INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE FOR CHILDREN AND YOUTH

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Pediatric Transforming Clinical Practice Initiative
PRIMARY CARE AND BEHAVIORAL HEALTH VIRTUAL INTEGRATION IN SKAGIT COUNTY

• Primary Care Provider (PCP) Perspective
• Behavioral Health Provider (BHP) Perspective
• Support from Pediatric Transforming Clinical Practice Initiative (P-TCPI)
FRANCIE CHALMERS, SKAGIT PEDIATRICS

- 6 FTE provider independent primary care clinic
- Skagit County, WA

- Medicaid Population: 59%
- Visits with BH component: 25%
- Gaps in Referral Care: 50%
3 THINGS HAPPENED AT THE SAME TIME

1. Skagit Pediatrics embarked on formalizing its structure as a Patient Centered Medical Home
2. Providers became increasingly aware of gaps in access to behavioral/mental health services for families
3. Skagit Pediatrics signed up with P-TCPI
QUESTIONS THAT NEEDED ANSWERS

• What is the problem?
• What is the best process for making improvements?
• What’s is in this for families? For providers?
• What Skagit Pediatrics’ strengths can we build on?
• How can we learn from and improve the process?
WHAT IS THE PROBLEM?

• Recognizing gaps in care
• Wanting to improve care for families
• Family Story
WHAT IS THE BEST PROCESS FOR MAKING IMPROVEMENTS?

- Communication is key
- Follow up to make sure what was put in place is actually happening
- Regular meetings to discuss progress and brainstorm improvements
- PDSA Cycle approach
WHAT’S IN THIS FOR FAMILIES?

• Clarity about the process of getting to see a behavioral health provider
• Improved access, follow up, and outcome
• Systems of Care Framework
WHAT’S IN THIS FOR PROVIDERS?

• Standardized process for communicating with families and the BH Providers
• Confidence that there will be fewer referral gaps, and that follow through will be assisted as needed in a timely way
• Confidence any medical information will be made available to the BH provider at the point of care
• Timely feedback in a clear and usable format
WHAT ARE SKAGIT PEDIATRICS’ STRENGTHS WE CAN BUILD ON?

• Desire to keep the patient/family at the center of the process
• EMR ability to formalize processes and workflows
• Development of communication tools/forms and workflows with flexibility to adjust as needed
• Recognition of value in re-examining and improving workflows and processes over time
HOW CAN WE LEARN FROM AND IMPROVE THE PROCESS?

- Record keeping regarding referral outcomes
- Continue to look for gaps in care processes
- Involve families by getting their feedback
- Continue to meet regularly with community providers
BEFORE...

• Referrals were discussed with patient/family in the course of a busy well child visit

• Patients were sent out of the room with a blue half sheet of paper with the APN/BHO intake number in bold, and advised to call for an intake appointment

• Families often did not end up seeing a behavioral health provider

• The medical provider often did not know this until the next WCC visit or behavioral crisis

• Medical records sent to CCS with referrals were not always available to the BHO provider at the point of care
NOW

Tailored EPSDT referral form is completed and faxed to CCS

- What does CCS need to know?
- Medication management vs counseling?
- Medical records sharing
- Best format for communication

When received by CCS a set of actions are put into place

- CCS receives information before the point of care
- Timely alert when no appointment made/kept
- Best format for communication
How are we doing? Is this working?

• Tracking referrals
• Recognized gaps prompt care coordination
• Regular meeting to review and improve
• PDSA process ongoing
FUTURE GOALS

• **Continue** to meet regularly to refine and improve the process

• **Formalize** a system of Care Coordination within Skagit Pediatrics to complement the work done by CCS

• **Expand** the process to additional community providers not just in behavioral and mental health but other circles in the Systems of Care Framework

• **Remember** to keep the patient and family’s needs central to the processes
We Believe...
...in every child growing up in a safe, loving and nurturing environment.
3 THINGS HAPPENED AT THE SAME TIME

1. The NSBHO started a PIP to “increase care coordination” for EPSDT kids
2. Skagit Pediatrics contacted CCS to talk about ways to improve communication
3. CCS signed up with Pediatric TCPI
QUESTIONS THAT NEEDED ANSWERS

• Why do we want to do this?
• What’s is in this for families?
• How will we make decisions?
• When do the contacts happen?
• What CCS strengths can we build on?
WHY DO WE WANT TO DO THIS?

It’s a good idea because we know that care coordination works.
CARE COORDINATION

- From the medical perspective: care coordination is more efficient for “chronic conditions”
- From the behavioral health perspective: care coordination fits for complex mental health problems with multiple live domain needs (school, peer, home, DCFS, medications)
- Uses the same principals as Wraparound/WISe
LET'S START WITH A SUBGROUP

- EPSDT
- Medication referrals
EPSDT

**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is: “comprehensive and preventative health care service” for children under age 21 who are enrolled in Medicaid.

EPSDT is initiated by:

1) PCP paper referral, or
2) At behavioral health assessment, the family indicates the PCP wanted them to come in.
WHAT’S IN IT FOR FAMILIES?

Use the Systems of Care framework.
SYSTEMS OF CARE CORE VALUES

• Child centered & family focused
• Community based
• Culturally competent
EVIDENCE BASE FOR SYSTEMS OF CARE

from, Beth A Stroul, M.Ed- National Technical Assistance Center for Children’s Mental Health; Georgetown University Center for Child and Human Development

Evidence of Improved Outcomes and Investments

• Federal Children’s Mental Health Initiative established by Congress in 1993 to fund communities, tribes, and territories to implement the system of care approach
• National evaluation of the CMHII and other studies have found:
  • Positive outcomes for children and families
  • Improvements in systems and services
  • Better investment of limited resources
• Results have led to efforts to expand implementation of the approach so more children and families benefit (Stroul, Goldman, Pires, & Manteuffel, 2012)
Evidence Base for Systems of Care

EVIDENCE OF IMPROVED OUTCOMES AND INVESTMENTS

- Federal Children's Mental Health Initiative established by Congress in 1993 to fund communities, tribes, and territories to implement the system of care (SOC) approach
- National evaluation of the CMHI and other studies have found:
  - Positive outcomes for children and families
  - Improvements in systems and services
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- Results have led to efforts to expand implementation of the approach so more children and families benefit (Stroul, Goldman, Pires, & Manteuffel, 2012)

SOCs IMPROVE THE LIVES OF CHILDREN AND YOUTH

- Decrease behavioral and emotional problems (depression, anxiety, aggression)
- Decrease suicide rates
- Decrease substance use
- Improve school attendance and grades
- Decrease involvement with juvenile justice
- Increase stability of living situations
- Increase strengths

SOCs IMPROVE THE LIVES OF FAMILIES

- Decrease caregiver strain
- Increase capacity to handle their child’s challenging behavior • Improve problem-solving skills
- Increase ability to work
- Increase peer-to-peer support
- Increase family education and supports
- Improve the service experience of caregivers and youth

SOCs IMPROVE SERVICE SYSTEMS

- Improve system management
- Create interagency partnerships (structures, agreements, braided funding)
- Result in systematic development and implementation of strategic plans to improve services
- Improve requirements in contracts with MCOs, providers, regulations, Medicaid rules, standards, practice protocols
- Improve accountability and use of data for quality improvement and decision making

SOCs IMPROVE SERVICES

- Expand services to broad array of home- and community-based services
- Customize services with individualized, wraparound approach to service planning and delivery
- Improve care management and coordination (especially for youth with most complex, costly problems)
- Increase family-driven, youth-guided services
- Increase cultural and linguistic competence of services
- Increase use of evidence-informed practices
- Increase training of children's mental health workforce
HOW WILL WE MAKE DECISIONS?

• When we know the PCP wants to collaborate/communicate
• When we can take families out of the messenger role
SYSTEM OF CARE FRAMEWORK

- Recreation
- Vocational Services
- Social Services
- Mental Health Services
- Primary Care
- School
- Child and Family

Operational Services
WHEN DO THE CONTACTS HAPPEN?

- Beginning
- Middle
- End
WHAT CCS STRENGTHS CAN WE USE?

• EMR
• Collaborative Documentation
**BEGINNING**

- **EPSDT - potential clients referred by PCP (faxed)**
  - Cover sheet explaining that a letter was sent to a family within 7 days of receiving an EPSDT referral from the PCP
  - Copy of invitation letter sent to family

- **EPSDT - potential clients that did not respond to letter (faxed)**
  - Cover sheet informing PCP family did not come in for an assessment within 30 days of the PCP referral
  - Copy of original invitation letter sent to family

- **All clients (mailed)**
  - Cover letter requesting medical records (in some cases a letter will be sent to the PCP letting them know a records request has been made and a separate request letter is sent to the records department)
  - Copy of ROI

- **EPSDT - newly assessed clients (mailed)**
  - Cover letter informing PCP assessment was completed
  - Copy of ROI
  - Assessment Summary

**NEW! From meetings with Skagit Pediatrics**

**CCS Strength: use EMR to create new assessment summary**
END

EPSDT – and/or medication management clients transferring back to PCP (faxed)
  ▪ Cover sheet explaining upcoming transfer of medications
  ▪ Two most recent medication management session notes

EPSDT – and/or ongoing medication management clients lost to contact (mailed)
  ▪ Copy of medication management reengagement letter sent to family

EPSDT - clients lost to contact (mailed)
  ▪ Copy of reengagement letter sent to family

NEW! From meetings with Skagit Pediatrics
COLLABORATIVE DOCUMENTATION

What is it?

Collaborative Documentation is a process in which clinicians and clients collaborate in the documentation of the Assessment Service Plan documentation of the Assessment, Service Plan, and Progress Notes.

Collaborative Documentation is a clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understanding of important issues and focus on outcomes.

The Client must be present and engaged in the process of documentation development
- **EPSDT - and/or medication evaluation referral clients (faxed)**
  - Cover sheet identifying the upcoming action
  - Collaborative documentation Session Summary describing the referral initiation
- **EPSDT - ongoing clients (faxed)**
  - Cover sheet identifying the cause for concern (if the concern is significant, one version will request follow-up with PCP)
  - Collaborative documentation Session Summary describing the cause for concern

**NEW! Proposed from meetings with Skagit Pediatrics**

**CCS Strengths:** use EMR to create new session summary, use Collaborative Documentation
“But first, a distraction.”
PEDiatric Transforming Clinical Practice Initiative

1. Support more than 140,000 clinicians in their practice transformation work
2. Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
3. Reduce unnecessary hospitalizations for 5 million patients
4. Generate $1 to $4 billion in savings to the federal government and commercial payers
5. Sustain efficient care delivery by reducing unnecessary testing and procedures
6. Build the evidence base on practice transformation so that effective solutions can be scaled
CLINICAL GOALS OF PEDIATRIC TCPI

- Improve immunization rates
- Increase well child exams
- Improve asthma outcomes
- **Improve behavioral health care and access**
- Decrease avoidable ED visits
- Improve coordination of care

Alignment with common measure set and VBP measures
STRATEGIC AREAS FOR BEHAVIORAL HEALTH

Integration
- Toolkit
- Build bridges between Primary Care Providers (PCPs) and Behavioral Health clinicians

Access
- Create venues for PCPs and behavioral health providers to connect
- Work within regional teams to understand resources in the community

Training
- Peer training for PCP’s in the management of behavioral health needs within primary care setting (ADHD, inherited antipsychotic medications, depression, anxiety) and when to refer to specialists
ACCOUNTABLE COMMUNITIES OF HEALTH
### REGIONAL TEAMS

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<th>Behavioral Health Champion</th>
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<td>Beth Harvey, Olympia</td>
<td>Joelle Blair, Seattle</td>
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BEHAVIORAL HEALTH CHAMPIONS

- Part of regional teams
- Recruit behavioral health providers to P-TCPI
- Build succinct document of community BH resources
- Facilitate dialogue and forge relationships between behavioral health centers and PCPs
THREE ESSENTIAL QUESTIONS FROM PEDIATRIC PRIMARY CARE

1. **ACCESS:**
   How can I get my patient in the door to receive behavioral health care?

2. **ONGOING COMMUNICATION:**
   How do I know that the referral “stuck”- that my patient and family followed through and received care?

3. **INFORMATION SHARING:**
   How do I know what happened? How can I learn status, progress, and/or outcome of behavioral health interventions before the patient comes back to my office?
LESSONS FROM BETTER HEALTH TOGETHER

ROCKWOOD PEDIATRICS AND FRONTIER BEHAVIORAL HEALTH

Meet regularly

• Confirm with PCP when intake occurred, indicating diagnosis

• Confirm with PCP when counseling appointment occurred, sharing treatment plan with PCP

• Update PCP after the client/patient was seen by a medication provider, indicating meds prescribed and who to contact for info about meds or medical concerns
LESSONS FROM BETTER HEALTH TOGETHER, CONT

ROCKWOOD PEDIATRICS AND FRONTIER BEHAVIORAL HEALTH

• “Nobody would have thought you need to design a form!”
• Collaborate on simple tasks to improve reliable communication
• Work with the culture of your agency
  ✓ Develop document
  ✓ Instruct your people in how to use it
  ✓ The time it takes to accomplish this was a surprise
• Now Frontier is using this form universally with all their primary care clinics
CONCLUSIONS

We share the same passion

• Divergent vocabulary

• Lack of relationship, knowledge about each other’s roles and services

Relationships and face time are everything

Sharing information is foundational

don’t take for granted that it’s happening!

Forms aren’t glamorous – but a great place to start

Assign responsibility within each silo

Continuously assess, monitor and problem solve unexpected barriers

Steal shamelessly

• Use the Toolkit to establish relationships to share care in your community
QUESTIONS

How can we help you? What questions do you have?
EXERCISE

Think about a case when:

Collaboration between Behavioral Health and Primary Care improved outcomes for a child or youth.

✓ What happened?
✓ Identify specific elements that contributed to successful collaboration

Share with the group these elements
THANK YOU