Washington State Health Care Authority

REPORT TO THE LEGISLATURE

# Partnership Access Line (PAL) Plus Program

## Final Report

Second Engrossed Substitute House Bill 2376; Section 213(1)(ww); Chapter 36, Laws of 2016

December 31, 2018

# Partnership Access Line (PAL) Plus Program

Washington State Health Care Authority

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# Executive Summary

The Legislature authorized the Partnership Access Line (PAL) Plus pilot program through Second Engrossed Substitute House Bill (2ESHB) 2376 (2016). This legislation included the following requirement:

> "By December 31, 2017, the authority shall make a preliminary evaluation of the viability of a statewide PAL plus service program and report to the appropriate committees of the legislature, with a final evaluation report due by December 31, 2018. The final report must include recommendations on sustainability and leveraging funds through behavioral health and managed care organizations."[1]

The Health Care Authority (HCA) submitted the preliminary evaluation on December 31, 2017.[2]

PAL Plus services are targeted to help children and their families with Washington Apple Health (Medicaid) coverage who have mental health concerns who are not already being served by the regional Behavioral Health Organization (BHO) or other local specialty providers. This group is only receiving services from their primary care provider. The pilot focused on residents in both Benton and Franklin counties. Targeted for inclusion in the pilot are children and youth ages 12 through 17 with mild to moderate symptoms of depression, and children ages 4 through 11 with disruptive behaviors.

PAL Plus focuses on offering brief, in-person counseling and therefore does not enroll patients with high severity mental health symptoms. PAL Plus services are offered by local mental health providers who deliver in person and telephonic services when requested by the primary care provider and include:

1. Rapidly accessed evaluation and diagnostic support;
2. Brief behavior management coaching (for parents/caregivers of children with disruptive behavior);
3. Brief behavioral activation treatment (for teens with depression and their parents/ caregivers);
4. Referral support to help families access alternative local services (evidence-based programs when available) if identified needs do not match current PAL Plus program offerings; and
5. Communication with PCPs regarding identified needs, treatment progress and standardized measure tracking for program participants.

This is the final report for the PAL Plus pilot and includes a summary of children and families referred and their participation in the program. The pilot's purpose is to collect information to evaluate the viability of a statewide PAL Plus service program. In addition to evaluating the

[1] 2ESHB 2317 (2016), Section 213(1)(ww)(iv), <http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/House/2376-S.SL.pdf>, accessed on September 21, 2018.
[2] *Provider Access Line (PAL) Plus Program Preliminary Report* (December 31, 2017)", <https://www.hca.wa.gov/assets/2eshb-2376-pal-plus-12-31-17.pdf>, accessed on September 21, 2018.

characteristics of the population being served and the services provided, the PAL Plus team measured symptom improvement and patient and provider satisfaction. Comparison of claim data as referenced in the legislative language is not included because the number of participants in the PAL Plus program is too small, no client identification data is available, and the program participants decided whether to participate, resulting in self-selection bias.

The PAL Plus pilot began taking referrals in December 2016. Between December 2016 and July 1, 2018, the program received 160 referrals either from primary care providers or school staff. One hundred and twelve were reached for telephone screening. In-person intake assessments were completed on 77 children. Of these, 62 started treatment in either the depression or disruptive behavior program. At the end of the pilot, 28 had completed treatment, and fewer than 10 children remained in treatment. [3] Fifty-one of the 62 who initiated treatment completed two or more sessions with a mental health provider. Referrals were made to additional services for 39 of the families and included psychotherapy and medication management. Among those who initiated treatment and attended at least 2 sessions, improvements were seen over time (17.8 percent depression symptom reduction based on 12 participants; 24.3 percent disruptive symptom reduction based on 42 participants).

Results from the PAL Plus pilot in Benton and Franklin counties did not result in enough information to determine that the program should be implemented statewide or if the program is cost-effective. It appears the brief intervention may be an effective strategy for addressing mild to moderate depression and disruptive behaviors. However, the uptake of the model in the pilot was very limited.

[3] We suppress Apple Health client numbers throughout this report that are fewer than 10.

# Background

The Legislature funded the Partnership Access Line (PAL) Plus[4] pilot program at $608,000 in fiscal year (FY) 2017, $625,000 in FY 2018, and $625,000 in FY 2019 as part of the general budget. The PAL Plus program expands upon the PAL model by training behavioral health providers within the local community to provide in-person, brief services that are consistent with research-based interventions. By training and supporting local service providers, PAL Plus seeks to expand access to needed behavioral health services in the communities it serves.

The PAL Plus program seeks to promote the implementation of integrated care, to increase access to effective interventions, and to lessen the number of children and families with life-altering dysfunction due to behavioral or mental health conditions. PAL Plus employs child psychiatrists and social workers affiliated with Seattle Children's Hospital and the University of Washington to deliver consultation services to primary care providers (PCPs) regarding the mental health needs of their patients. PAL staff advise PCPs on medication decisions, provide referral information for services available in the local community, or meet with families via tele-video technology to inform PCP recommendations. Other PAL Plus staff provide training and supervision to local Behavioral Health Service Providers (BHSP's).

# Outreach

Since the fall of 2016, PAL Plus team staff marketed the PAL Plus services to primary care physicians and health plans in the Benton Franklin area. PAL Plus staff participated in many community events to promote the new program and educate health care providers on the referral process. Handouts used during the marketing of the programs and the referral form used by the primary care providers are included in Appendices A and B.

Due to the relatively low service use in the first seven months of the pilot, the PAL Plus team began working with school personnel in addition to the primary care providers to identify children for the program. The rationale being that school staff see children daily and may be in a better position to recognize children/teens with mild to moderate mental health needs.

# Services Delivered

The BHSP's are from the local area and provide evidence-based interventions. Each BHSP receives 3 to 8 hours of training via tele-health on the brief intervention models, depending on their prior experience with similar interventions. The PAL Plus psychologists are employed by Children's Hospital and the University of Washington. Their role is to train and provide weekly supervision and caseload support to the BHSPs. The PAL Plus psychiatrists advise the child's primary care

[4] See "PAL Plus", <https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/pal-plus/>, accessed on September 9, 2018.

provider on the use of psychiatric medication, when indicated, based on severity or lack of treatment progress.

Both the disruptive behavior and the depression programs include an intake session with the patient and/or family of 60 to 90 minutes duration, followed by four 60-minute treatment sessions with flexibility to add an additional session or extend the session length if needed.

# Referrals

Referral data reflects the period from December 2016 through July 2018. PCPs and school staff submitted 160 referrals for PAL Plus services for depression and disruptive behavior. One hundred and twelve were reached for telephone screening. In-person intake assessments were completed for 77 patients. Of these, 62 initiated treatment in either the depression or disruptive behavior program. At the end of the pilot, fewer than 10 children remained in treatment and 28 had completed treatment. Fifty-one of the 62 who initiated treatment completed 2 or more sessions with a BHSP. Referrals were made to additional services for 39 of the families and included psychotherapy and medication management.

# Service Utilization

In PAL Plus, BHSPs support families in accessing and engaging with alternative treatments when those are recommended, including follow-up phone calls to see if the family has set up an appointment and to assist if they had not.

For families with whom phone contact was made but the in-person intake was not completed, the most common reasons given for not initiating the program were that family was seeking or believed they had been referred for a different type of service (individual child therapy or medication consultation) or that the clinician determined that the program was not appropriate for the family's primary concerns (e.g., autism spectrum disorder, severe depression, or suicidal behavior requiring more intensive treatment).

For families who completed an intake but no further sessions, the reason was most often that a different type of therapy service was recommended to address the family's concerns (e.g., cognitive behavioral therapy for trauma-related concerns, anxiety or depression; higher intensity parent training intervention, such as Parent Child Interaction Training).

Of families that dropped out or lost contact after initiating the disruptive behavior program, some did share that they experienced barriers related to time and transportation. In several cases, the families moved out of the area or experienced a major disruption preventing further session attendance (e.g., death, major illness, or change of custody in the family) during the treatment period.



## Depression Program

Of the 46 adolescents referred to the Depression program, 36 (78 percent) of their parents/caregivers program responded to BHSP contact attempts. Of those who responded to a contact attempt, 19 percent declined services and 47 percent were referred to other mental health services due to exclusionary factors. For patients that responded to the BHSPs contact attempts, 31 percent were considered eligible during the initial assessment meeting, and treatment initiated. Of the remaining 12 patients, fewer than 10 completed the program to date and the remaining are in on-going treatment.

## Disruptive Behavior Program

Of the 114 children referred to the Disruptive Behavior program, 76 (67 percent) of their families responded to the up to three contact attempts by phone and one mail attempt. Of those who responded to a contact attempt, 28 percent declined services, and 20 percent were referred to other services by the BHSP due to screening out of eligibility or needing a different service. Of families with whom BHSPs made contact, almost 50 percent were considered eligible during the intake meeting, and treatment was initiated. Forty-seven (67 percent) of families in the Disruptive Behavior program who initiated treatment after the intake, completed the intervention as planned. PAL Plus treatment was still in progress for fewer than 10 families at the time of the final report. Eighteen (about 25 percent) of care-initiated families dropped out of the program after initiating but before completing all planned treatment sessions.

# Outcomes

Since July 2018 the PAL Plus team has continued and expanded its outreach to community partners. This has included an in-person meeting between PAL Plus staff and school staff (predominantly school counselors) from four area schools in September 2018. Plans were made for PAL Plus staff to provide support and additional training to area school staff regarding topics of interest (e.g., screening and support strategies for students with depression and anxiety; tutorial on crisis management strategies and resources; understanding and responding to non-suicidal self-injury; problem-solving intervention for student stressors, etc.). By deepening the supportive relationship with area school staff, the PAL Plus team hopes to increase identification and referral of teens in need.

PAL Plus also hosted a continuing medical education conference in September 2018 for 21 providers in the Tri-Cities with a focus on how to identify and manage teen depression and child disruptive behavior problems in primary care. The conference topics included how to implement routine screening tools for teen depression and child disruptive behavior, education regarding the evidence-supported treatment approaches used in PAL Plus, as well as in-depth discussion of common referral barriers and how to overcome these. The PAL Plus team has also initiated a monthly newsletter providing links to PAL Plus referral information as well as brief articles on mental health topics that are likely to be of interest to both PCPs and school staff.



In addition to ongoing programming in the Tri-Cities, the PAL Plus team is identifying BHSPs statewide who are working in integrated settings and may be interested in receiving training on both the depression and disruptive protocols. Integrated (on-site) BHSPs are likely to be more effective at connecting with parents after primary care referrals, and can efficiently support PCPs in serving their families' mental health needs. Any on-site BHSPs PAL Plus works with will be expected to collect clinical outcomes data to share with HCA.

As part of PAL Plus, outcomes were examined by comparing behavioral health symptom and functional impairment scores at the first session to those at the last session.

## Depression

There were 12 youth in the Depression program who had data at two or more-time points for the primary outcome measure, the Patient Health Questionnaire (PHQ-9). The average PHQ-9 score decreased from 14.5 at the first session to 11.9 at the last session attended, indicating an average reduction of 18 percent for this outcome. This decrease represents a small to medium improvement. Depression symptoms were also measured from the parent/caregiver perspective using the Short Moods and Feelings Questionnaire (SMFQ). The average baseline score was 13.5, the average final session score was eight, and the average percent reduction in score from baseline to final session was 42 percent. The Weiss Functional Impairment Rating Scale (WFIRS) was also completed by parent/caregiver at baseline and final session and indicated a decrease of 4 percent in functional impairment.

Although anxiety symptoms were not a primary target of the depression program, they are a common co-occurring problem, and thus changes over time were examined using the General Anxiety Disorder-7 (GAD-7). Fewer than 10 adolescents had data at multiple time points, showing an average score of 10.9 at treatment initiation and 10.5 at the last attended session, corresponding to a 3.4 percent reduction.

## Disruptive Behavior

For the Disruptive Behavior program, changes in parent-reported Home Situations Questionnaire (HSQ) scores, which measure behavior problems in a variety of situations, were measured over the course of treatment. Based on 42 parents, average scores decreased from 40.0 at treatment initiation to 30.3 at the final session, indicating an average symptom reduction of 24.3 percent. This is considered to be a medium sized improvement. The WFIRS was completed at baseline and final treatment session. Parent scores on the WFIRS also indicated a 25.1 percent decrease in functional impairment across time.

## Program Evaluation Survey Data

The PAL Plus team tried various processes to gather data three months or more after patients discharged from the program. Originally, the process included sending the program evaluation and service use survey to parents from the Depression and Disruptive Behavior program and adolescents from the Depression program. Results of family/patient satisfaction surveys were



generally positive although the response rate was too low to draw conclusions about the program. In contrast, final session feedback surveys given to program completers were more reliably obtained, with results as follows.

## Depression Program

- All 12 teens in the Depression program said, "It helped somewhat," and parents in Depression program reported either, "It helped somewhat," or, "It helped a great deal."
- All teens and parents reported they would "probably" or "definitely" recommend the program to other teens/parents.
- A total of 83 percent in the depression program felt that there were enough sessions.
- About 80 percent of teens and 33 percent of parents reported that most or all their needs were met, while 67 percent of parents and 20 percent of teens reported that only a few of their needs had been met.

The relatively lower ratings from parents likely reflects that the program focused predominantly on teen goals and spent less session time working directly with parents.

## Disruptive Behavior Program

- All final session survey respondents (47 total) in the Disruptive Behavior program reported it helped; 33 (70 percent) of which said "It helped a great deal."
- All respondents said that they would "probably" or "definitely" recommend the program to other families.
- A total of 41 respondents (88 percent) in the disruptive behavior program felt that there were enough sessions.
- A total of 44 respondents (94 percent) reported that most or all their needs were met; the remaining families reported that "only a few of my needs have been met."

Comments about the Disruptive Behavior program mentioned that the skills helped families view their child's behavior in a new way and use strategies for handling difficult situations. The only suggestions for improvement were to include more sessions and to use a larger room where the parent and child could be observed together.

## Providers

- Four primary care providers provided feedback on the PAL Plus Program, two of whom were "very satisfied" with the program, and the other two of whom were "mostly satisfied."
- All PCPs indicated that the referral process was easy, and some found it easy to coordinate care with the behavioral health specialists and indicated that it was a valuable addition to existing mental health resources.



### Depression Program

- The two BHSPs who completed at least one depression case reported that the:
    - Depression-focused behavioral activation curriculum was easy to conduct (average rating of 6 out of 7); and
    - Materials were user-friendly (average rating of 6 out of 7); and that the protocol offered sufficient flexibility to meet families' needs (average rating of 5.5 out of 7).
- Results were mixed regarding the ease with which they could coordinate with the PCP (average rating of 4.5 out of 7) and adequacy of the length of treatment (average rating of 5 out of 7).
- Both BHSPs were satisfied with the program (one reported "mostly satisfied" and the other reported "very satisfied."

### Disruptive Behavior Program

- After completing at least four PAL Plus cases, the BHSPs surveyed rated the Disruptive Behavior program's:
    - Treatment protocol as easy to conduct (average rating of 6 out of 7) and offering sufficient flexibility to meet families' needs (average rating of 5.3 out of 7);
    - Materials were user-friendly (average rating of 6 out of 7);and
    - Length to be adequate (average rating of 6.6 out of 7).
- Results were mixed regarding the ease with which they could coordinate with the PCP (average rating of 4.6 out of 7).
- All providers rated themselves as "mostly satisfied" with the program overall.

## PAL Plus — PAL Child and Adolescent Psychiatrist Collaboration

Despite being a program designed to deliver a brief community-based therapy intervention, some of the patients referred to the Depression or Disruptive Behavior programs had complex histories, including adverse reactions to psychotropic medications, multiple medications prescribed, psychiatric and medical comorbidity, developmental disorders, and safety concerns.

Prior to connecting with the PAL psychiatrist, the primary care physicians were previously managing complex patients without psychiatry support. Despite the complexity and in some cases acuity of the referred patients, the child and adolescent psychiatrist team members collaborated with the primary care provider to make useful therapy and medication intervention recommendations to improve the patients' mental health care through support of the primary care provider. None of the patients the psychiatrists consulted on had seen a child psychiatrist in the last year. Desire for local child psychiatry support regarding complex patients was mentioned by the primary care physician in fewer than 10 consultations, but excessive wait to access child psychiatry locally was also mentioned.



# Conclusion

The PAL Plus pilot yielded important information about providing behavioral health services to pediatric primary care patients. One central challenge in the pilot was in getting appropriate referrals from primary care physicians. Nearly one-third of referred families did not respond to contact attempts, which indicates challenges in "handing off" the transfer of care from PCP to BHSP. The rates of non-response were higher for the behavior track, possibly indicating a lower level of acuity and perceived need by these families compared to families of depressed adolescents, who may have felt more urgency to identify treatment resources. Consistent communication between families and PCPs about the reason for referral, in addition to a more immediate or personalized hand-off to the BHSP, may help to increase interest and follow-through.

Of the parents who responded to PAL Plus BHSP outreach, about 70 percent were both interested in enrolling and identified as appropriate for the program. The rate of families who did not screen-in for PAL Plus programming reflects the challenges PCPs have in completely discerning the mental health needs of youths they encounter in brief medical visits, how to match them with the best evidence based treatments, and the extent of family motivations to seek additional care. For those children/families who did participate in the PAL Plus intervention, these brief, evidence based interventions yielded positive treatment outcomes.

Overall the PAL Plus pilot numbers do not represent enough of the state population to determine if the program should be implemented statewide or if the program is cost-effective. As implemented, the PAL Plus program is not sustainable for statewide implementation. It is premature to recommend leveraging funds through BHOs and MCOs due to limited data. It is clear further work is needed in this geographical area to increase the number of referrals.

Discussions with Seattle Children's Hospital PAL Plus staff has resulted in modifications for the current fiscal year. Emphasis will be placed on training BHSP's who are interested in participating and who are working in an integrated setting across the state on both the depression and disruptive protocols. The BHSP's will bill for the services they provide, offering opportunities to compare costs. Data will be collected by all participating BHSP's which will increase the data and represent the state more accurately. We will work with Seattle Children's Hospital to improve clinical outcomes for patients.

# Appendix A: Community Handout

## PAL Plus Depression Program
### School Staff Information

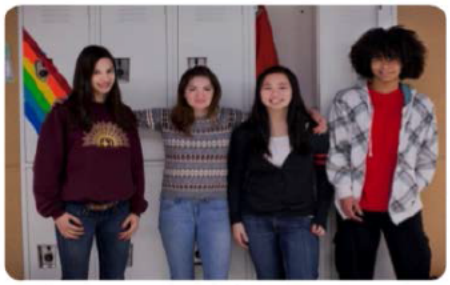
**What Is PAL Plus?** Brief skill-based treatment for mild to moderate depression. The program works with local therapists to provide 5 free in-person sessions. Care is coordinated with the student's primary medical doctor.

**Who Qualifies?** Students 12-17 years old in Benton/Franklin with state insurance.*

**How to refer a student?** School based professionals need to identify and refer students by:

1. Contacting parents/caregivers to assess their interest, verify state insurance, and collect primary care provider's name.
2. Complete the online referral form on our website at www.seattlechildrens.org/PALPlus.

Our team will call parents/caregivers to screen for eligibility.



*State insurance plans include Amerigroup, Community Health Plan, Coordinated Care, Molina, Medicaid, United Health Care Community Plan

**Learn More!**
Web: www.seattlechildrens.org/PALPlus
Email: PALPlus@seattlechildrens.org
Phone: 866-599-7257

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## PAL Plus Depression Program
### School Staff Information


**PAL Plus Topics and Skills:**

- Help teen understand patterns that contribute to poor mood
- Address problematic sleep patterns contributing to mood
- Help teen engage in activities that can boost mood
- Help teen identify what is important to them, and how to take steps in that direction, using SMART goals (Specific, Measureable, Appealing, Realistic, Time Bound)
- Provide caregiver/parent support to understand depression and how to support and communicate more effectively with teen

**How You Can Support a Student in the Program:**

- Continue to check in with the student if it feels appropriate
- Ask about the program, how the student is feeling, what s/he is learning that seems to help
- Support the use of new skills


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# Appendix B: Referral Form



Seattle Children's
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PAL Plus

## PAL Plus Referral Form

For questions or more information, call 866-599-7257 or email PAL Plus.

**Patient name***

First Name Last Name

**Patient date of birth***

**Patient has Medicaid (Amerigroup, Community Health Plan, Coordinated Care, Molina, Medicaid, United Health Care Community Plan). PAL Plus serves only Medicaid patients.***

Yes No

The PAL line is available to primary care providers regardless of patient insurance. Call PAL at 866-599-7257.

**Preferred language of care**

### Parent/Guardian Information

**Parent/guardian name***

First Name Last Name

**Parent/guardian relationship**

## Primary Care and Referring Provider Information

### Primary Care Provider

**Primary care provider name***

First Name | Last Name

**Credentials**

**Primary care provider telephone**

**Primary care provider fax**

**Primary care provider email**

### Referring Provider

**Referring provider name**

First Name | Last Name

**Credentials**



**School-based referral?**

○ Yes ○ No

**Referring provider phone**

**Referring provider fax**

**Referring provider email**

## Referring Provider

**Referring provider name**

**First Name** **Last Name**

**Credentials**



**School-based referral?**
- Yes
- No

**Referring provider phone**

**Referring provider fax**

**Referring provider email**

## Referral Information

**Referral reason***

**PAL program requested***
- Disruptive Behavior (Ages 4–11)
- Depression (Ages 12–17)

Patients with these additional concerns may be excluded from PAL Plus; however, our clinicians will help connect families with a local mental health agency.

**Additional concerns**
- Alcohol/substance abuse/dependency
- Anorexia/bulimia
- Bipolar/mania
- Child abuse
- Post-traumatic stress disorder
- Psychosis
- Self-injury
- Suicidality
- Other: