MEMO TO THE CPMT
April 27, 2018

Presentation Item 1: Pro-Bono Outpatient Therapy Project – Give An Hour Update

ISSUE:
That the CPMT learn more about and the progress of the implementation of the Pro-Bono Outpatient Therapy/Give An Hour Project

BACKGROUND:

1. *A brief description of the project, including how it will accomplish Blueprint strategies*

Give An Hour (GAH) is actively developing a "branded" Fairfax County section of their national website for income eligible children, youth and families living in Fairfax County and the Cities of Fairfax and Falls Church residents. They are actively recruiting licensed mental health providers in Fairfax County and across the borders in neighboring jurisdictions. Social marketing materials, branded for Healthy Minds Fairfax and Fairfax County, are in development and will be ready for distribution in the very near future. A proclamation will be presented by Supervisor Penny Gross at the July 10, 2018 Board of Supervisors meeting with an anticipated launch at a reception before the meeting.

Contracted Give An Hour mental health therapists provide outpatient therapy for children and youth with emerging mental health issues whose families lack the financial resources to access it. It addresses Blueprint Strategy 13D, "Expand access to timely and available behavioral health services for school age children and youth with emerging mental health issues who have not been able to access such services." Give an Hour (GAH), a non-profit, was founded by Barbara Van Dahlen, Ph.D., a licensed clinical psychologist. Since its inception in 2005, GAH has developed a national network of volunteers who are capable and committed to responding to the mental health needs of individuals in our society. Historically, GAH volunteer therapists responded to the mental health needs of military service members and their loved ones affected by the ongoing conflicts in Iraq and Afghanistan. To date, GAH volunteer therapists provide direct counseling pro bono for the duration of the treatment episode. They can also work to reduce the stigma associated with mental health treatment by participating in and leading education, training and outreach efforts in schools and the community. GAH volunteer therapists are licensed, hold malpractice insurance and are vetted through GAH staff before placed in their network. There are over 7,000 volunteer therapists nationally in the GAH fold who have provided 244,821 hours of mental health care, valued at over $24 million. There are currently 201 volunteer therapists in Fairfax County currently serving this military population.

GAH is now branching out to other populations, specifically youth at risk. Fairfax County is one of the first to join their efforts to provide pro bono outpatient therapy to children, youth and families. Los Angeles County is also engaged with GAH to provide the same service to their

community. We are benefitting from their trailblazing efforts in this newly developed service for their community. GAH therapists have historically provided easy, accessible and free care for the duration of the treatment need. GAH capitalizes on the spirit of service and has successfully engaged therapists across the nation to participate. GAH will identify, vet and mobilize therapists in our community to "give an hour" of their time each week to support the child or youth and family seeking mental health treatment. GAH also encourages those who have received help to give back in their own community.

2. *Target Population*

Children and youth presenting with depression, anxiety or trauma in households/families unable to access mental health services with their own resources.

3. *Income Eligibility*

Children and youth in households/families with incomes less than 400% of poverty level. For example, a family of four, income eligible for this service, would need to be making less than $98,000 a year.

STAFF:

Betty Petersilia, Healthy Minds Fairfax Director

MEMO TO THE CPMT
April 27, 2017

Presentation Item P- 2: Review Proposed Community Integration Plan

ISSUE:
That the CPMT review and comment on a proposed community plan for implementing tiered levels of integration in order to increase access to appropriate behavioral health services for all children, youth and their families.

BACKGROUND:
Children's Behavioral Health System of Care Blueprint Goal #7 is to "improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care." To achieve that goal, a primary action step identified in the Blueprint is to "develop a community plan for implementing tiered levels of integration in order to increase access to appropriate behavioral health services for all children, youth and their families." For the past eight months, an inter-agency Blueprint work group has been developing a community integration plan for consideration by the CPMT.

While the primary focus of the plan is on integrating pediatric primary care and behavioral health care, it also addresses integration of behavioral health care into the school settings. Although a fully integrated primary care practice is an ideal method for families and youth to access a comprehensive array of high quality services and supports, there are several other options for primary care providers and behavioral health clinicians to increase their level of collaboration and improve care for their young patients. Some practices, agencies, and organizations may benefit from support at the level of integration they currently are at or wish to achieve in the near term.

In order to understand the barriers for primary care practices and behavioral health agencies to achieving a higher level of integration, the Integration Committee conducted two focus groups: one with behavioral health clinicians who serve children and families and the other with pediatricians. Group participants were from across Fairfax County and represented a diverse array of practices and agencies. While the views presented were not necessarily representative of all providers in the community, the focus groups highlighted challenges that practices currently face and the need for an array of strategies to support or promote integration. Membership of the Integration Committee includes:

Dr. Gloria Addo-Ayensu, Dr. Raja'a Satouri, Dr. Gill Bailey, Dr. Benjamin Schwartz: Health Department
Dr. Diane Dubinsky: Health Department Consultant
Dr. Rick Leichtweis: INOVA
Daryl Washington, Lyn Tomlinson: CSB
Jim Gillespie, Betty Petersilia, and Jenny Sell: Healthy Minds Fairfax
Mary Jo Davis, Dr. Dede Bailer: FCPS

ATTACHMENT:
Healthy Minds Fairfax Behavioral Health Integration Plan

STAFF:
Jim Gillespie, Betty Petersilia, Jenny Sell, Healthy Minds Fairfax
Dr. Diane Dubinsky, Health Department Consultant

DEFINTIONS

Children and Youth: As used throughout this document, children and youth refer to any client or patient up to age 18 or early adulthood.

Primary Care Providers: Throughout this document, primary care providers refers to primary care pediatricians and pediatric nurses.

Behavioral Health Clinicians: Throughout this document, behavioral health clinicians refers to child psychiatrists, psychologists, social workers, counselors, or any other behavioral health professional serving children and youth.

Pediatric Mental Health Access Program: A pediatric mental health access program is a model used by numerous states across the country in which there is a central phone number that a primary care provider can call and get connected to behavioral health consultations and coordinated referrals. Each state's model varies, but generally a doctor can call one number and a care coordinator answers the call. The care coordinator triages the doctor's needs and either provides an appropriate referral to community behavioral health providers or schedules a phone or video consultation with a child psychiatrist or other behavioral health clinician.

Care Coordinator. A care coordinator is a member of a pediatric mental health access program team, but could also stand alone as a single position. The care coordinator is a single point of contact who doctors can call to get appropriate behavioral health referrals for their young patients.

REACH Training : The REACH institute offers patient-centered mental health training for pediatric primary care providers that includes a three-day interactive course focused on building skills and confidence in diagnosing and treating pediatric behavioral health problems, followed by a six-month, case-based distance-learning program.

FCPS: Fairfax County Public Schools

FCCPS: Falls Church City Public Schools

CSB: Community Services Board

SAMHSA-HRSA: Substance Abuse and Mental Health Services Administration and the US Department of Health and Human Services Health Resources and Services Administration

For each strategy action step, there is a signifier of the level of effort or change needed to accomplish the action step. They include:

Easy: Requires a low level of effort or resources to accomplish, or is already approved and in progress

Moderate: Requires some financial resources but does not require significant systemic change

Complex: Requires higher commitment of resources and systemic change

NEEDS STATEMENT

This community plan for supporting and promoting integration is in support of the Blueprint goal #7: *Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care.*

While a fully integrated primary care practice is an ideal method for families and youth to access a comprehensive array of high quality services and supports, there are several other options for primary care providers and behavioral health clinicians to increase their level of collaboration and improve care for their young patients. Some practices, agencies, and organizations may benefit from support at the level of integration they currently are at or wish to achieve in the near term.

In order to understand the barriers for primary care practices and behavioral health agencies to achieving a higher level of integration, the Integration Committee conducted two focus groups: one with behavioral health clinicians who serve children and families and the other with pediatricians. Group participants were from across Fairfax County and represented a diverse array of practices and agencies. While the views presented were not necessarily representative of all providers in the community, the focus groups highlighted challenges that practices currently face and the need for an array of strategies to support or promote integration.

Below is a summary of challenges highlighted by community pediatricians and behavioral health clinicians:

Limited Knowledge of Available Resources. The primary care providers and behavioral health clinicians represented in the focus groups share the challenge of not knowing what resources exist for their patients throughout the county. Providers want to have a readily accessible and regularly updated directory of primary care and behavioral health providers who are comfortable providing different levels of behavioral health care, including current insurance information. Providers also want more information on available behavioral health training.

> *"A lot of psychiatrists won't take insurance anymore. I'm referring them and [psychiatrists] said 'we don't take it anymore.' I think, 'oh my god, how is my client ever going to afford this.' They don't have that kind of money"*
> *– Behavioral Health Clinician*

Limited Knowledge, Experience, or Comfort with Interdisciplinary Care. A strong theme that emerged during the focus groups was that primary care providers are hindered by a limited knowledge of behavioral health care, difficulty identifying or distinguishing a behavioral health issue from a medical issue, and being unfamiliar or uncomfortable with medication side effects. Discomfort with medication side effects contributes to concerns about liability. Behavioral health clinicians similarly expressed that their patients often have co-occurring medical conditions, for which they desire more

understanding on how to integrate medical considerations into behavioral health treatment.

> *"What stands out to me is that in the nine years that I practiced prior to this, I probably missed a whole slew of children that presented as headaches and abdominal pain. And where did those kids go? I'm not sure. So, now [that I've been trained] I feel a little bit more comfortable managing that."* – *Primary Care Provider*

Cost and Availability of Training. Primary care providers expressed that the cost of behavioral health training and the secondary cost of the primary care provider being taken away from providing primary care to patients is a barrier for providers getting the training they need to provide quality behavioral health care. Nurse practitioners expressed that there are limited training or fellowship opportunities for those who want to manage behavioral health care in their practice.

Time Constraints. Primary care providers noted that they are concerned about dedicating the time needed to address patients' behavioral health issues and expressed concerns for losing that time when patients are unable to show for their appointments. Other primary care providers have developed effective internal processes for managing appointment schedules and waitlists, highlighting that the perceived time constraints may be addressed by sharing best practices.

Insurance and Billing. Providers from both groups acknowledged that insurance is a major barrier – both for families accessing behavioral health care and for pediatric providers and behavioral health clinicians trying to provide services. While there are higher-level policy concerns affecting clinicians' ability to accept insurance, there are also knowledge barriers among individuals and practices. Primary care providers expressed that they would be able to better manage behavioral health care if they were equipped with information on how to effectively bill insurance for their time.

Access to Behavioral Health Clinicians. The main concerns that emerged from the focus groups regarding the ability to coordinate or collaborate with behavioral health clinicians is the limited availability of behavioral health providers who accept insurance and/or have available openings in all areas of the county, as well as a limited number of affordable child psychiatrists.

> *"That's the first question I always ask when they want the [psychiatric] referral. 'How much do you want to pay? How quickly do you want to be seen? I can find you somebody who can see you today if you have $400, but if you want to use your insurance, it's a whole different story.'"*
> – *Behavioral Health Clinician*

Communication. All providers involved in the focus group discussions conveyed that current interdisciplinary communication is very poor. The combination of varied office schedules, confidentiality considerations, and the lack of a streamlined information sharing process is both discouraging to providers and a hindrance to providing collaborative, quality behavioral health care.

"Some parents don't want to sign a release form. There's all these things on the list - this one, that one - they just say 'no, no.' So, for whatever reason, that becomes an issue because without the release you cannot [share] it with anyone else." – Behavioral Health Clinician

"[There is] a lot of pushback around, 'sign this consent or go to this specialist, or go here and go there.' Those are really insurmountable recommendations for our families... The perception that we're creating more business for the family to deal with, [is] a lot of times where that push back happens." – Behavioral Health Clinician

"We have so much diversity in our area and there's a lot of cultural factors that play into the consent and privacy. The fact that, for some families, they even sought out mental health treatment already is a stigma. So, to let the school know that their child is in mental health treatment - that's huge." – Behavioral Health Clinician

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Cost to Bring on Interdisciplinary Providers. While behavioral health clinicians in the focus group expressed a desire to have a psychiatric nurse available to them at the agencies and practices in order to reduce the demand for child psychiatrists, some identified the cost of bringing on additional staff as a barrier.

Limited Space for Integrated Staff. Most primary care providers represented in the focus groups expressed that space in their practices is limited. Many expressed a high need for tele-mental health services so that patients can access behavioral health services from either the pediatrician's office or other community access points.

Limitations of Treatment in Integrated Facilities. At least one participant pointed out that, even in fully integrated facilities, providers are limited in the level of behavioral health care they can provide. In these settings, there is still the need to refer particularly challenging clients or clients with specialized needs.

LEVELS OF INTEGRATION

Experts tend to agree that integration occurs on a continuum and, while there have been several adaptions of the integration continuum, SAMHSA-HRSA Center for Integrated Health Solutions proposes a national standard framework for integration that has six levels of collaboration and integration under the three main categories: coordinated, co-located, and integrated care (Heath, Wise Romero, & Reynolds, 2012).

Six Levels of Collaboration/Integration

Coordinated		Co-Located		Integrated	
Level 1: Minimal Collaboration	Level 2: Basic Collaboration at a Distance	Level 3: Basic Collaboration Onsite	Level 4: Close Collaboration Onsite with Some System Integration	Level 5: Close Collaboration Approaching an Integrated Practice	Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice

From SAMHSA-HRSA Center for Integrated Health Solutions (Heath, Wise Romero, & Reynolds, 2012)

Coordinated Care

- Level 1: Minimal Collaboration
  Behavioral health and primary care providers work in separate facilities under separate systems. They communicate only as needed and have minimal understanding of each other's' roles. (Heath, Wise Romero, & Reynolds, 2012)

- Level 2: Basic Collaboration at a Distance
  Behavioral health and primary care providers work in separate facilities under separate systems. They communicate with each other regarding shared patients' issues and interact as part of the larger community. They understand each other's roles and use each other as resources. (Heath, Wise Romero, & Reynolds, 2012)

Co-Located Care

- Level 3: Basic Collaboration Onsite
  Behavioral health and primary care providers work in the same facility, but not necessarily the same offices, and they work under separate systems. Providers communicate regularly about shared patients and collaborate in order to secure a reliable referral. Communication is primarily at a distant, but providers meet occasionally to discuss cases. (Heath, Wise Romero, & Reynolds, 2012)

- Level 4: Close Collaboration Onsite with Some System Integration
  Behavioral health and primary care providers work in the same facility and share space and some systems (i.e. scheduling systems or patient/client records). Providers have regular face-to-face meetings to discuss cases and collaborate for consultations and treatment plans for more challenging patients. (Heath, Wise Romero, & Reynolds, 2012)

Integrated Care

- Level 5: Close Collaboration Approaching an Integrated Practice
  Behavioral health and primary care providers work in the same space, in the same facility, and under the same system. Providers communicate frequently in person and have regular team meetings to discuss patient care and issues. (Heath, Wise Romero, & Reynolds, 2012)

- Level 6: Full Collaboration in a Transformed/ Merged Integrated Practice
  Behavioral health and primary care providers work in the same facility and share the same practice space, serving as one integrated system. Providers communicate and collaborate regularly in order to provide team care to patients. (Heath, Wise Romero, & Reynolds, 2012)

STRATEGIES

Strategies to Expand Behavioral Health Clinicians' and Primary Care Providers' Access to Resources and Training

Strategies and Action Steps	Target Dates
1) Optimize Online Navigation Tool	**6/2018-10/2018**
• *Action Step 1 (Easy):* Collaborate with the Blueprint workgroup responsible for the Online Navigation Tool in order to incorporate feedback from primary care and behavioral health providers to ensure that the needed resources and referral information are available in a user-friendly format.	6/2018-10/2018
• *Action Step 2 (Easy):* Instruct the Online Navigation Tool workgroup to communicate with emergency departments, updating them on current primary care practices providing behavioral health services.	6/2018-10/2018
2) Expand REACH Training	**9/2018-Ongoing**
• *Action Step 1 (Easy):* Host an additional REACH training for pediatricians in the fall of 2018.	9/2018-12/2018
• *Action Step 2 (Easy):* Host an additional REACH training for pediatricians in the spring of 2019.	3/2019-5/2019
• *Action Step 3 (Moderate):* Expand REACH or other behavioral health training to family practice providers.	
• *Action Step 4 (Moderate):* Explore the development of a local program for training primary care providers in behavioral health practices with children and youth.	7/2019-12/2019
3) Offer Additional Behavioral Health Training for Primary Care Providers	**10/2018-Ongoing**
• *Action Step 1 (Easy):* Explore existing training programs that help primary care providers' improve their capacity to manage behavioral health care of children and youth, and encourage a stratified referral process to best use the limited local mental health resources that currently exist.	10/2018-3/2019
• *Action Step 2 (Easy):* Seek out funding partners to implement additional training programs.	4/2019-7/2019
• *Action Step 3 (Moderate):* Offer trauma-informed and other behavioral health training for primary care providers.	8/2019-Ongoing
• *Action Step 4 (Moderate)*: Promote the use of common and appropriate behavioral health screening tools for use by primary care providers, including the viability of the use of the SBIRT (Screening, Brief intervention and Referral to Treatment practice).	1/2019-Ongoing

Strategies to Enhance Primary Care Providers' Access to Care Coordination and Behavioral Health Consultation Services

Strategies and Action Steps	Target Dates
4) Facilitate Case Review Sessions	**10/2018-Ongoing**
• *Action Step 1(Easy):* Facilitate quarterly case review meetings where primary care providers and behavioral health clinicians will come together to review difficult cases and seek interdisciplinary support	10/2018-Ongoing
5) Establish Pediatric Mental Health Access Program	**6/2018-10/2019**
• *Action Step 1 (Easy):* Determine if Virginia is planning to implement a state-level access program. If a state-level initiative exists, identify strategies to optimize local utilization of the program.	6/2018-12/2018
• *Action Step 2 (Easy):* Advocate for the development of a state-funded pediatric mental health access program.	6/2018-12/2018
• *Action Step 3 (Complex):* If no state-level initiatives exist, prepare a proposal to establish a county-level access program, using county funding as necessary and also maximizing the use of grant funding and the financial participation of local healthcare systems	1/2019-10/2019
5a) Access Program Alternative: Establish Care Coordinator Position for Local Primary Care Providers.	**6/2018-10/2018**
• *Action Step 1 (Easy):* Explore capabilities within current county government system for establishing a care coordinator function.	6/2018-7/2018
• *Action Step 2 (Moderate):* Submit budget request for care coordinator.	7/2018-10/2018
5b) Access Program Alternative: Promote Behavioral Health Consultation	**6/2018-10/2018**
• *Action Step 1 (Easy):* Explore whether local behavioral health providers have the ability to conduct telephone consultations with primary care providers.	6/2018-7/2018
• *Action Step 2 (Moderate):* Submit budget request for telephone consultations with primary care providers.	
• *Action Step 3 (Moderate):* Support expansion of CR2 (mobile crisis response) to respond to primary care providers.	7/2018-10/2018

Strategies to Improve Information-Sharing Between Primary Care Providers, Behavioral Health Providers, and Schools

Strategies and Action Steps	Target Dates
6) **Standardize Methods of Sharing Discharge Summaries**	**9/2018-11/2018**
• *Action Step 1 (Easy):* Meet with local inpatient mental health facilities to create strategies to improve discharge processes and ensure that primary care providers receive discharge summaries of shared patients.	9/2018-11/2018
7) **Create a Multidisciplinary Work Group to Develop and Plan for the Disseminating of Best Communication Practices Between Primary Care Providers, Behavioral Health Providers and School Staff.**	**6/2018-2/2019**
• *Action Step 1 (Easy):* Create a work group made up of primary care providers, behavioral health clinicians, and school staff.	6/2018-8/2018
• *Action Step 2 (Easy):* The new work group will draft best practices for clear inter-professional communication and acquiring consent from children, youth, and their parents/guardians.	8/2018-12/2018
• *Action Step 3 (Easy):* The new work group will determine best methods for disseminating and encouraging best practices and establish dissemination plan.	1/2019-3/2019

Strategies to Facilitate Integration of Behavioral Health Services in Primary Care Practices

Strategies and Action Steps	Target Dates
8) **Promote a Behavioral Health-Focused Education Track for Nurse Practitioners**	**7/2018-6/2019**
• *Action Step 1 (Moderate):* Encourage the development of a fellowship program for local nurse practitioners at local universities.	7/2018-6/2019
9) **Support Expansion of GMU's Center for Psychological Services Partnerships with Local Pediatric Practices**	**6/2018-8/2018**
• *Action Step 1 (Easy):* Meet with GMU Center for Psychological Services to discuss their partnership with a local pediatric practice to assess opportunities for expansion.	6/2018-8/2018
10) **Increase Insurance Participation**	**9/2018-8/2019**
• *Action Step 1 (Easy):* Standup the Blueprint workgroup dedicated to improving insurance use and participation.	9/2018-10/2018
• *Action Step 2 (Easy):* Advocate for recognition of the issue locally and at the state level.	9/2018-8/2019
• *Action Step 3 (Easy):* Explore ways to increase insurance participation for behavioral health services with behavioral health and primary care providers	9/2018-8/2019
11) **Facilitate a Dialogue Between Local Primary Care Providers, Behavioral Health Clinicians and Schools on Best Practices for Integration**	**3/2019-10/2020**
• *Action Step 1 (Easy):* Facilitate a collaborative conversation on innovative ways to integrate, such as in a county-wide conference.	3/2019-10/2020

Strategies to Promote Integration of Medical care into Public Behavioral Health

Strategies and Action Steps	Target Dates
12) **Create Nursing Positions in CSB Youth Programs**	**6/2018-12/2018**
• *Action Step 1 (Moderate):* Submit budget request to integrate nursing positions into CSB youth programs for the purpose of providing patient advice around medication side effects and other medical issues, thus freeing up child psychiatry and mental health provider time.	6/2018-12/2018