Behavioral Health Integration – Children and Youth Collaborative Learning Exchange Project Description

Please complete this Project Description and return it to Anna Baer by 10/31/2024.

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1. **As part of CQC's Behavioral Health Integration – Children and Youth Collaborative Learning Exchange, organizations will identify an improvement project to work on during the collaborative. Can you confirm what project you will be working on?**

   As part of CQC's Behavioral Health Integration – Children and Youth Collaborative Learning Exchange, our team will focus on the pediatric collaborative care model specifically for patients identified as high-risk or who screen positive for suicidal ideation. Unlike traditional collaborative care for adults, in pediatric care, we emphasize early intervention to quickly connect patients with resources, prioritizing non-medication-based approaches. The primary care providers, behavioral health team, and the ACEs case management team will collaborate to provide trauma-informed and timely care for children who have suicidal ideation. We will standardize the post-suicidal ideation screening workflow and refine evaluation processes to clarify roles, ensuring a clear distinction between primary care provider and behavioral health responses. We also aim to provide the appropriate level of care for pediatric patients with suicidal ideation, whether this is short-term care provided by Behavioral Health within AltaMed or long-term, higher acuity care with community mental health partners.

2. **How will you measure success of the project?**

   To measure the success of our project, we will focus on several key metrics that reflect the quality and timeliness of behavioral health referrals for patients screening positive for suicidal ideation. Our primary goal is to increase the percentage of these referrals completed within 72 hours, ensuring that at-risk individuals receive timely and appropriate care. To achieve this, we will utilize the Ask Suicide-Screening Questions (ASQ) tool as an additional screen when patients answer "Yes" to the suicidality questions in the PHQ-9, providing a better understanding of their mental health status. We will measure the completion rate of both the PHQ-9 and the ASQ tools. Additionally, we will monitor the number of behavioral health appointments that patients attend, as this indicates their engagement in the care process. By ensuring the ASQ is completed for all at-risk patients, we will enhance our ability to identify and address suicidal ideation

effectively. Collectively, these metrics will help us improve access to care and ultimately support the well-being of our patients.

3. What are key milestones you can plan for during the project?

Key milestones we plan to establish during the project include:

1. Collect data on the number of patients aged 12-18 who screen positive for suicidal ideation through our electronic health record system, EPIC (Patients who answer yes to number 9 on the PHQ-9, depression screen).
2. Identify how many of the patients who answered yes to question number 9 on the PHQ-9 have completed a suicide risk assessment via the ASQ screen.
3. Stratify this data to determine who received behavioral health referrals and how long it took to complete those referrals, aiming for a turnaround of 72 hours post-screening.
4. Patients who identify at risk have a follow up with the primary care provider within 72 hours.
5. Based on the identified gaps, we will identify areas for workflow improvement and assess enhancements in warm and urgent handoffs between the primary care provider, behavioral health department, the ACEs youth services case management team.

6. What barriers do you anticipate?

We anticipate decision-making as a barrier. Pediatric care is patient and family–centered care. Treatment decisions need to meet the needs and values of both the patient and the family. This may lead to difficult and ongoing discussions to ensure the patient at risk for suicide gets the treatment they require. Additionally, there may be a lack of community resources specific to pediatric behavioral health support and access for families once they are identified as screening positive for suicidal ideation. It is also worth noting that AltaMed's behavioral health department typically provides short-term care, which may not meet the ongoing needs of these patients. There are also many questions about the payment structure for these types of services. The topics we would like to explore during CQC's Behavioral Health Integration – Children and Youth Collaborative Learning Exchange include the financial support for the time-intensive care and training for the staff who will support this model in an FQHC setting, differences in care and resources when comparing pediatric and adult patient populations, and the reimbursement structure that does not account for the specific needs of each population.

7. What support could you use?

To enhance our project's effectiveness, we would greatly benefit from examples or workflows from other institutions without co-located behavioral health services. Additionally, within our own organization, establishing a direct line of communication between the primary care providers, the Department of Behavioral Health, and ACEs case Management is crucial for effective collaboration and streamlined referral processes. Support in identifying ways to integrate behavioral health needs into the primary care team's workflow would be invaluable, as well as suggestions for resources beyond the behavioral health team that could serve as additional support for our patients and families. Lastly,

we would like support in identifying how we can train more individuals who support these services.