Care codes
- PCPs appreciate support for behavioral health navigation

Concluding Thoughts

- How can this become a reality for all kids?
 - Partnerships, clinical commitment, communications and operations
- What financing gap(s) need to be addressed?
 - Funding to support infrastructure. PAWI provided by SCCN, County and CHPW to support implementation start-up.

7/13/2021

HCA Children & Youth Behavioral Health Work Group
Behavioral Health Integration Subgroup Meeting

Molina Healthcare of WA
Behavioral and Physical Health Integration
Experience, Progress, Challenges & Opportunities

Victoria Evans, LICSW, MHP, SUDP
Molina Healthcare, WA State Director Behavioral Health / Integration



IMC

- Launched April 2016 in SW WA
- Molina in all regions of WA State
- Currently serve > 1M members in WA
- Financial Integration – complex and time intensive
- Clinical Integration (BH – SUD & MH Integration)
- Clinical Integration (BH & PH Integration)

What is integration?

- Early on no common “language” or means for conceptualizing and discussing integration
- Adopted SAMHSA’s 6 Levels of Integration as a basis for discussion
- Extensively involved with provider education re: integration

How can we measure providers' current state and improvement related to integration?

- No existing tool - Molina developed a *Behavioral and Physical Health Provider Integration Assessment Tool* to assess *pediatric & adult* providers
- Tool designed to assess
 - BH providers (SUD & MH) related to BH integration & BH/PH integration
 - PH providers related to BH integration – MH & SUD
 - Screening practices, use of brief interventions, tx (internal staff and telepsych/telehealth), external referrals (MOU's), integrated care planning, need for TA and other support
 - Cadence of screening and f/u - for depression, anxiety, suicide risk, alcohol, drug use, etc. (providers checked off screening tools used i.e., PHQ9, GAD7, AUDIT, CRAFFT, DAST, etc. and indicated other screening tools used)
- Assessment Tool emailed and returned via email
- BH & PH providers (adults and peds) complete tool electronically (typically by clinic site unless standard practice across clinic locations)
- 85% + of regional providers complete and return assessment (typically one assessment *per site unless* standard work across sites then one assessment completed)
- Molina - chart results by region and looked at YOY improvement. Meet with providers to better understand needs and to determine next steps. Agreed upon action plan established.

Provider F/U meetings after completed tool

- Common themes

ACH's Integration Work

- Providers directed to ACH's for support/funding (Medicaid Transformation Funds)

P-TCPI

- Molina involved incl. establishing standard work for pediatric PH providers
- Addressed VBC's (obstacles/ opportunities)

What we've learned...

- Overall PH & BH (MH/SUD) adult and pediatric providers – high interest, engagement, and many advancing integration practices. Providers see the benefits and are struck by how many need “integrated” whole person care.
- Common provider concerns - cost of integration (staff, office space, time developing/implementing standard work), establishing closed loop referrals/MOU's for those needing “specialty BH care” or PH care, establishing integrated care plans for those referred out due to lack of communication. Need for “care navigators”.
- Significant workforce issues related to staff recruitment and retention.
For PH – difficulty recruiting PhD, LICSW/other licensed clinical staff
For BH – difficulty recruiting PH staff (ARNP, MD/DO, etc.)
- Concerns...some providers screen based on sx and no routine practice w/ standard cadence, lack of cadence for f/u. Lack of registries or EHR capabilities for tracking and f/u. In BH no common screening tool or standard work for assessing common PH conditions. EHR configuration issues and other concerns.
- Telehealth/TeleBH surge - new opportunities/innovative approaches

Next Steps

Thank you! Questions?



First Approach Skills Training Program Overview

Erin Gonzalez, PhD
Nat Jungbluth, PhD

Partnership Access Line
Department of Psychiatry and Behavioral Sciences
Seattle Children's Hospital



FAST: A blueprint for evidence-based youth mental health treatment in primary care



FAST Goals

- Empowering PCPs manage mental health
- Creating access to meaningful, brief treatments
- Adapting EBPs to primary care realities
- Hyper-efficient training and implementation



What is FAST?

- Currently training and supporting 4 programs:
 - FAST-Anxiety
 - FAST-Behavior
 - FAST-Depression
 - FAST-Parenting Teenagers
- In development:
 - FAST-Trauma
 - FAST-Safety?
 - FAST-Sleep?



FAST-A case example

- 13yo Male – OCD presentation: excessive handwashing, unplugging electronics, switching lights on/off, lock checking, closing/checking blinds.
- Intake, 7 active treatment sessions, 2 relapse prevention (~30 min each)
- SCARED pre: 24, post: 4
- “[Anxiety] used to control everything he did. We now have the tools to handle this. I didn’t know what to do before. I’m not worried anymore because I know what to do about it and we have a plan that we can use if anxiety were to come back.”

Primary care adaptations

- Brevity
- Ease of use
- PCP & BHSP tools
- Parent/caregiver involvement—so they can take over
- Streamlined to core components
- Does not require in-depth diagnostic evaluation
- Strategic focus on most common, mild-to-moderate concerns
- Streamlined training:
 - Asynchronous (2 hours)
 - Live training (2 hours)
 - On-going case-based learning (bi-weekly)

Where did FAST come from?

- Pilot: WA legislature through HCA
- Benton & Franklin Counties (Tri-Cities)
- Treating: Depression & Disruptive Behaviors
- Implementation:
 - “Regional resource model”
 - Trained BHSPs from local community MH orgs
 - Rapid phone outreach to PCP referrals
 - Strict 4-5 session limit
- Much enthusiasm, intensive outreach, but never reached capacity

FAST Pilot Results

- Statistically significant improvement in:
 - Caregiver-reported disruptive behavior
 - Improved child functional impairment
 - Caregiver-reported depression
- Unanimous family acceptability
- Majority felt the short program met their needs
- Depression-referred population was more acute
- High clinician acceptability

What did we learn?

- Clinics often lacked routine screening
- Needs were not fully assessed in primary care
- Unrealistic to expect existing primary care staff to assess, triage, and engage families
- Improved connection rates, but
- BUT, many families did not respond or follow through with outside referrals.
- FAST programs clinically promising

What did we learn?

- Clinics often lacked routine screening
- Needs were not fully assessed in primary care
- Unrealistic to expect expect primary care staff to assess, triage, and engage families
- Improved connections
- BUT, many families did not or follow through with outside referrals
- FAST program



**Greater
Integration
Needed!!**

Psychiatric Services, 2021

Barriers to Increasing Access to Brief Pediatric Mental Health Treatment From Primary Care

Erin Schoenfelder Gonzalez, Ph.D., Nathaniel Jungbluth, Ph.D., Carolyn A. McCarty, Ph.D., Robert Hilt, M.D.

A quality improvement process targeted mental health care uptake and system capacity in an underserved region. The pediatric program created pathways for rapid referral from primary care and schools to four sessions of evidence-based treatments for disruptive behavior and depression with community clinicians. Of 250 referrals, 46 families enrolled in treatments for disruptive behavior and 21 for depression. Many families did not respond or

required more intensive treatment. Acceptability of the program was high for participating families, referrers, and clinicians. Brief treatment met most participating families' needs. The process demonstrated barriers to mental health care access and delivery and the need for integrated and multitiered care delivery.

Psychiatric Services 2021; 00:1-4; doi: 10.1176/appips.202000457

More than 25% of pediatric primary care patients present to care with a psychosocial problem (1), yet less than one-third of children referred to mental health treatment by their primary care provider (PCP) complete an outpatient visit (2, 3). Although most parents report interest in receiving child behavioral treatments through primary care (4), existing referral and handoff processes to mental health care are insufficient to engage the majority of families. Additionally, evidence-based treatments (EBTs) for pediatric mental health problems can be lengthy, cost-intensive, and burdensome. Common barriers to engagement include lack of trained providers, limited treatment capacity, and logistical and transportation problems among patients. Thus, there is a need to improve integration of mental health care with primary care through consultation or team-based processes

project period for working within existing community care systems provided opportunities to understand system barriers and to test solutions designed to improve care delivery and quality.

The state-funded quality improvement process was conducted in Benton and Franklin counties, located in South Central Washington State, with limited specialized health services and without integrated services in primary care. Over 29 months, we sought referrals from primary care (and later from schools) of children with disruptive behavior problems and adolescents with depression, all with Medicaid insurance.

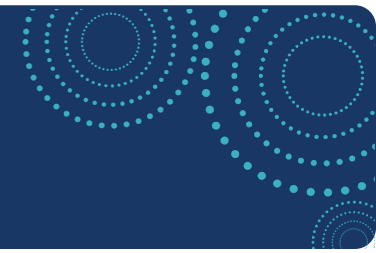
We developed brief treatments to enhance system capacity and family engagement. Two four-session First Approach Skills Training (FAST) treatment manuals were adapted from full-length EBTs and reviewed by child clinical psy-

The pivot to co-location (2018)

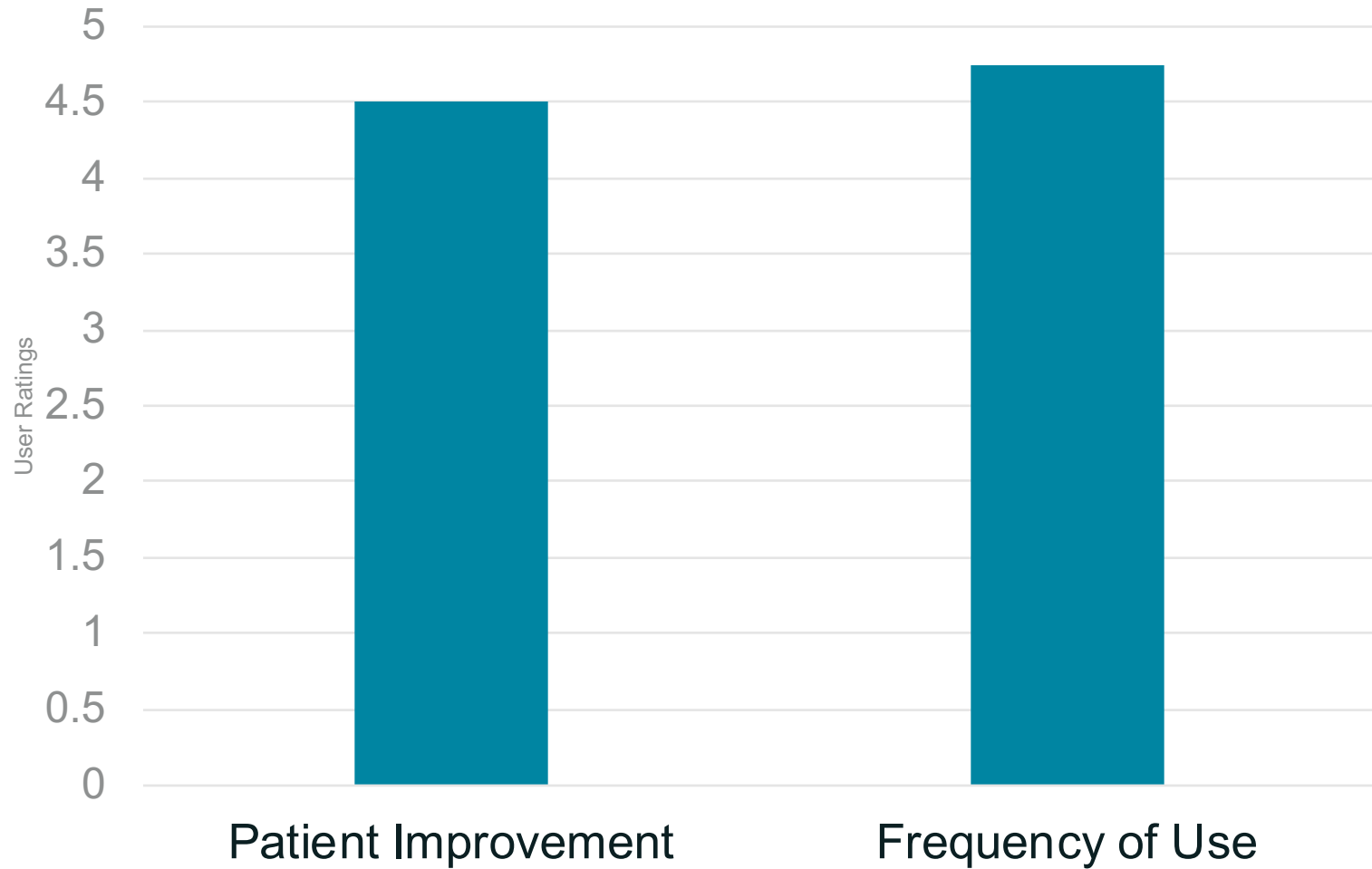
- Free training and bi-weekly case consultation
- Collecting implementation data and feedback
- Immediate requests for anxiety program, developed with user-centered design approach
- All materials updated/adapted in iterative process



FAST-A development



Clinicians Without Formal Training



Washington State FAST Stakeholder Advisory Committee

- Kathryn Boelk, MSW, LICSWA
HopeSparks Family Services, Tacoma
- Jacob Cowan, MSW, LICSW
HopeSparks Family Services, Tacoma
- Zoe Damm, MSW, MHP, LICSWA
HopeSparks Family Services, Tacoma
- Becca Disbrow, LMHC
Catholic Community Services, Kitsap County
- Leslie Graham, MSW, LICSW
UW Neighborhood Kent-Des Moines Clinic
- Nicole Hamilton, LMHC, CMHS
Nicole Hamilton, PLLC, Kennewick
- Nancy Namkung, MSW, LICSW
Virginia Mason, Seattle
- Sarah Trajano, LICSW
Skagit Pediatrics, Mount Vernon
- Rose Welser, MSW
Walla Walla Clinic, Walla Walla

Participating Organizations

Catholic Community Services/Family Behavioral Health, Everett Clinic, HopeSparks, Island Hospital, Kaiser Permanente, Mason General Hospital, Olympia Pediatrics, Peace Health, Pediatrics Northwest, Northwest Pediatrics, Skagit Pediatrics, UW Neighborhood Kent-Des Moines Clinic, UW Roosevelt Clinic, Virginia Mason, Walla Walla Clinic, Yakima Valley Farm Workers Clinic

On-Going Evaluation

- Implementation pilot cases & stakeholder feedback
- HopeSparks/Pediatrics Northwest program evaluation
- Seattle Children's Care Network (SCCN) project
- Kaiser Permanente R01 using FAST
- FAST-P Pilot Trial, funded by Seattle Children's Research Institute (SCRI)
- School version of FAST-T, being evaluated in multi-state NIMH R01
- PCORI grant plans

FAST-Anxiety

- Adaptable to broad age range
- Anxiety
 - Avoiding or dreading normal situations
 - Excessive worry
 - Stress-related somatic complaints
- Exposure Therapy (CBT)
 - Understanding anxiety
 - Using “brave practice” to overcome fears
 - Building new skills, making plans or changing the environment when needed for realistic fears



FAST-Depression

- Ages 12-18
- Depression
 - Low or irritable mood
 - Lack of enjoyment
 - Withdrawal, isolation
- Behavior Activation Therapy
 - Sleep/exercise
 - Getting unstuck from low moods
 - Problem solving
 - Steps toward goals
 - Caregiver support skills
 - Coping & stress management



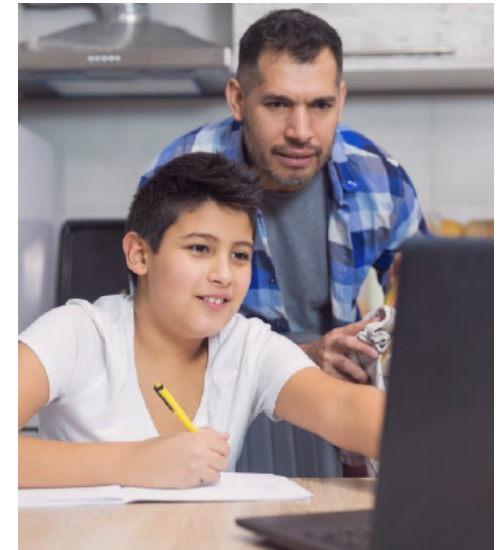
FAST-Behavior

- Ages 4-11
- Disruptive Behavior
 - Oppositional behavior
 - Tantrums
 - ADHD
 - Parenting problems
- Parent Behavior Management Training
 - Relationship building
 - Praise and ignoring
 - Rewards & consequences



FAST-Parenting Teens

- Ages 11-18
- Challenges with teen communication & behavior
 - Emotion escalations
 - Parent/teen conflict
 - Increasing structure
 - Schoolwork problems
- Parent Training + Emotion Coaching
 - Emotion validation
 - Conflict/problem solving
 - Expectations and limits for schoolwork and home tasks



How to get FAST

- Download materials at www.seattlechildrens.org/FAST
- Register for combination video & live trainings
- Reach out to us with needs or questions at FAST@seattlechildrens.org

Behavioral Health Integration Financing

July 2021

BHI Program Cost (hiring BH staff)

- For practices hiring a BH professional
- Start-up costs estimated \$240-250k
- Annual cost estimated around \$120-140k including:
 - 1.0 FTE BH professional salary and benefits
 - Care coordination
 - Scheduling
 - Overhead and facility
 - Physician time
 - Psychiatric consultation

BHI Program Cost (contracting with BHO)

- For practices partnering with a behavioral health organization
- Costs for medical practice estimated \$75,000 including:
 - Donated therapy rooms for BH staff 1.5 FTE
 - Monthly psychiatrist consultation with full MD team
 - Scheduling, huddles, warm handoff

Literature of cost savings potential

- Walter et al. (2019) implemented BHI program in MA from 2013-2017
 - Shift from specialty to primary care BH only increased ambulatory spending by 8% over 5 years
 - Increase in access but not a substantial increase in cost
 - Total BH-related emergency spending decreased by 19%, although it was not sustained.
 - A local ED, without a BHI program, saw an 86% increase in BH volume over the same time period.
 - Early identification and intervention in lower-cost primary care settings can decrease overuse of high-cost emergency BH services.

Literature of cost savings potential

- Yu, Kolko, & Torres (2017) completed an RCT to compare Collaborative Care to Usual Care (UC), looking specifically at behavior problems and ADHD.
 - Higher intervention cost compared to UC but lower cost per patient (Table 1)
 - Lower use of community mental health services during intervention and 6 months post intervention (Table 2)

Intervention Costs

Category	BHI Intervention	Usual Care
Training	\$4,885.74	\$1,651.86
Outreach and communication	\$900.00	\$900.00
Equipment	\$2,200.00	\$2,200.00
Clinical intervention	\$73,717.87	\$36,891.35
Total	\$81,704	\$41,643
Cost per patient	\$520 (157/160)	\$595 (70/161)

Costs of Community Mental Health Services

Time	BHI Intervention	Usual Care
6-month intervention period	\$87.51	\$599.01
6-months post-intervention	\$279.55	\$985.31
12-months post-intervention	\$453.14	\$1324.71

*No significant differences at 18 or 24 months, suggesting highest impact during time immediately following BHI intervention

Questions?

- Tatiana Sarkhosh tsarkhosh@wcaap.org