

CYBHWG Behavioral Health Integration (BHI) subgroup

Date: July 12, 2022
Time: 10 a.m. to noon

Leads: Kristin Houser and Sarah Rafton

Regional Support Centers

Bob Hilt & Larry Wissow, *Seattle Children's*
See page 3 for slides

Highlights

- There is a need for regional support and coordination to make behavioral health integration a stepped or tiered system.
- There is value in having a framework for collaborative fast brief therapeutic treatments to support mental health practitioners.
- 12 groups in Seattle Children's Care Network (SCCN)
 - Each site has unique needs, but they do collaborate to learn from other sites.
 - SCCN collaborative allows for greater quantity of screening and has nearly doubled screening capabilities.
- Partnership Access Line (PAL); mental health referral service line
 - The overall referral team is made up of sub teams and each case will be managed by one of three internal teams with regional specialization to increase efficiency.
 - Looking to specialized referral process for targeted referral help.
- PAL for schools – a pilot program that works with school districts to have a psychiatrist come in to offer support and consults.
- PAL primary care clinician line is only for primary care providers in the state.

Discussion & Q/A

- Certified Community Behavioral Health Clinics (CCBHCs) are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth.
- In addition, CCBHCs must provide care coordination to help people navigate behavioral health care, physical health care, social services, and the other systems they are involved in.
- One reason we're so enthusiastic about the CCBHC model is that it can be a great way to involve those individuals with more serious diagnoses/symptoms in the integrated care model, especially since this population faces barriers to receiving integrated care in a primary care-first setting.
- National Council for Mental Wellbeing – [What is a CCBHC?](#)
- Are the CCBHC's focusing on individuals/families that need most of their care in the BH sector versus general physical care?
 - Yes, so CCBHC would be a key partner and could be a "home" for a regional collaboration that supports both early intervention and care for the important but lesser severity care.

Continued Discussion of Legislative Priorities:

- Maximizing alternative payment models, such as CCBHCs and Hubs to coordinate care, centers of excellence, and training centers is a priority.
- One of the most important things that families need is support by peers and parent partners prior to treatment; try to incorporate.
- Successful referrals and coordination between primary care and behavioral health clinics.

Next Steps

- Continue to discuss legislative priorities; send any thoughts/ideas to Kristin and Sarah.
- Next meeting is August 23, 2022, from 10 a.m. to noon.

Attendees:

Kelsey Beck, Kaiser Permanente
Dr. Phyllis Cavens, Child and Adolescent Clinic
Gabe Evenson, Health Care Authority (HCA)
Maria Fernanda, Child and Adolescent Clinic
Libby Hein, Molina Healthcare
Andrew Hill, Excelsior Wellness
Dr. Bob Hilt, Seattle Children's
Nat Jungbluth, Seattle Children's
Bridget Lecheile, Washington AIM
Mike McIntosh
Connie Mom-Chhing, Community Health Plan
Of Washington

Julia O'Connor, The Washington Council
Avery Park, Advocate
Liz Perez, HCA
Wendy Pringle, HopeSparks
Noah Seidel, Office of Developmental
Disabilities Ombuds
Ashok Shimoji-Krishnan, Amerigroup
Cindi Wiek, HCA
Larry Wissow, University of Washington (UW)
Jackie Yee, ESD 113

Ideas for a strategic statewide network of next generation integrated care

Building on what we have now

Bob Hilt, Larry Wissow on behalf of SCH/UW/SCCN pediatric integrated care projects

With

Kristin Houser, Sophie King, Sheryl Morelli

The problems we still need to solve

- Not enough services
- Geographic (mal)distribution
- Want more early identification and help
- Families need continuity – problems don't go away and the “system” isn't one
- Neither primary care nor community mental health can do it alone
- Need to grow and stabilize the mental health workforce
- Need to keep promoting evidence-based and diversity-capable care

Current model of integrated care

- Mental health clinician(s) co-located with primary care
- Primary care practice capacitated to screen, share mental health care
- Community health worker in primary care helps link families to care (multi-generational)
- Small amount of child psychiatrist time for collaborative care consultation
 - Example: 1 scheduled hour per week reviewing clinic cases, possibly involving a mental health case tracking registry

Expanded collaborative care would add

- Collaborative relationship with community mental health agency
- Collaborative relationship with school-based health/mental health program
- Regional child/youth mental health provider simultaneously supports the primary care practice, the community mental health agency, and the school-based mental health program
 - Training in evidence-based interventions tailored to setting, population (including crisis interventions)
 - Availability of one-off assessments if they cannot be provided in the community
 - Selected special “tele into the practice services”
 - “Golden ticket” access to services above the level that can be provided in the community

What to build on (1)

- Ongoing integrated care “learning collaborative” for Seattle Children’s Care Network and UW community practices
 - Coaching in practice transformation
 - AIMS Center training on collaborative care model
 - Training for primary care providers and co-located mental health clinicians (some of which comes from Children’s PAL+ program, FAST brief therapeutic trainings, crisis consult services)
 - Help establishing registries and tracking outcomes

IBH Cohort

(All)

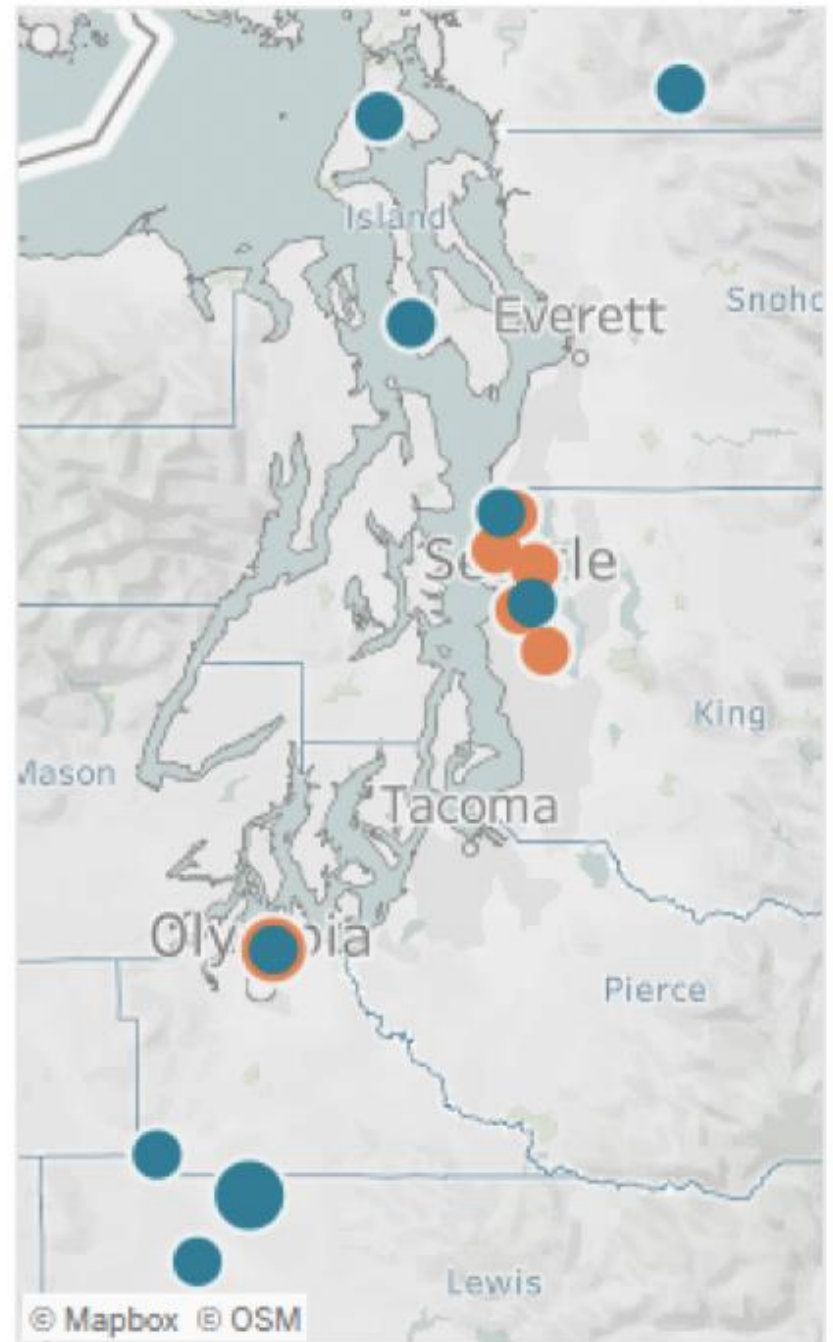
Cohort 1

- Northwest Pediatric Center
- Odessa Brown Children's Clinic
- Olympia Pediatrics
- Pediatric Assoc Of Whidbey Island
- Richmond Pediatrics
- Skagit Pediatrics



Cohort 2

- Ballard Pediatric Clinic
- HopeCentral
- North Seattle Pediatrics
- South Sound Pediatrics
- UW Harborview
- UW Roosevelt



SCCN Cohort 1 BH, developmental, maternal MH, SDOH screening growth

Network Review of Screening Over Time

Cohort 1

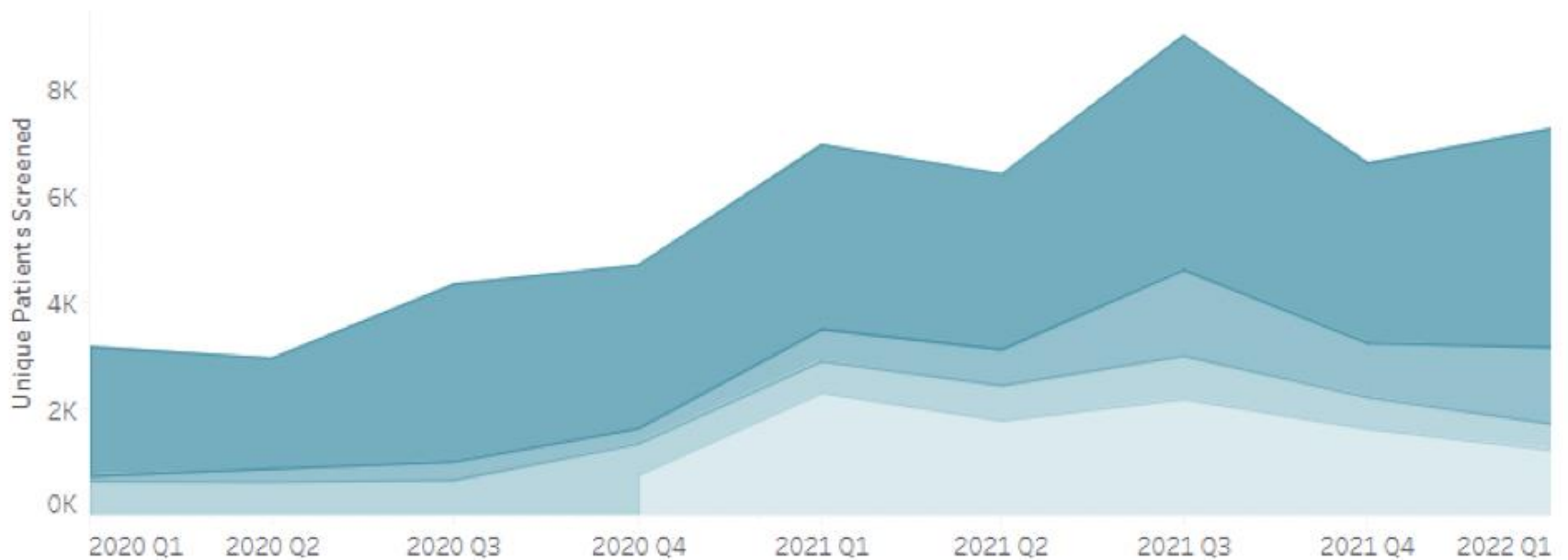
Select a Practice

(All)

- Behavioral Health
- Developmental
- Postpartum Depression
- Social Determinants of Health

Unique Patients Screened per Category from 2020 Q1 through 2022 Q1 *All ages*

Practice: All



SCCN Cohort 1 BH visits ages 6-18 since start of collaborative

SCCN Behavioral Health Total Visits

4566 ✓

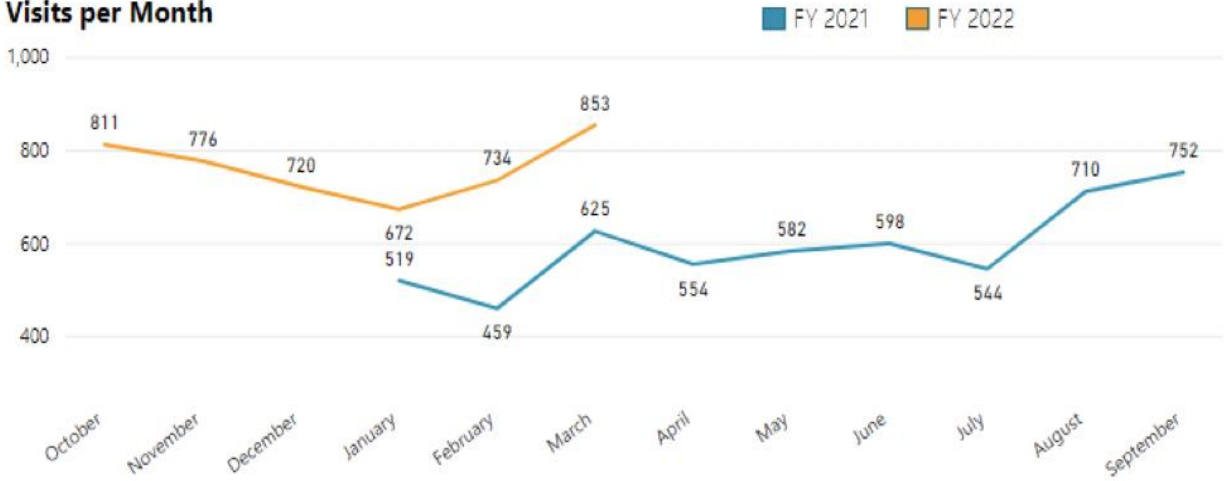
Goal > Prior FYTD: 1603 (+184.84%)

Metric Definition: Total number of behavioral health encounters for patients age 6-18 years old at SCCN primary care locations during FY22.

Goal: More visits than prior FYTD.

FY22 Q1 Goal > 0 FY22 Q3 Goal > 3337
 FY22 Q2 Goal > 1603 FY22 Q4 Goal > 5343

Visits per Month



Data Source: SCCN primary care practices participating in an Integrated Behavioral Health program. Data currently represents Cohort 1 (n=5 practices), launched in November 2020. A second Cohort 2 launched in November 2021, with data to be added at a later date.

What to build on (2)

- New state initiatives for integrated care and CHW's
- PAL mental health referral service line
 - Already developing internal team regional specialization
 - Could serve strategic practices around the state to help them locate resources that their navigators could then help families access

What to build on (3)

- Experience with PAL for Schools: processes for backing up school-based mental health programs with their Tier 2 and Tier 3 multi-tier level of support (MTSS)
- PAL primary care clinician line: could develop dedicated support for practices and (if mandate expanded) and community mental health facilities involved in the program
- Seattle Children's experience with telemedicine contracts with community mental health agencies

Statewide program (1)

- Identification through an RFP process of a small number of strategically-placed practices and community mental health agency teams in strategic locations around the state
 - Bellingham, Mount Vernon, Omak, Spokane, Yakima, Pasco are places where we may already have connections
 - Pick places based on under-served populations and significant geographic challenges in accessing care
- Initially work with the practices and agencies to develop or refine integrated care programs, including help with practice transformation, negotiating community partnerships, staff training, developing business model
 - Likely 2-year period

Statewide program (2)

- Transitions to maintenance phase
 - Ongoing support from; refresher training, help onboarding new staff, help with data analysis
 - Practices and agencies self-fund bulk of work through collaborative care codes and other billing mechanisms
- What we would expect to get
 - Reduction in visits to community hospital emergency rooms (and other markers of mental health severity); reduced boarding in emergency rooms for those seen there
 - Reduction in waiting times for care for children/youth identified as having a mental health problem
 - More efficient use of community-based mental health services
 - Reduced staff turn-over in community-based mental health services