CYBHWG Behavioral Health Integration (BHI) subgroup

November 1, 2022

Leads: Kristin Houser and Sarah Rafton

Preliminary findings from key-informant interviews on care coordination

See page 4 for slides

Highlights:

- Interviewees included Pediatricians from Skagit, pierce and King County, University of Washington, Kent Des Moines, Olympia, a mental health professional from Yakima, and 2 adolescent Psychiatrists from Seattle Children's' hospital.
- Care coordination is defined as assisting patients and caregivers with the resources they need to access mental and behavioral health services.
- Children's needs have not been well represented in our healthcare system with care coordination.
- There is not a lot of waste in pediatric healthcare so care coordination is more preventative.
- Quote from Dr. Woodris – "80% of the work relates to addressing social need and structural inequities and 20% relates to medical needs."

Key takeaways

- Funding for care coordination is coming from grants and without the grants it would not be possible to reimburse for these services.
- Care Coordination would be transformational for patients and families.
- Families need help, they are finding that the health system is overwhelming and inconsistent, therefore care coordination would be a benefit.
- Care coordination requires flexibility.
- Care coordination is taxing the licensed work force; they are working outside their work hours to try and help patients and families get the help that they need and feeling ineffective about it which is a huge contributor to burnout.
- Having care coordination in primary care is a key component of helping children and families to get the needed resources and connect to services.

Gaps identified

- Lack of staff to address social determinants of health.
- Differential access in rural communities and the opportunity to build better connections and meet patients where they are at.
- There's a need to integrate behavioral health in primary care and in schools; important to connect those connection points that are critical and then introduce a streamlining workflow.

- Need to have someone responsible for this work that knows what community resources are available and where to find them.
- Since care coordination has started there is positive feedback from families.
- Care coordinators can proactively support the family's navigation in getting the services they need.

First Approach Skills Training (FAST), Partnership Access Line (PAL) and Referral Assist

Nat Jungbluth, *Seattle Children's*

Highlights:

- FAST stands for first approach skills training, with the trainings designed as brief interventions for primary care with evidence -based programs focusing on treatment strategies.
- The FAST program is directed through the partnership access line with funding related to programming specific to primary care and is expected to end in June 2023.
- Program is designed with four 50–60-minute sessions.
- FAST is used as a bridge to care for families and caregivers that need support.
- Over 100 primary care-based clinicians have participated in the FAST trainings and over 30 live trainings have been given in clinic settings.
- There are plans to roll out some self-guided videos to extend the personnel resources to hopefully help more families.
- Screening tools offer brevity, usability, and validity; asking mental health providers to use during their care.
- Many of the screening tools available are excellent measures for primary care providers to use in a systematic way for universal screening.
- Asking for additional staff funding to meet the increased demand, with the knowledge that funding will not come until next summer.
- There is a difference in the processing time for Medicaid versus non-Medicaid. Medicaid referrals are taking on average 18 days to find one person with availability for services, while commercial health plan entails lots and lots of calling around and generally takes longer due to the lack of services available in the community.

Attendees:

Kailani Amine, Washington Chapter of the American Academy of Pediatrics (WCAAP)
Rachel Burke, Health Care Authority (HCA)
Phyllis Cavens, Child and Adolescent Clinic
Rachel Dumanian, Childhaven
Leslie Graham, University of Washington (UW)
Elizabeth Hein,
Bob Hilt, Seattle Children's Hospital
Whitney Howard, Molina Healthcare
Avreayl Jacobson, King County Behavioral Health and Recovery
Julia O'Connor, The Washington Council
Liz Perez, HCA
Wendy Pringle, HopeSparks
Noah Seidel, Office of Developmental Disabilities Ombuds
Ashok Shimoji-Krishnan, Amerigroup
Amber Ulvenes, Advocate
Cindi Wiek, HCA

CONNECTED CARE

CHILDREN'S BEHAVIORAL HEALTH

University of Washington MHA Policy Team 2022

Table of Contents

01 Care Coordination

Role of Support

- Assisting patients and caregivers with...
  - Resources
  - Navigating the healthcare field and beyond
  - Building collaborative relationships with providers

Examples of Work

- Therapeutic Support
  - Mental/behavioral health resources (therapy, psychiatry, inpatient services, etc.)
- Medical Support
  - Primary care, specialty care, etc.
- Social Determinants of Health
  - Housing & Food Security
  - School Support
- Prevention
  - Screening/Assessments

02 Importance of Work

- **Addressing...**
  - Mental/Behavioral Health needs
  - Social Determinants of Health (SDOH)
  - Medical needs
  - Family needs
  - Advocacy Work
    - Ensuring quality
- **Pediatric Considerations**
  - How this population has been historically underrepresented & underserved
  - Role of the COVID-19 pandemic
  - Continuum of care support

"80% [of work] relates to addressing social needs, structural inequalities, and SDOH; while 20% relates to medical needs"

-Mary Ann Woodruff

03 Interviewees

Name	Title and Organization
Rick Levine	Pediatrician, Skagit Pediatrics
Mary Ann Woodruff	Pediatrician, Pediatrics NW
Leslie Graham	Pediatric LICSW, UW Primary Care Clinic
Beth Harvey	Pediatrician, South Sound Pediatrics
Mary Virginia Maxwell	LMHC, Educational Service District 105
Doug Russell	Attending Psychiatrist, Seattle Children's Hospital
Bob Hilt	Child Psychiatrist and Director of PAL, Seattle Children's Hospital
Loryn Moore	Care Coordinator, Compass Health & Coordinated Care
Wendy Pringle	Director of Pediatric HealthCare Integration at HopeSparks Network

04 Themes

- **Funding** for care coordination is currently in part from grants, otherwise it would not be completely possible
- **Reimbursement** for BH care coordination would be transformational and crucial to patient-centered care
- Families need the assistance because the **work to find care is overwhelming and inconsistent**
- Care coordination necessitates **flexibility** in time, travel, and attention
- A lack of specified care coordinators **takes healthcare professionals away from their work** and contributes to burnout
- Care coordination revolves around **connecting care to the patient at the right time** with effective referral and resource tracking among a collaboration network
- Care coordination **serves SDOH, structural inequalities, and medical needs**

04 Care Gaps/ Needs

- **Organizational Limitations**
  - Lack of staff to address SDOH areas
  - Integrative Programs
    - Access for rural communities/families
    - Focus on how to build closer connections and meet patients where they are at
- **Identified Needs**
  - Integrated behavioral health in primary care visits and in schools to be able to provide better care.
  - Standardization between providers like PCP and Mental health providers
  - Personalized care directed at specific patient needs
- **Streamline Workflow**
  - Finding reliable resources: reducing time it takes outside of productivity commitments
  - Needs are continuous – not able to be “one and done” when resources/care is provided

05 Stories

“Right Services at the right time in real time”

-Mary Ann Woodruff

"Since we have started using Care Coordinators in July 2022, we have continuously received positive feedback from our families. Upon receiving a call from one of our Care Coordinators, some of our families were shocked that the purpose of the phone call was purely relational and the intent was to simply inquire if they were connected to a mental health resource in the community".

- Rachel Lettieri, MS, MHP, AAC
Manager of Care Coordination

A 5-year old was repeatedly presenting with severe stomach pain on school days, though this was a physical symptom providers looked at the patient from a holistic perspective and ultimately determined that this was a symptom of severe separation anxiety from his parents. Care coordination allowed this patient to be connected directly with the behavioral services he needed!

-Story shared by Wendy Pringle

"The current COCM billing does not allow for consultation with teachers which I find ridiculous. Meaning, technically, the way it is written, we cannot bill for consulting-with-teachers time; only psychologists or counselors. I do not think this is wise. Teachers spend the majority of time with students and often have a good assessment of their needs. The language in the current billing needs to be more clear."

- Leslie Graham
Peds LICSW, UW Primary Care Clinic

06

Next Steps...

- **Billing Capabilities**
  - Less stress on providers
    - Productivity
    - Finding appropriate code to bill (if at all)
  - Measuring impact
    - Obtaining measures to see how work can impact patient's health & quality of care
    - Appropriate compensation for providers – improving staff & patient retention

- **Furthering Collaboration**
  - Appropriate record/data keeping
    - Providers can see impact of Care Coordination