CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Quarterly Steering Committee:

Increasing Pediatric Integrated Behavioral Health Capacity with Community Health Workers

September 20, 2024

Agenda

Topic	Speaker	Time
Welcome/Introduction	Linda Cabral, CTC-RI	9:00-9:05am
Practice Updates and PDSA's	Liz Cantor, CTC-RI Charlotte Vieira, TEAM UP	9:05-9:30am
Data and Evaluation Review for Y1	Andrea Chu, Hassenfeld Institute Emily Feinberg, Hassenfeld Institute	9:30-9:45am
Y2 Upcoming Milestones	All	9:45-10:00am

Thank you to our funding partners

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Participating Practices

Track 1
Coastal Medical Bald Hill Pediatrics
Coastal Medical Waterman Pediatrics
CCAP
Pediatric Primary Care, Hasbro Children's Hospital *

Track 3
Family Care Center Care New England Medical Group
Wood River Health

* Track 1+

Practice Facilitation Updates: PDSAs

Both Coastal practices

- Epic transition continues to impact screening workflows and data collection
- CHW works in both practices, had to take a medical leave, so the practices paused over the summer, resuming this month

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Coastal Medical Bald Hill Pediatrics

- Before the pause: practice working on roles and referral pathways; team developed a tracking system for referrals/outcomes; still working on prioritizing BH navigation vs other SDOH needs

Coastal Medical Waterman Pediatrics

- Before the pause: CHW was engaged with 16 families on BH Navigation; completed 7 BH screens for a range of patients ages 5-12 referred to IBH
- New patient navigator who is working toward CHW certification

Practice Facilitation Updates: PDSAs

CCAP – focus on expanding screening

1. Expanding ASQ to include 48 months (and ensure 9, 18, 30 mos robust)
   - Data: By May, 100% for 9, 18, 30 and 48 mos; added ASQ to 36 mo visit
     August: 9, 18, 30 mos 79%; 48 mos 81%; 36 mo 80%
2. Positive ASQ Personal/Social Domain -> ASQ SE and WHO to CHW (pilot)
   - Data: By May, 100% WHO rate, lower SE completion rate (time/schedule); Plan to extend to all providers in the fall

Next up: Rollout the PSC-17 for ages 5-11 – starting with a pilot provider

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Hasbro – focus on increasing IBHC capacity to provide clinical services

	Telephone Encounters	Face-to-face visits	Pts walked to ED	Safety plans created
Baseline Avg	61	39		
Midpoint Avg	43	42	1.3	4.7
Final Avg	47	45	No data	No data

- Overall number of TEs decreased while face-to-face visits increased; clinic started offering “bridge” appointments
- IBHC left – not his preferred model of working
- Important lesson learned – now trying to hire new IBHC
- Data not available for ED/Safety plans

Practice Facilitation Updates: PDSA's

Wood River

- Roll out of PSC-17 for the 4–12-year-old population in progress – began with 1 PCP piloting, increased from 0% patients screened to 23%; expanded to all PCPs in August, utilizing Phreesia functionality to support implementation, data from June-August shows screening rate continued to increase (36%)
- Working to codify CHW caseload standards and increase referrals from PCP and BH teams – CHW has maintained ~25 discrete care plans, defined by need, i.e., 1 family = 1 care plan if need is common to family unit vs 2 care plans if 1 child needs school support and 1 needs EI referral
- New BH Director working to build capacity and improve workflows amongst BH team

FCC

- Working to define new approach to BH screening for adolescents – initially using GAIN-SS for 16-17, transitioning to combination of PHQ-9, GAD-7, and substance use screening
- Improving workflows for handoff and triage – steadily working to increase referrals to CHWs
- Building infrastructure to enable CHW billing – currently working with EPIC team to finalize CHW documentation templates so that they are compliant with Medicaid billing requirements

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Increasing Pediatric IBH Capacity using Community Health Workers: Baseline Data

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ADVANCING INTEGRATED HEALTHCARE

September 20, 2024

Project Goal: Increase capacity of pediatric practices to identify and manage behavioral health

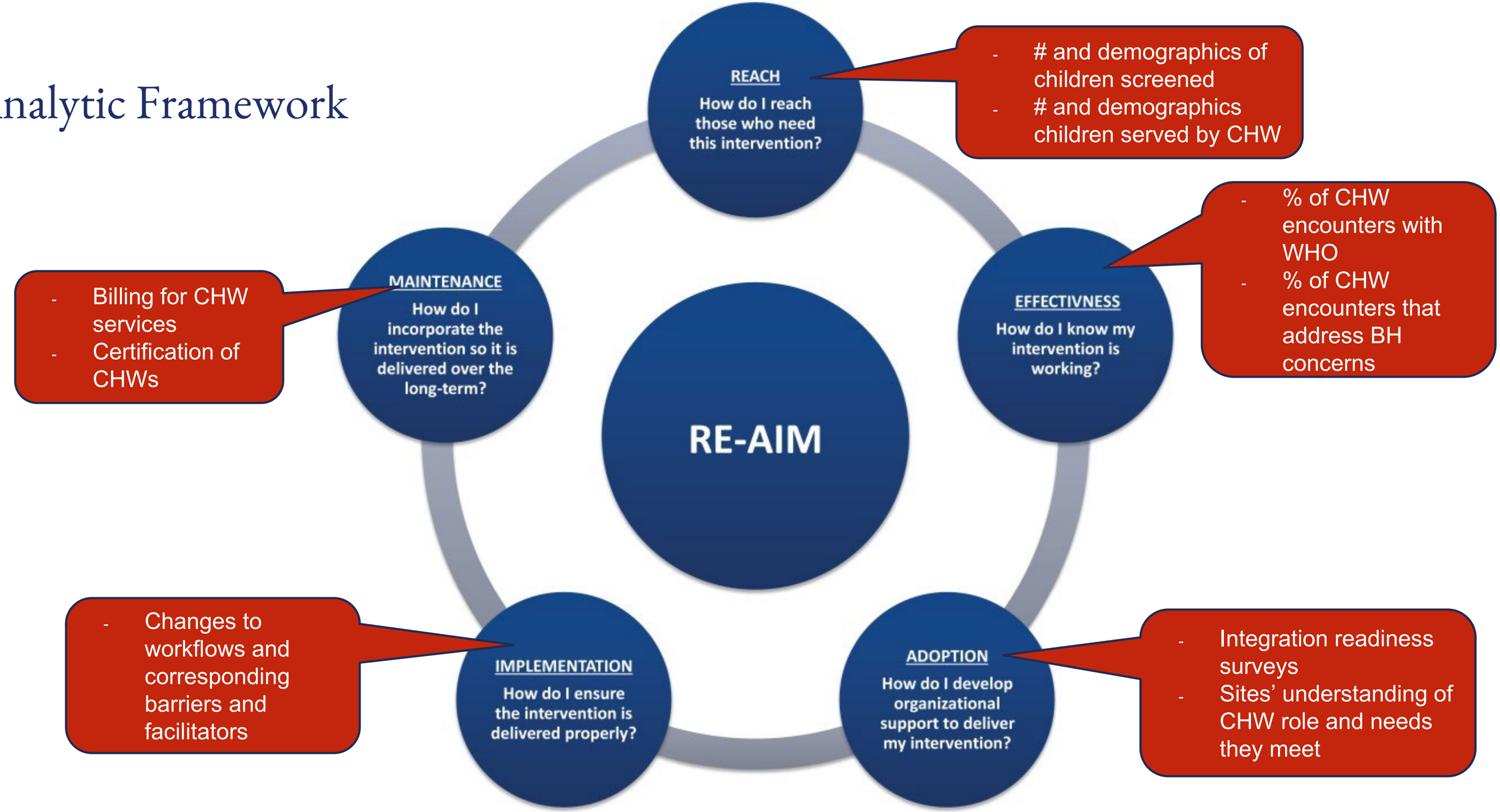
Improve Identification of behavior health concerns

- Evaluation metric: screening rates

Expand IBH capacity through addition of CHW to IBH team

- Evaluation metrics:
  - Warm hand-offs to CHWs
  - Proportion of CHW encounters that address BH needs vs health related social needs
  - Adoption and implementation of CHW role

Analytic Framework



- # and demographics of children screened
- # and demographics children served by CHW

- % of CHW encounters with WHO
- % of CHW encounters that address BH concerns

- Integration readiness surveys
- Sites' understanding of CHW role and needs they meet

- Changes to workflows and corresponding barriers and facilitators

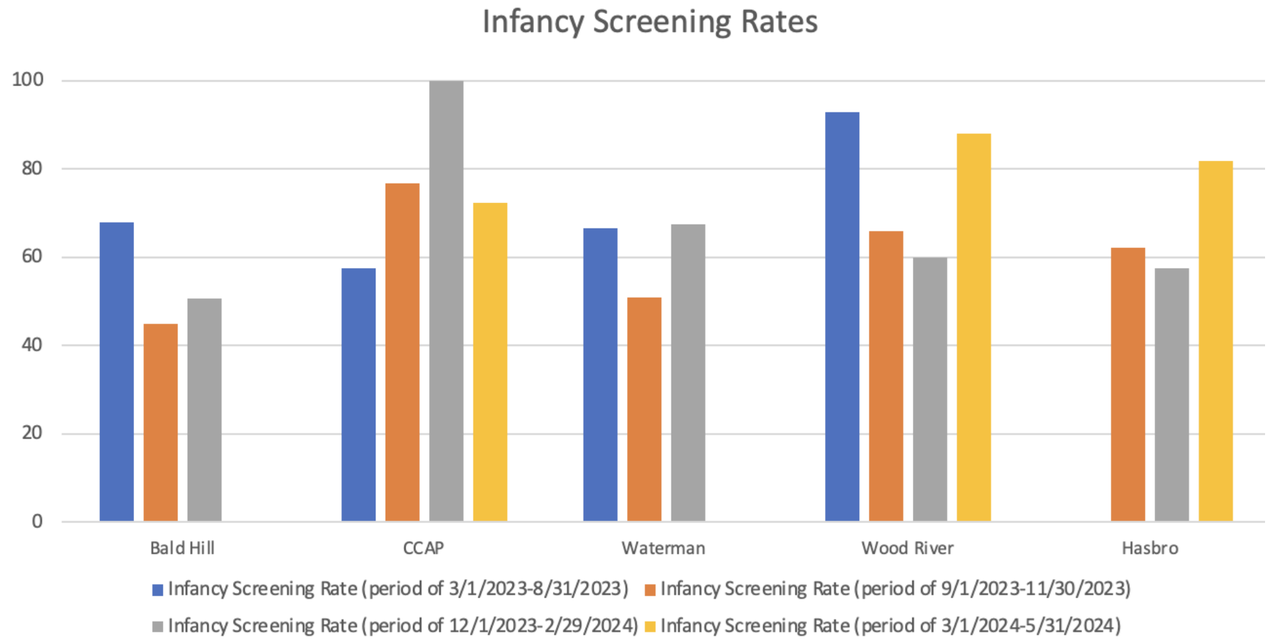
- Billing for CHW services
- Certification of CHWs

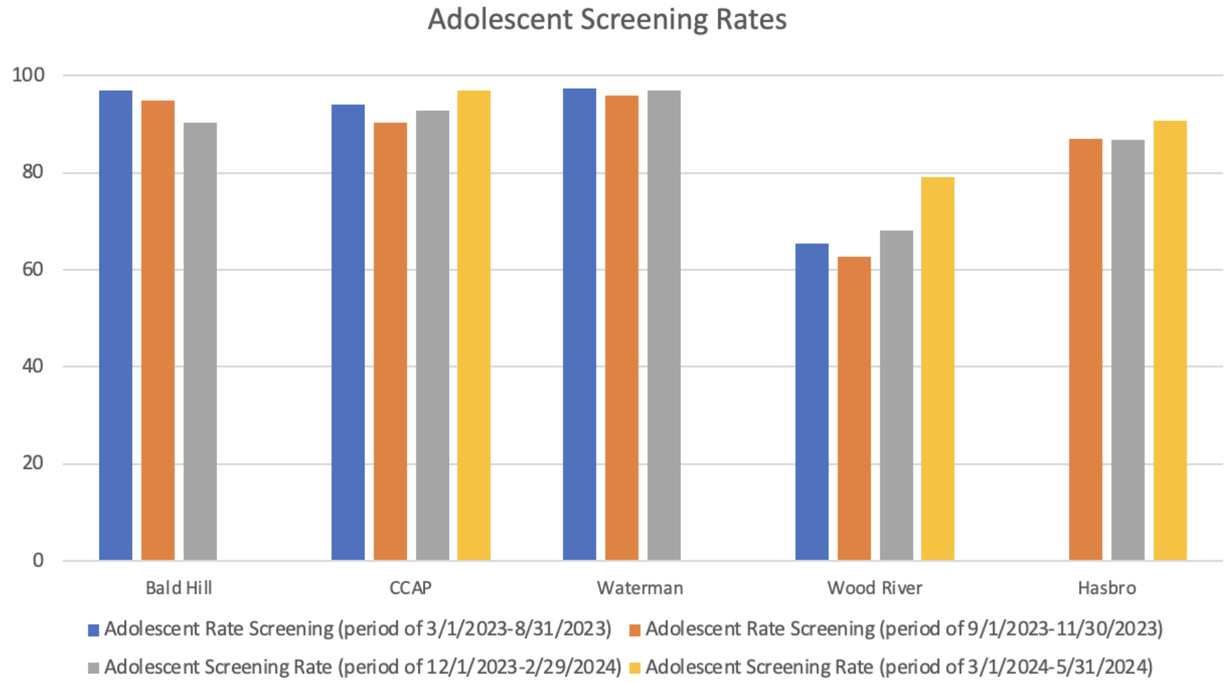
ORY, M. G., ALTPETER, M., BELZA, B., HELDUSER, J., ZHANG, C., & SMITH, M. L. (2015). PERCEIVED UTILITY OF THE RE-AIM FRAMEWORK FOR HEALTH PROMOTION/DISEASE PREVENTION INITIATIVES FOR OLDER ADULTS: A CASE STUDY FROM THE U.S. EVIDENCE-BASED DISEASE PREVENTION INITIATIVE.

Screening Rates

	Screening Reporting		
	Infancy & Early Childhood	**School Age Children** ***We recognize you may not be screening school age children. Please make sure to enter the number of eligible children. If you are screening, select from the list of tools below.***	**Adolescents**
Number Screened			
Total children eligible for screening			
	Select the tools used at your site:		
Required Reporting Tools:	○ Survey of Wellbeing of Young Children (SWYC) ○ Ages and Stages Questionnaire ○ Parents' Evaluation of Developmental Status (PEDS) reset	○ 35-item Pediatric Symptom Checklist (PSC) ○ 17-item PSC (17-Item PSC) reset	○ PHQ-9 reset

Screening: Reach





Screening: Adoption

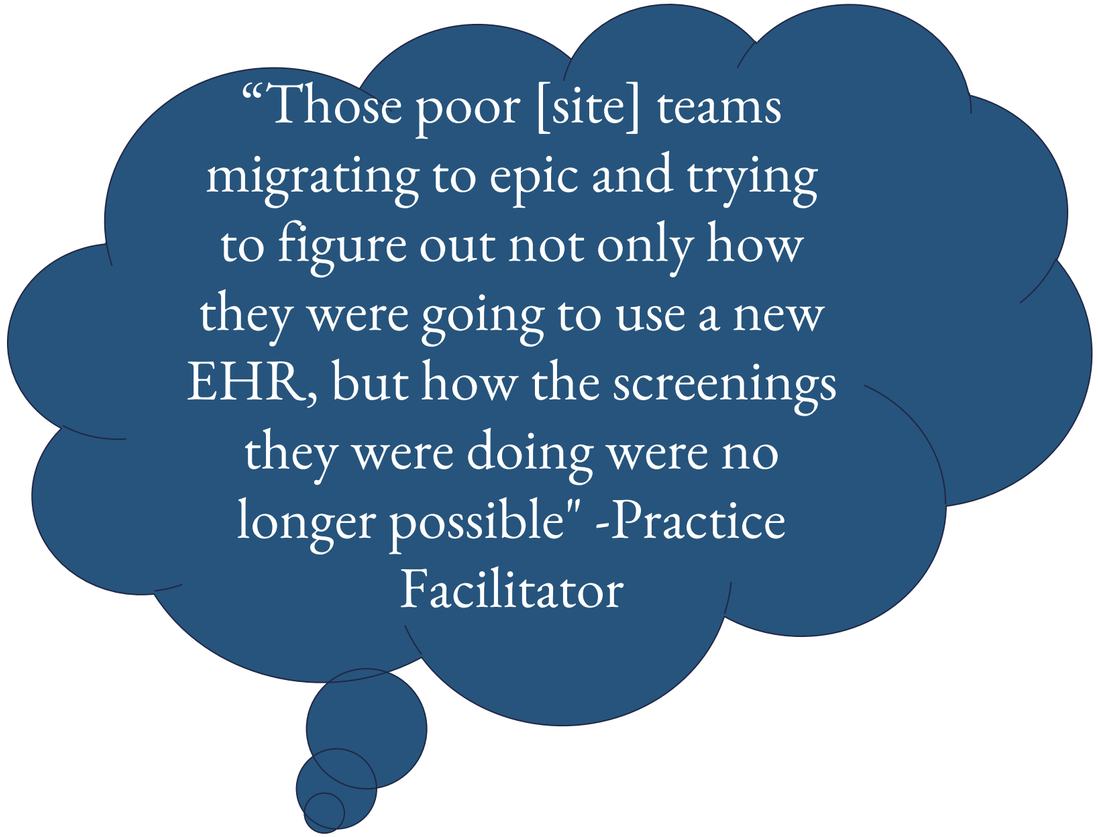
- During interviews, core implementation team members recognized the gap in their screening protocols for school-aged kids and endorsed the value of screening all children.
- Concerns raised about sites' capacity to meet the needs of this large group of children and overwhelming limited resources.
- School-aged screening is now the focus of PDSAs

"[the sites] have also been leaders in terms of thinking about the universal screening question. Really kind of moving forward with expanding into use of the PSC in that school age population, which we had identified kind of a universal gap across the sites." - Practice Facilitator

"With the increased screenings it's increased [the CHW's] workload for sure...We had just talked about the importance of delegation." - Director of IBH

Screening: Implementation

- Challenges in expanding school-aged screening included technology and ease of access to screening tools, which initially were not embedded in site EMRs.



IBH Capacity

CHW Role

- CHW patient form used to describe the tasks done by CHWs and how they are spending their time
- To be completed for every patient seen during a one-week period, every 3 months
- We have 4 data collection timepoints
  - January 2024
  - March 2024
  - June 2024
  - September 2024

CHW Data Collection Form				Clinic Name:		CHW initials:
Date	Child age	Child Gender M F	Child Race/ethnicity	Contact conducted in language other than English?	Y N	If yes, language:

1. Is this a new patient/referral for CHW services? ☐ Yes ☐ No

2. If yes, was the new patient referred by warm hand-off? ☐ Yes ☐ No

3. Reason for CHW/FP contact/referral: (Check all that apply)

☐Assistance completing a screening tool (SWYC, PSC, etc.)

☐Request from patient/family ☐ Request from PCP ☐ Request from BHC

☐Follow up on existing issue/referral

☐Other/Free text to provide more detail if necessary

_____

4. Goals identified/Assistance requested by family: (Check all that apply)

☐Housing resources ☐ Food resources ☐ Other material needs_____

☐ Referral to EI ☐ IEP or school-based services

☐ In-home services ☐ Off site outpatient counseling ☐On site IBH services

☐ Autism or developmental delay evaluation

☐ ADHD evaluation ☐Parent group or support

☐ Other _____

5. Issues addressed during this contact: (Check all that apply)

☐ Housing resources ☐ Food resources ☐ Other material needs_____

☐ Referral to EI ☐ IEP or school-based services

☐ In-home services ☐ Off site outpatient counseling. ☐On site IBH services

☐ Autism or developmental delay evaluation

☐ ADHD evaluation ☐Parent group or support ☐ Other_____-

6. Type and Length of contact: (Check all that apply)

Type of contact	With whom (specify)		Length of contact (minutes)					
	Caregiver	Collateral (not family)	<5	6-15	16-30	31-45	45-60	Other
In-person								
Virtual (zoom)								
Phone								
Email/ patient portal								
Text								
Fax or mail								

7. Treatment plan following visit: (Check all that apply) REQUIRED

☐ New/additional services needed ***(COMPLETE QUESTIONS 9 & 10, SKIP 8)*****

☐ Continue with current services (defined as services in the past 12 months) ***(COMPLETE 8 & STOP)*****

*****If patient will continue with current services AND needs new/additional services, complete Q8-10***

☐ Issue resolved; No further services needed ***(STOP)***

☐ Further services offered but declined ***(STOP)***

8. The patient already receives: (Check all that apply)

☐ Continual CHW support ☐ PCP management. ☐ Integrated BH services

☐ On-site (non-integrated) BH services ☐ Other on-site services (care management, etc.)

☐ Off-site BH/developmental services ☐ EI or IEP (established) ☐ In-home therapy

9. Type(s) of new/additional service(s): (Check all that apply) *(COMPLETE #10)*

☐ CHW support ☐ PCP follow-up ☐Integrated BHC follow-up

☐ Other care team member follow-up

☐ On-site specialty services. ☐ Off-site services ☐ Other_____

10. What was the identified need or concern which led to referral for new/additional services?

_____

CHW Reach: Patient Demographics (N = 327)

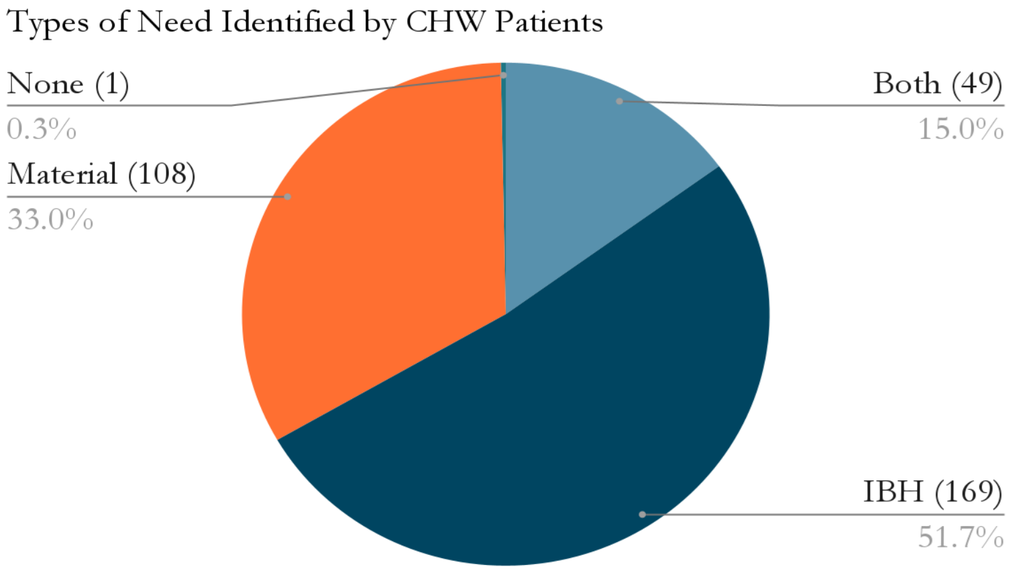
Variable	N	% of Total
Race/Ethnicity		
Hispanic	120	37%
Non-Hispanic White	113	35%
Non-Hispanic Black	48	15%
Multiple Races	7	2%
Other	4	1%
Unknown/Refused	35	11%
Gender		
Male	169	52%
Female	157	48%
Non-Binary	1	<1%
Age		
0-5 years	118	36%
6-11 years	85	26%
12+ years	121	37%
Not Disclosed	3	<1%

CHW Integration: Effectiveness

Measured as:

- proportion of encounters that responded to a BH or developmental concern
- proportion of CHW encounters initiated via warm handoffs

"You provide support, validation, encouragement. You provide education, psychoeducation. You provide so much for these families and just the ability to provide that rapport in the initial meeting with somebody in a handoff. And be able to connect them with services and help them to follow through is an admirable skill that you just possess"- IBH Director



Time	Total N	N (%) with Material Needs	N (%) with IBH Needs	N First Encounters	% of First Encounters with a Warm Handoff
Jan 2024	63	24 (38%)	47 (75%)	26	89%
March 2024	81	34 (42%)	61 (75%)	38	82%
June					

% of Patients with the Following Goals Identified or Requested (N = 327)

Type of Goal	Goal Requested	N	% of Total
Material	Food Resources	48	15%
	Housing Resources	40	12%
	Transportation	37	11%
	Other Material Resources	34	10%
	Insurance	18	6%
	Diapers	12	4%
	Cash Assistance	10	3%
Non-Material/IBH	IEP or School-Based Services	68	21%
	Counselling Services	67	21%
	Other Non-material Needs	44	13%
	Parent Group or Support	29	9%
	In-home Services	18	6%
	Case Coordination/Referral Support	14	4%
	Referral to EI	12	4%
	ADHD Evaluation	12	4%
	ASD/Developmental Delay Evaluation	11	4%
	Help Completing Questionnaires/Forms	10	3%

CHW Integration: Adoption

- Overwhelming clinical staff buy-in to integrate CHWs into the practice to:
  - alleviate staffing issues
  - support families
  - increase clinicians' capacity to focus on the provision of clinical care

CHW Integration: Adoption

- Despite buy-in, staff struggled to understand scope of CHW role and how to define it
  - uncertain when to use CHWs and how their roles interfaced with other team members
  - Further training desired on CHW integration

"We're curious how other practices are instructing folks on the different roles within the practices... everybody is super excited about the CHW role but they get very easily confused by when do I go to social work, when do I go to the BSW, when do I go to the CHW?" - IBH supervisor

"There are certain individuals even in our system who are having a hard time grappling with the fact that we have a CHW on our IBH team who we are saying they are not as suited to take an SDOH need such as like meeting with a patient to do SSDI forms that would go to SDOH CHW. I think that because we are called community health workers, the doctors, they get confused about the specifics of this role on our IBH team..." -- IBH Director

Case Study

“...One of the providers came to me and said ‘Oh I have this patient’ and she said ‘I don’t know. I feel like I’m missing something...I don’t see mom very [engaged] with the things I’m saying to her about the daughter...can you just go and talk to her to see? Maybe help me out’...So I went, talked to mom. Mom only speaks Spanish...We went to sit down outside...sat in the garden and talking to her you know she told me you know her story. And then by talking she told me that she’s not, you know, able to write or read in any language. I was like oh my god that’s why she was not engaging with the physician, with the doctor, because she couldn’t read all the papers she was given...So after talking to the provider she [the provider] said ‘Oh my god’. She’s been...the doctor for this family for many years... and never knew” -CHW

Case Study

“Sometimes we have moms that come in and don’t know where to go so to speak. They need help navigating—whether it is the healthcare system or the educational system. Um they find that something is not right with their child, but they are not sure or they are too ashamed or it is taboo. Coming from the Hispanic culture, it is unheard of to say depression, anxiety, autism, bipolar disorder. So, these things are now being talked about. And so a lot of times we get families that are afraid to address these things. And so we can talk about that now. And I’m that voice sometimes…even if the provider is you know assisting in that , I can be that other set of hands and be the voice for them to provide that educational piece and to be that shoulder to cry on and to be that support person to say hey there are services available. Let’s work together as a team. We are here for you.” -CHW

CHW Integration: Implementation

- Sites struggled to implement CHW role and make corresponding changes to existing workflows:
  - Triaging appropriate referrals for CHW (SDoH vs IBH)
  - Space and visibility for CHW

"I do get consistent referrals from um a handful maybe like a couple of the doctors, not all of them.. I haven't gotten anything from providers since we switched EMRs. We still have to figure out how that, how we want that workflow to go. But they just Teams me if they have a patient that they want to discuss...."- CHW

"In listening to this conversation, I'm having a realization that we should probably have [CHW] and [IBH clinician] actually come to one of our doctor meetings at lunchtime for just 20 minutes and just kind of re-teach us now that you both are in place..." - PCP

Case Study

“We had a conversation regarding a patient that I just visited and there was some miscommunication in the office…I thought that I just had to go straight to the doctor's point person and something [the form] wasn’t completed…I talked to her [the IBH Clinician] and I was like that clearly [the process] wasn’t working, like we need to figure a different way to make sure the patient forms…are like getting completed or I’m getting a message back saying they need extra information… So we figured out a way to you know get the forms directly from the doctor and for me to have that direct connection with the doctor instead of having to go through a middle person. I appreciated that she [the IBH Clinician] advocated for me to be able to have that direct connection with the providers” -CHW

CHW Role: Maintenance

- Many sites are currently working toward allowing the CHW services to be billable.
    - credentialing and approval by compliance is done
- Some sites have reported progress towards reaching this goal while others expressed needing more support from upper management.
- Challenges include:
    - Transitions to new EMRs
    - Lack of IT support

Key Takeaways

Summary of Findings

- Despite initial challenges, sites have implemented workflow changes to fully integrate CHWs and expand IBH capacity
  - Commitment to expand school-aged screening
  - Shift from utilizing CHW for only SDoH needs to utilizing them to address IBH needs
    - CHWs remain an important resource to help families meet critical needs
  - Increase in warm handoffs
  - Pursuing CHW reimbursement

Next steps

Next Steps

- Continue screening rates and CHW data collection
- Conduct midpoint qualitative interviews around January and final interviews in May
- Analyze pre and post IBH integration surveys
- Prepare final report at end of Y2

Y2 Upcoming Milestones

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Milestone	Status
Required Meetings	
Learning Collaborative Meetings: 1. **Y2 Mid-Point Meeting** (*Zoom*) 2. **Wrap-Up Meeting** (*In person, 4-5PM*)	 February 2025 (Tentative) August 7, 2025
CHW meetings with TEAM UP *1-hour Zoom meetings*	1 Completed Monthly from September 2024-August 2025
Core Team Based Care Training *8-9 am Zoom meetings with all core team members – PCP, BHC, and CHW*	September 17, 2024, ***Complete*** November 6, 2024 January 14, 2025 March 3, 2025 May 7, 2025
CHW Specific Trainings *Quarterly, in-person, half-day; January virtual*	October 11, 2024, 9:30 – 1:30 – School Navigation January 10, 2025, 9:30 – 1:30 – CHW Billing April 11, 2025 – 9:30 – 1:30 – TBD July 11, 2025 – 9:30 – 1:30 – TBD
2-Day IBH Clinician Training *In person, in Boston, 9:30-4:30*	October 25, 2024 November 8, 2024 Spring 2025, TBD
Optional 1-Day IBH clinician Early *In person, in Boston, 9:30-4:30*	November 15, 2024
BHC Case Consultation with TEAM UP *Zoom meetings from 10-11am*	First Tuesday of Every Month

Y2 Upcoming Milestones

ADVANCING INTEGRATED HEALTHCARE

Milestone	Status
PDSA/Quality Improvement	
1. Implementation of universal BH screening for ages 0-17, with demonstrated improvement against baseline and end-of-year-1 performance **2. Select 1 of the following quality improvement projects** a. Development and piloting of workflow/process mapping for school navigation (this could include navigation to Early Intervention, school-based assessment and services) Development and piloting of workflow/process mapping of warm hand-offs between PCP, IBH Clinician and CHW	Initial plan due Nov 15, 2024 Midpoint due March 31, 2025 Final due Aug 15, 2025
Assessments	
Post Assessments • AAP Mental health Practice Readiness Inventory • Maine Health Access Foundation (MeHAF) Assessment • Maslach Burnout Inventory **BH Screening Rates** **Evaluation Interviews with Hassenfeld** **CHW data collection sheet** **CHW Questionnaire**	May-June 2025 4 data collection timepoints January-February 2025 July-August 2025 5 data collection timepoints Completed once at end of program

Next Steps

- Practices continue monthly Practice Facilitation meetings
- Next Core Team based Training is November 6th
- Next CHW Specific Training is October 11th, in person, covering School Navigation
- 2-Day IBH Clinician Training in person in Boston is on October 25th
- Next Steering Committee Meeting – December 20, 2024


Any Questions?