MidAtlantic Path Forward
CoCM Summer Lunch Series

www.mhamd.org/pathforward

- Shared experiences implementing/sustaining collaborative care programs
- 3 virtual sessions - 12-1pm, recorded and shared
  - Two presentations: 15-20 minutes each, followed by Q&A
  - Organizations in and outside of MD, with varying profiles
- Focus on
  - Startup, funding, leadership buy-in/support
  - Workflows & Training
  - Barriers and solutions

OSI BALTIMORE

Leonard & Helen R. Stulman CHARITABLE FOUNDATION

Johnson & Johnson

PATH FORWARD

Focus: a few scalable, high -impact reforms to improve access to MHSUD care

AMERICAN PSYCHIATRIC ASSOCIATION

BOWMAN FAMILY FOUNDATION

THE GOODNESS WEB
Great Leaders | Big Hearts | Bold Bets

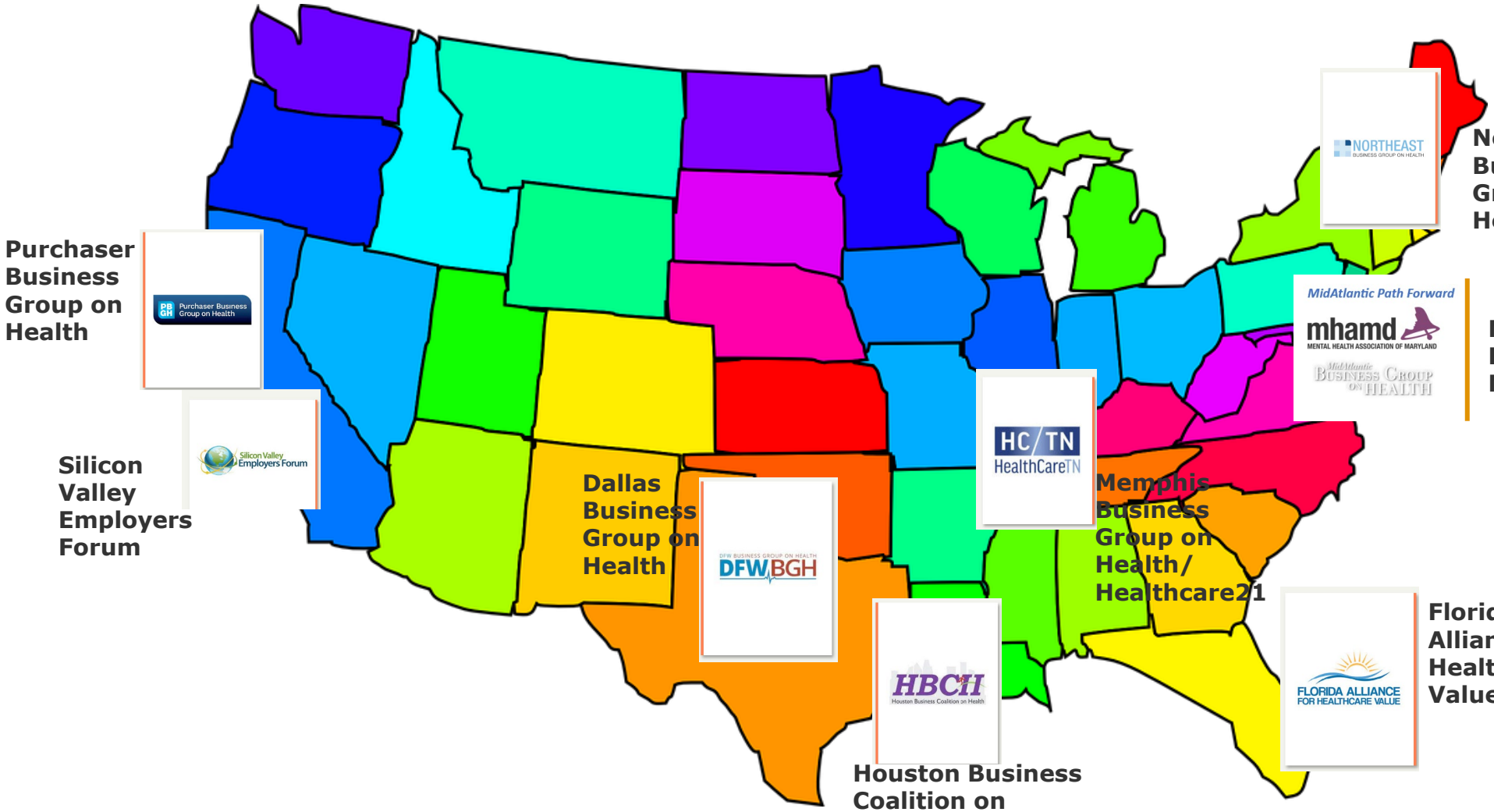
HRPA HR POLICY ASSOCIATION®

JED
The Jed Foundation

MEADOWS MENTAL HEALTH POLICY INSTITUTE

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

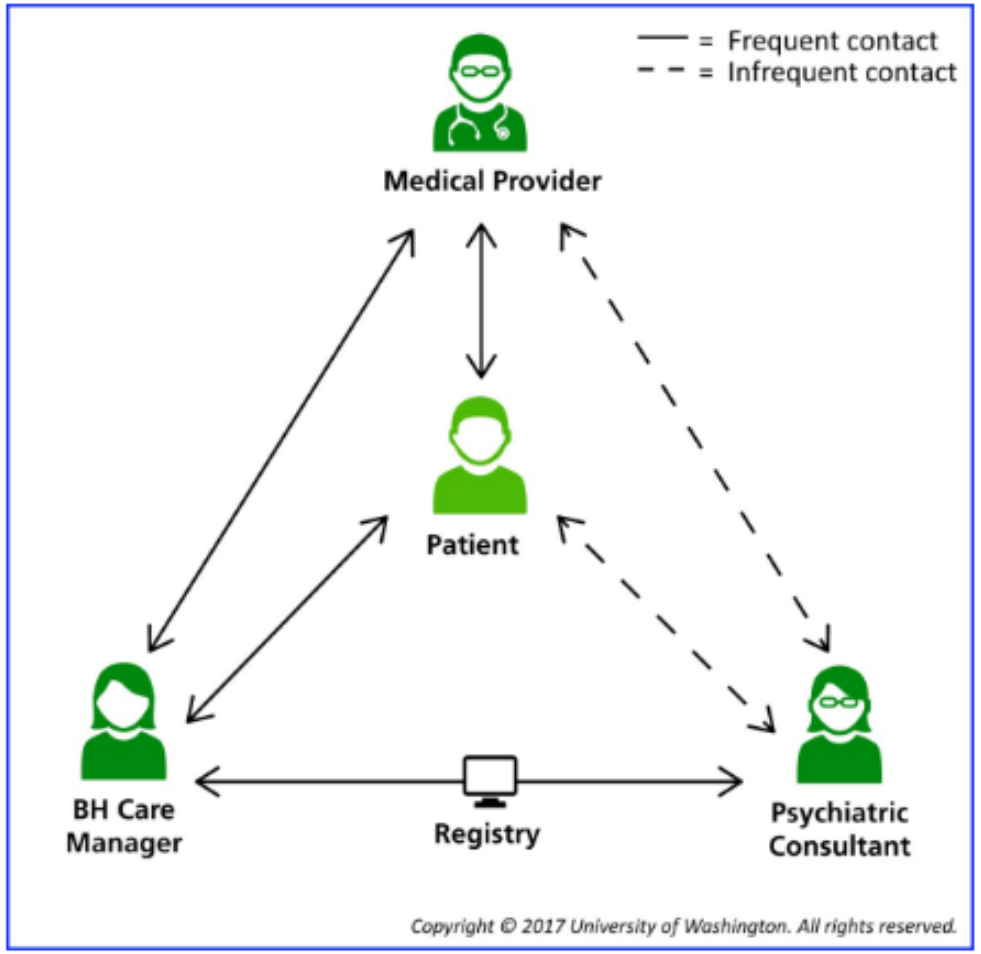
REGIONAL IMPLEMENTATION PARTNERS



The Collaborative Care Model

PCP maintains treatment responsibility for patient

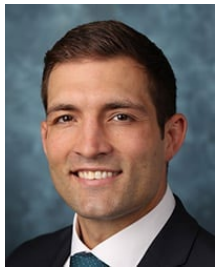
Evidence-based medication or psychosocial treatments



Case consultation, treatment adjustment for patients not improving as expected

Today's Session

John Parkhurst, PhD, Coordinator



Dr. Parkhurst directs the **Mood, Anxiety, ADHD Collaborative Care Program at Lurie Children's Hospital of Chicago**. He is a clinical child and adolescent psychologist and Psychology Director of Primary Collaborative Care in the Pritzker Department of Psychiatry and Behavioral Health at Ann and Robert H. Lurie Children's Hospital of Chicago, and an Assistant Professor of Psychiatry at the Feinberg School of Medicine, Northwestern University

Dana Wolf

Dana is the Director of Quality at **Med First Primary and Urgent Care in Raleigh, NC**. She has more than 20 years of experience in the healthcare industry, with 7 years dedicated to value-based care. Dana grew on Maui and received her degree from Oregon State University.

Virna Little, PsyD, LCSW-r

Dr. Little is the Co-founder of **Concert Health, a national organization providing behavioral health services to primary care providers**. She is an executive advisor recognized internationally for her work integrating primary care and behavioral health, developing sustainable integrated delivery systems, and suicide prevention.

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The development of the Mood, Anxiety, ADHD Collaborative Care (MAACC) Program

John Parkhurst, PhD

Director of Primary Collaborative Care

Ann & Robert H. Lurie Children's Hospital of Chicago

Pritzker Department of Psychiatry and Behavioral Health

Assistant Professor of Psychiatry Northwestern Feinberg School of Medicine

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Nothing to disclose

All data collection/presentation has been approved by Lurie Children's Institutional Review Board. Some data has not yet been published.

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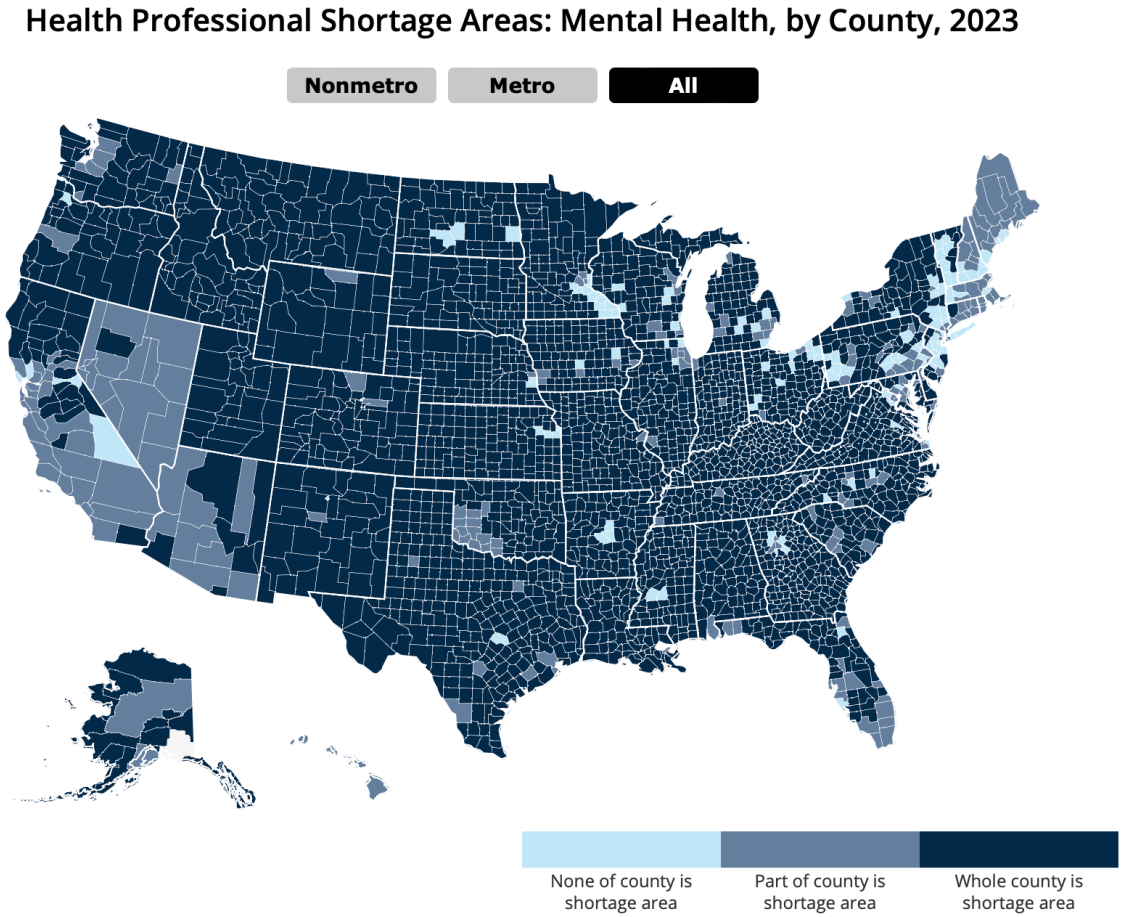
The need BHI for youth

- 15 million children or adolescents in US have diagnosable BH condition
- Annual treatment costs ~$40 billion
- Longstanding shortages of pediatric BH clinicians
- Many youth receive no services
- Some receive services in schools or pediatrics, where expertise may be limited
- Untreated BH conditions lead to greater social, educational, occupational, and economic consequences over time



Walter HJ, Vernacchio L, Trudell EK, et al. Five-Year Outcomes of Behavioral Health Integration in Pediatric Primary Care. Pediatrics. 2019;144(1):e20183243;
picture source: data.HRSA.gov

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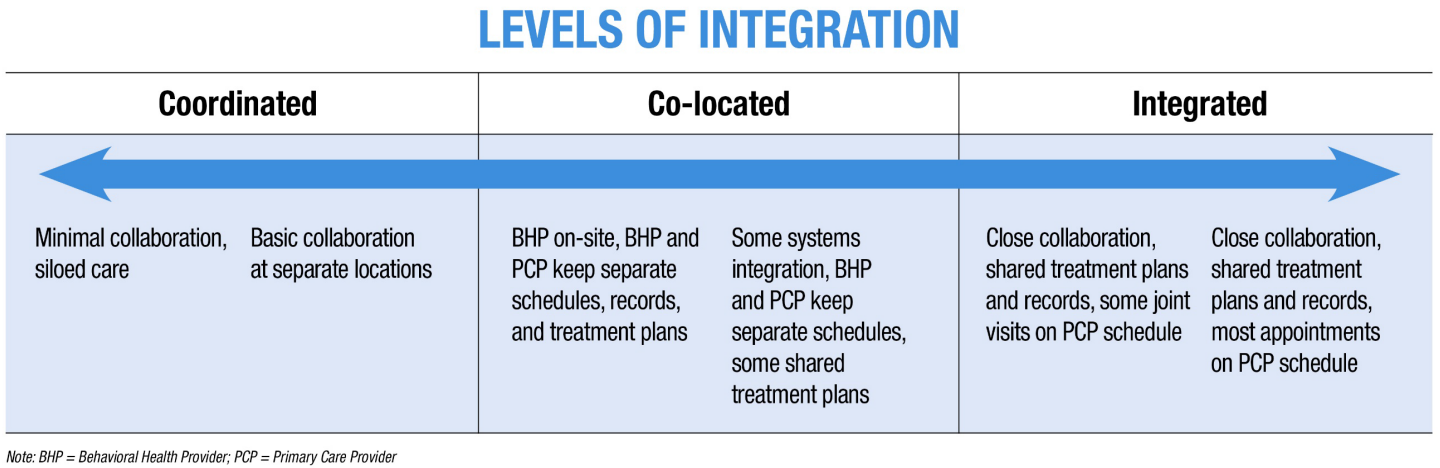
How Does BHI for Youth Work?

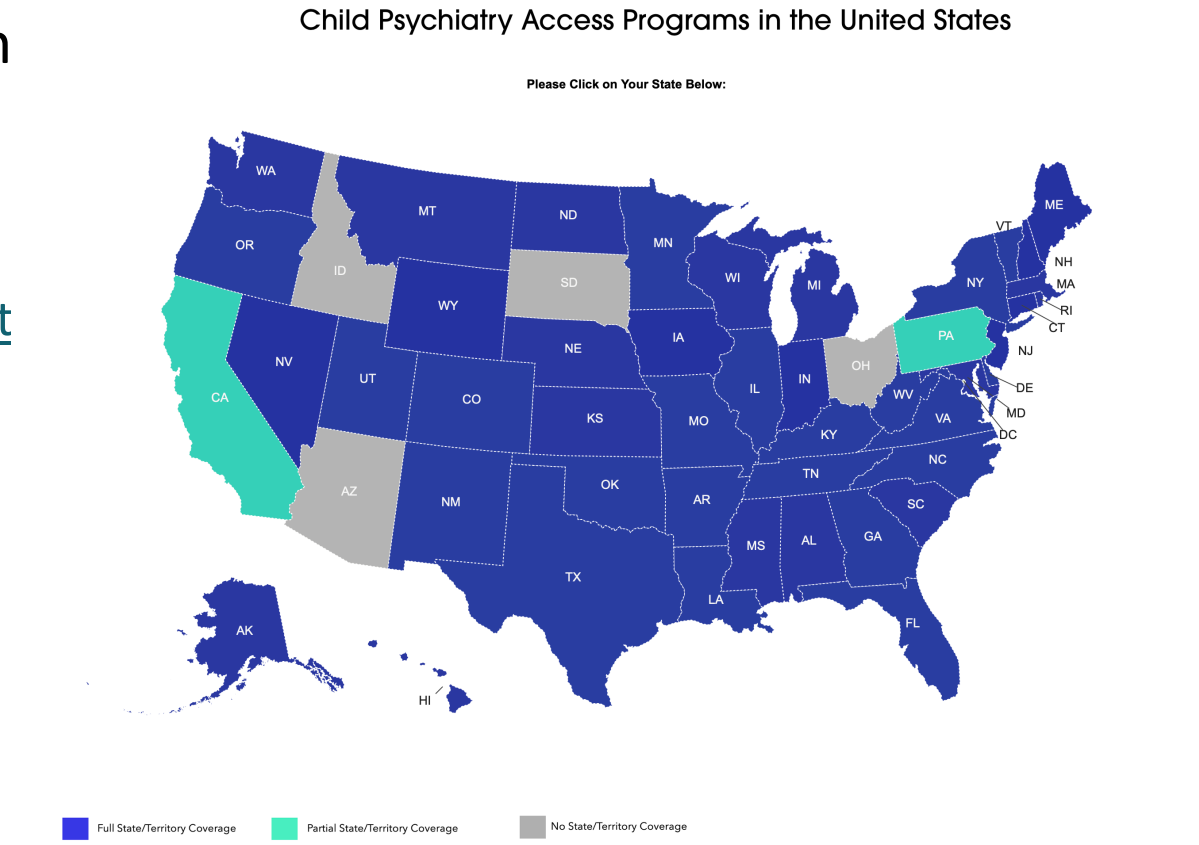
- Multiple models have been implemented and tested
- Various age ranges and diagnoses
  - From 2-4 children with behavioral disturbances, 5-12 children with ADHD to 13-17 with anxiety and depression
- Range from coordinated care (on or off site) to co-located care to collaborative (or fully integrated) care
- Include various staffing structures
- Programs are typically built around the pediatric or family medicine practice



Note: BHP = Behavioral Health Provider; PCP = Primary Care Provider

BHI Examples

- Child psychiatric telephone consultation models, often called Child Psychiatry Access Programs
  - Massachusetts Child Psychiatry Access Program – MCPAP (2004– present) – Straus et al, 2014
- Many others, including
  - NEP-MAP (Nebraska)
  - CPAN (Texas)
  - PAL (Washington)
  - DocAssist (Illinois)



Yonek J, Lee C, Harrison A, Mangurian C, Tolou-Shams M. Key Components of Effective Pediatric Integrated Mental Health Care Models: A Systematic Review. *JAMA Pediatr.* 2020;174(5):487–498. doi:10.1001/jamapediatrics.2020.0023
Stein BD, Kofner A, Vogt WB, Yu H. A national examination of child psychiatric telephone consultation programs' impact on children's mental health care utilization. *Journal of the American Academy of Child & Adolescent Psychiatry.* 2019;58(10):1016-1019.
Image source: https://www.nncpap.org/map

BHI Examples

- Healthy Steps (1995-present)
  - Infants and toddlers (0-5 yo) – ACEs, preventive services, child development, and effective parenting practices – includes co-located components, as well as education and parent groups (Minkovitz et al 2003)

- Primary Care Behavioral Health (PCBH) Model
  - Accessible team-based care that is highly productive and includes education; visits are focused and BH provider works primarily as a consultant (Reiter et al, 2018)
  - Nationwide Children's Hospital – Hostutler et al, 2021

- Screening and MBC initiatives with integrated BH clinicians
  - University of Nebraska Medical Center (Matthews et al, 2023)
  - MAACC Program (Lurie Children's Hospital) – Parkhurst et al, 2020

BHI Examples

- Integrated Care for Kids (InCK)
  - CMMI-funded – early identification, risk stratification, service integration in the context of APM (Jones et al, 2023)
- Pediatric Collaborative Care (CoCM)
  - Integrated Pediatric Mental Health (Duke) – Copeland et al, 2022
  - Seattle Children's Care Network Integrated Behavioral Health Program – Richardson et al, 2014

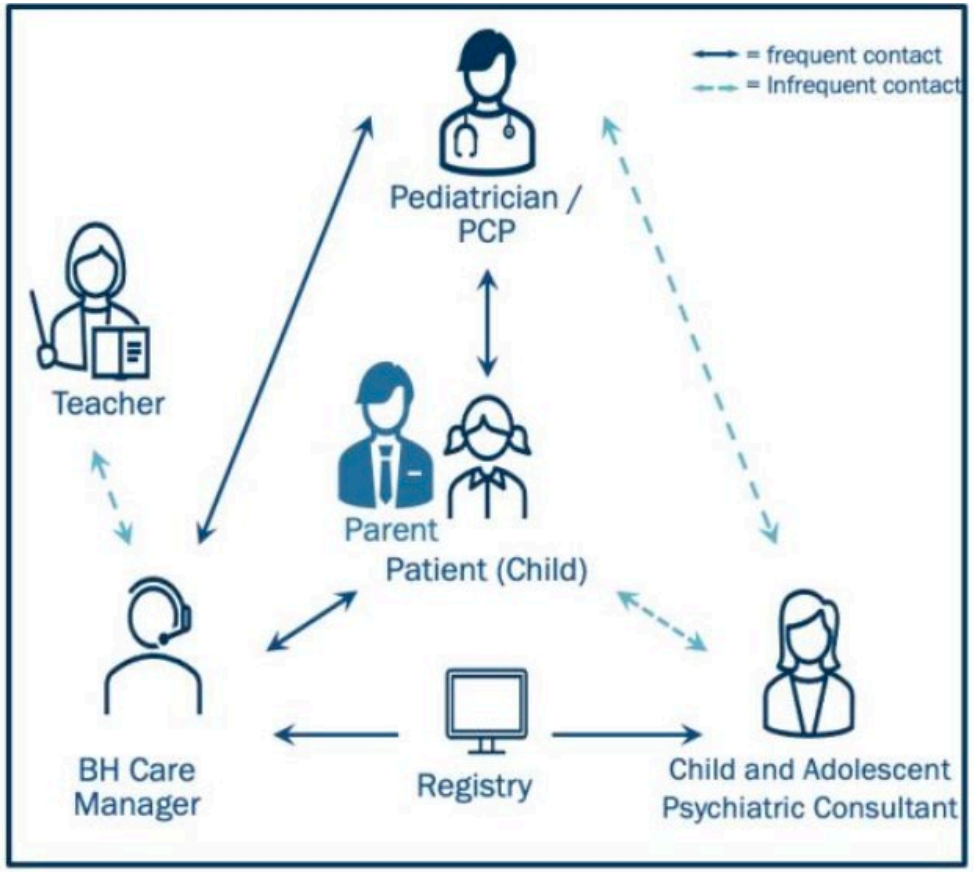


Image source: Meadows Mental Health Policy Institute - https://mmhpi.org

Lurie Children's Spectrum of Primary Care Collaboration

The Settings

- Academic General Pediatric Resident clinics
- Town & Country Pediatrics
- MAACC – Mood, Anxiety, ADHD Collaborative Care Practices (49 and counting)

The Challenge

- **Standard pediatric clinic visit**
  - < 15 minutes face-to-face with the doctor
  - Varity of anticipatory guidance
  - "They'll grow out of it" is still the norm for mental health concerns

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Mood Anxiety ADHD Collaborative Care

Contextual factors/barriers that drive deployment

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Primary Care factors:

- Education/experience treating mental health disorders
  - Understanding of EB screening/detection
  - Understanding of EB psychosocial treatment
  - Understanding of EB medication management
- Age of the population in practice
  - Impacts treatment selection
- Office space availability for treatment
- Mental health billing
  - Insured and publicly insured

Community resources:

- Treatment providers
  - Available EBT therapists
  - Available Psychiatry/medication management
- Linkage to hospital system with psychiatry

Hospital resources:

- Intention/funding to support community providers
- Integrated network
  - Shared communication and data management systems

Sanchez et al. 2017; Wissow et al. 2016

Objectives

- Expand mental health services for children with mild-moderate anxiety, depression and ADHD
- Increase timely, patient-centered access to mental health treatment
- Optimize evidence-based treatment by training pediatricians and improving collaboration between pediatrics, psychiatry and psychology
- Employ measurement-based care to improve patient treatment gains
- Track costs and reimbursement to assess

Resources

- Philanthropic funding for startup costs
- Network of community pediatricians
- Medical center team of academic psychologists and psychiatrists
- Large regional group of community mental health therapists

Participants/Target Population

- Community pediatricians
- Youth 6-18 with mild-moderate anxiety, depression, ADHD

Intervention

- Population-based care
  a) Patient registry and systematic screening
- Patient-centered care team approach:
  a) Timely access to evaluation and treatment planning
  b) Three discipline collaboration
  c) Navigator referral to therapists
- Evidence based care
  a) Web-based training in pediatric mental health diagnosis and psychopharmacology
- Measurement-based care for treatment monitoring
- Cost and reimbursement tracking

Results

Output metrics

- Treat ≥ 150 youth in 18 months
- Fully train ≥ 50 pediatricians in 18 months

Process metrics

- Timely access to evaluation in ≤ 14 days
- 80% of pediatrician endorsing comfort in treatment of anxiety and depression
- Establish measurement-based to monitor treatment and outcomes
- Costs and reimbursements

Outcome metrics

- Collect ≥ 1 symptom-report following evaluation for each patient
- Significant patient symptom improvement from baseline measures

Parkhurst et al. 2021. Extending Collaborative Care

MAACC Model

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Collaborative Care Model (CoCM) Asarnow et al 2015; Campo et al. 2018; Spencer et al. 2018; Yonek et al. 2020

- Flexible application of model elements
  - Population-based care, measurement-based care, and access to evidence-based mental health services impact clinical gain (Yonek et al. 2020)
  - Off site care management works too (Whitfield, 2022)

CoCM is a treatment model and not explicitly a "training" model, but programs inherently include:

- Education & learning collaborative
- Multidisciplinary consultation
- Direct treatment provision

Function of MAACC model

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Pediatrician (PCP)

- Engagement in training
- Willing to treat as needed

Care Coordinators (Behavioral Health Care Manager)

- Registry management
- Measurement based care, data collection

Psychologists

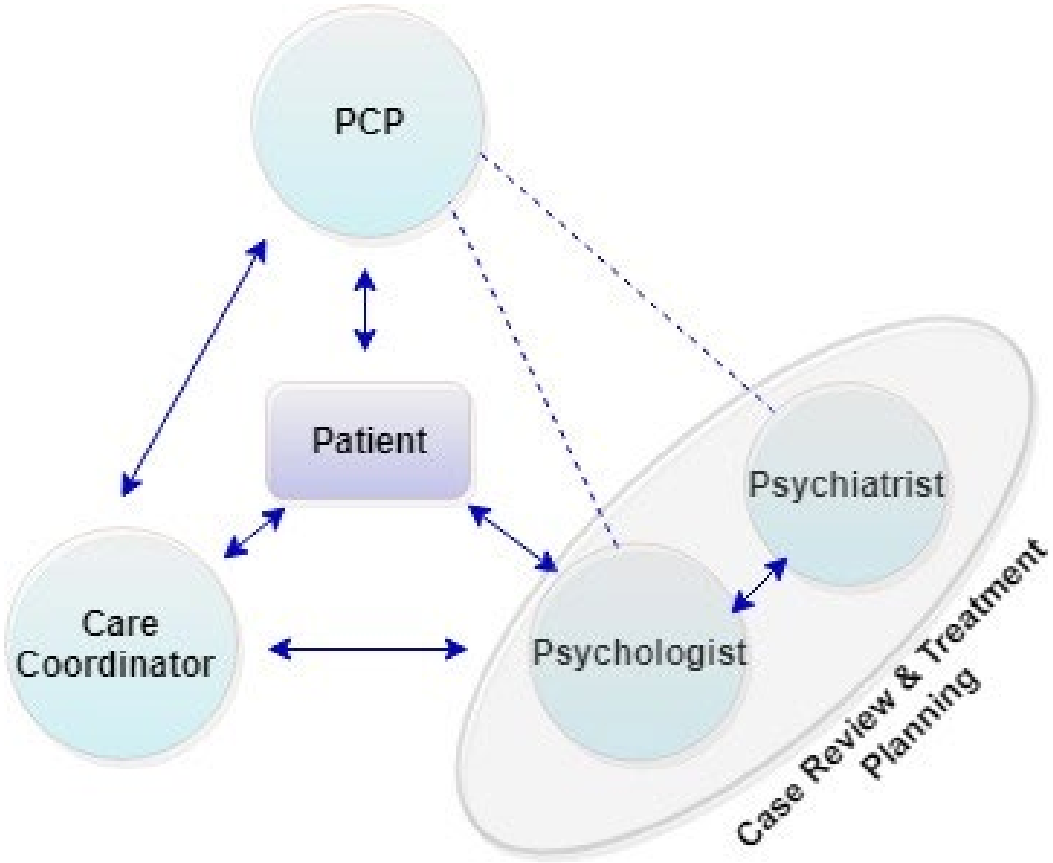
- Support PCP in diagnosis and ongoing assessment
- Collaborate with coordinator to monitor treatment

Psychiatrists

- Support PCP in prescribing and treatment
- Collaborate with coordinator to monitor treatment

Community Therapists

- Engage in initial vetting
- Accepting of timely referrals



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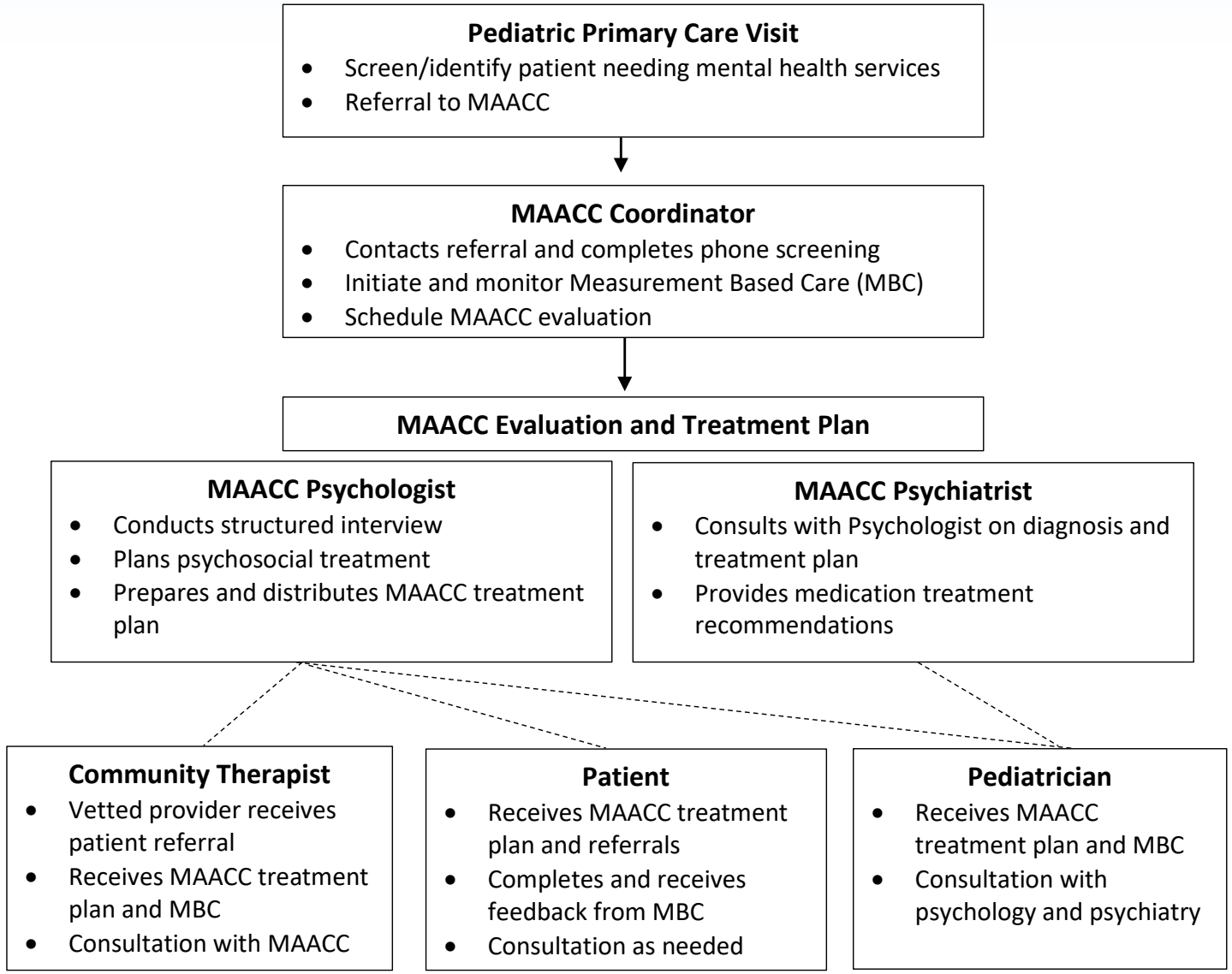
MAACC referral & evaluation

- All referred & evaluated patients added to **registry**
- MBC monthly and care manager resource navigation for families
- Consultation between pediatrician and specialists, monitored through registry/documented in EHR



Pediatrician engagement 2018-2022

97 of 145 clinicians approached and engaged in MAACC across in **39** practices. (66% enrollment rate)

- Engagement entails:
  - RAMP on-demand modules
  - Monthly learning collaborative
  - Referral

Pediatric Clinicians referred **8** patients on average (SD 10.5) and **23.5** referrals (SD 28.6) by practice

Cohort		1	2	3
Cohort Start Date		06/2018	09/2019	05/2020
Number of Providers		53	27	65
Number of Practices		15	5	19
Average Practice Size		5.9	8	7.1
Board Certification	MD	51 (96%)	23 (85%)	57 (88%)
	DO	2 (4%)	2 (7.5%)	6 (9%)
	APP		2 (7.5%)	2 (3%)
Training	Approached	53	27	65
	Enrolled[a]	49 (92%)	19 (70%)	29 (45%)
Location	Urban	2 (4%)	26 (96%)	5 (8%)
	Suburban	51 (96%)	1 (4%)	60 (92%)

Pediatrician reported outcomes

Attitude & Satisfaction [a]	Baseline (*n* = 83), *n* (%)		Mid-MAACC (*n* = 39), *n* (%)	
	Disagree/ neutral	Agree	Disagree/neutral	Agree
I am satisfied with my:				
Training on assessment of mental health concerns	64 (77%)	19 (23%)	4 (10%)	35 (90%)
Ability to assess & treat behavioral health concerns	60 (73%)	22 (27%)	7 (18%)	32 (82%)
Access mental health education & resources	58 (70%)	25 (30%)	2 (5%)	37 (95%)
Access psychosocial consultations	62 (75%)	21 (25%)	7 (18%)	32 (82%)
Access medication management consultations	71 (86%)	12 (14%)	5 (13%)	34 (87%)
I am comfortable with:				
Screening with measures for ADHD	11 (14%)	70 (86%)		
Diagnosing ADHD	20 (24%)	62 (76%)		
Treating ADHD	26 (32%)	56 (68%)		
Identifying psychosocial referrals for ADHD	27 (34%)	52 (66%)		
Screening with measures for anxiety disorders	38 (46%)	44 (54%)	8 (21%)	31 (79%)
Diagnosing anxiety disorders	42 (51%)	40 (49%)	6 (15%)	33 (85%)
Treating anxiety disorders	58 (71%)	24 (29%)	16 (41%)	23 (59%)
Identifying psychosocial referrals for anxiety	40 (49%)	42 (51%)		
Screening with measures for mood disorders	20 (25%)	60 (75%)		
Diagnosing mood disorders	53 (65%)	29 (35%)	10 (26%)	29 (74%)
Treating mood disorders	64 (79%)	17 (21%)	21 (54%)	18 (46%)
Identifying psychosocial referrals for mood disorders	46 (57%)	35 (43%)		

Community Therapists

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213 Community Therapists

- 5 regional list serves to direct patient referrals
- Select training in EBP
- Insurance matching as best possible

Expectation was to respond to request if available to treat within 3 weeks

Characteristic	n (% Sample)	Average (SD)
Degree/Certification	213	--
Phd/PsyD	98 (46%)	--
LCSW/APSW	49 (23%)	--
LCP/LCPC/NCC	61 (29%)	--
Other[a]	2 (1%)	--
Identified training in CBT	150 (74.6%)	–
Identified training in PMT	50 (39.6%)	–
Accepted commercial insurance	146* (69.1%)	—
Average Years in practice		9.98 (8.46)

Patient Demographics

1152 referrals, **696** evaluated and provided treatment referrals

- Average age 12.12 (3.1)

EBA Evaluation Process (Youngstrom et al. 2015) with confirmatory ADIS-IV (Silverman et al. 2005)

- **Anxiety disorder** (n= 308, 45.4%)
- **ADHD** (n= 208, 30.7%)
- **Mood disorder** (n= 115, 17.0%)
- One or more comorbid diagnoses were observed in 69.6% (*n* = 472) of patients.

64.7% had prior therapy

33.9% had prior medication

Characteristic (N = 696)	n (%)
Gender	
Female	380 (54.6%)
Male	296 (41.9%)
Other	20 (2.8%)
Race	
White	466 (66.8%)
African American	44 (6.3%)
Asian	32 (4.6%)
Biracial	21 (3.0%)
American Indian/Alaskan Native	4 (0.6%)
Other	92 (13.2%)
Declined/Unknown	39 (5.6%)
Hispanic	122 (17.7%)
Insurance type (Medicaid)*	125 (18%)

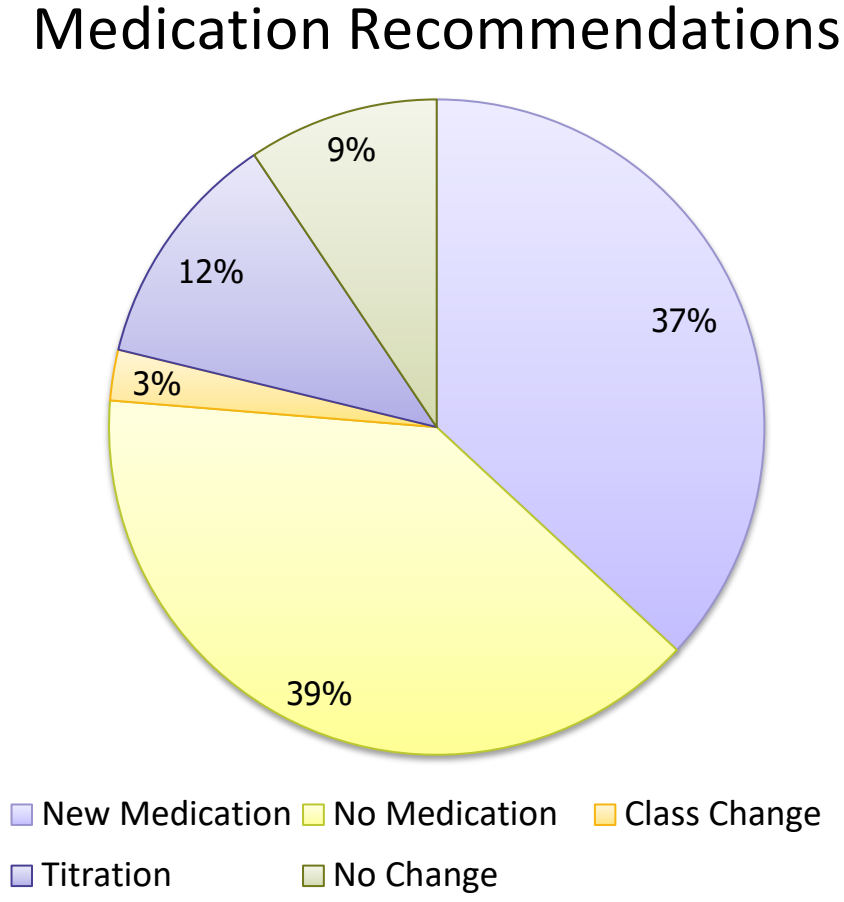
Clinical outcomes: Referrals post evaluation

Therapy outcomes

- 28.9% of patients were in active therapy at time of referral
- Following evaluation:
  - 75.5% (n = 524) received new therapy referrals
    - 8.1% (n =57) remained with prior therapist
    - 5.6% (n = 40) Switched therapy providers

Medication outcomes

- New medication trials (36.9%, n = 248)
  - Psychostimulant (51.6%, n = 126)
  - SSRI (47.1%, n = 115)
  - Other (1.2%, n = 3)



Clinical Outcomes: Measurement Based Care

- Measurement to target at 6, 12, 18 weeks
  - PROMIS Anxiety Short Form (Parent/Youth) (Varni et al. 2014; Irwin et al. 2012)
  - PROMIS Depression Short Form (Parent/Youth) (Varni et al. 2014; Irwin et al. 2012)
  - Parent NICHQ Vanderbilt (Wolraich et al. 2013)

- 58.2% (n = 401) completed initial progress monitoring

PROMIS Short Form Parent V2.0 Scores

	12/12/2022 11:07 AM	5/17/2023 5:01 PM	7/18/2023 12:39 PM
Parent Anxiety	50 (Within Normal Limits)	45 (Within Normal Limits)	50 (Within Normal Limits)
Parent Depression	**64 (Moderate-Severe) (BPA)**	**70 (Moderate-Severe) (BPA)**	48 (Within Normal Limits)

PROMIS Short Form Youth V2.0 Scores

	12/17/2022 2:41 PM	5/17/2023 5:01 PM	7/18/2023 12:39 PM
Youth Anxiety	34 (Within Normal Limits)	45 (Within Normal Limits)	48 (Within Normal Limits)
Youth Depression	35 (Within Normal Limits)	**62 (Mild-Moderate)**	46 (Within Normal Limits)

	12/12/2022 11:05 AM	5/17/2023 5:08 PM	7/18/2023 12:43 PM
Parent Reported Vanderbilt Score			
ADHD-I (Symptom Count out of 9)	4	7	6
ADHD-H/I (Symptom Count out of 9)	0	2	0
ODD (Sum Total)	12	18	8
Conduct (Sum Total)	0	1	0
Anxiety/Depression (Sum Total)	12	17	11
Performance Items (Symptom Count out of 8)	2	1	3

Sustainability & Future Directions

4-Prong funding

- Philanthropy (Initial funding)
- Research funding
  - PCAY (PCORI)
  - Suicide Prevention (L-SPARC)
- Lurie Children's Pediatric Partners (CIN)
- Billable service
  - Future focus on CoCM billing
    - CoCM codes support time in consultation and co-management of care
    - Codes must be *initiated and billed by through the primary care provider.*
    - Care minutes accrued and billed monthly

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Resources for Advancing Mental Health in Pediatrics

RAMP

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concert

MEDFIRST
Primary & Urgent Care

Collaborative Care : Partnership Success MedFirst and Concert Health

Dana Wolf, Director of Quality, MedFirst
Virna Little, PsyD, LCSW Co-Founder Concert Health

About The Speakers

Dana Wolf

- Director of Quality at Med First Primary & Urgent Care

VIRNA LITTLE, PsyD

- Concert Health Co-Founder, and CCO

America's Leading Behavioral Health Medical Group Delivering Care Via The Collaborative Care Model

18+

Board Certified Psychiatrists & Experienced Psych NPs

150+

Masters Level BH Clinicians

60,000+

Patients Cared For

17+

States and Growing

AR, AZ, CA, CT, FL, GA, IL, MA, MD, MO, NC, NY, OK, SC, TX, WA, WI

60 + Partners

AdventHealth

CommonSpirit

Mercy

Trinity Health Of New England

Women's Health USA

Partnership Values

- ACCESS & OUTCOMES
- SAVE PCPs TIME AND STRESS
- FINANCIAL SUSTAINABLE
- VALUE-BASED CARE ALIGNMENT

Med First Primary & Urgent Care Fact Sheet

- Company Founded: 2004
- President & CEO: Paul Feneck
- Chief Financial Officer: Wes Edwards
- Model: Hybrid: Primary & Urgent Care
- Marketplace: Secondary & Rural Markets
- Number of Facilities: 23 (Projected at 28 by 12/31/23)
- Annual Patient Volume: 190,000 +
- Number of Employees: 300+
- Number of Providers: 80+
- EMR Platform: Athena
- Corporate Location : Raleigh, NC
- ACO Affiliation: Aledade / BCBS-NC + Other Commercial & Medicare Payors

The BH Journey: Clinical Workflow

Provider

Concert

Patient presents to PCP office and is administered the GAD7/PHQ9 screening	PCP refers patient to Collaborative Care through EHR referral	A Collaborative Care Engagement Specialist contacts patient same day/next day	Patient is assigned a Collaborative Care Clinician. Engagement specialist closes referral, opens episode of care and creates initial encounter in EHR.	Collaborative Care Clinician uses evidence-based interventions to help reduce patient symptoms and meet goals documented in EHR.	Concert's Psychiatric Consultant reviews patient's chart and makes treatment and medication recommendations in EHR.	PCP prescribes medication as needed based off recommendation in EHR.	Concert Health team works with patient until their symptoms are in remission. Concert Health will close the episode of care in EHR.

Note: Patients may be re-referred to Concert Health at any time

Engagement Strategies

Implement the foundational elements of Collaborative Care and foster ongoing engagement to evolve the partnership to serve your patients.

Screening — Automatic & frequent GAD & PHQ with Best Practice Alert prompting referral

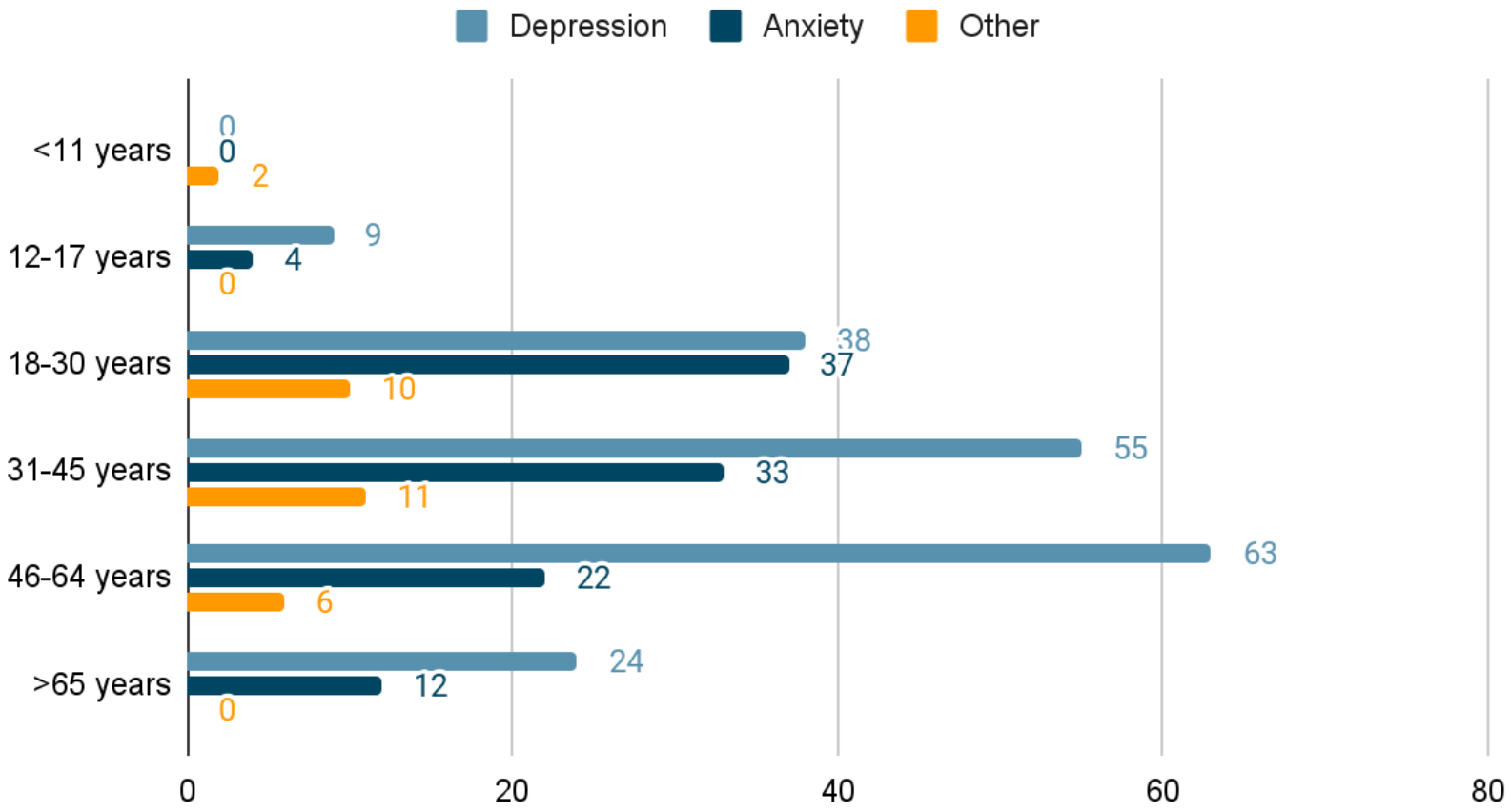
Education — Partner with **all** staff (including providers, residents, office staff, etc.) to understand CoCM model & identify provider champions within each clinic, improve Warm Hand Off

Engagement — Educational series, **population health**, CME trainings, and on-site visits, office hours

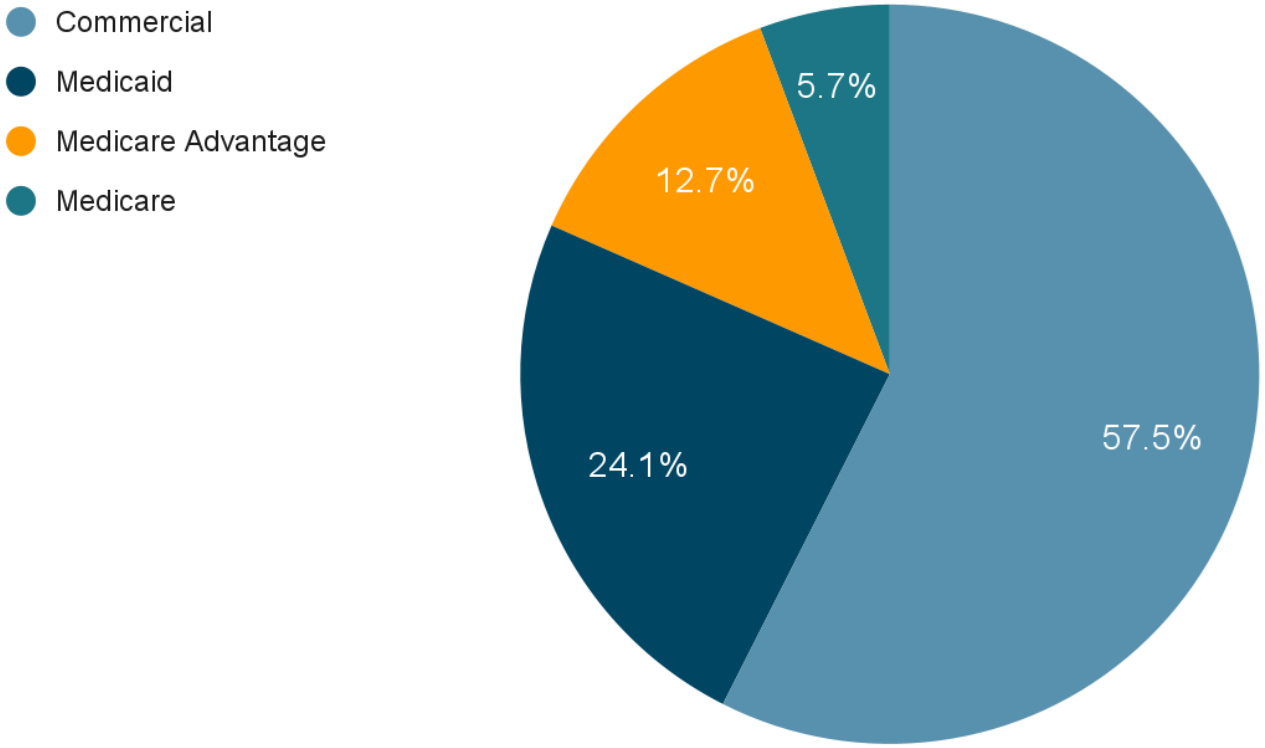
Metrics — Patient and provider NPS, **feedback from site managers**

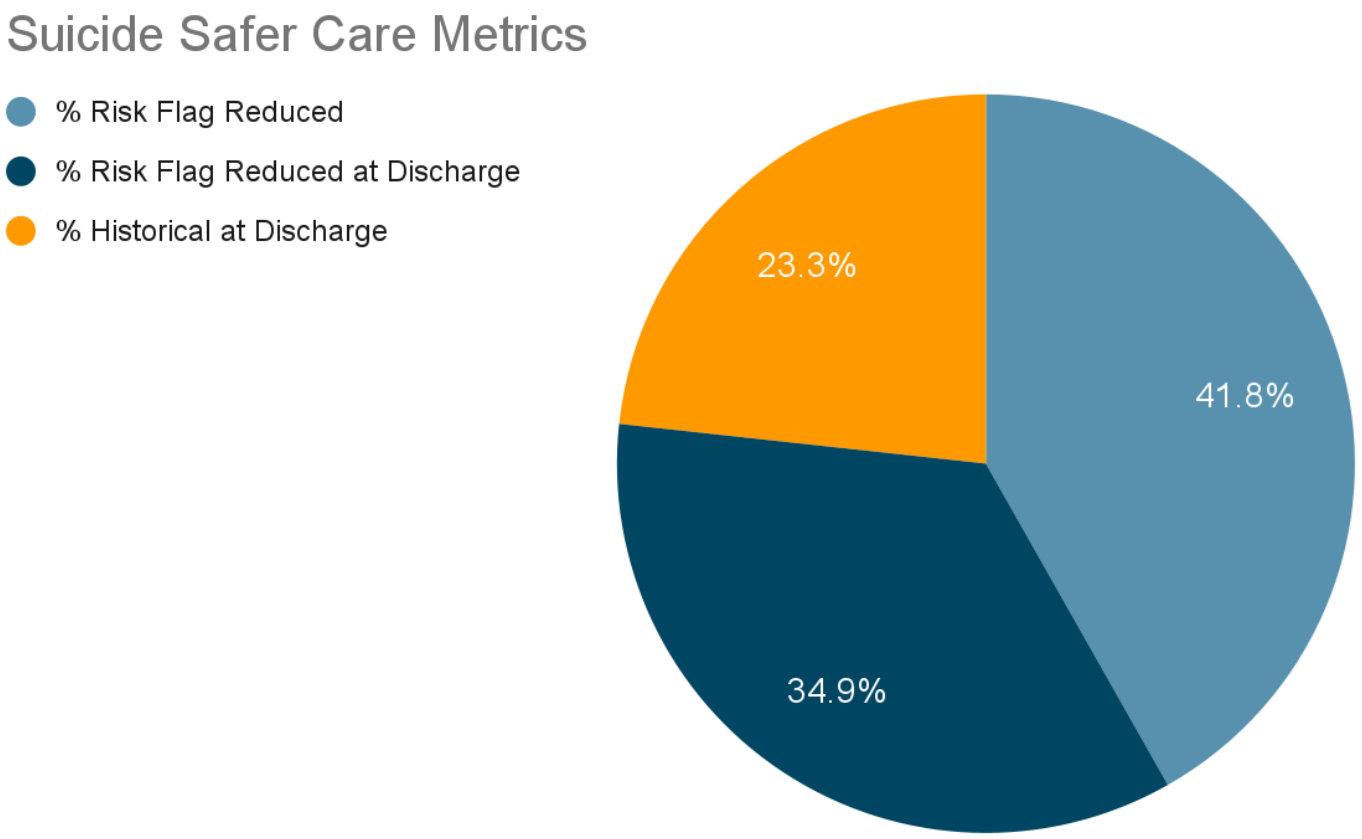
Learnings — Set goals and measure progress towards these goals. Implement action steps to meet industry standards.

Patients Treated by Age Demographic & Diagnosis Category



Patients Treated by Insurance Type

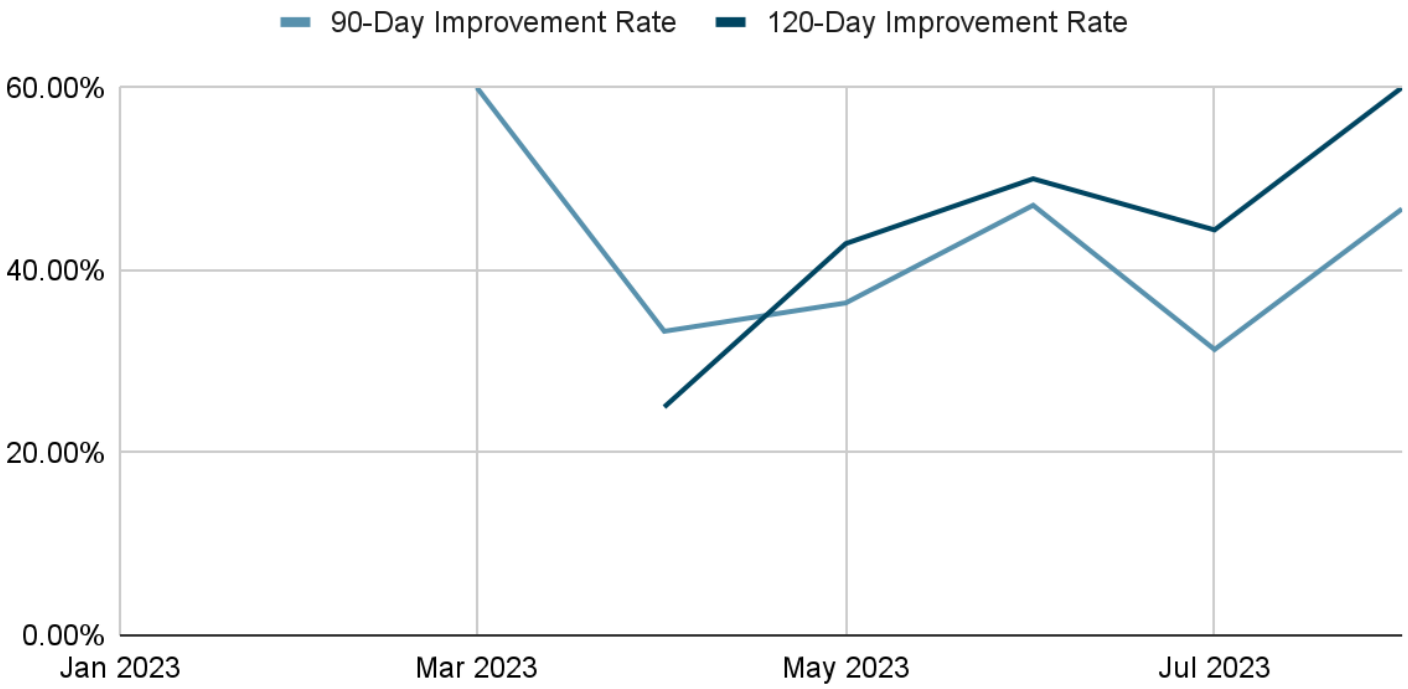




- Currently, **18.5%** of NC Med First patients are flagged for suicide risk.
- The average number of days between the initial risk flag regression and the most recent risk flag improvement (with no subsequent regression) is **96.6**.

PHQ-9 Improvement Rates

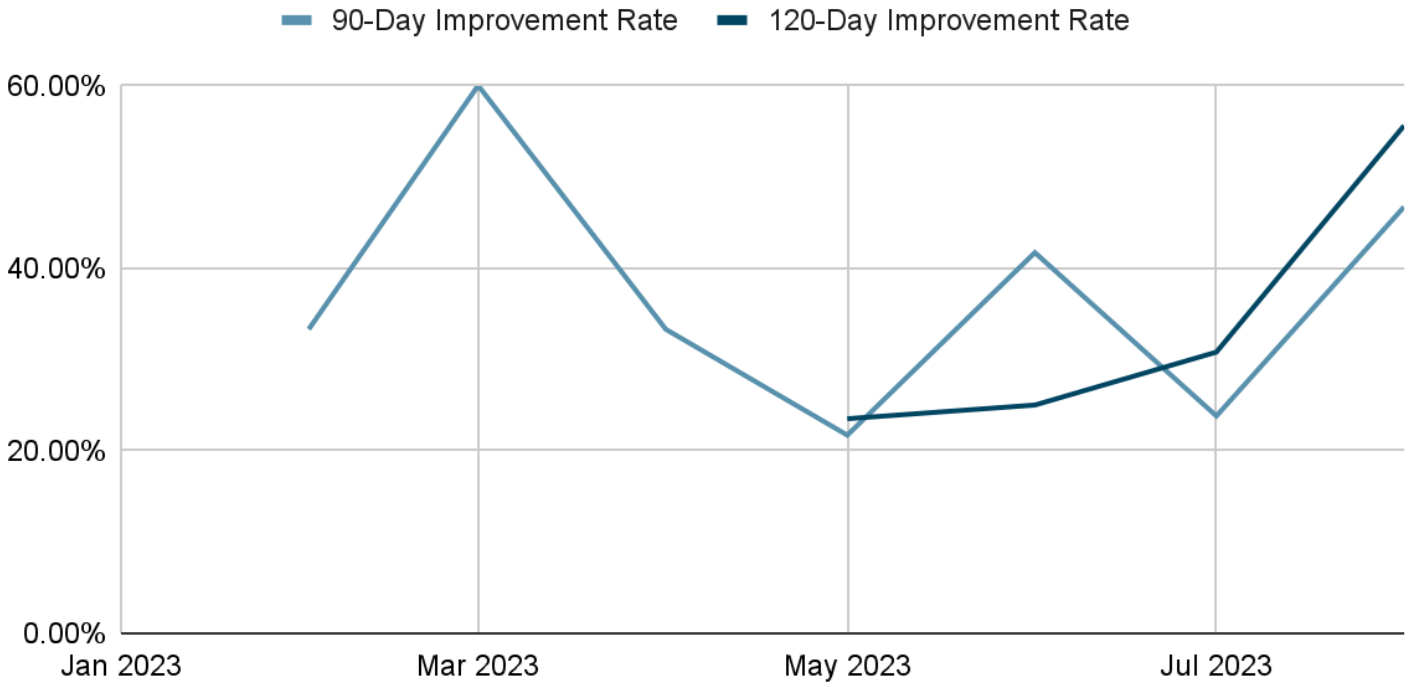
Qualifying episodes having improved score within 90 and 120 days



35.7% of discharged patients had a subclinical score of 10 or below,
while **34.0%** had a remission score of 5 or below.

GAD-7 Improvement Rates

Qualifying episodes having improved score within 90 and 120 days



35.5% of patients discharged had a subclinical score of 10 or below,
while **32.2%** had a remission score of 5 or below.

Executive Summary

33% Clinical Improvement Rate

TBD Net Promoter Score

46% of Providers are Currently Referring

3.64 → 3.60

Slight decrease in Referrals per Provider

709 Patient Referrals

447 Patients Cared For

Source: Med First CoCM data inception through July 31, 2023

Collaborative Care Goals

Patient Improvement Rate

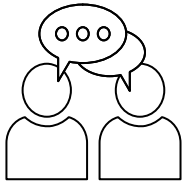
Benchmark: 50% of patients to obtain a 50% reduction or 10 point reduction on the screening tools

Actual Results: 33% of patients obtained a 50% reduction or 10 point reduction on the screening tools

Patient Experience – NPS

Benchmark: 70 NPS

Actual Results: 100 (limited sample size)



Conversion Rate

Benchmark: 75-80% referral conversion rate

Actual Results: 51% referral conversion rate

Provider Referrals

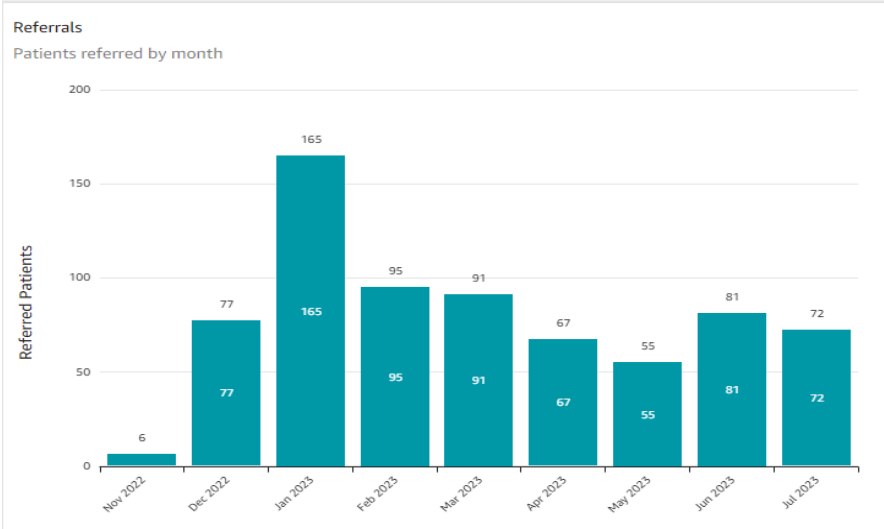
Benchmark: 8-10 referrals per month per provider

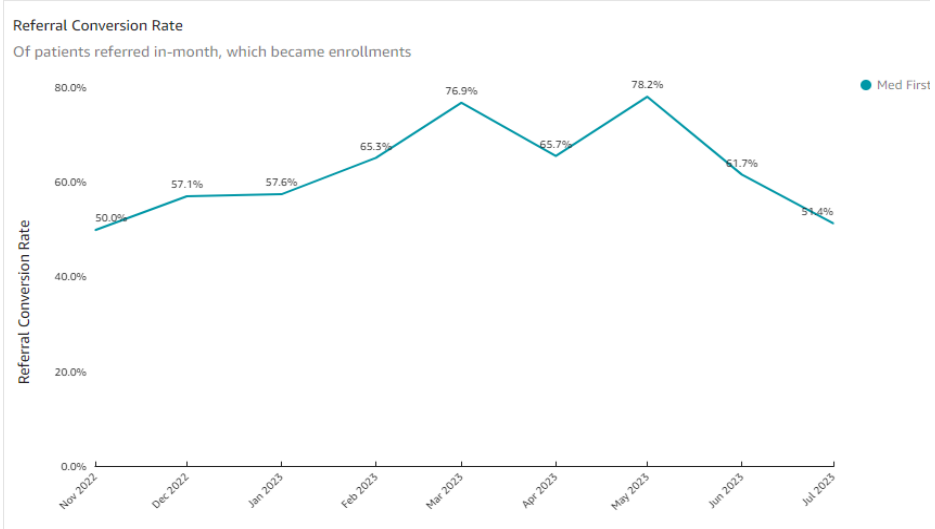
Actual Results: 3.6 referrals per month per provider *(as of July 2023)*

Program Updates

- Athena **integration** progress - Went live 7/1
  - All CCCs are now live with integration
- No longer holding weekly office hours
  - Worth scheduling monthly/bi monthly or are there All Provider meetings we should attend to seek feedback?
- **46% of providers** are actively referring
  - Active providers and referrals per provider remained nearly the same as the previous month.
- Received Dr. Haga's letter of support for the PCORI grant
  - More information to come once we receive a determination

Collaborative Care Dashboard





- Total referrals remained at a similar level to June.
  - Greensboro had spike in June (16 referrals) and dropped to 2 in July.
  - Athena app

- Conversion rate dropped by 10%. Breakdown of referrals by status and full conversion rate list by provider to be sent.

Referral Breakdown (July)

Referrals by Contact Status

Contact Status	Patients
Enrolled	31
Cold (no response)	23
Patient declines services	9
Discharged patient	4
New	2
Working	2
Ineligible for enrollment	1
	72

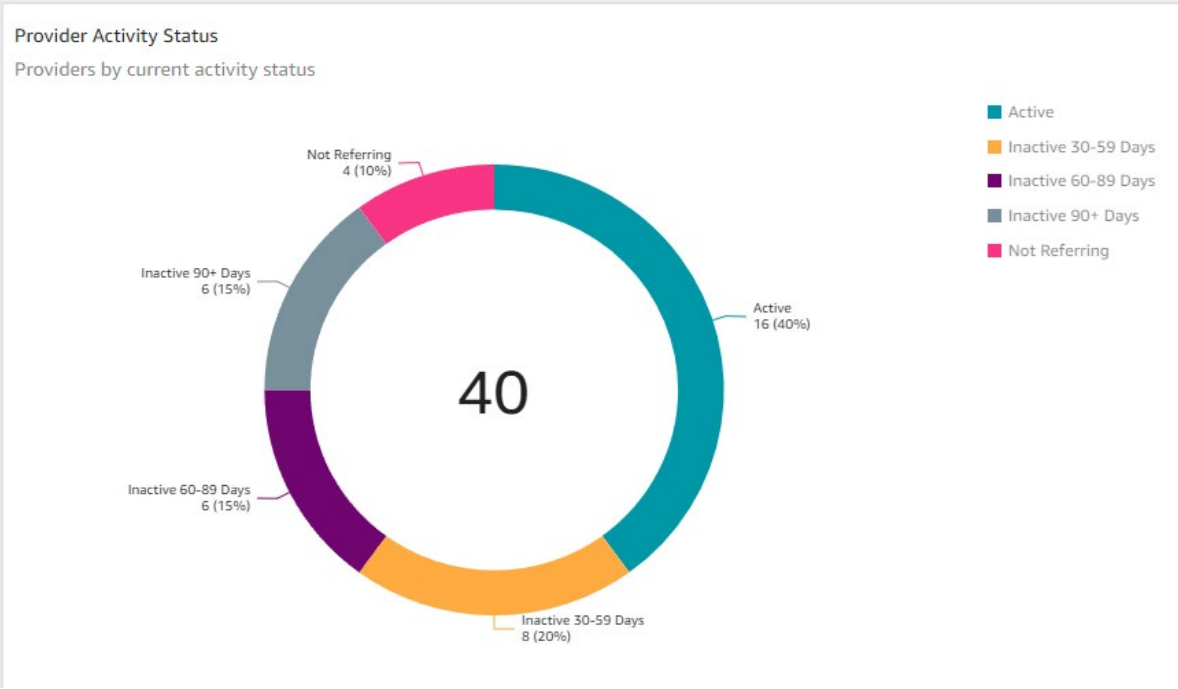
Referral Conversion Rate by Provider

Referrals and conversions by provider

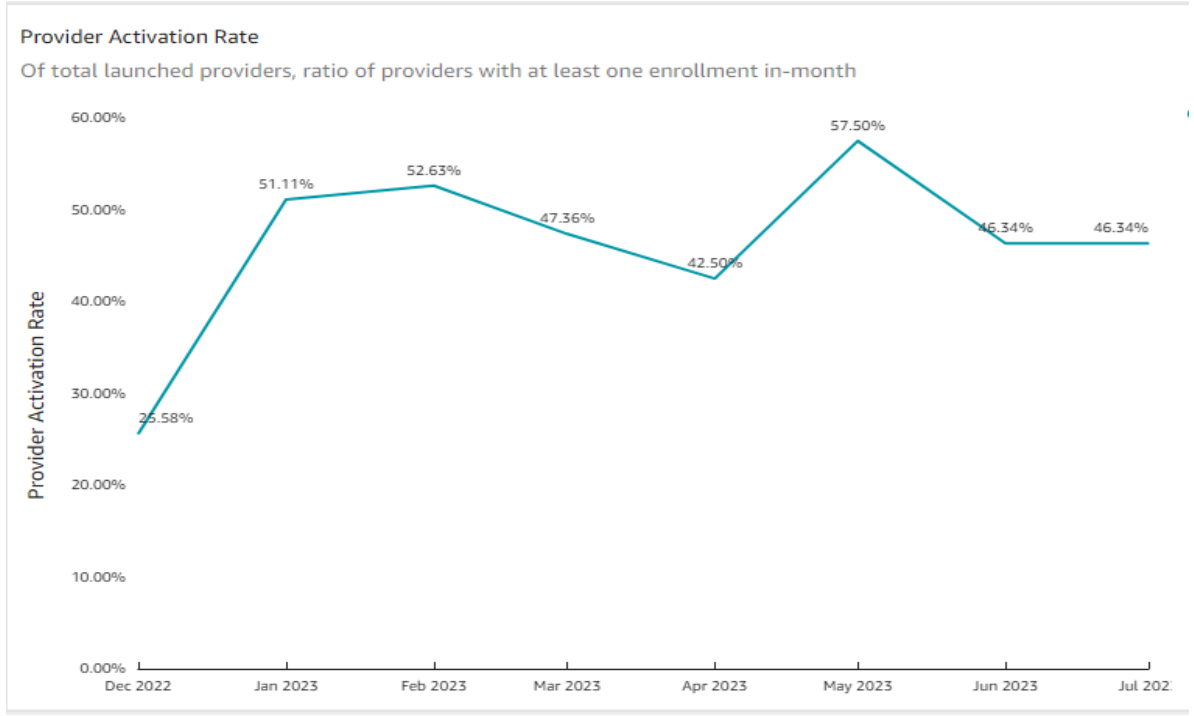
Site	Provider	Referrals	Conversions	Rate
Chapel Hill [Med First]	Christa Fleming	1	0	0.0%
Dillon [Med First]	Menelaos Voulgaropoulos	1	0	0.0%
Emerald Isle [Med First]	Kaitlyn May	1	0	0.0%
Holly Springs [Med First]	Ginger Kenney	1	0	0.0%
New Bern [Med First]	Jennifer Lipsky	1	0	0.0%
Thomasville [Med First]	Penny Taylor	5	1	20.0%
Statesville [Med First]	Menelaos Voulgaropoulos	23	7	30.4%
Dillon [Med First]	Kellie Foxworth	2	1	50.0%
Greensboro [Med First]	Daniel Kashdan	2	1	50.0%
James City [Med First]	Samantha Carlson	2	1	50.0%
Roxboro [Med First]	Tami Lee	2	1	50.0%
Southport [Med First]	Natasha Anderson	5	3	60.0%
Quality Department [Med First]	Maisha Pesante	3	2	66.7%
Sneads Ferry [Med First]	Stephanie Adamchak	3	2	66.7%
Wake Forest [Med First]	Maria Marshall	4	3	75.0%
PIC - North Marine Blvd [Med First]	Edward Wayne Haga	5	4	80.0%
		72	37	51.4%

- Opportunities to improve hand-off process:
  - Centralized phone number (updated marketing materials)
  - Setting expectations w/patient
  - 13% Declined treatment

Collaborative Care Dashboard Cont.



- Full list of inactive providers by status to be provided on a monthly basis



- 46% of providers are actively referring, which is the same as June and the range that we've been in since launch.

Q&A

Closing Remarks

Next Session: September 29, 2023

12:00 – 1:00 pm ET

Thank you!