INCREASING PEDIATRIC INTEGRATED BEHAVIORAL HEALTH CAPACITY USING COMMUNITY HEALTH WORKERS

MIDPOINT EVALUATION

SEPTEMBER 2023 - AUGUST 2024

This report was prepared by faculty and staff at the Hassenfeld Child Health Innovative Institute (HCHII) in collaboration with the Care Transformation Collaborative of Rhode Island (CTC-RI).

We would like to acknowledge the following funders: United Healthcare, Blue Cross Blue Shield of Rhode Island, and the Hassenfeld Child Health Innovative Institute. We would also like to thank the community health workers for their dedication towards the families with whom they work.

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Executive Summary

Background

Brown University’s Hassenfeld Child Health Innovative Institute’s (HCHII) and Care Transformation Collaborative of Rhode Island (CTC-RI) share a common goal to transform pediatric care to provide equitable access to behavioral health services for families and children. In early 2023, CTC-RI received funding from UnitedHealthcare and Blue Cross Blue Shield of Rhode Island to increase the capacity of pediatric practices to provide integrated behavioral health care by integrating community health workers (CHWs) into the practice. Funds support project management, practice transformation facilitation, CHWs’ salaries, and comprehensive training for CHWs to participate as full members of the integrated behavioral team. Six practices have received two years of funding.

HCHII has collaborated with CTC-RI to design and conduct an evaluation of the project. The objectives of the evaluation are to:

1. Measure sites’ level of integrated care before and after implementation of the integrated behavioral health (BH) model
2. Gain an understanding of the CHW role in integrated pediatric settings; and
3. Assess barriers and facilitators to the integration of the CHW role.

To accomplish the evaluation’s objectives, we have implemented a mixed-methods approach that gathers data in the following domains: level of current BH integration and readiness for further BH integration, provider burnout, BH screening rates, and CHW tasks performed. Specific data sources and approach to analyses are described. This report presents interim findings of the first year of the project.

Key Findings of Evaluation and Focus for Year 2

Screening

- All sites are consistently screening children from 9 months to three years and adolescents
- PDSA cycles focused on expanding screening of school-age children are in progress and a major focus of Y2 activities.

Expanding IBH Capacity

<u>Reach</u>. CHWs are reaching a racially and ethnically diverse population that includes children birth through adolescence and equal numbers of males and females.

<u>Effectiveness</u>.

- Warm handoffs to the CHW, one of our key metrics of effectiveness, were occurring in over 80% of first encounters.
- A focus on behavioral health needs, which was our second key metric, occurred in ~ 65% of encounters (51% addressed only behavioral health needs, 17% addressed both behavioral and material needs, and 31% addressed only material needs).
    - The most common material needs were assistance with food, housing, and transportation.

    - The most common behavioral health needs were counseling services and connection to school supports.

Adoption. Overall, there was overwhelming buy-in to integrate CHWs in primary care practices.

- Challenges related to defining the CHW scope of practice and their role relative to other staff members were experienced by several sites.

Implementation. Implementation of the CHW activities has occurred in a range of practice settings. They have served as advocates, navigators, and links between families and their PCPs.

- Sites continue to address challenges related to implementation of consistent workflows related to specific activities and communication.

Maintenance and sustainability. There is a strong commitment and desire to maintain the CHWs after the funding period ends.

- Advancing billing practices as well as advocating within health systems for the sustainment of the CHW role are priorities for the upcoming year.

INTRODUCTION

Nationally, nearly one in five (20%) adolescents and children experience a behavioral health (BH) disorder each year, and almost half of all youth experience this by the age of 18 years old.[1] In Rhode Island, child mental health issues are even more acute. Among children aged three to 17, more than one in four (28.7%) had an emotional or behavioral health concern, and a staggering 59% of children who needed mental health care reported barriers to receiving that treatment in Rhode Island in 2022.[2] These data suggest that children across Rhode Island have critical unmet behavioral health needs as a result of navigating an often fragmented and decentralized healthcare system. Behavioral health disorders pose a significant threat to child health. They can negatively impact daily functioning and are correlated with poor health outcomes throughout the life course.[1,2] LGBTQ+, low-income, and racial and ethnic minoritized youth are at even greater risk.[1–3] Despite efforts to reduce rates of child mental health disorders, prevalence steadily increased between 2010 and 2020.[1] Although children experienced mental health conditions before 2020, youth rates of anxiety and depression increased after the onset of the coronavirus pandemic and preexisting disparities widened.[1–3] In response to proliferating rates, in 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) declared children's mental health a national emergency.[1,3] To recognize the state-wide crisis, in 2022, Rhode Island pediatric and behavioral health organizations also declared child and adolescent mental health a state of emergency.[2]

Causes of disparities in BH care are multifactorial and rooted in differences in access to care. They encompass structural barriers such as insurance coverage, cost of care, transportation issues, and rigid work hours, as well as low mental health literacy, mental health stigma, and cultural incompetence among providers.[1,4] Data indicate the pediatric BH workforce shortage is an important driver exacerbating existing disparities.[1] Accordingly, increased attention has been focused on the clinical value of incorporating CHW models of care delivery into BH services.[5] Given the significant workforce gaps, CHWs are an underutilized resource that can help bolster the availability of care to meet growing BH needs.[5] Their unique knowledge as members of local communities allows them to sensitively address issues related to culture and stigma that can underlie disparities in BH outcomes.[5] Growing evidence shows that integrating BH into primary care settings is an effective strategy to promote improved child outcomes.[1,6]

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PROJECT SETTING

The six participating practices (see Figure 1), which serve approximately 30,771 of the state's children, hired and trained CHWs with the goal of expanding their BH capacity. TEAM UP for Children, a Massachusetts' based pediatric integrated behavioral health (IBH) initiative, which has extensive experience providing clinical education and organizing learning communities, has provided CHW training and support.[7] The practice types include federally qualified health centers, private group practices, family medicine training programs, and a large academic medical center (See Table 1 for site specific demographics). Each of these practices incorporates team-based care, comprehensive screening for developmental and behavioral concerns, workflows to support internal referrals and connections to specialty care, and supplemental core workflows based on site priorities. CHWs and representatives from each pediatric setting have monthly meetings with practice facilitators. Practice facilitation is an implementation strategy "used to build practice capacity and support practice changes to improve health care outcomes." This process supports overall program implementation and the conduct of specific quality improvement projects.[8]

Figure 1. Map of Participating Sites

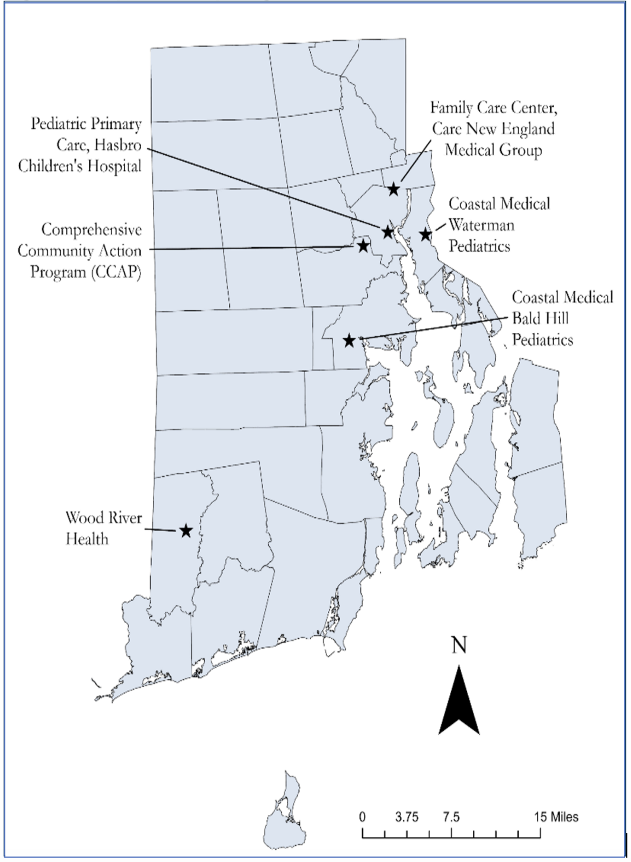


Table 1. Demographic Breakdown of Patients by Site

Site	Race: White	Race: Black	Race: American Indian/ Alaskan Native, Asian, or Native Hawaiian/Pacific Islander	Race: Other*	Race: Unknown	Language: English as Primary Language
Coastal Waterman	66%	5%	5%	24%	0%	99%
Coastal Ball Hill	77%	5%	5%	13%	0%	96%
Family Care Center	52%	22%	2%	24%	0%	93%
CCAP	38%	10%	15%	4%	33%	87%
Wood River Health	77%	2%	3%	3%	15%	99%
Hasbro	17%	31%	3%	49%	0%	79%

*The majority of "other" racial group is assumed Hispanic/Latinx

DATA SOURCES AND ANALYTIC APPROACH

Data Sources

We relied on multiple data sources for this evaluation:

- Site surveys to assess mental health integration readiness
- Individual staff surveys to assess provider burnout
- Behavioral health screening rate data from site electronic medical records
- CHW activity forms to evaluate tasks CHWs performed
- Qualitative interviews with key informants
- Review of Plan-Do-Study-Act (PDSAs) plans that were implemented with support of the practice facilitators

Specific data sources are described below.

Site Level on Integration Surveys

Prior to the onboarding of the CHWs, sites were asked to complete two surveys: the Maine Health Access Foundation (MEHAF) Site Self-Assessment Survey and the Mental Health Practice Readiness Inventory (MHPRI).

The MEHAF is a 21-item questionnaire that assesses practices' currently available integrated behavioral health services, as well as organizational supports towards additional behavioral health integration.[9] Questions are asked across 4 domains: reducing barriers to care, changing care delivery, building relationships, and laying the foundation. Each item is rated along a 1-10 scale, with numbers grouped into 4 levels of quality. Average scores for each site, across all domains, were calculated and mapped onto a letter grade: A (score of 8-10), B (score of 5-7), C (score of 2-4), and D (score of 1).

The MHPRI is a 32-item survey that assesses the extent to which a practice's current leadership, services, and resources support provision of mental health services.[10] The extent of mental health service integration is measured across 5 domains: community resources, health care financing, support for children and families, clinical information systems/delivery system redesign, and decision support for clinicians. Respondents answer each question on a 5-point Likert scale (1=strongly disagree; 2= disagree; 3= don't know/NA; 4=agree; 5=strongly agree). An average score across all domains for each site was calculated.

Surveys were administered electronically via a REDCap survey link. Sites were instructed to convene their core implementation teams (i.e. the clinician champion, behavioral health clinician, and other administrative support) to review the surveys and come to a group-consensus on each of their responses. Because of this, only one MEHAF and one MHPRI were collected from each site. Mean scores for items and subscales were calculated for each measure.

Burnout Inventory

In order to assess the impact of the CHW role integration on other members of the team, we administered the Maslach Burnout Human Services Survey for Medical Personnel.[11] This is a 22-item survey that assesses how health professionals view their own jobs and roles as well as those of other team members. Questions explore three domains: emotional exhaustion (feeling of exhaustion or burnout as a result of one's work), depersonalization (feeling impersonal towards patients), and personal accomplishment (feeling of success and achievement as a result of one's work). Responses are rated along a 6-point Likert scale (0=Never; 1=A few times a year or less; 2=Once a month or less; 3=A few times a month; 4=Once a week; 5=A few times a week; 6=Every day). This survey was administered individually to clinic staff, providers, and medical assistants via a REDCap survey link. Total and average scores for each domain were calculated. Further analysis will look at scores by role (e.g. PCP, IBH clinician)

The tools described above will be readministered at the end of the project period and we will assess for change.

Behavioral Health Screening Rates

A central piece of the IBH model is the implementation of universal behavioral health (BH) screening. Sites were expected to screen for psychosocial functioning in infancy and early childhood (among 0-3 year-olds) and in middle childhood (among 4-11 year-olds). Additionally, sites were required to screen for anxiety and depression in adolescents (among 12-17 year-olds). Common screening tools utilized by sites included the Survey of Well-being of Young Children (SWYC), the Ages and Stages Questionnaire (ASQ) (infants and young children), the Pediatric Symptoms Checklist (school-age children), the Patient Health Questionnaire (PHQ-9), and the Generalized Anxiety Disorder 7 (GAD-7) (adolescents).

Baseline screening rates were obtained from March 1, 2023 – August 31, 2023. Rates are abstracted from the electronic medical record (EMR) on a quarterly basis for each subsequent 3-month period, and reviewed during monthly practice facilitation meetings with sites. Screening rates are calculated by the following formula:

Number of children screened/Number of children eligible to be screened

The number of eligible children for a screen was defined as the number of children within a specific age group, for a specific screener, who attended a well-child appointment and therefore had an opportunity to be screened. We excluded patients who had canceled or rescheduled their appointments, or who did not show up to their appointments. The number of children screened refers to the number of children who attended a well-child screening appointment and received the appropriate screening tool for their age group. Screening rates continue to be tracked over time. See Appendix A for more information about our screening rate metrics.

CHW Activities

In order to describe the role of CHWs in an integrated pediatric setting, the evaluation team developed a form to capture the reason why patients were referred to the CHW, the tasks performed by CHWs, and the time spent on these tasks (see Appendix B). This form, referred to as the CHW Activity Form, is completed by CHWs for every patient encounter during a one-week period, every 2-3 months. This approach was adopted given the inability to abstract data directly from the EMR and to minimize the burden of documentation. The forms were completed on paper and were scanned and sent to the evaluation team at the end of each data collection period. Data was entered into a REDCap database for analysis.

Qualitative Interviews with CHWs and Core Implementation Teams

To better understand the barriers and facilitators of IBH implementation, we conducted qualitative interviews with the core implementation teams at each site and individual interviews with the CHWs and the two practice facilitators supporting practice transformation efforts. Interview questions were guided by the RE-AIM framework. Questions asked included:

> "*What are other needs the site has to better integrate the CHW into the IBH team? What tasks are the CHWS asked to do? How has the addition of the CHW impacted your workload and workflows?"*

Please see Appendix C for the interview guides utilized. All interviews were done remotely via Zoom and were audio recorded. We utilized Zoom's transcription function to transcribe the interviews and compared them against the audio recording to reconcile any discrepancies.

After transcripts were reviewed for accuracy, the team analyzed the data using a rapid qualitative analysis approach. This approach is less time-consuming, requires less resources than traditional qualitative analytical approaches, and is compatible with health services and implementation research.[12] Two members of the evaluation team, a first year Masters in Public Health student and a PhD Health Services student, analyzed the data. Consistent with the rapid qualitative analysis approach, they created standardized memos summarizing data from the interviews into pre-identified domains of interest (e.g. CHW role, workflow changes, barriers to implementation). In order to ensure that consistency was established across both summarizers, 3 interviews were summarized by both team members prior to summarizing the remaining transcripts independently.

After the summaries were completed, they were organized into two matrices: one for interviews conducted with the core implementation teams (including interviews with the practice facilitators) and another matrix for individual interviews conducted with CHWs. The matrices were then reviewed to identify themes and variation in responses.

PDSA Projects

Practice facilitators worked with the core implementation team at each site to identify 1-3 improvement areas for each year of the project. Sites were instructed to focus their PDSAs around establishing workflows that would support the integration of the CHW role. Sites report updates during the monthly practice facilitation meetings.

Analytic Approach: REAIM

We used the RE-AIM implementation science framework and its extension to report project findings. RE-AIM is used to assess evidence-based initiatives and takes into account individual, staff, and environmental level views to holistically measure impact. The RE-AIM framework with the extension examines the domains of **R**each, **E**ffectiveness, **A**doption, **I**mplementation, and **M**aintenance of a project, taking into account health equity and sustainability.[13,14]

- **Reach** assessed the number and representation of individuals involved in the project in order to determine if the target population was engaged.
- **Effectiveness** focused on the impact of the project to increase IBH capacity and improve screening. It also included any unintended effects on the population.
- **Adoption** reflected attitudes, perceptions, and reasoning regarding the adoption of the project across the different sites and staff.
- **Implementation** examined the continued and consistent incorporation of the project as intended (fidelity), as well as adaptations made.

- **Maintenance** assessed strategies used to support IBH in pediatric practices and what practices, policies, and procedures are needed to ensure its sustainability over the long term.

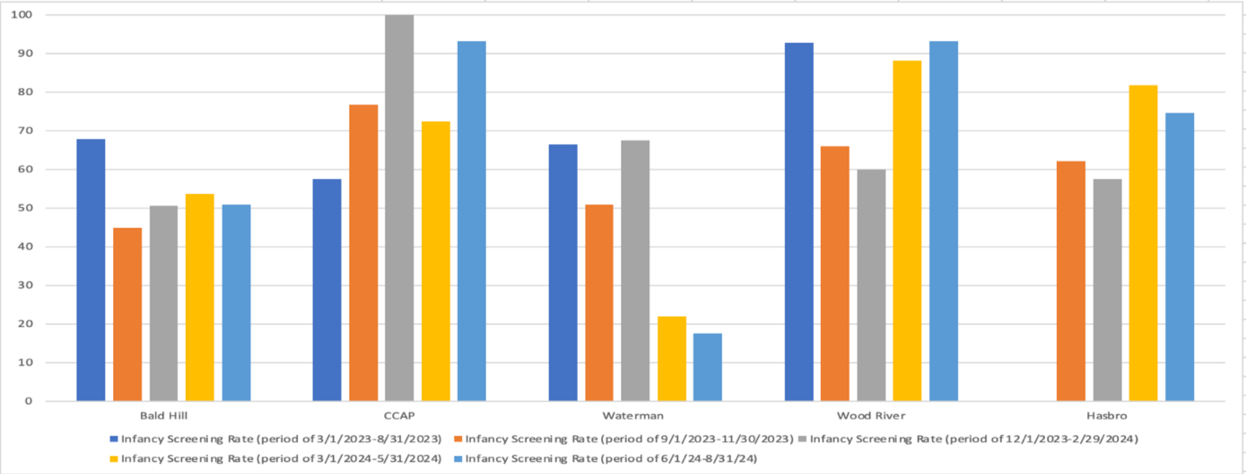
The RE-AIM framework has been used in both quantitative and qualitative studies to evaluate interventions. A study by Cheng, et al. used the RE-AIM framework to evaluate a low-barrier telephone nurse hotline, its value to callers, and recommendations for future change.[15] Another study that used the RE-AIM framework assessed practices in the National Diabetes Prevention Program.[16] This program intended to prevent or delay type 2 diabetes for individuals at high risk during their 4-year funding period. The RE-AIM evaluation identified an increase in the number of sites participating in the program, highlighted private insurers/public payers funding the lifestyle intervention, assessed demographics of employees/participants, and indicators for improved outcomes.

KEY FINDINGS

Screening Rates

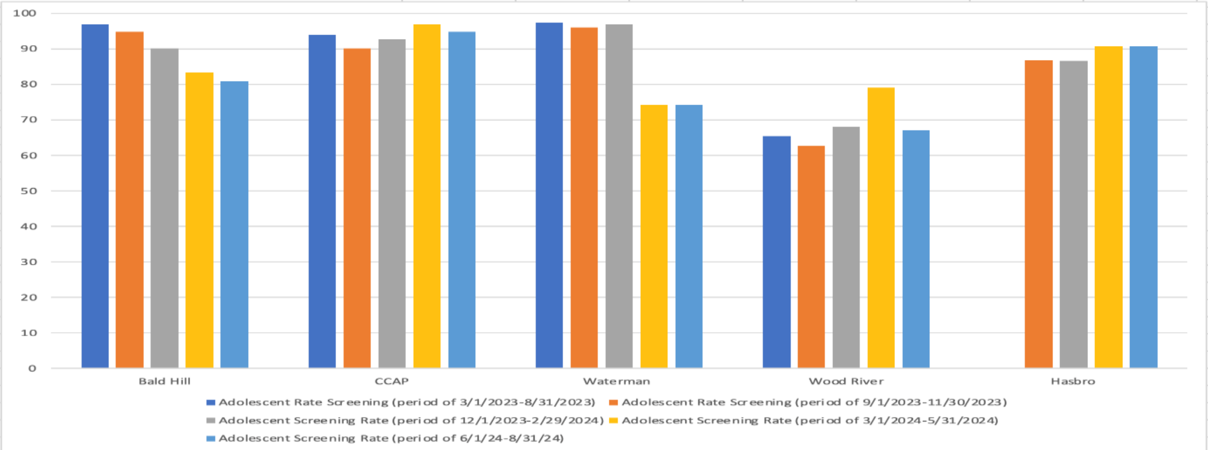
Tracking screening rates allows us to assess the reach of the project. Universal screening is the foundation for equitable identification of children with behavioral health needs. It provides every child and family the opportunity to report behavioral and developmental concerns. We assessed screening rates stratified by three age groups: infants/early childhood (9 months – 3 years), middle childhood (4 – 11 years), and adolescents (12-17 years). We found that across sites and time periods, 55.5% of infant/young children and 86.6% of adolescents were screened. None of the sites consistently screened middle childhood/school-age children for behavioral concerns at the beginning of the project. Thus, screening rates reported for this age group are limited. While there were minor variations by site and time periods (Figures 2 and 3), overall, screening protocols were implemented successfully for young children and adolescents and sustained over time.

Figure 2. Infancy Screening Rates



(Note: The initial screening rate for the infant age group is low due to incorrectly including children under 9 months, who do not have the opportunity to be screened, in the denominator. This error was corrected in later periods.)

Figure 3. Adolescent Screening Rates



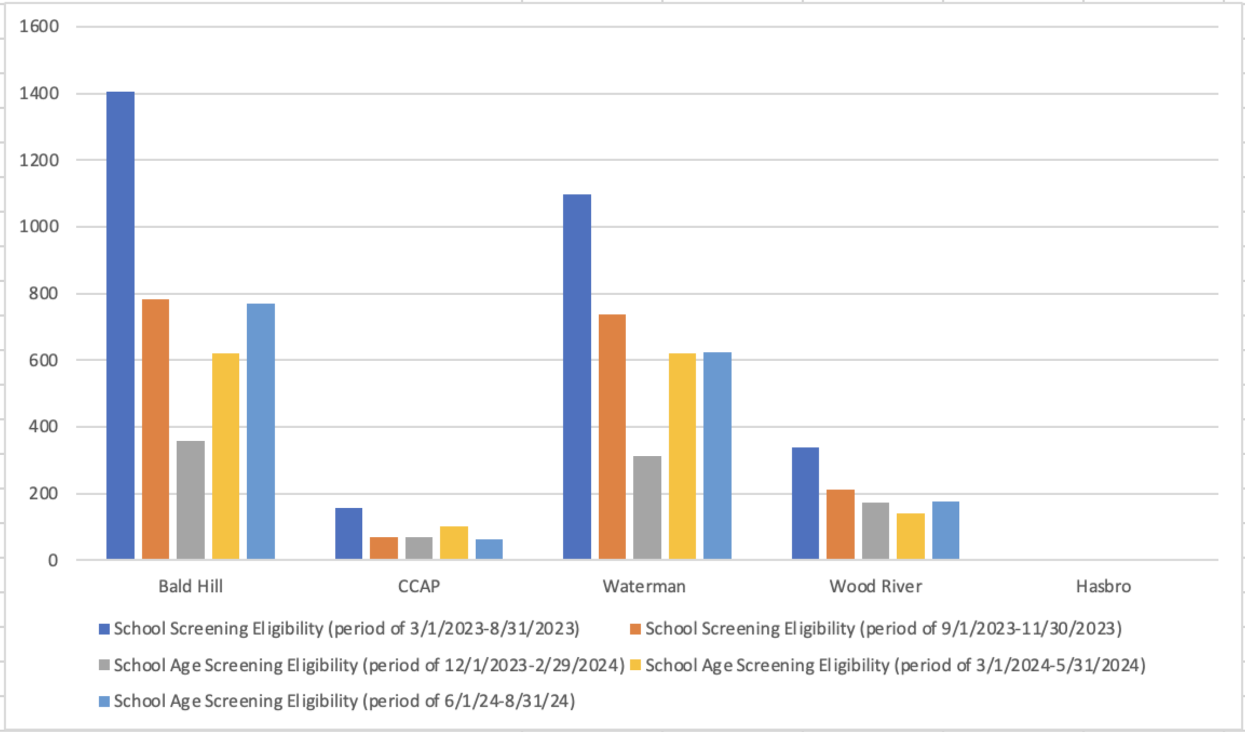
A new electronic health record system (EHR) was implemented at several sites during the year. CHWs and the healthcare teams had difficulty incorporating screeners into their practice due to challenges with technology. Initially, some of the screening tools were not embedded in the EHRs but staff remain optimistic that these obstacles would subside.

> *“ The technology has absolutely been a challenge. We would have had the PSC [the school-age screener] in place long before we did if we were able to get [EMR system] onboard on a better timeline…I've been assured that once we're ready to go clean up all the other [technology] issues that it's going to be pretty easy to implement the new screening and get it out there to our target age group.” -Director of Care Coordination*

During interviews with the core implementation teams, concerns about the expansion for school-age screening were discussed (see Figure 4 for number of screen eligible school-age children). Despite recognizing the gap in their screening protocols and endorsing the value of universal screening, sites were concerned about their capacity to meet the needs of this large group of children with the team’s limited resources.

> *“With the increased screenings? It's increased [the CHW’s] workload for sure…We had just talked about it today…the importance of delegation because now [there are] more tasks coming to her for this population of children, even though [the CHW] would have seen some of that before.” - Director of IBH*

Figure 4. School-Age Screening Eligibility Counts



Sites appreciated receiving data reports that could help them identify gaps in their workflows or assist them with identifying patient needs. One practice facilitator stated:

> *"[the sites] have also been, I think, like leaders in terms of thinking about the universal screening question. Really kind of moving forward with expanding into use of the PSC [the screening tool to be used for school-age children] in that school-age population, which we had identified [as] kind of a universal gap across the sites."*

Given the project's goal to support all sites to screen all children in their practice, adoption and implementation of screening school-age children became the focus of PDSA projects (Appendix D). We will continue to track site implementation of screening school-age children over the next year as an indicator of the project reach.

Relative to the RE-AIM framework, screening data has been useful in assessing the implementation of screening workflows. However, we lack data to accurately evaluate its reach and effectiveness. To do so requires 1) examining screening rates by race, ethnicity, and language to determine whether all children are screened equitably and 2) examining screening results to assess the effectiveness of screening to identify behavioral health concerns.

Expanding IBH Capacity

The project's success in increasing IBH capacity was evaluated using multiple data sources. The two main metrics for evaluation of effectiveness were 1) the proportion of CHW encounters that were initiated through a warm handoff and 2) the proportion of encounters that responded to a behavioral health or developmental concern. Additional metrics of interest were the patient populations served and the distribution of behavioral health versus material needs. The qualitative interviews were used to further understand the perspectives and sentiments towards the ongoing process of increasing IBH capacity. Below we present the results of efforts to increase IBH capacity within the RE-AIM framework.

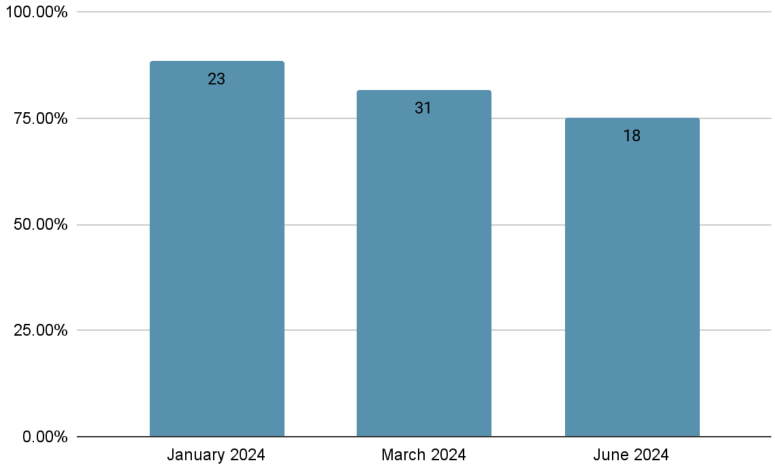
REACH: We used the CHW Activity Form to describe the patient population. We examined a total of 233 patient encounters over 9 months at 6 different clinical sites in order to gain a snapshot of the families with whom CHWs worked and what the CHWs did. (Note - as described above, data collection occurred for 1 week every 3 months so data does not reflect the totality of CHW work). Data revealed that CHWs worked equally with males and females, with the majority identifying as Hispanic or Latinx (36%) or White (36%). Most individuals were from the 12+ age group (41%), followed by the 0-5 age group (33%), which, interestingly, aligns with the population screened (see Table 2). CHWs engagement with children and families was generally proportional to the patient demographics of each clinic. There was a possible trend suggesting that Wood River and Waterman CHWs were more likely to serve Black or African American families and Hasbro, FCC, Bald Hill, and CCAP CHWs were more likely to serve Hispanic families than would be expected based on their respective proportion of the patient population.

Table 2. Demographics of Population from CHW Activity Forms

Variable	N	% of Total
Race/Ethnicity		
Hispanic	85	36%
Non-Hispanic White	84	36%
Non-Hispanic Black	36	15%
Multiple Races	2	1%
Other	7	3%
Unknown/Refused	19	8%
Gender		
Male	117	50%
Female	115	49%
Non-Binary	1	<1%
Age		
0-5 years	78	33%
6-11 years	58	25%
12+ years	95	41%
Not Disclosed	2	1%

EFFECTIVENESS: We identified two key metrics to evaluate the project's effectiveness: 1) the proportion of CHW encounters that were initiated through a warm handoff and 2) the proportion of encounters that responded to a behavioral health or developmental concern. In order to assess contact initiated through a warm handoff to the CHW, we restricted the analysis to first-time encounters (N=88) between families and the CHWs. Overall, sites were successful at implementing warm handoffs; on average, over 80% of first-time encounters were initiated by a warm handoff: variations over time were not significant (Figure 5).

Figure 5. First Encounters with Warm Handoffs Over Time



We analyzed the full data set of 233 encounters to assess the proportion of encounters that responded to a behavioral health or developmental concern. We found that 51.5% of encounters addressed BH needs (behavioral or developmental concerns); 31.3% addressed materials needs (food resources, housing resources, transportation, etc.), and 16.7% of encounters addressed both types of needs (Figure 6). See Table 3 for further breakdown of BH and materials needs.

Figure 6. CWH Encounters Addressing Material vs. Behavioral Health Needs

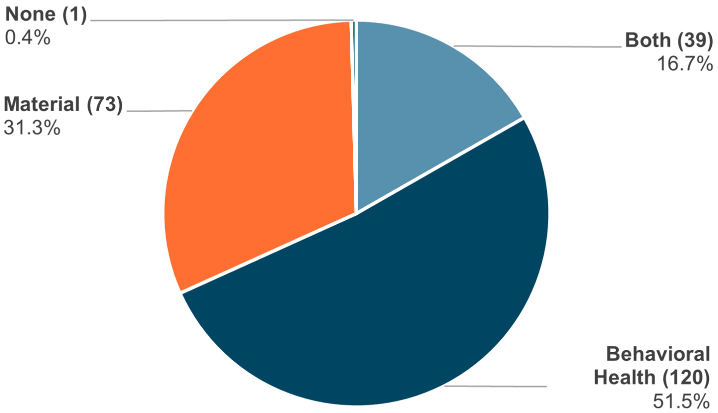


Table 3. Distribution of Resource and Service Needs

Type of Goal	Resource and Services Needs	N	% of Total
Material	Food Resources	39	17%
	Transportation	31	13%
	Housing Resources	29	13%
	Other Material Resources	26	11%
	Insurance	12	5%
	Diapers	12	5%
	Cash Assistance	3	1%
Non-Material/IBH	Counseling Services	55	24%
	IEP or School-Based Services	48	21%
	Other Non-material Needs	27	13%
	Parent Group or Support	22	9%
	In-home Services	14	6%
	Case Coordination/Referral Support	12	5%
	ADHD Evaluation	10	4%
	Referral to EI	8	3%
	ASD/Developmental Delay Evaluation	7	3%
	Help Completing Questionnaires/Forms	7	3%

Over the project period, the BH needs addressed decreased from 61% to 39%, whereas the material needs increased from 24% to 43% (Table 4). This finding may be related to challenges of task allocation to the CHWs (see implementation section below) or it may be a result of the fact that later data points did not include data from 2 sites where the CHW was on leave and relied more heavily on data from Hasbro which serves a higher need population than some of the other practices.

Table 4. Proportion of CHW Encounters Addressing Material and BH Needs Over Time

	Jan 2024 N = 62	March 2024 N = 81	June 2024 N = 89
Material Needs	15 (24%)	20 (25%)	38 (43%)
BH Needs	38 (61%)	47 (58%)	35 (39%)

ADOPTION: The adoption of the CHW role was measured by the readiness assessment completed by each site and through the qualitative interviews with CHWs and core implementation teams. Before the implementation of the CHWs, most sites scored similarly on their level of readiness for BH integration. Sites scored an average of 3.6 out of 5 on the MHPRI assessment and all locations scored a B for the MEHAF assessment.

The qualitative interviews provided additional context related to the early adoption and implementation of the CHW role. Interviews revealed varied sentiments toward integrating CHWs into primary care based integrated behavioral health teams. Overall, there was overwhelming buy-in from clinical staff to integrate CHWs into the primary care practice. The staff expressed support for having CHWs as part of the team. They considered the use of CHWs as a feasible strategy to alleviate staffing issues and decrease the demand on PCPs and BH clinicians to complete tasks that could be managed by individuals with less BH clinical training. Some clinicians expressed being overwhelmed by families' health related social needs and did not have the bandwidth to address such needs within their medical practice prior to the CHWs' hire. With the presence of a CHW, clinical staff could transition back to focusing on working to the top of their skill level while the CHWs made deeper connections to assist patient needs.

One IBH clinician states:

> *"It frees me up to do that [clinical work] if she is able to do some of the other pieces – coordination and parent support, education, those kinds of things."*

Despite the buy-in from clinical staff, sites did face some challenges with the adoption of the CHW role. Some staff were uncertain and hesitant regarding when to use CHWs within their work. These challenges affected team functioning. Clarifying role boundaries between other team members required a clear focus. Some team members, such social workers, were worried about their jobs being replaced by the CHW because the role was not clearly defined. A Director of IBH states:

> *"...We've had to do some work on that, and to kind of retrain social work that they certainly can do a lot of the work that they were previously consulted for, but they don't*

> *have to now. And in particular, shifting [the IBH clinician's] mindset that [they] can now begin to address the more clinical aspects of the needs of the [patients]."*

Many sites struggled with understanding the potential scope of the CHW role and how to define it. Throughout the duration of the project, they expressed an ongoing need for staff training about the role of CHWs, defining their scope of practice, and how to best integrate them into the behavioral health team. This is an ongoing challenge that sites are currently working to resolve. For example, one site has a CHW assigned to their IBH team and another CHW whose role specifically addresses SDOH need*s:*

> *"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 [is] not as suited [compared to the SDOH CHW] to take an SDOH need such as like meeting with a patient to do SSDI forms... I think that because [they] are called community health workers, the doctors, they get confused about the specifics of this role on our IBH team…" -Director of IBH*

IMPLEMENTATION: Implementation successes and challenges were discussed in depth in the qualitative interviews. The CHW role allowed for authentic relationship-building with families, resulting in increased patient satisfaction. Patients were able to receive assistance with material needs such as food resources, housing resources, transportation, etc. As for non-material or IBH needs, CHWs assisted with IEP/school-based services, counseling services, and much more. The Director of IBH stated:

> *"You [CHW] 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."*

The CHWs carried a sense of pride toward the impact they were having on patients. Their role allowed them time to have necessary conversations that delved more deeply into family struggles. Often conversations with parents unveiled ongoing issues in the families' lives not recognized previously. The CHWs were able to provide a safe place for patients through having a shared language and culture, often reducing structural barriers to care. One CHW recalls:

> *"...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"*

The CHWs served as advocates for families navigating an unfamiliar healthcare system. Since many CHWs were from the communities they were serving, they better understood the barriers and needs of the patients. Through the CHWs' lived experience they were able to guide families towards resources and normalize the need for support. By working toward eliminating stigma, CHWs were able to gain trust and uplift parents in supporting their children. A CHW states:

> *"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."*

Nonetheless, many sites struggled to implement consistent workflows to assign CHWs appropriate tasks that utilized the full range of their skills. Warm handoffs varied at the sites depending on the understanding of the CHW role and the ease of technology to communicate. The switch to new EMR systems posed a barrier to incorporating the CHWs into medical appointments.

> *"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*

When asked about desired changes for the project, several sites mentioned additional staff training on the role of CHWs, hiring more CHWs for the behavioral health team, and offering CHWs more support on available resources and training.

> *"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*

Lastly, some sites noted space as a limitation that separated the CHWs from the team.

> *"...I think a challenge on the [site] end is just space. There's an upstairs space that's more administrative. There's a downstairs space where all the physicians are working and there just is no space for [CHW] to have her own space...my worry has always been that the separation interferes with the seamlessness of the warm handoff" -Clinician Champion*

MAINTENANCE AND SUSTAINABILITY. Sites expressed a strong desire to maintain the CHW role.

> *"I will do whatever it takes [to sustain the CHW role], I think this role is essential...we will do whatever it takes grant-wise or system-wise"- Director IBH*

To ensure the sustainability of the CHW role as a member of the IBH team, many sites are currently working on billing for CHW services. Some sites have reported progress towards reaching this goal while others expressed needing more support from upper management. The sites plan on advancing billing during year 2 of the project.

KEY FINDINGS OF EVALUATION AND FOCUS FOR YEAR 2

Below we have summarized key findings and the foci for the second year of the project. We will continue all data collection activities and conduct a second round of qualitative interviews during this project year.

Screening

- All sites are consistently screening children from 9 months to three years and adolescents
- PDSA cycles focused on expanding screening of school-age children are in progress and a major focus of Y2 activities.

Expanding IBH Capacity

Reach. CHWs are reaching a racially and ethnically diverse population that includes children birth through adolescence and equal numbers of males and females.

Effectiveness.

- Warm handoffs to the CHW, one of our key metrics of effectiveness, were occurring in over 80% of first encounters.
- A focus on behavioral health needs, which was our second key metric, occurred in ~ 65% of encounters (51% addressed only behavioral health needs, 17%, addressed both behavioral and material needs, and 31% addressed only material needs).
    - The most common material needs were assistance with food, housing, and transportation.
    - The most common behavioral health needs were counseling services and connection to school supports.

Adoption. Overall, there was overwhelming buy-in to integrate CHWs in primary care practices.

- Challenges related to defining the CHW scope of practice and their role relative to other staff members were experienced by several sites.

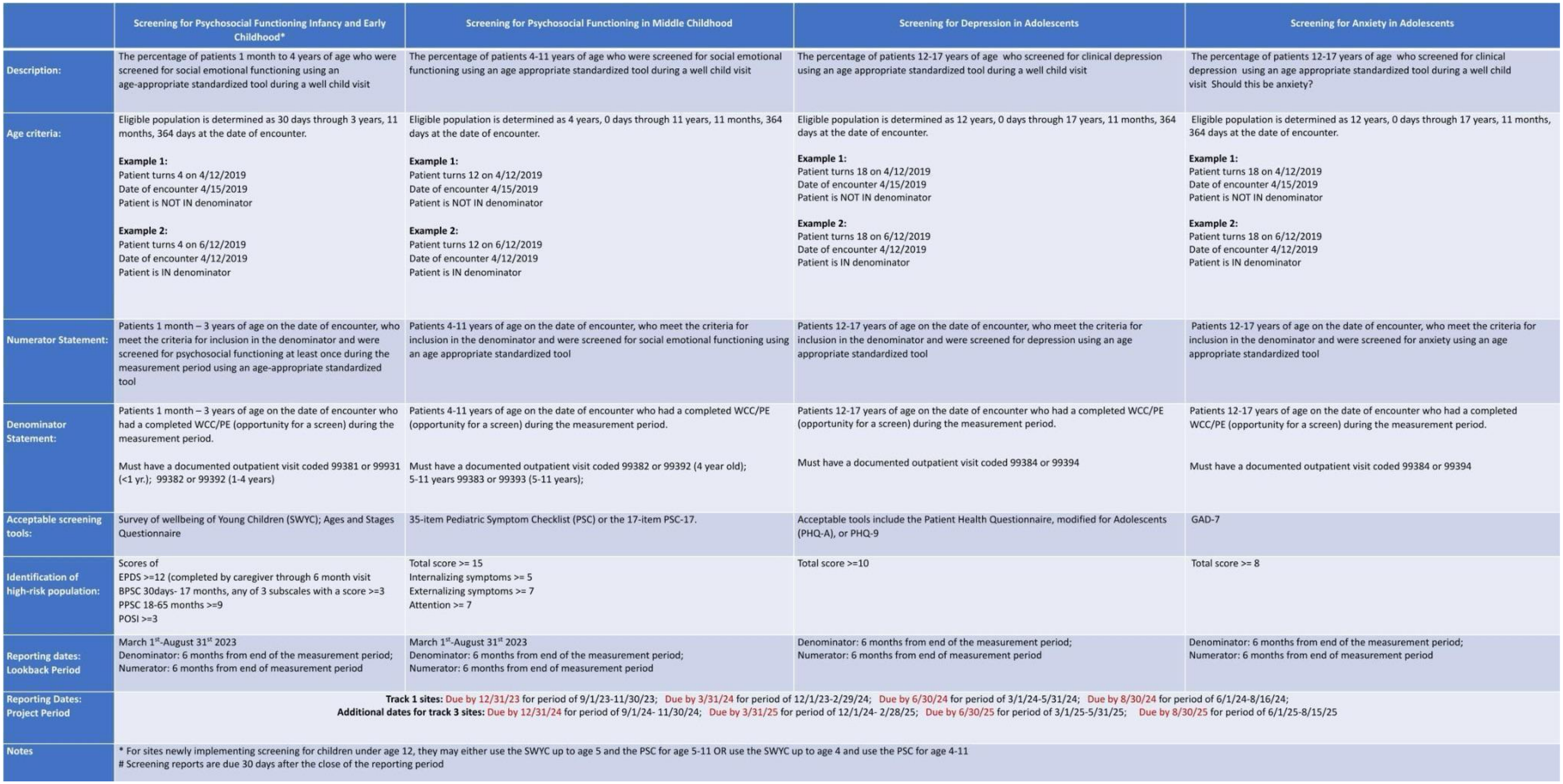
Implementation. Implementation of the CHW activities has occurred in a range of practice settings. They have served as advocates, navigators, and links between families and their PCPs.

- Sites continue to address challenges related to implementation of consistent workflows related to specific activities and communication.

Maintenance and sustainability. There is a strong commitment and desire to maintain the CHWs after the funding period ends.

- Advancing billing practices as well as advocating within health systems for the sustainment of the CHW role are priorities for the upcoming year.

Appendix A. Screening Metrics



	Screening for Psychosocial Functioning Infancy and Early Childhood*	Screening for Psychosocial Functioning in Middle Childhood	Screening for Depression in Adolescents	Screening for Anxiety in Adolescents
Description:	The percentage of patients 1 month to 4 years of age who were screened for social emotional functioning using an age-appropriate standardized tool during a well child visit	The percentage of patients 4-11 years of age who were screened for social emotional functioning using an age appropriate standardized tool during a well child visit	The percentage of patients 12-17 years of age who screened for clinical depression using an age appropriate standardized tool during a well child visit	The percentage of patients 12-17 years of age who screened for clinical depression using an age appropriate standardized tool during a well child visit Should this be anxiety?
Age criteria:	Eligible population is determined as 30 days through 3 years, 11 months, 364 days at the date of encounter. **Example 1:** Patient turns 4 on 4/12/2019 Date of encounter 4/15/2019 Patient is NOT IN denominator **Example 2:** Patient turns 4 on 6/12/2019 Date of encounter 4/12/2019 Patient is IN denominator	Eligible population is determined as 4 years, 0 days through 11 years, 11 months, 364 days at the date of encounter. **Example 1:** Patient turns 12 on 4/12/2019 Date of encounter 4/15/2019 Patient is NOT IN denominator **Example 2:** Patient turns 12 on 6/12/2019 Date of encounter 4/12/2019 Patient is IN denominator	Eligible population is determined as 12 years, 0 days through 17 years, 11 months, 364 days at the date of encounter. **Example 1:** Patient turns 18 on 4/12/2019 Date of encounter 4/15/2019 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 6/12/2019 Date of encounter 4/12/2019 Patient is IN denominator	Eligible population is determined as 12 years, 0 days through 17 years, 11 months, 364 days at the date of encounter. **Example 1:** Patient turns 18 on 4/12/2019 Date of encounter 4/15/2019 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 6/12/2019 Date of encounter 4/12/2019 Patient is IN denominator
Numerator Statement:	Patients 1 month – 3 years of age on the date of encounter, who meet the criteria for inclusion in the denominator and were screened for psychosocial functioning at least once during the measurement period using an age-appropriate standardized tool	Patients 4-11 years of age on the date of encounter, who meet the criteria for inclusion in the denominator and were screened for social emotional functioning using an age appropriate standardized tool	Patients 12-17 years of age on the date of encounter, who meet the criteria for inclusion in the denominator and were screened for depression using an age appropriate standardized tool	Patients 12-17 years of age on the date of encounter, who meet the criteria for inclusion in the denominator and were screened for anxiety using an age appropriate standardized tool
Denominator Statement:	Patients 1 month – 3 years of age on the date of encounter who had a completed WCC/PE (opportunity for a screen) during the measurement period. Must have a documented outpatient visit coded 99381 or 99931 (<1 yr.); 99382 or 99392 (1-4 years)	Patients 4-11 years of age on the date of encounter who had a completed WCC/PE (opportunity for a screen) during the measurement period. Must have a documented outpatient visit coded 99382 or 99392 (4 year old); 5-11 years 99383 or 99393 (5-11 years);	Patients 12-17 years of age on the date of encounter who had a completed WCC/PE (opportunity for a screen) during the measurement period. Must have a documented outpatient visit coded 99384 or 99394	Patients 12-17 years of age on the date of encounter who had a completed WCC/PE (opportunity for a screen) during the measurement period. Must have a documented outpatient visit coded 99384 or 99394
Acceptable screening tools:	Survey of wellbeing of Young Children (SWYC); Ages and Stages Questionnaire	35-item Pediatric Symptom Checklist (PSC) or the 17-item PSC-17.	Acceptable tools include the Patient Health Questionnaire, modified for Adolescents (PHQ-A), or PHQ-9	GAD-7
Identification of high-risk population:	Scores of EPDS >=12 (completed by caregiver through 6 month visit BPSC 30days- 17 months, any of 3 subscales with a score >=3 PPSC 18-65 months >=9 POSI >=3	Total score >= 15 Internalizing symptoms >= 5 Externalizing symptoms >= 7 Attention >= 7	Total score >=10	Total score >= 8
Reporting dates: Lookback Period	March 1st-August 31st 2023 Denominator: 6 months from end of the measurement period; Numerator: 6 months from end of measurement period	March 1st-August 31st 2023 Denominator: 6 months from end of the measurement period; Numerator: 6 months from end of measurement period	Denominator: 6 months from end of the measurement period; Numerator: 6 months from end of measurement period	Denominator: 6 months from end of the measurement period; Numerator: 6 months from end of measurement period
Reporting Dates: Project Period	**Track 1 sites:** Due by 12/31/23 for period of 9/1/23-11/30/23; Due by 3/31/24 for period of 12/1/23-2/29/24; Due by 6/30/24 for period of 3/1/24-5/31/24; Due by 8/30/24 for period of 6/1/24-8/16/24; **Additional dates for track 3 sites:** Due by 12/31/24 for period of 9/1/24- 11/30/24; Due by 3/31/25 for period of 12/1/24- 2/28/25; Due by 6/30/25 for period of 3/1/25-5/31/25; Due by 8/30/25 for period of 6/1/25-8/15/25			
Notes	* For sites newly implementing screening for children under age 12, they may either use the SWYC up to age 5 and the PSC for age 5-11 OR use the SWYC up to age 4 and use the PSC for age 4-11 # Screening reports are due 30 days after the close of the reporting period			

Appendix B. CHW Activity Form

CHW Data Collection Form				**Clinic Name:**		**CHW initials:**	
Date	Child age	Child Gender __M __F __Non-binary	Child Race/ethnicity	Contact conducted in language other than English?	Y N	If yes, language:	Is child on Medicaid? __Y __N __ Don't Know

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								
Scoring screening tool								

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?

____

Appendix C: Interview guides

Core Implementation Team (CIT) Interview Guide

Participant Type	Question
CIT	1. Tell me about your overall experience with this project thus far. 1. What is going well? What challenges have you experienced?
	PURPOSE
CIT	2. Describe the purpose of the project in your own words. a. Is the project being implemented as you expected?
	ROLE
	3. Please describe your role in the project. a. Describe how your role interfaces with the CHW(s).
	CHW Role
CIT	4. Describe the CHW's role in the project. b. How were roles/tasks defined? c. Are there tasks CHWs perform now that you performed previously? d. How has the addition of a CHW impacted your workload?
CIT	5. What tasks are the CHW asked to perform? 1. Who assigns those tasks to the CHW? 2. How are tasks communicated to the CHW?
	6. In some practices, CHWs spend most of their time helping families address SDOH concerns, such as food and transportation. At other sites, CHWs focus more on BH issues – like helping to coordinate school and offsite services and conducting screenings. Where does your site fall along that continuum?
	WORKFLOW

CIT	**7. How do you introduce the CHW to patients?** 1. **What changes were made to the clinical workflow to integrate the CHW(s)?** 2. **Has the workflow changed more than once since the CHW joined the team? If so, how/why?**
	STAFF BUY-IN
CIT	**8. What strategies were implemented at your site to ensure everyone in your department was aware of the project and bought into its idea?**
	TRAINING & SUPPORTS
CIT	**9. In your perspective, are there other needs the site has to better integrate the CHW into the IBH team?**
	SUSTAINABILITY
CIT	**10. Some practices are using this opportunity to pursue reimbursement for CHW services under Medicaid. Tell me what that has been like for your site in terms of thinking about the sustainability of this model.** a. **What else would be needed to ensure the sustainability and maintenance of this model?**
	PERCEPTION OF SUCCESS
CIT	**11. Do you feel the project has been executed according to your expectations?**
CIT	**12. How do you know the project has been a success?**
	DESIRED CHANGE
CIT	**13. What changes would you make to the project and why?**

Community Health Workers (CHW) Interview Guide

Participant Type	Question
CHW	1. Tell me about your overall experience with this project thus far. a. What is going well? b. What challenges have you experienced?
	CHW ROLE
CHW	2. Describe your role at your site. (outreach and engagement, service delivery, care coordination and referral, and data collection) a. How does your role differ from other staff members? b. In your perspective, is your role and the tasks you are expected to perform clearly defined? c. What is your role in screening and connecting patients to BH and SDoH services?
CHW	3. Has your role on the IBH team changed over time? If so, how?
CHW	4. What tasks are you asked to perform most frequently? a. Are there tasks you want to support, but aren't able to?
	5. In some practices, CHWs spend most of their time helping families address SDOH concerns - like food and transportation. At other sites, CHWs focus more on BH issues – like helping to coordinate school and offsite services and conducting screenings. Where does your role at your site fall along that continuum?
CHW	6. Tell me about a family or patient encounter in which they were referred for SDoH services. Walk me through the steps you took and the outcome.
CHW	7. Have patients ever shared information with you that they were uncomfortable sharing with the physician?
	SUPERVISION
	8. Who (what is their title) supervises your work? a. Can you explain how your work is supervised by (blank)? b. How supportive is your supervisor?

	TECHNOLOGY
CHW	**9. Describe your experience entering health data into EHRs at your site.**
	WORKFLOW
CHW	**10. Which member(s) of the CIT do you work with most often?** **a. Tell me about your relationship with the IBH clinician. How do you work together?**
	11. Describe the referral workflow between CHWs and nurses/physicians at your site.
CHW	**12. How do people on the CIT interact/communicate with you?** **a. If applicable, how do people on the CIT communicate with other CHWs on the team?**
CHW	**13. How does other staff introduce you to your patients?**
	TEAM RAPPORT
CHW	**14. In your perspective, does staff encourage your participation in patient care?**
CHW	**15. Do you feel part of the team at your site? Why or why not?** **a. Do you feel your recommendations are valued by the team? Why or why not?** **b. How supportive is the clinical team?** **c. Describe how your patient recommendations have been used by other providers you were working with.** **d. In what ways do you feel empowered in your role?** **e. In what ways has the organization welcomed your contributions?**
	PERSONAL REFLECTIONS
CHW	**16. What part of your lived experience do you feel patients and their families relate to most? (Common language, residence in similar community, similar culture)** **a. Can you share an example of how your support positively impacted a patient?**
CHW	**17. What have you accomplished so far in your role that you are most proud of?**
	BARRIERS
CHW	**18. What about your organization gets in the way of you doing your job?**
	TRAINING

CHW	19. Were the skills you learned from the CHW trainings helpful? Why or why not? a. In your perspective, do you need additional training that you did not receive?
	PERCEPTION OF SUCCESS
CHW	20. In your perspective, has the project been executed according to the implementation plan? Why or Why not? a. Do you think the project has been successful thus far? Why or Why not?
CHW	20. How do you know the project has been a success?
	DESIRED CHANGE
CHW	21. What changes would you make to the project and why?

Appendix D: PDSAs

	PDSA topic/focus area	PDSA status
BaldHill	Integrate a CHW into pediatric integrated behavioral health workflows identified through remote patient monitoring or warm handoffs from the IBH clinician for behavioral health navigation or connecting to community resources; goal = 50 patients	Last updated April 2024: To date, the CHW has engaged with 3 Bald Hill patients. To reach our goal of engaging 50 unique patients through this work, we needed to engage 9 patients per month. We are under target. Some factors that have affected the outcome have been our EPIC migration in February and other critical operational needs that were required to support Coastal following our migration which forced us to re-evaluate workflows and resources to support critical organizational needs.
Waterman	Coastal Medical will use CHWs to increase pediatric IBH capacity at the Waterman pediatric practice through increasing referrals to and engagement with CHW to 50 unique patients by July 31, 2024. Referrals to the CHW following IBH services may include connecting patients with community resources or supporting patients in engaging with an external behavioral health provider.	Last updated April 2024: To date, the CHW has engaged with 16 Waterman patients and has completed 7 screenings. To reach our goal of engaging 50 unique patients through this work, we needed to engage 9 patients per month. We are under target. Some factors that have affected the outcome have been our EPIC migration in February and other critical operational needs that were required to support Coastal following our migration which forced us to re-evaluate workflows and resources to support critical organizational needs.
CCAP	Original goal: To increase the number of children screened with the Ages and Stages Questionnaire ; Goals for March 30, which is the 3-month mark: Increase ASQ screening rates for all children who are scheduled for it: • Increase screening rate to 50% for 48 months • Increase screening rates to 90% for 9, 18, 30-month	**May update:** In regards to the first goal, we were able to increase the screening rate at 48 months from 0 to 100%. For the second goal, we were able to increase to 100% for the 9-, 18- and 30-month screenings. **Final data:** still waiting on final data - Jess on vacation at the end of August

	May update: As a next step, the team will add a goal of administering the ASQ at all 36-month WCVs	
FCC 1	Expand GAIN-SS screening to 12-15 years (now 16-17 years)	Paused while pediatric team considers overhaul of universal screening more broadly
FCC 2	Improve PCP handoff to CHW role	Initial stages complete, tracking data to see initial impact
FCC 3	Begin billing for IBH CHW services	Initial planning and development underway
Hasbro	The goal of our quality improvement project is to strengthen our IBH model by increasing number of clinical SW visits that are scheduled due to MH and SDoH supports being provided by CHWs.	COMPLETED August 2024: See data table below While the number of face-to-face visits with our LICSW fluctuated monthly, the overall number of scheduled and completed clinical appointments were higher than the year prior. We did not previously schedule bridge therapy appointments prior to having CHWs embedded in the clinic, and this model was not particularly appealing to the LICSW. When able to fill this position, we expect to see a significant increase in number of clinical visits to address mental health needs of PP patients.
Woodriver 1	Pilot PSC for school-age population	Complete
Woodriver 2	Establish caseload standards for CHW and track referrals	Initial stages complete, tracking referrals to monitor impact
Woodriver 3	Expansion of PSC-17 implementation for school-age population	Initial stages complete, tracking data to see initial impact

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