Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

May 14, 2024

Glossary of Terms

CHW: Community Healthcare Worker
CMS: Center for Medicare and Medicaid Services
HCA: Washington State Health Care Authority
HMA: Health Management Associates
SDOH: Social Determinants of Health
WCAAP: Washington Chapter of the American Academy of Pediatrics

Meeting Topics

- Social Determinants of Health (SDOH) Screening
- Findings from the BHI Learning Network
- Debrief of Retreat
- Group Discussion of Topics of Interest

Discussion Summary

Social Determinants of Health (SDOH) Screening

1. University of Washington Primary Care Kent Des Moines Clinic:
    a. Discussed the impact of Social Determinants of Health (SDOH) screening on pediatric patients and their families.
    b. Covered the design and implementation process of the SDOH screener.
    c. Presented data collected from the screening over the past two years.
    d. Shared feedback from families through qualitative interviews to assess the process and support provided.
2. Importance of Social Determinants of Health:
    a. SDOH includes conditions in which people are born, grow, work, live, and age.
    b. Only 20% of health outcomes are related to healthcare; 50% are influenced by SDOH such as living conditions, education, job status, and income.
    c. Systematic screening and referrals during well-child checks can lead to more community resources being distributed and legitimize discussions of sensitive topics.
3. Goals for SDOH Screening:
    a. Identify modifiable SDOH.
    b. Connect patients to available community resources.
    c. Include family input throughout the process.
    d. Minimize bias in screening and referrals.
    e. Ensure accessibility in all languages.
    f. Balance the screening to avoid fatigue from multiple screeners.
    g. Build trust and conduct the process in a trauma-informed manner.

4. Implementation Process:
    a. Established a Community Advisory Board in May 2021, including patient and family representatives.
    b. Finalized the screening tool with community input.
    c. Began implementation in May 2022, training front desk staff, medical assistants, and providers.
    d. Tracked referrals and outcomes.
5. Community Advisory Board Composition:
    a. Included front desk staff, administrative members, social worker, health navigator, faculty, residents, parents, and members from Within Reach and Unite Us.
6. Principles for SDOH Screener:
    a. Trauma-informed approach.
    b. Recognize health literacy concerns.
    c. Acknowledge resource limitations.
    d. Respect family autonomy.
    e. Ensure equitable screening.
7. Screener Design:
    a. Questions focused on food, homelessness, utilities, transportation, and other family needs (e.g., childcare, dental care).
    b. Screening conducted at specific well-child checks (2-4 weeks, 6 months, 12 months, 18 months, 2 years, then annually).
    c. Translated into six most common languages at the clinic, with phone interpreters used for other languages.
8. Workflow Process:
    a. Front desk includes screener in the patient's packet.
    b. Medical assistant introduces and enters screener results into Epic.
    c. Providers review and discuss responses, provide resources, or refer to social work/community health worker team.
9. Initial Screening Results:
    a. From May to June 2022, 720 initial screens were completed.
    b. Consistent assistance percentages for food (4%), homelessness (3%), utilities (11%), transportation (2%).
    c. Significant increase in requests for other resources (30% to 60%).
10. Commonly Requested Resources:
    a. Clothing and furniture (e.g., cribs, shoes).
    b. After-school programs and childcare.
    c. Mental health resources.
    d. Legal support, English classes, education help, dental care, ophthalmology referrals.
11. Impact on Staff Workflow:
    a. Majority of staff reported the screening adds less than one minute to their workflow.
    b. Quadrupled social work team's workload, highlighting the need for capacity to handle referrals.
    c. Providers found it saved time and was useful in identifying families needing resources.
12. Family Feedback:

a. Conducted interviews with 14 randomly selected parents who screened positive and received outreach.
b. High needs in housing (70%), utilities (40%), food (15%), and other resources (20%).
c. Majority of families (71%) found the process great or easy.
d. 86% received some form of outreach from the clinic.
e. 93% thought the clinic should continue screening.

13. The Center for Medicare and Medicaid Services (CMS) has mandated hospitals to screen patients for social determinants of health, including food, housing, transportation, utilities, and interpersonal safety and submit two measures:
    a. The number of patients screened.
    b. Those identified with one or more social risk factors.
14. Current voluntary screenings at clinics may become mandatory in the future
    a. Requires additional social work support to manage urgent disclosures like domestic violence, which is currently excluded from some surveys due to capacity constraints.
15. The screening process is considered crucial for providing holistic care, which families appreciate.
    a. Significantly changes the clinic's workflow by necessitating more community health workers to support the social work team with numerous positive screenings.
16. Questions:
    a. What is the patient population and community health workers at the Kent Des Moines clinic for resource allocation understanding?
        i. Clinic has diverse and complex patient demographics.
        ii. The clinic initially had just two staff members handling community health work, which proved overwhelming.
            1. Currently, there are two community health workers (CHWs), but the need for more support remains.
        iii. Clinic sees about 7,000 pediatric patients, with around 2,500 screened.
        iv. Social work referrals have significantly increased, with some months seeing referrals quadruple.
        v. Community Health Workers (CHWs):
            1. The clinic employs two CHWs, one for ages 0-5 and another for K-12, dividing social work referrals accordingly.
            2. Community health workers face challenges in connecting with families who prefer clinic visits over community meetings.
            3. Training in trauma-informed care for CHWs and social workers is essential to appropriately assess and support families' needs.
            4. Ongoing relationships between CHWs and families are critical, extending beyond initial contact.
            5. Documentation of all contacts by CHWs is maintained, though it needs to be leveraged to secure funding and demonstrate value.
        vi. Families often request text communications over phone calls.
        vii. Financial reimbursement for social work activities is currently lacking.
    b. Concerns about screening for interpersonal violence, noting its importance in healthcare settings like Seattle Children’s Hospital.

i. While pediatricians inquire about safety at home, addressing domestic violence among adults is complex due to patient confidentiality and responsibility boundaries.
ii. Challenge of recording sensitive information about parents in children's medical records.

c. G1036 (published Nov 2023), a CMS code for assessing health-related social needs, which Washington State aims to implement for Medicaid following budget proviso support.
    i. The necessity of using evidence-based tools for these assessments was discussed, with an emphasis on balancing validated questions with practical, non-judgmental queries.
    ii. Clinic approach of integrating validated questions from various screeners into a customized tool, which includes a unique question about immediate practical needs (e.g., cribs, car seats).
        1. Tool has noted efficacy and acceptance, with plans to further validate and possibly standardize it.

d. Further follow up needed on policies regarding interpersonal violence screening among Medicaid partners.

e. Child and Adolescent Clinic's experience with universal screening, achieving a 98-100% screening rate in visits, and maintaining a 15% positive rate for health-related social needs.
    i. The universal screening approach is well-accepted and helps identify fluctuating needs among patients, such as housing stability impacting health conditions like asthma.

Findings from the BHI Learning Network

1. 2022 Legislative Priorities:
    a. Grants for clinics to build behavioral health integration were allocated by the legislature in April 2022.
    b. Focus on family practice or pediatric clinics with a significant number of children on Medicaid.
2. Funding and Support:
    a. The Washington Chapter of the American Academy of Pediatrics (WCAAP) applied for funding, receiving $30,000 from the Americas Foundation.
    b. The Healthcare Authority notified clinics of startup funds, leading to collaborative efforts to assess needs and build a support curriculum starting June 2022.
3. Collaboration and Networking:
    a. Key partners and experts collaborated to support clinics, emphasizing community learning.
    b. Regular bi-monthly meetings were held to brainstorm and support clinics.
4. Participating Clinics:
    a. Ten clinics from across Washington state were selected, with nine remaining active after one clinic closure.
    b. Clinics varied in stages of development, from those just starting pediatric care to those expanding existing adult-centric programs to pediatric care.

5. Curriculum and Topics:
    a. Topics included collaborative care and team building, implementing screeners, data collection best practices, and overcoming barriers.
    b. Regular coaching calls were offered, and clinics were encouraged to engage in collaborative learning.
    c. Emphasis on financial sustainability, which was planned for a follow-up meeting.
6. Implementation and Feedback:
    a. Clinics received individualized consults and educational resources.
    b. A website (Basecamp) was created to share slides, links, and other resources for easy access.
    c. Feedback was gathered from clinics to evaluate the helpfulness of the support provided and to plan for future needs.
7. Key Outcomes:
    a. Educational materials on pediatric collaborative care, such as the manual from the Aim Center, were distributed.
    b. Clinics shared registry models and other resources to avoid redundant efforts.
    c. In-person visits were highly valued for providing tailored support.
    d. Two clinics onboarded new behavioral health care managers and licensed social workers.
    e. Peer support among clinics was facilitated through Zoom calls.
8. Future Recommendations:
    a. Ongoing support, both clinical and technical, is needed.
    b. Continued and broadened collaborative relationships.
    c. Effective clinical supervision for healthcare managers.
    d. Focus on financial sustainability as a critical need.
    e. Development of funding and effective use of CHWs.

Debrief of Retreat

1. Excelsior Family Medicine launched a collaborative care model with an embedded social worker in their primary care clinic.
    a. Emphasis on maintaining the boundaries of the collaborative care model and avoiding scope creep.
2. Ongoing Support Needs:
    a. Importance of maintaining connections and relationships with key for guidance on policies and program design.
    b. Navigating financial stability and advocating for necessary funding in a fee-for-service environment.
3. Child and Adolescent Clinic's Grant Experience:
    a. Transition to a co-managed model with behavioral health therapists and unlicensed social workers as community health workers.
    b. Stratification of patients into mild, moderate, and severe groups for targeted management.
    c. Challenges in achieving desired outcomes and the need for better partnerships with schools and behavioral health agencies.
4. Challenges in Integrated Care:

   a. Critical issue of cross-sector communication not being covered financially, impacting care for children with high mental health needs.
   b. AAP's set of tools and codes for care coordination, highlighting the potential for transitioning to value-based payment models.
5. Practical Considerations for Service Delivery: important to schedule services to avoid pulling children out of school, suggesting after-school hours (3 PM to 8 PM) as ideal.
   a. Advocacy for raising this issue in the Children and Youth Behavioral Health Work Group.
6. Innovative Approaches in Schools:
   a. Successes with telehealth services in schools, allowing children to access therapy without leaving school premises.
   b. Benefits of working with parents during school hours on behavior management, impacting the child's well-being.
7. Integration of Behavioral and Physical Health:
   a. Important to connect Wise teams with primary care to ensure cohesive care for children.
   b. The need for improved communication between medical and school-based services for holistic child care.
8. Mission of supporting integrated care, early identification and treatment of behavioral health issues, and overcoming barriers to care.
   a. Vision includes sustainably funded, high-quality accessible care with a focus on early relationships and upstream interventions.
9. Workforce Issues and Diversity:
   a. Addressed the preparation, support, and roles of the integrated care workforce.
   b. Important to reach historically underserved and marginalized populations, ensuring accessible and effective care for diverse children and families.
10. Sustainability and Support for Clinics:
   a. Discussion on helping clinics start and sustain integrated care programs.
   b. Importance of tailoring integrated care to children's needs and ensuring the sustainability of successful clinics.

Group Discussion of Topics of Interest

Want to decide by August 27th what to keep on docket out of 5 buckets:

1. Needs of clinics that have integration, how to address so can make sure are successful? What measures do we need to use and how to standardize? Work with HCA partners and this subgroup.
   a. Hope Sparks in Pierce County examples of emergency service utilization, succeeding access with kids upstream of the emergency department.
   b. Screening measures year to year – follow up on specific patients over longer time period.
   c. Would be easier if using the same registry to track information, within the SCCN data like this is hard to pull.
   d. Statewide Surveys to tag into? Possibly link with school based subgroup.
   e. Oregon Child Integrated Data set – not specific to integrated care but helps make data-based policy decisions looking across system: school, child welfare, health care, birth to 5 specifically, etc.
      i. Oregon Social Emotional Health Metric used to incentivize payment for plans and tracking outcomes
      ii. Share with HMA, Rep Kallan, Jason Miguel.

2. Where is behavioral health integration happening right now for kids? Whole areas of state aren't covered, how do we find and target them?
    a. WISe team data – what target areas are they working on? They collect physical health info but could be helpful for BH and utilization/reduction in hospital visit info.
    b. Administrative burden of collecting data on clinics and currently difficult to support.
        i. Potential for ACH clinic transformation funding with screening performance access.
3. Startup and existing funding for more clinics through legislation?
    a. Waiting lists by evaluation – potential for dollars for children via WISe? ($3600/month) HCA by case management?
    b. Target significant need areas and where that is, one per ACH?
    c. Also cannot find care for anyone on the waiting lists, especially if in rural areas, ethnic/racial barriers, etc.
    d. Need to identify high need children on waiting lists and fund money to them, potential to increase funds with primary care integration.
4. Sustaining program financing
    a. Collaborative care financing good but counting minutes and doesn't cover everybody.
    b. Kaiser integration: 2500 Medicaid to 5000 commercially insured ratio.
    c. Ask: CVCH Columbia Valley and FQHC Central Washington for their integration best practices and culturally effective care model.
5. Early Childhood/Upstream focus:
    a. CHWs are a big part of providing more support to children and families in early years.
    b. Harborview presentation had relevant info.
    c. Ruby project got psychotherapy funding for kids in early years.
        i. Offered telehealth for extended service reach to underserved communities through wellness centers (Excelsior) instead of family medicine.
6. Issues to bring to the Workforce and Rates Subgroup:
    a. Raising rates, paying in-between care, paying for kids without diagnosis, gaps in supervision and primary care.

Look Ahead: 24/25 Schedule

- *Other subgroups will deliver their workforce and rates priorities by the June 21 meeting.*