Behavioral Health Integration subgroup meeting January 5, 2021

Action items

	Action Items/Decisions				
#	**Action Item**	**Assigned To:**	**Date Assigned:**	**Date Due:**	**Status**
1	Recruit additional family advocates, incl. from WCAAP pediatric improvement work group	Co-leads; staff; others	1/5		
3	Work with HCA staff on data queries after legislative session	Co-leads	1/5		
4	Work with HopeSparks to get relevant data.	Co-leads, Joe	1/5		
5	Get relevant data from CPAA ACH	Co-leads, Kyle	1/5		
6	Adjust draft goals, landscape, etc., as described in slides, based on meeting input	Co-leads	1/5		
7	Reach out to additional stakeholders to accomplish some of this work.	Co-leads	1/5		
8	Set up presentations for initial post-session meetings.	Co-leads, staff	1/5		

Agenda Items	Summary Meeting Notes
Co-leads' comments	**Kristin Houser and Sarah Rafton** Representation from: providers from various types of communities (rural, urban, etc.), plans (commercial and Medicaid), Developmental Disabilities Administration, eastern and western WA, ACH representatives, various divisions of HCA, administrators who have gotten integrated programs underway who can share their experience.
Review potential scope of work	*See page 7.* Discussion: • There is no one model to point to that is the gold standard. • Great variability based on setting (startup costs, funding, region, etc.). Looking for models that work in particular situations. • Are we looking at integrating physical health into behavioral health as well? *Sarah: Would like to offer that we focus scope on integrating BH into PH.* • Put in parking lot as an important piece that we don't want to lose. • As far as legislation around integration, there is strong advocacy from many of the groups around need to be bi-directional. Not doing so really leaves out a whole population. • It may be beneficial to establish a separate subgroup focused integrating primary care into behavioral health settings. This mode of integration has not received enough attention. • Power differentials in initial BHI legislation – physical health care and MCOs focused on very mild BH needs. Where does this leave the behavioral health centers and specialty BH providers? Focusing on mild or moderate needs also eliminated another important player – counties – who may have resources to bear given counties spend a significant amount of

	their funds for juvenile justice and homelessness. A committee member acknolwledged the need to limit scope but is concerned to continue a power differential with physical health driving. [System level concern.] • One reason primary care is so interested is because children haven't got early services. • The system of care value of putting primary care into behavioral health settings is much higher for adults (with serious/persistent mental illness) than for kids in general. So I support keeping this workgroup more limited to BH into primary care as step one to process. • Some committee members noted that bringing primary care services into BH settings can be very fruitful for adults, but less so for children; it is not considered a model practice for children, whereas it can be for adults. Some committee members shared bringing primary care into BH seetings could make a big difference for homeless youth who are less likely to engage or refusing to engage in primary care otherwise. • A current state assessment and data is needed. Also, we should strive to be building stepped care and payor agnostic models, that focus on the pediatric lifespan. I am unaware of the depth and breadth statewide.Really important for there to be a continuum outside of primary care. Important not to consider behavioral health outside of primary care as only intensive or only specialized. • Continuity for families – not needing to retell stories. • *Sarah: Revise goals to include continuum of care and tiered system.* • Importance of telehealth. Current landscape: • Biggest issue: children and youth who are commercially insured and thus are under-insured. Very little, beyond facilities to refer them to. *Sarah: Add to financing scope.* • Other questions re "what does BH in WA state look like for kids?" • For those in the court – barriers: timely access, extensive wait times, scarcity of psychiatric appointments. Missing: access to testing. Needs to be a shift in thinking about behaviors – a lot of judgement of youths and of parents – not recognizing that that's part of the underlying condition. • How our models partner/interface with the Early Intervention system for children B-3 is critical to understand and be paying attention to. There is also a HUGE gap for kids 3-5. • I think the tricky piece we hear with 0-5 is when/how to make the distinction about when referral to developmental specialists' vs infant and early childhood mental health is more appropriate. • Understanding gap 3-5 sounds outstanding. Just trying to say that reliable identification of developmental issues 0-3 and timely referral to ESIT can be taken on more effectively elsewhere. • A few thoughts: 1. Mental healthcare needs are increasing for kids in particular during COVID, but not so the number of providers. 2. The state's referral service has observed that access is notably more difficult statewide for commercially insured kids vs Medicaid kids, so commercial plan support for integration is an issue, 3. Promise of integration is providing more stitch-in-time access service support to help more kids before things blow up, but we still need that specialty care too • Don't think we have a good read on what access is for kids' BH services. There aren't services for a lot of kids. services. What is the breadth? Look through race, income, other lenses. Would be fabulous to have data about the diagnoses in these different areas and what we spend, and interventions we could do further upstream.

	• MCOs and HCA: Is there data around 1st contact and time of services? *Building a series of queries for HCA for post-session; discussed with MaryAnne.* • Looked at timing to access (rural area.) How about that whole piece around integrating in the community? We are pretty siloed. Our integration isn't great. • How do we include parents, schools, other stakeholders in our process? Other group: Parents, school personnel bringing in the barriers they are experiencing in real time. • What are the complexities or barriers we are experiencing/seeing? We are really working hard to move away from FFS and more outcome-driven, but the only way it is financed in a BH clinic is FFS. And, in every clinic, we have children with Medicaid and with private insurance. Can't bill for 20 different commercial plans. And for Medicaid, need billing system that is not so administratively burdensome. • The beauty of integrated program is that we can treat patient/family as a 'whole' and we learning about them over time. Behavioral health can be an important piece but also not necessarily the family's priority in the moment when they lack enough food or have violence in the home. Collaborating with schools and their personnel is/can be essential. I think having voices of those we collaborate with and serve, is needed. • Agreed, it is particularly important we provide integrated care for youth with I/DD. Very few experts who can do this..which leads to these youth ending up in ERs. • We have a mix of private insurance and Medicaid so the private insurance is an important piece of this as well. This also is key in the continuum of services, specialty care, crisis care. As an example, one challenge is the many months long process of getting therapists paneled with insurance companies. • We REALLY need care coordination support to be able to do out BHI well. • More extensive application of models specific to pediatric settings; compiling data for pediatric clinics across the state to spread these models; care coordination considerations, esp for kids with high needs/high spend. • Currently navigators are not a reimbursable service. • What is the cost savings of BHI? (savings in ED visits). *Study shows it may not save a huge amount, but may reduce the growth of costs.* • Youth who are receiving BH services in a community setting, are also not getting PH services they need – some are not comfortable in physical health setting. • Start with financing or start with care being received? Get a better understanding of a familiy's needs by starting with what the gold standard is. See better outcomes when we look at the policy levers, like financing afterward. Focus on the model of care first. • How will we know we're doing a good job, from the perspective of parents and kids receiving care? • One of the requirements in the MCO contracts is to assessment of the level of integration in our networks. Do we need a common assessment? How do we know when we've achieved that model of care? Is there a gold standard? How do MCOs support a practice that just wants to stay at a certain mid-level? MCOs have a role in assessment, but it isn't clear how we collect and analyze the data, and how we involve stakeholders. Has been focused more on bi-direction care at the adult level than at the children and youth level. Still at least a quarter or two away from being able to look at children and youth. • Consider questions around how the MCO interacts with families end-to-end? • HopeSparks is using the AIMs model to fidelity – only using the care coordination codes. We've had at least one MCO who is interested in modeling these things out for sustainability. Allows us to test it, hire the staff we need, do the billing, and see what we find with the data. Will have meaningful data by ?

	• Kyle: CPAA ACH: provided funding for private clinic – bill collaborative care codes – have good data. 20% Medicaid. Will check with them on their funding data. • Does need to be a standard or best practice, but also need to look at how/if we're serving all populations. Clearly, one model will not serve all populations. Hope that our measures are not outputs, but outcomes…not whether they're taking a medication, but whether they're stabilized. Funded in a way that allows providers to meet all of the unique needs. • *Sarah: This group is wanting to tackle financing across different sectors and parts of our system. What can we do that is iterative and where do we start? Concerns about the breadth of scope that is coming up today. How do we be effective? PH and BH perspectives: Keep at the forefront: What is the spectrum? And how do we tier?* • *Kristin: Collaborative care billing codes set up certain requirements. Awareness that FFS rates are not adequate.*
Members' ideas of where we would like to be one year from now	• Finding ourselves in a model that can be globally integrated so we can connect with other practices. Private insurance important. • More extensive BH funding models – PCBH, partnership model, collaborative care, etc. – specific to pediatric settings. Compiling data from across the state from pediatric practices. More funding for care coordination, including kids with highest need/highest spend. Navigators. • Understanding of best ways to use the collaborative care codes. In a tiered system of care, knowing that all the levels are working effectively. Funding navigators positions, to get at social determinants of health. • Robust list of the gaps and challenges that are unique for Medicaid payers. Road map of what is next based on these gaps and challenges. We can engage with the AWHPs. • Early presenters: Yakima Valley, Kent-Des Moines, Hope Sparks. • To have a good understanding of how integrated BH fits in the spectrum of care, gaps and barriers, understanding the challenges, translate into legislative recommendations – what are the steps that we need to move legislatively – low-hanging fruit, standards of care and practice, tiered support conversations, budget and funding issues. Describing that landscape. Where does BHI for kids fit in the whole landscape. Understanding how this subgroup can tie into the whole picture but not tackle the whole picture.
Wrap Up/Next Steps	Subgroup will meet monthly when session ends, with sub-subgroups meeting in between.

Attendees

Endalkachew Abebaw (Health Care Authority [HCA])
Rachel Burke (HCA)
Representative Lisa Callan
Jean Clark (CHOICE Regional Health Network)
Teresa Claycamp (HCA)
Diana Cockrell (HCA)
Devon Connor-Green (Association of Advanced Practice Psychiatric Nurses)
Jamie Elzea (Washington Association of Infant Mental Health)
Dr. Thatcher Felt (Yakima Valley Farmworkers Clinic)
Alicia Ferris (Community Youth Services)
Sylvia Gil (Community Health Plan of Washington)
Leslie Graham (UW Neighborhood Clinics)
Kimberly Harris (HCA)
Libby Hein (Molina Healthcare)
Dr. Bob Hilt (Seattle Children's Hospital)
Kristin Houser (Parent)
Avreayl Jacobson (King County Behavioral Health and Recovery)
Nichole Jensen (DSHS-Developmental Disabilities Adminstration)
Nat Jungbluth (Seattle Children's Hospital)
Michelle Karnath (Family, Youth and System Partner Round Table [FYSPRT], Clark County Juvenile Court)
Garrison Kurtz
Sarah Kwiatkowski (Association of Washington Healthcare Plans, Premera-Blue Cross)
Joe Le Roy (HopeSparks)
Alice Lind (HCA)
Dr. Sheryl Morelli (Seattle Children's Care Network)
Jennifer Polley (Northwest Pediatric Center)

Wendy Pringle (HopeSparks)
Sarah Rafton (Washington Chapter of the American Academy of Pediatrics [WCAAP])
Shannon Re (Kitsap Children's Clinic)
Kyle Roesler (CHOICE Regional Health Network)
Caitlin Safford (Amerigroup)
Daniel Smith (Community Health Plan of Washington)
Mary Stone-Smith (Catholic Community Services of Western Washington)
Beth Tinker (HCA)

Behavioral Health Integration Subgroup of CYBHWG

January 5th, 2021

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BHI Subgroup of CYBHWG: Agenda

- Introductions
- Subgroup expertise & interests
- Overview of potential scope
- Discussion of potential scope
- Future vision of subgroup

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BHI Subgroup of CYBHWG: Overarching Goals

- What is the model practice / gold standard to aspire to – nationally and in WA?
- What are barriers to implementing this model or best practice in WA State?
- What are policy recommendations to remove barriers and to support growth of this model statewide?

❖ *Set common goals.*

3

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BHI Subgroup of CYBHWG: Current Landscape

- What progress has occurred establishing pediatric integrated BH care in Washington state?
- Where in WA is there integrated behavioral health care for kids in primary care?
  - *Race, ethnicity, language of kids receiving BH integration?*
  - *Where is integrated behavioral health in primary care occurring in a partnership with a BH clinic, e.g., a BHC employee; where is it employed within clinic?*
- Annual spend on BHI for children/adolescents and numbers of children/adolescents served (compared to adults)?

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BHI Subgroup of CYBHWG: Financing BH integration

- What are the typical start-up costs and what funding is available?
- What are the costs to operate an integrated BH program? (and how many children does that serve?)
- What does Medicaid reimbursement look like now for integrated programs, including both billing under the collaborative care codes and fee for service billing for therapy?
  - *What is parallel funding for commercial insurers?*
  - *What payor mix is sustainable?*
- In clinics where reimbursement is not adequate, how big is the gap between cost and revenue? What has funded the gap?

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BHI Subgroup of CYBHWG: Role of Apple Health MCOs and HCA

- What is the role of Apple Health Managed Care Organizations in supporting adoption of BHI in primary care for kids?
  - *Start up costs?*
  - *Existing billing opportunities?*
  - *Other contractual opportunities?*
- What is the role of HCA in supporting the development of BHI for kids?
  - *Payment Systems*
  - *Contract provisions*

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BHI Subgroup of CYBHWG: Programmatic considerations

- What are the model practices to aspire to?
- How can communication between specialty BH providers (private practice and community BH centers) and primary care be more reliable?
- What are opportunities to serve children and families prenatal-to-5?
- What is the potential role of a health navigator or coordinator to support the communication needed with schools, outside agencies, families?
- Are there rule adjustments needed to reduce the burden of billing documentation and make reimbursement more available for care coordination services?

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Current Landscape

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What knowledge or information could you contribute (based on your unique role/experience)?

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BHI Subgroup of CYBHWG: Future Vision

Where we would like this subgroup to be one year from now?