CYBHWG Behavioral Health Integration (BHI) subgroup
June 13, 2023

Leads: Kristin Houser and Sarah Rafton

Update on BHI Start-up Grants

Becky Carroll, *Health Care Authority (HCA)*

Highlights

- Opened the application process back up due to lack of applicants and continued community interest.
- The first round of applicants has been identified but results will not be finalized until all applicants are received.
- The BHI Grant webpage will be updated once the winners have been formalized.

Questions contact Rebecca.carrell@hca.wa.gov

Chat: Behavioral Health Integration (BHI) Grants webpage

Behavioral Health (BH) Integration for Children

Joe LeRoy & Wendy Pringle, *HopeSparks; see page 4 for slides*

Highlights

- Using a team approach to meet the families first to normalize the conversation.
- The care team approach allows Pediatric providers to feel supported and to work at the top of their licensure.
- In 2020, 1, 500 families were added to the care team with a 92% connection rate to mental health services compared to a 16% connection rate for the previous approach of giving the family a list of resources.
- The care team administers a universal screening at all well child visits with the goal of treating all kids with mild to moderate needs within pediatrics.
- The team can bill collaborative care codes for services and all patient information is shared in an Electronic Health Record (EHR) program called EPIC.
- Extensive follow-up on referrals is used to build relationships and make connections with families interested in services, to make sure if they want services, they get them.

Q / A

Highlights

- How many clinicians are on the team?
  There are currently 7 but we are continually adding staff.

- How large are the caseloads?
  Around 45 in each case load.
- Who do clinicians include?
  Therapist, 2 ARNP's; doesn't include community health workers.

Update on Washington Chapter of the American Academy of Pediatrics (WCAAP) BHI learning network

Highlights

- Supporting a learning network for the clinics to have access to these experts who have years behind them and to build behavioral health integration.
- The clinics will be supported with education, networking, and coaching, as well as using an integrated care assessment tool that the state has adopted to assist in determining clinic needs.
- Will share future updates and learnings with the group.

Clinical bundles

Sarah Walker, *University of Washington (UW) Co-Lab*

Highlights

- Stakeholders engaged in a rapid evident review was completed and informed by multiple voices.
- Findings included:
  - There is not an evidence-based payment model for pediatric mental health
  - Primary care is different than specialty care.
  - Recommended do not do a lot of for pay indicators, would be better to create a shared understanding between system, payer, and provider, looking at the different levels and what does it look like at the different levels/tiers.

Practice report – Value-Based Models in Pediatric Mental / Behavioral Health Care

Thinking for 2024 recs

Highlight

- Important to go upstream to early childhood and relational health.
- Think about trajectory and the spectrum of need.
- Investigate situations where kids are not receiving collaborative care model services and how to meet the need.
- Look at collaborative care models for in home medical services for kids that are not able to have interventions delivered

Attendees

Nikki Banks, Health Care Authority (HCA)
Rachel Burke, HCA
Becky Carrell, HCA
Phyllis Cavens, Child and Adolescent Clinic
Stella Chang, HCA
Christine Cole, HCA
Megan Gillis, Molina Healthcare
Andrew Hill, Excelsior Wellness
Libby Hein, Molina Healthcare
Bob Hilt, Seattle Children's Hospital
Connie Mom-Chhing, Community Health Plan of Washington (CHPW)
Julia O'Connor, The Washington Council
Liz Perez, HCA
Wendy Pringle, HopeSparks
Beth Tinker, HCA
Amber Ulvenes, Advocate
Cindi Wiek, HCA

June 13, 2023

Transforming Pediatric Healthcare in Pierce County:

Addressing the Mental Health Crisis

Speakers

- **Joe LeRoy,** LICSW, CEO, HopeSparks
- **Wendy Pringle,** LMHC, Senior Director of Pediatric Healthcare Integration – HopeSparks

pediatrics NORTHWEST PS
Mary Bridge Children's

HopeSparks
family services

Our Story

Pediatrics Northwest
& HopeSparks

HopeSparks
family services

- Behavioral Health
- Children's Developmental Services (ages 0-3)
- Relatives Raising Children
- Family Support Services
- HopesCloset
- Pediatric Healthcare Integration

- Pediatrics Northwest is a regional, multi-specialty pediatric group dedicated to improving the health of children and families in our communities..
- Caring for 40K children, over 45 years
- 32 pediatricians in 4 offices in the South Puget Sound

Our Goal

"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete."

- R. Buckminster Fuller

pediatrics NORTHWEST PS
Mary Bridge Children's

HopeSparks
family services

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From the Beginning

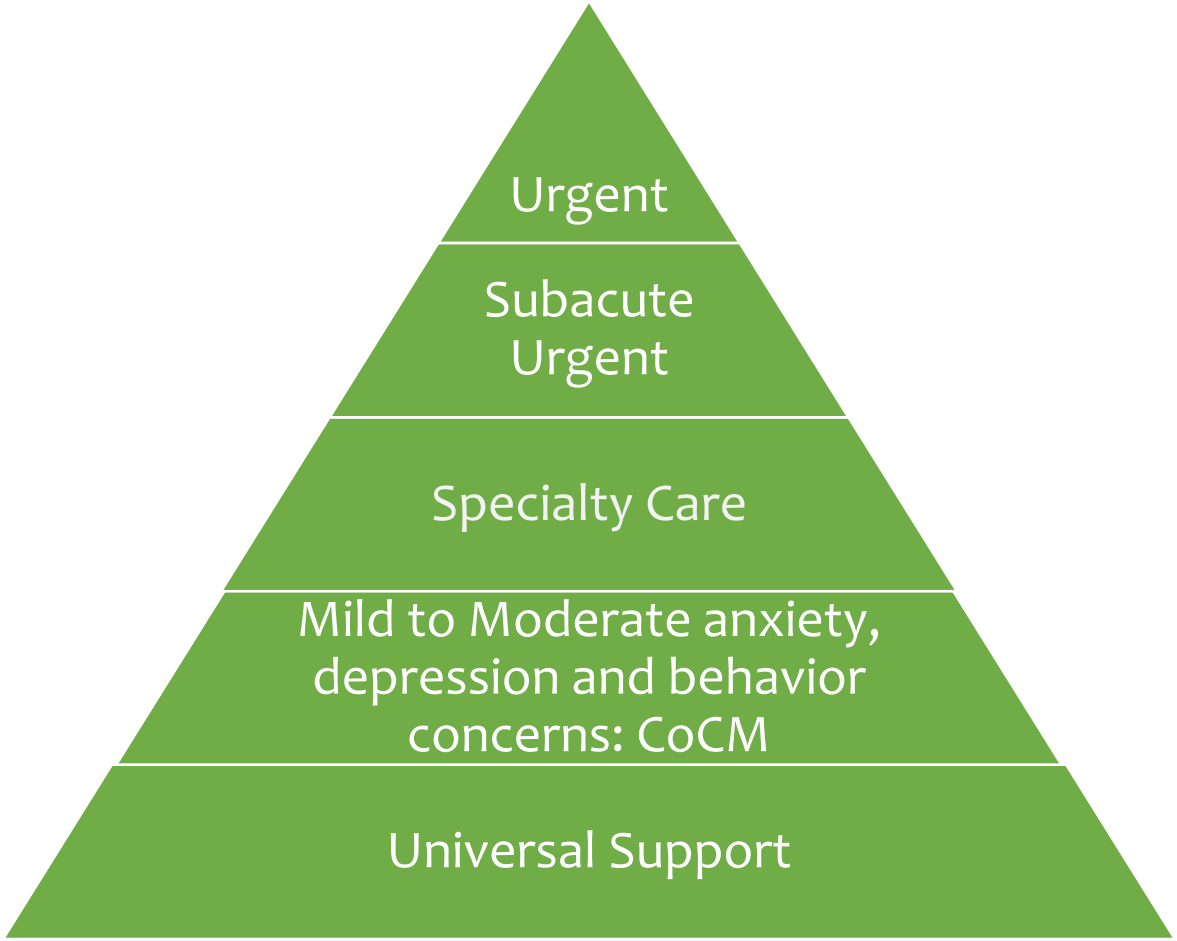
Power of Prevention

Early Identification

Early Treatment

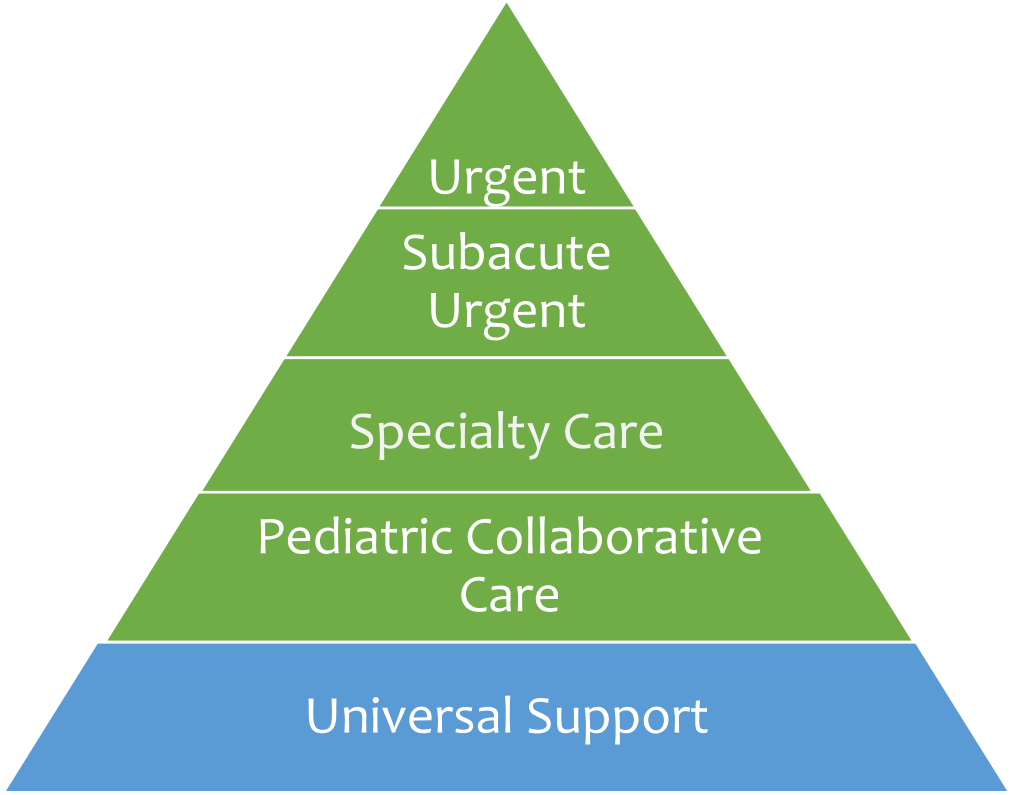
A Team Approach

Mental Health Care Stratification



Universal Support

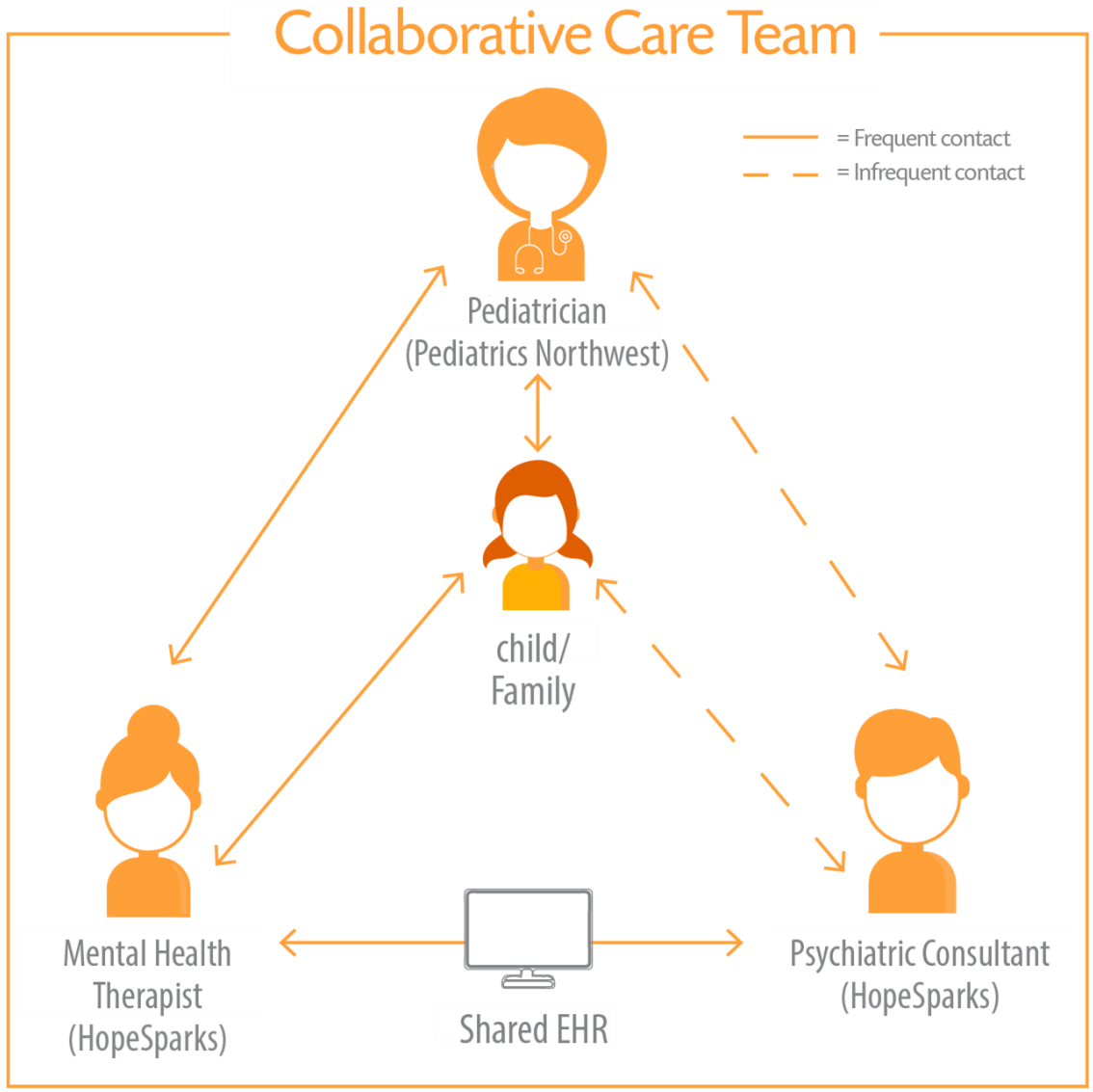
- Universal mental health screening/support
  - Birth to Three:
    - Perinatal Mood disorder Screening
    - Developmental Screening and Surveillance with validated screening, Reach Out and Read and Promoting First Relationships
  - Ages 4 to Young Adult
  - Common Factors Approach
  - Motivational Interviewing



The Collaborative Care Model

- Identification via universal mental health screening at well child visits (validated tools)
- Intended for mild to moderate concerns for ages 4-young adult
- Team approach at the medical home: enhanced communication between team members
- Brief evidence based therapy
- Engagement and progress tracked on a registry
- Shared Electronic Health Record
- Billing collaborative care codes

The Who and Where of Collaboration



First Approach Skills Training (FAST)

- Psychotherapy curriculum created by Seattle Children's
- Evidence based treatment adapted to primary care realities
- Brief targeted intervention, 20-30 min sessions
- FAST-A (anxiety)
- FAST-B (behavior)
- FAST-D (depression)
- FAST-E (early childhood)
- FAST-P (parenting teens)
- FAST-T (trauma)

Screening is Foundational

Birth to 3	4 to 7	8 to 11	12 to 18	19+
• Edinburgh • Ages and Stages • M-CHAT	• Pediatric Symptom Checklist - 35	• SCARED • PSC-35	• SCARED • PHQ-9 • ASQ*	• PHQ-9 • GAD-7 • ASQ*

Secondary screening: CATS, CTS, Vanderbilt
*ASQ: Ask Suicide-Screening Questions

The Data: Access

From primary care referral to first contact with Behavioral Health Care Manager

2.47 calendar days

Referral to Collaborative Care

1463 Referred

PCP to MH Clinician

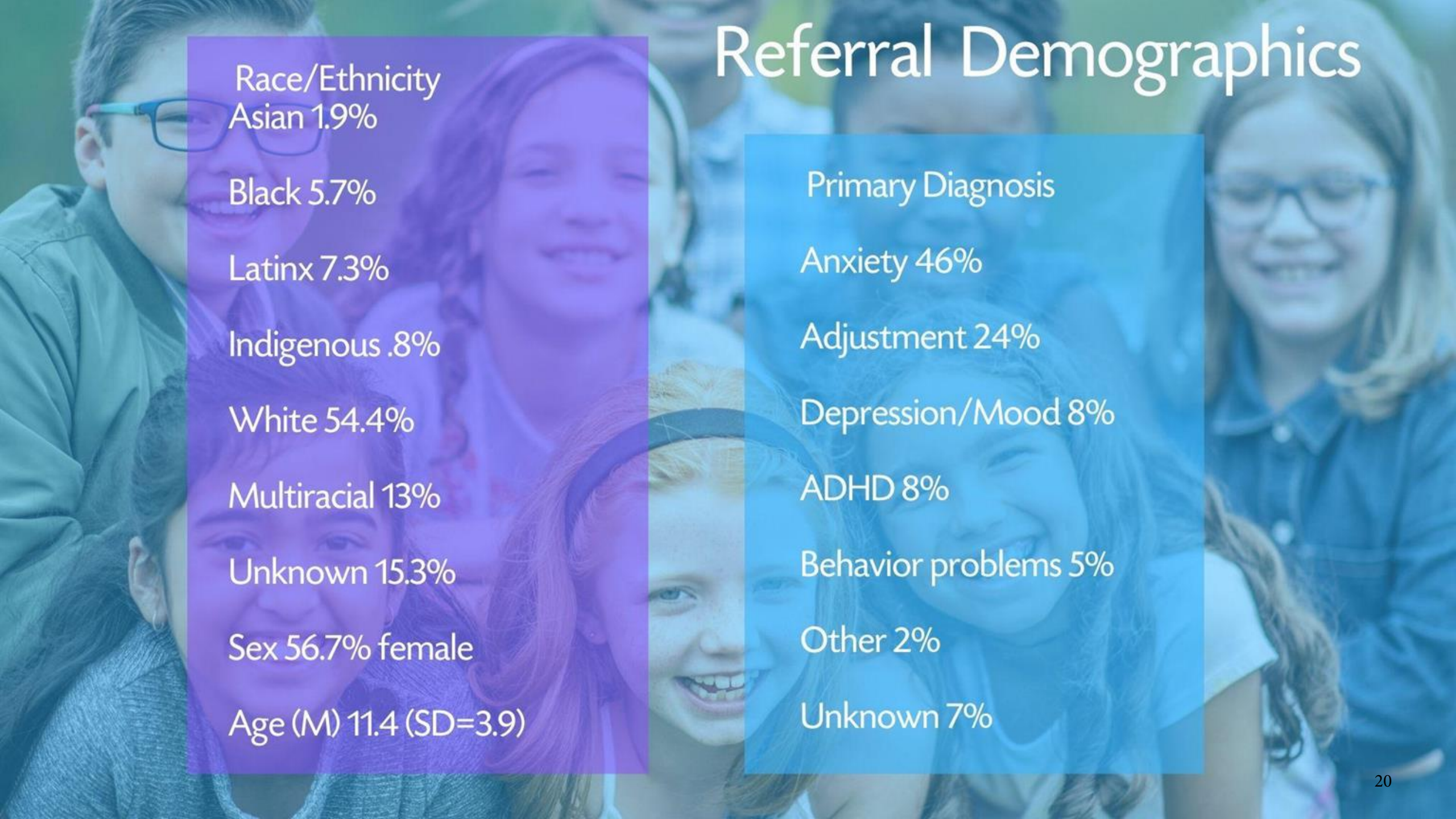
Connect Rate 92%!

At least 1 visit with MH

Mean = 11.5 visits

Range 1-43
Median = 10
Mode = 5
SD = 8

Referral Demographics



Race/Ethnicity
Asian 1.9%

Black 5.7%

Latinx 7.3%

Indigenous .8%

White 54.4%

Multiracial 13%

Unknown 15.3%

Sex 56.7% female

Age (M) 11.4 (SD=3.9)

Primary Diagnosis

Anxiety 46%

Adjustment 24%

Depression/Mood 8%

ADHD 8%

Behavior problems 5%

Other 2%

Unknown 7%

Collaborative Care Program Outcomes

- Paired Samples Effect Sizes

Outcome	Effect Sz.	Standardizer	Pt. Est.	95% CI
PSC-35	Cohen's d	7.66	**1.0**	.65 – 1.33
	Hedge's	7.72	**.99**	.65 – 1.32
SCARED	Cohen's d	11.69	**1.10**	.79 – 1.32
	Hedge's	11.74	**1.05**	.79 – 1.30
PHQ-9	Cohen's d	6.14	.63	.35 - .90
	Hedge's	6.18	.62	.34 - .89
GAD-7	Cohen's d	4.74	.61	.26 - .95
	Hedge's	4.78	.60	.26 - .94

- Effect Sizes
  - Small = .2
  - Med = .5
  - **Large = .8 +**

- **Behavior, depression and anxiety symptoms change after IBH+FAST!**

10 yr old female referred for anxiety:

Presenting Concerns:

- Generalized worries and fears
- Not sleeping on her own
- School avoidance
- Panic symptoms
- Abdominal pain
- Vomit phobia

SCARED score: **Total: 36**

Panic/Somatic: 13
Generalized: 6
Separation: 4
Social: 13
School Avoidance: 0

Patient: “I feel hopeless. I don’t know if things can actually get better” August, 2022

10 yr old female referred for anxiety:

After Completing FAST-A:

- Sleeping on her own every night
- In a leadership role at school
- Panic symptoms gone
- Abdominal pain gone

SCARED score: **Total: 10**

Panic/Somatic: 2
Generalized: 1
Separation: 1
Social: 6
School Avoidance: 0

Patient: “I don’t feel hopeless anymore. I feel confident.” October, 2022

8 yr old male referred for behavior:

Presenting concerns:

- Big feelings, especially anger
- “Meltdowns”, hits himself
- Throws things, screams, cries
- Low self esteem, negative self talk

PSC-35: Total: 26

Attention: 5
Internalizing: 3
Externalizing: 3
Other: 15

Patient: “Why do I get so angry?”
Parent: “I don’t know how to help him.”
April, 2022

8 yr old male referred for behavior:

After Completing Fast-B:

- He is thriving at school and football
- He can tell mom why he is upset
- He can talk about what might help
- He is not hurting himself or others

PSC-35: Total: 10

Attention: 3
Internalizing: 0
Externalizing: 1
Other: 6

Parent: “We can talk things out, he’s so insightful!”
October, 2022

14 yr old female referred for mood:

Presenting concerns:

- Low mood
- Poor sleep and low energy
- Some social anxiety

PHQ-9: **Total: 11**

Mild to moderate

January, 2021

14 yr old female referred for mood:

After completing FAST D:

- Regular sleep schedule
- Self-care bedtime routine
- Exercising with family
- Kickboxing class
- Met new friends, joined a club

PHQ-9: **Total: 1**

Minimal / none

Patient: “Talking about things has been so helpful. I’m seeing progress!”
September, 2021

15 yr old female NOT enrolled at well child visit:

Presenting concerns:

- ADHD symptoms
- Hard to focus in class
- Social anxiety
- School avoidance
- Mild depression

SCARED Score: Total: 23
Panic/somatic: 1
Generalized: 5
Separation: 0
Social: 10
School avoidance: 2

PHQ-9: Total 9 (mild depression)

15 yr old female enrolled at FOLLOWING year well child visit:

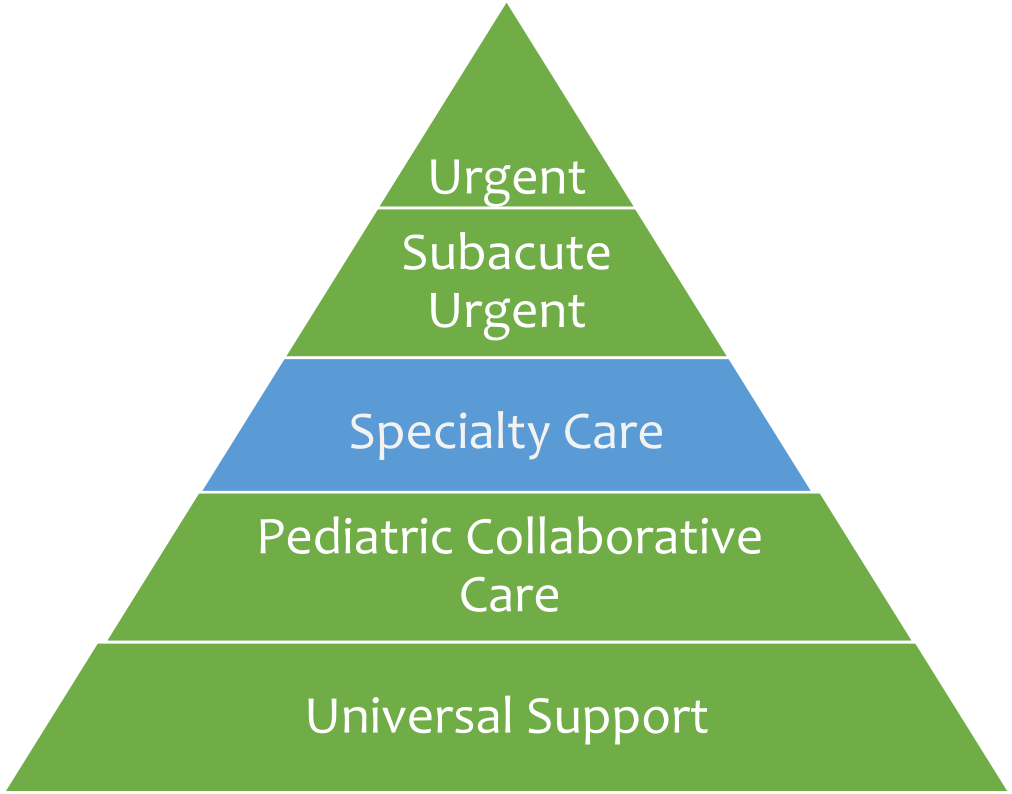
Presenting concerns:

- ADHD symptoms
- Somatic symptoms (new)
- Social anxiety increased
- School avoidance increased
- Depression increased

SCARED Score: Total: 41
Panic/somatic: 12
Generalized: 9
Separation: 1
Social: 14
School avoidance: 5

PHQ-9: Total 17 (moderately severe)

Specialty Care Referral



Care Coordination

- 2 Community Health Workers started July 2022, added an additional 6 with new funding authorized by the legislature (focus prenatal-5, MH connections, social health needs)
- Washington State Mental Health Referral Service for Children and Teens
- Connects youth and families with evidence-supported outpatient mental health services
- Care Coordination will be following up with the patient/family to ensure a successful connection was made and to do any barrier reduction
- Mary Bridge Crisis Social Workers

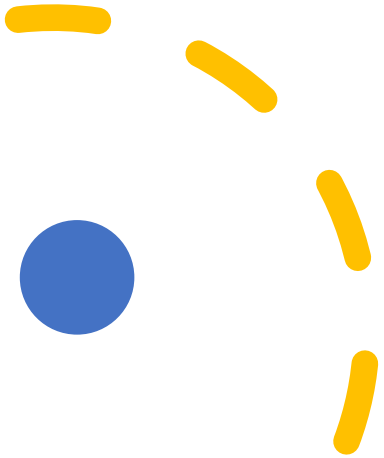
Right Resource at the Right Time in Real Time

- **CoCM WORKS!**
- Who is best served? Those with mild to moderate anxiety, depression and behavior concerns
- Those who will benefit from a 20-30 minute session
- This creates space in the community for higher acuity concerns
- It prevents problems from getting worse
- Telehealth is ideal format for this CoCM team approach: meeting the needs of families

Discoveries

- When help is offered, families embrace it
- Access to care is vastly improved with CoCM
- As access is improved, equity is addressed
- CoCM has triage capabilities
- CoCM addresses scarcity of resources
- Improved patient outcomes
- Improved patient experience
- Improved provider experience
- Scalable
- “I didn’t know how much these worries were taking up my time!” from a teenager completing her treatment in Collaborative Care

Replicable and Sustainable



- Decreased staff turnover
- Increased workplace satisfaction
- Roles are clear
- Intentional dedication of resources
- Integrated Care is financially stable

- Joy is contagious!

“At first people refuse to believe
that a strange new thing can be done.

Then they begin to **hope** it can be done.

Then it is done and all the world **wonders** why
it was not done centuries ago.”

- The Secret Garden,
Frances Hodgson Burnett