

H3

Healthy Minds, Healthy Children, Healthy Chicago

**Integrating Behavioral Health
into Urban, Pediatric Settings**



Illinois Children's
Healthcare Foundation

About the Illinois Children’s Healthcare Foundation

The vision of Illinois Children’s Healthcare Foundation (ILCHF) is that every child in Illinois grows up healthy. ILCHF cultivates, supports and promotes initiatives that improve the health and wellness of children in Illinois, primarily in the high-need areas of children’s oral and mental health.

ILCHF’s philosophy is that healthcare must address the whole child and that the healthcare system in Illinois must be responsive to the needs of all children. Working through grantee partners across Illinois, ILCHF focuses its grant-making on identifying and funding solutions to the barriers that prevent children from accessing the ongoing healthcare they need. Since its inception in 2002, ILCHF has invested more than \$80 million in organizations that work tirelessly throughout the state to improve the health of children in their communities.

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Executive summary

TODAY, MORE THAN 200,000 ILLINOIS CHILDREN cannot access needed mental health services.¹ There is a well-documented lack of adequate service providers and quality mental health services for children and their families.² While there is the very real potential to solve this problem, we are all faced with the challenge to create and implement care models that are family-centered, holistic, evidence-based, culturally sensitive, efficient, scalable, financially sustainable and legally compliant. In Illinois, and across the nation, this challenge is complicated by the lack of an appropriately trained workforce to provide necessary assessments, treatment and coordination of care. Even though all of these problems cannot be solved immediately, integrating mental healthcare into a child's medical home, or primary healthcare setting, appears to add efficiency and effectiveness to the overall service system.

Meeting children and families in their natural community—home, school and healthcare settings—is both a primary benefit and defining characteristic of integrated healthcare, a model that overcomes many challenges related to access to services. It is for this reason that ILCHF developed the Healthy Minds, Healthy Children, Healthy Chicago (H3) project.

H3 was a five-year grant program that integrated primary and mental healthcare in clinic settings. The project was funded by ILCHF. While many options were considered, it was determined that federally qualified health centers (FQHCs) had the infrastructure and mission necessary to adequately examine the possibility of integrated care. As a result, H3 worked with both community service agencies and FQHCs in Chicago to examine this proposition. Two lead grantees, Erie Family Health Centers (Erie), an FQHC, and Metropolitan Family Services (MFS), a community mental health provider, partnered, respectively, with Community Counseling Centers of Chicago (C4), a community mental health provider, and Mile Square Health Center (Mile Square), an FQHC. These partners were provided resources to design and implement their own primary health and mental health integrated care models now known as H3 West (Erie and C4) and H3 South (MFS and Mile Square).

Starting in 2013, ILCHF invested \$2.2 million in H3 South and H3 West. In addition, the UCLA Center for Health Services and Society was awarded a \$700,000 contract to evaluate the two programs. During the five-year project, more than 14,000 children and their families, as well as many healthcare providers, were impacted by H3 and the integrated care models.

ILCHF is profoundly grateful to all those who participated in H3. The participating organizations demonstrated remarkable perseverance, commitment and dedication to the children and families they serve.

H3 taught us many lessons and raised a number of questions that are addressed in this report.

Integrated primary and mental healthcare benefits children, families, communities and healthcare providers.

Asking about mental health-related concerns creates change. The H3 grantee partners found that the opportunity to talk about mental health, which resulted from mental health screening during routine care, began to normalize and destigmatize the topic of mental health.

The effectiveness and precision of standard mental health screening tools warrants additional study in settings similar to H3. Fewer children than anticipated were identified with problems on mental health screening instruments used in primary care practice. However, the use of these instruments led to discussions between parents, caregivers and trusted pediatricians that elicited verbal expressions of concerns. These discussions resulted in the enrollment of children into H3 and the subsequent provision of mental health services. This raises the question as to why those concerns were not fully captured by the standardized screening tools. Sites identified potential answers to this question, including concerns about labeling children with emotional problems, parental literacy and immigration status. How can we help parents feel more comfortable in identifying and discussing areas of need? How can we better understand the impact of these conversations and is there a way to standardize and normalize these conversations so that providers can consistently gather and respond to information that positively impacts children's mental health?

Integrating mental healthcare into primary care settings requires commitment to improved patient care, persistence and patience. The H3 model required two FQHCs to significantly change their pediatric practice models. It is difficult and time-consuming to fully integrate mental health services, even when provided by an experienced community mental health organization, in the primary care setting. Workflows, record keeping and billing complications abound. H3 provides two examples of organizations that overcame many challenges; their workflow models can serve as a starting point for those interested in adopting integrated care into their medical system.

Models for providing effective integrated mental and general healthcare can and do vary depending on the community. The H3 projects took different approaches to staffing their integrated care models:

H3 South was staffed by a master's level, licensed mental health professional, an unlicensed master's level mental health professional and a family resource developer (FRD). The FRD is a parent-peer who has navigated the child-serving systems on behalf of their own child and has direct personal experience with the systems.

H3 West was staffed by three master's level, licensed mental health professionals called behavioral health consultants (BHCs) and a bachelor's level integrated health associate (IHA).

The work of the FRD and the IHA yielded different results. There were benefits and challenges associated with each approach.

The realities of current integrated clinical practice are complex and include many barriers. These include access to services, sustaining services due to restrictive funding through the various public payers and regulatory impediments to clinical practice.

The significant challenges faced by the H3 grantees in terms of billing and financial sustainability provided the following lessons:

The long-term viability of improved practice models is dependent upon not only their effectiveness but also on their financial sustainability. Illinois has among the lowest Medicaid reimbursement rates in the country.³ This, along with the administrative challenges of obtaining service funding through Medicaid and FQHC funds, makes it extremely difficult to efficiently provide appropriate levels of services with appropriately qualified staff. H3 reinforces the lesson that in order to improve child health it is necessary to increase payment rates, expand the array of available services, allow flexibility in mental health staff credentials and reduce administrative burden to improve access to care.

The practice limitations, administrative burden and billing requirements imposed upon FQHCs and community mental health providers prohibit effective, efficient integration of mental health services into FQHC general health operations.

H3 mental health services included same-day access, brief interventions and case-management. H3 had the ability to provide care both in and out of the clinic setting due to the inclusion of a community mental health center partner. Illinois Medicaid and FQHC billing mechanisms made this difficult if not impossible to sustain after ILCHF grant funding concluded. Rule changes to allow FQHCs to bill for case management, bachelor's level providers and out-of-clinic services are necessary. While Illinois Medicaid allows for these services, the administrative burden in that system is such that the services cannot be provided as expeditiously as is necessary to meet the needs of families.

H3 represents ILCHF's first long-term investment in an integrated care model within Chicago. Prior to H3, ILCHF's system-level investment in children's mental health was through the Children's Mental Health Initiative. CMHI 1.0 was an eight-year, \$12.2 million investment enabling four communities outside Chicago to build and sustain their children's mental health systems of care. (*Learn more at <https://ilCHF.org/executive-summary-community-mental-health-initiative-project-findings/>*)

ILCHF continues to invest in Illinois' children's mental healthcare system. The Children's Mental Health Initiative 2.0 is a \$12.6 million, seven-year investment in a second round of systems-of-care development grants. In July 2018, ILCHF awarded planning grants for five additional Illinois communities to develop and implement models for a local children's mental health system of care. The lead grantees and communities served are:

- Centerstone, serving Perry, Franklin, Jackson and Williamson counties
- Community Foundation of Kankakee River Valley, serving Kankakee County
- Heritage Behavioral Health, serving Macon and DeWitt counties
- Kane County Health Department, serving Kane County
- Primo Center for Women and Children, serving homeless youth and families in Chicago

As we work with these new grantee partners, we will learn additional ways to strengthen the children's mental health system in Illinois.



Introduction

Commitment. Community. Collaboration. Change. These four Cs were the vision for ILCHF as it pursued the goal of developing models for integrated children’s mental health in the Healthy Minds, Healthy Children, Healthy Chicago initiative. H3 focused upon:

- Families committed to caring for their children
- Community-based primary and mental health providers committed to families and children
- Primary care and mental health providers collaborating to change the system to strengthen families; a process vital to the health and well-being of all children

H3 brought together two community mental health providers with two federally qualified health centers (FQHCs) for the purpose of integrating children’s mental health services into the general pediatric primary care practices at the two FQHCs. The goal was to develop systems of fully-integrated primary care and mental health services that provided a comprehensive approach to children’s health. This integrated service system was to begin with the implementation of a mental, social and emotional health screening followed by the pediatrician follow-up and then provision of needed services or supports for identified children and their families.

Context

U.S. Census Data estimates Illinois has 12.8 million citizens with 22%—over 2,860,000—under 18 years old.⁴

One of six children in Illinois—over 476,000—are in need of mental health services, according to Whitney and Peterson in their recent child mental health prevalence estimates.⁵ The Illinois Children’s Mental Health Partnership (ICMHP) FY2017 Annual Report to the Governor reports that only 45 percent of these children are receiving mental health services.⁶

The ICMHP Annual Report concurs with the U.S. Attorney General’s Report on Children Exposed to Violence indicating that a substantial number of children “can expect to have their lives touched by violence, crime, abuse, and psychological trauma [each] year.” Exposure to violence can result in emotional, social and behavioral problems, with about one-third of children exposed to trauma developing post-traumatic stress disorder, according to The Illinois Criminal Justice Information Authority.⁷ Both H3 South and H3 West were located in communities heavily affected by violence.

Integrated care and H3

Improving access to effective children’s mental health services across Illinois is important and a major objective for ILCHF. This is an essential element of ILCHF’s strategy to fulfill its vision that every child in Illinois grows up healthy. H3, an initiative focused on improving access to children’s mental health care through an integrated care model, represents the foundation’s second major investment in children’s mental health in Illinois.

The Children’s Mental Health Initiative (CMHI 1.0) was ILCHF’s first significant, multi-year investment in integrating children’s mental health care into general health care. CMHI 1.0 was an eight-year, \$12.2 million investment by ILCHF to build and sustain children’s mental health systems of care through four projects based in Adams County, Livingston County, Springfield and the four county area of Carroll, Lee, Ogle and Whiteside counties. (*Learn more at <https://ilchf.org/executive-summary-community-mental-health-initiative-project-findings/>*).

Since CMHI 1.0 did not fund programs in the City of Chicago, home to more than 500,000 children,⁸ the ILCHF Board chose Chicago as the site for H3, its second long-term investment in integrated care models. The goal for H3 was to fully integrate general and mental health services in the primary care environment at two FQHC-based community pediatric practices that were facing substantial social, economic and environmental challenges. In this model, an FQHC partnered with a community mental health provider, whose services were to be embedded in the FQHC's pediatric clinic.

In February 2013, ILCHF awarded six-month planning grants to Metropolitan Family Services (MFS) and Erie Family Health Centers (Erie) of \$150,000 and \$170,000, respectively. MFS's partnership with Mile Square Health Center (Mile Square) was known as H3 South. Erie's partnership with Community Counseling Centers of Chicago (C4) was known as H3 West.

During the course of the planning grants, ILCHF retained Bennett Leventhal, MD, of the University of California, San Francisco, to serve as a project consultant. The UCLA Center for Health Services and Society (CHSS) was retained to perform the project evaluation with CHSS Associate Director Bonnie Zima, MD, PhD, serving as the principal investigator.

In October 2013, H3 South and H3 West each received a \$2 million, five-year grant to implement their integrated healthcare models. CHSS was awarded a five-year, \$700,000 contract to conduct the project evaluation. The project implementation grants concluded December 31, 2018. The evaluation concluded several months thereafter.

Community and project snapshot

H3 South and H3 West had many commonalities and some rather distinct differences. Both projects were in clinics serving low-income populations and involved the pairing of an FQHC and community mental health provider. Both projects had a focus on improving the mental health care provided to the children and families they serve.

H3 South was located in the Mile Square clinic in the Englewood community on the South Side of Chicago. The community and population served by the health center is predominantly African American. At this site, one pediatrician within the family medicine clinic provided pediatric primary care for the H3 project. One licensed clinical professional counselor assisted with the mental health screening and provided brief interventions while a second master's level clinician provided longer-term mental health care. In addition, a family resource developer (FRD) helped families with referrals and other service linkages. Over the course of the project, 2,930 children were seen through the H3 South model.

H3 West was housed in the pediatric clinic at Erie, located in the West Town community on the Chicago's West Side. The health center serves a predominantly Hispanic population with many families traveling to the health center from neighborhoods outside of West Town. Each day, two or three of the nine pediatricians on duty were selected to participate in the H3 model. The model implemented at H3 West utilized three master's level and licensed behavioral health consultants (BHCs) to administer mental health screening and provide brief intervention. Long-term mental health care was provided on-site by co-located C4 clinicians. A bachelor's level, integrated health associate (IHA) assisted with case management, referrals and other service linkages for families. Over the course of the project, 11,549 children were seen through the H3 West model.



Lessons learned across the initiative

Over the past five years, H3 South and H3 West have worked collaboratively with their provider partners to pilot and significantly change their approach to children's mental healthcare. In that work, much has been accomplished and learned.

Benefits of integrated care

Integrated primary and mental healthcare benefits children, families, communities and providers. The ability to receive same-day mental healthcare in a familiar pediatrician's office increases the likelihood that children will receive needed treatment and that their parents or caregiver will receive the necessary support. Factors supporting this conclusion include the following:

Asking about mental health-related concerns decreases stigma and creates an opportunity to intervene. Implementation of mental health screening created an opportunity for families and providers to discuss children's social-emotional development and functioning. Both sites found that screening facilitated and destigmatized conversations about mental health with both children and parents. The cultures in the clinics changed significantly in this respect.

Both sites were surprised to find relatively low rates of positive mental health screens (29% at H3 South and 11% at H3 West) given the high levels of poverty, trauma and violence in their respective communities. Positive screens indicated concern regarding mental health problems. H3 South and H3 West expected positive screen rates to be in the range of 50 percent based on their knowledge of the populations they serve. However, at both sites, it was observed that the vast majority of youth who received behavioral health services and support through the H3 care models obtained this care because a parent, youth or medical provider expressed a verbal concern about a child's behavioral health. This was the case even though the child had screened negative on the standard screening instruments.

At H3 South, it oftentimes seemed that the screening process itself was an intervention. It served as a source of education for families and created an opportunity to inform families that behavioral health issues were of interest and concern to the primary care providers. With increased attention to screening, the H3 South staff became more sensitive to and comfortable addressing the behavioral health and social service needs of their patients.

H3 South data indicated that 29% of children receiving mental health services had screened positive while 71% entered H3 services due to a concern expressed by a parent, provider or the youth.

At H3 West, of children entering H3 services, 11% had a positive screen while 48% entered due to a parent concern, 30% due to a provider-expressed concern and 11% due to youth expressing a concern. H3 West practitioners suggested that families were reluctant to endorse concerns about their children on paper-screening instruments due to immigration complications and limitations in English literacy. However, families appeared to be far more comfortable talking with trusted medical providers about these sensitive topics.

H3 West providers found that asking screening questions of families created an environment in which families thought about the questions ahead of the actual time with the doctor. They would then discuss these questions with the pediatricians. This process normalizes the topic of mental health. Children and families also remember that they were asked the questions and later consider how they might benefit from services. Over time, practitioners and families became more accepting of discussing mental health and were more open to receiving services. And, because the discussion of mental health concerns took place at one visit, families expected that they would be asked these questions again at subsequent visits. Mental health conversations became part of routine care.

Adding mental health capacity increases medical productivity and efficiency.

According to both sites, prior to H3, when a child was identified with a behavioral health concern, it created a challenge for the pediatrician. Once a problem was identified, it required that they take extra time with the patient and family that was not available in their already busy schedules. Furthermore, the physicians often did not feel adequately trained to deal with many of the patients' mental health symptoms and behavioral problems. Due to these limitations, prior to H3, in the face of a mental health concern, the standard practice was to make a referral to external mental health providers. There was limited to no ability for the primary care team to know if their patients had been linked to services and whether the concerns were addressed.

Through H3, the primary care medical staff found that the integrated model provided the appropriately credentialed staff to address the mental health service needs of the patients and did so more effectively and efficiently than the primary health care staff alone. Mental health services and case management were provided by a mix of licensed and unlicensed mental health professionals with appropriate credentials and training to address the array of behavioral health needs encountered by the primary care staff. The combination of onsite mental health providers and a psychiatric consultant created a team that supported the pediatricians to better manage these problems. Increased pediatrician confidence in prescribing basic behavioral health medications decreased referrals to psychiatry. This was particularly true in the area of medications for attention deficit disorders and depression.

Based on the observations of the pediatricians at both sites, H3 services were extremely beneficial to their practices. Even though there were generally low levels of positive screens in the children, having a structured practice of asking questions about mental health created an expectation for all that mental health concerns were important, open for discussion and missed much less often.

Integrating mental healthcare into primary care settings requires commitment to improved patient care, persistence and patience. H3 made it possible for two FQHCs to examine and significantly change their pediatric practice models. Prior to implementing the H3 model, Mile Square and Erie made referrals to external mental health providers with little to no information regarding the outcome of these referrals.

Having a structured practice of asking questions about mental health created an expectation for all that mental health concerns were important, open for discussion and missed much less often.

spotlight

H3 WEST: Sara Naureckas, MD

Dr. Sara Naureckas has been a pediatrician at Erie Family Health Centers for 26 years. At this point in her career, she divides her time between caring for children and administrative leadership in the system. She currently cares for approximately 1,000 children each year. Her longevity in the system is reassuring for her patients and families. Of the 1,000 children she currently cares for, approximately 100 of them are children whose parents were also her patients when they were children.

According to Naureckas, the American Academy of Pediatrics began recommending that pediatricians screen children for mental health problems over 20 years ago. She said that prior to H3 coming to Erie, the Pediatric Symptom Checklist, a screening instrument, sat on her desk, unutilized, for 15 years. As a pediatrician, she did not want to screen for a problem that she did not have the resources to adequately respond to. Having integrated behavioral health staff through H3 on her team made her confident that they can screen for and respond to any problems they find.

As a pediatrician, Naureckas always seeks to find problems early on so bigger problems can be prevented down the road. She's excited by the way the screening process, and the resulting conversations with children and families, allows for earlier identification and response. "Normalizing having mental health conversations lets the families know we are interested in this part of their lives," she said. "They will tell us things they wouldn't have thought to mention before H3."

As a lead medical provider at Erie, Naureckas plays an important role in helping the other pediatricians adapt to having mental health staff as part of the team. She notes that all the providers were pleased to have a way to respond to their patient's full array of problems. The other providers were quick to come on board. She noted that the one area where there were some concerns from medical staff had to do with the extra time the screening and behavioral health consultants' (BHC) response would add to the medical schedule.

According to Naureckas, Erie developed an effective process through attention to the workflow. Currently, if a patient presents with a problem that is clearly mental health related, she converts it to a behavioral health visit and brings in the BHC to intervene. Then she feels comfortable moving on to the next patient on her schedule. Naureckas stressed that from her perspective a key benefit of H3 for medical providers is their increased confidence that they can take care of the whole child.

It is difficult and time-consuming to fully integrate mental health services, even when provided by an experienced community mental health organization in the primary care setting. Workflows, record keeping and billing complications required repeated study and problem solving. A single solution rarely solved these problems.

The pediatric well-child visits involve many aspects of children's health that are addressed in a brief 15-minute period of time. Among these are immunizations, developmental assessment, vital signs and management of chronic conditions. The decision to implement mental health screening added another required task for primary care staff, thus impacting all other aspects of the pediatric visit, especially use of limited, valuable, face-to-face time. Adding mental health staff to the clinic workflow also complicates the existing processes of moving patients through a clinic traditionally focused only on primary general healthcare. Success in achieving screening and mental health follow-up at both sites depended on engineering detailed workflow processes so that all clinic staff made the process as thorough and efficient as possible. These processes were revised many times based on the clinic staff determining what worked and what was creating barriers. The H3 South and H3 West screening workflows illustrate the level of detail that was considered, as well as the creative solutions developed. *(Please see Appendix A).*

Models of providing integrated mental health and primary care can vary. The H3 sites took different approaches to staffing their integrated care models. The mental health component of H3 West was staffed by three clinically licensed master's level BHCs and an IHA who provided case management. In addition to the BHCs, who provided brief interventions of up to eight sessions, there were clinically licensed master's level mental health staff on site at H3 West from C4 to provide longer-term therapy.

H3 South used master's level mental health professionals, one of whom provided brief interventions and the other who provided longer-term therapy. One of these professionals held an independent clinical license and the other did not. H3 South also included an FRD who was a parent with previous experience navigating the child-serving systems on behalf of their own child in their local community. Thus, the FRDs have an intimate knowledge of the needs in the community, the quality of resources in their community and the ability to link families to effective and needed services. The work of and approaches taken by the FRDs and the IHAs yielded different results.

- **H3 South:** 78.7% of the families in the study were identified as needing social service referrals. Families at MFS received an average of four referrals.
- **H3 West:** 12.9% of families in the study were identified as needing social service referrals.

The populations at H3 West and H3 South differed in many respects. However, both lived in communities with high levels of poverty and violence.

The differing perspectives between team members at H3 South and H3 West is interesting. At H3 South, the FRD is more likely to have been the recipient of community services and more sensitive to the families' basic and service needs. Therefore, when the FRD conducts a family-needs screening as a routine part of the overall screening process, families appear more open to telling a peer about their needs. In contrast, at H3 West, the IHA may only have become aware of the need if it is identified by a mental health or primary care provider.

H3 illustrates how integrating mental and primary health services enhances the ability to connect children and families to care and resources at the time the need is identified.

A deeper understanding of whether one approach or the other is more appropriate, effective and acceptable to parents warrants further investigation.

At H3 West, the brief intervention model was based on a combination of psychoeducation and cognitive behavioral therapy models. H3 South used a similar theoretical model, also offering referral and case management services provided by the FRD. At both sites, early in the assessment process, a subset of children were identified with a need for long-term mental health services. These children were promptly referred to the external mental health providers. H3 South also offered long-term mental health services on location. The H3 West model provided referrals to C4 for longer-term mental health services at both their Erie site and their C4 clinic location.

While the models merit more study, H3 illustrates how integrating mental and primary healthcare services enhances the ability to connect children and families to care and resources at the time the need is identified. This availability prevents families from falling through the cracks between the referring primary care system providers and the receiving mental healthcare system providers. It also provides a mechanism for intervening earlier.

Brief interventions were typically enough. At H3 South, 49% of youth were served with a brief intervention and did not require referral for longer episodes of care. Overall, H3 South children received a brief intervention for a mean of 2.5 sessions. Long-term care, lasting five or more sessions, was provided for 18% of the H3 South youth.

H3 West found that 80% of youth who were promptly provided brief intervention services did not need referral for longer episodes of care. At H3 West, the mean length of brief intervention services was 1.7 sessions with only 1.2% of youth receiving eight or more sessions of mental healthcare.

At both sites, most children identified with behavioral health concerns during the clinical interview did not need longer-term mental healthcare. Instead, they required brief intervention focused on a specific problem.

The UCLA CHSS evaluation provided important information. CHSS Associate Director Bonnie Zima, MD, PhD, served as the principal investigator for the H3 evaluation. The objectives of the evaluation were to:

- Describe the H3 care processes received by children and families
- Examine the relationship between receiving H3 care and clinical outcomes
- Explore how clinical outcomes vary between the H3 South and H3 West care models

The evaluation sample included 277 of the 14,479 (2%) of children served in H3. By site, 2.6% of the children served at H3 South and 1.7% of the children served at H3 West were enrolled in the evaluation sub-sample. The initial plan was to enroll 200 children from each site for a total sample of 400. Ultimately, H3 South enrolled 75 and H3 West enrolled 202. The sub-sample of 277 was smaller than originally planned due to enrollment difficulties.

spotlight

H3 SOUTH: Coretta J. "CJ" Pruitt, Family Resource Developer

CJ Pruitt, who served as a family resource developer (FRD) for H3 South at the Mile Square Health Center in Englewood, grew up in a large family in the area. As a child, her mother demonstrated the value of caring for fellow community children and families. This is something Pruitt herself has carried forward in her life and work. She continues to live in the area and is well known there for her support of local families.

Pruitt has six children and has navigated the mental health, developmental disability, medical, early intervention and public education systems as she has advocated for them. This experience gave her special insight into how these systems work—or don't work—for families. This experience, and thus expertise, is at the core of being an FRD. When Pruitt started working as an FRD it was a natural fit for her. "I thought, 'Wow, this is what I was born to do!'" she said. "I was working at the same clinic I used to go to as a child."

As an FRD, Pruitt assisted in developing a basic-needs survey that each family completed. Rather than merely handing the assessment to families, Pruitt sits with them and talks through each area of need. She then provides families with resources to meet these needs, which may range from housing to food, employment, after-school programs and legal advocacy, as well as GED programs for parents. Perhaps most importantly, she follows up with both the families and medical staff at H3 South to make sure families actually receive the support they need. "We just have to make sure we follow up," she said. "We might not get them until the second, third, fourth time. That's the secret sauce of what's made the [FRD] role so successful. You have to be intent on following up with every family and never giving up on them, no matter how many times it takes."

When asked to elaborate on this "secret sauce," she said, "You have to be a parent; let them know that you have had the same troubles. It makes you speak the same language and they can hear you better. I think that [parent] language is universal."

The expertise and work of FRDs are unique in integrated healthcare and an important component in addressing the comprehensive health of children. Pruitt said, "I am truly honored and appreciative of the opportunity afforded me and my being able to make a difference in the lives of others."

According to the sites, enrollment difficulties included:

- Parents with multiple children in the clinics impatient and wanting to leave
- Survey instrument time burden
- Long waits in the pediatric clinic
- Parent anxiety about how screening might affect immigration status
- Changes in inclusion and exclusion criteria for the study

There were statistically significant differences between each site's patient and family populations on nearly 50% of the 109 variables addressed. There were also differences between sites in the care models, whether children entered the study following a well-child or an illness-related visit, and whether or not children entered the H3 care processes and evaluation based on a positive finding on a screener or through verbally expressed concerns. In addition, there were differences between the service packages described by the evaluators for the subsample and the services described by the sites for the populations at large. These differences made it complex to combine data across sites for analytic purposes and to have full confidence in the generalizability of the findings.

In spite of these complications, the external evaluation produced some important findings related to functional impairment and outcomes as well as utilization of services:

- One-third (33.5%) of children entering the study had significant functional impairment as measured by the Columbia Impairment Scale at baseline. This meant that the vast majority of children in the evaluation sample did not have measurable impairment using this instrument.
- Levels of probable parental depression and parenting stress were relatively low given the high community levels of poverty and violence. Using the Patient Health Questionnaire 9 to assess parents for probable depression, only 14.1% of parents overall scored in the clinical range: 20.0% at H3 South and 11.9% at H3 West. Using the Parenting Stress Index, only 6.2% of parents reported significant stress: 6.0% at H3 South and 6.3% at H3 West.
- Nearly all children and families in the study received some type of H3 care intervention because agreeing to receive H3 care was a requirement for entering the study. These interventions included psychoeducation, social service referrals, brief therapy and other interventions. Most members of the subsample only received one episode of service. Of the children who received a brief therapy intervention, 60% had only one session. Most families only received an intervention on the day of study enrollment.

H3 care services received	Total (n = 277)	H3 West (n = 202)	H3 South (n = 75)
Any parenting support or psychoeducation	95%	99%	84%
Any onsite therapy (short-term or specialty mental healthcare)	81%	99%	32%
Parent training	4%	3%	7%
Any mental healthcare	83%	99%	40%
Special education advocacy and support	21%	15%	36%
Referrals			
Referral for social services: economic support	16%	2%	53%
Referral for social services: early education	18%	8%	45%
Referral for developmental delay services	8%	4%	21%
Referral for medication evaluation	7%	6%	8%

Overall, families received lower than expected levels of services. The sites hypothesized that this was likely due to logistical difficulties such as transportation challenges for return appointments and high levels of missed and cancelled sessions. If high needs were identified from the onset, children were referred to specialty mental health providers, who could better meet their needs. Lower levels of functional impairment in the study sub-sample may indicate that available services were sufficient to meet the needs of the child and family and additional care was unnecessary.

Administrative requirements as barriers to access

Current billing regulations and practice requirements are barriers to access and service sustainability of integrated care at FQHCs in Illinois. The significant challenges faced by the H3 grantees in terms of billing and financial sustainability have provided the following lessons:

The current regulatory and administrative structures prevented financial sustainability. Financial sustainability of the integrated care models was a key goal for H3. At the beginning of the initiative, the Illinois Medicaid payment environment looked promising in terms of supporting integrated health programs. This did not prove to be the case during the five-year life of the H3 project. Illinois Division of Mental Health Rule 132 and Medicaid Rule 140 proved too cumbersome to support the service model identified as successfully supporting children and families. FQHC funding likewise did not allow for the flexibility in provider credential, service activity and location of care to meet the needs identified.

At the beginning of the project, the community mental health partners at both sites, C4 and MFS, became contractual partners of their respective FQHC. Thus, there were two separate public systems available to support different aspects of the integrated care models. However, the combined allowable billing did not fully support the behavioral health positions in the systems.

By the end of the ILCHF grant funding, both projects were able to sustain some parts of the care models, though not in the ways initially anticipated. At H3 West, the three original BHC positions dedicated solely to the pediatric population were eliminated. Instead, four BHC positions now cover both the pediatric and the adult clinic populations. The IHA position at H3 West and the FRD position and the unlicensed therapist position at H3 South were eliminated due to the lack of funding. The loss of the FRD position at H3 South was of particular concern as the FRD was central in identifying basic unmet family needs while also facilitating linkages between families and community resources.

There have been sustainable changes at both sites as a result of H3. In Englewood, Mile Square will continue mental health screening and has hired a part-time mental health clinician to provide behavioral health services for adults and children. Of note; the sites report that there is currently an eight-month wait time to see this clinician at Mile Square, while at Erie there is no wait time to get in to see the BHC staff for clinical services. Mile Square also changed their entire electronic health record system to integrate the behavioral health components into their EHR.

H3 West will implement universal Pediatric Symptom Checklist-17 (PSC-17) screening and grow from providing services to the patients of the original two to three pediatricians per day to cover all 13 pediatric providers plus 10 pediatric residents. H3 West is planning to expand the H3 model into additional pediatric clinic locations.

The benefit of integrated care presents an opportunity to improve the current systems to allow for sustainable implementation of the model. Illinois has among the lowest Medicaid reimbursement rates in the country. This puts providers at an immediate disadvantage in terms of building sustainable integrated practice models. H3 reinforces the lesson that Medicaid rates must increase and administrative burden must decrease in order to provide appropriate access to children's mental health services and improve children's health overall.

In summary, H3 demonstrated:

- Relatively low levels of impairment were found amongst children screened and examined
- Relatively high levels of need for social service support were found
- Families confide in the trusted medical teams when questions are asked about mental health and social service needs
- Brief and immediate interventions were essential and were the primary service provided

H3 results point to a need to enhance the ability of the healthcare system to identify social, emotional and basic needs in children and families and to then intervene as early and promptly as possible. The five-year H3 grant, provided by ILCHF, provided flexible funding that allowed the communities to devise the best service systems they could to meet the needs of their communities. Each arrived at the same conclusion through different mechanisms.

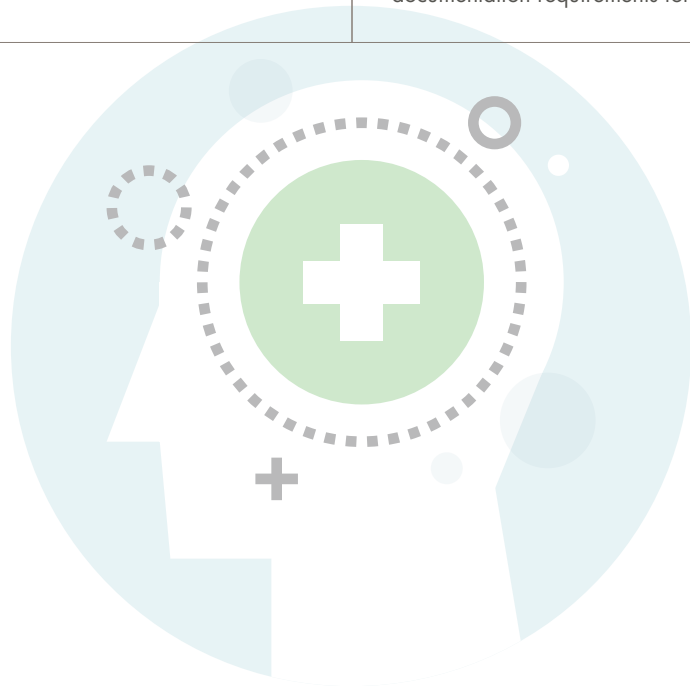
Behavioral health services in H3 are financially supported through two primary public system billing schemes. The first is through the FQHC model. The FQHC model allows for efficient connections between the family and the behavioral health clinician in the primary care clinic at the time the service need is identified. However, the FQHC funding model does not support case management services and requires a licensed mental health provider. In many parts of Illinois, it is difficult to find licensed mental health providers with child expertise. Moreover, the FQHC is only funded to provide clinic-based services.

The second, public billing mechanism is the use of Illinois Medicaid funding. This is available through the community mental health center provider. The CMHC model allows support for a flexible array of services and provider credentials. Services may include case management and other skill-building interventions provided in natural settings such as schools or in family homes. The array of providers who may be reimbursed for services ranges from the licensed master's level mental health clinician to rehabilitation service associates, who are over the age of 21 with on-the-job training. The Illinois Medicaid system is complex with burdensome documentation and assessments required in order to receive reimbursement. Burdens include long delays in payment to the agencies and limits on the number of services provided in a single day — to mention but a few. As a result, Medicaid is a practical resource only for the children and families with high levels of mental health need.

H3 results point to a need to enhance the ability of the healthcare system to identify social, emotional and basic needs in children and families and to then intervene as early and promptly as possible.

Strengths and weaknesses of funding through federally qualified health centers and community mental health centers

FQHCs	CMHCs
Pros <ul style="list-style-type: none"> ● Funding for immediate connection to mental health providers ● Does not require high levels of functional impairment (early identification encouraged) 	Pros <ul style="list-style-type: none"> ● Funds a broad array of services, including case management ● Funds flexible provider credential levels, including bachelor's level and persons with lived experience ● Services may be provided in non-clinic community settings, including homes and schools
Cons <ul style="list-style-type: none"> ● Does not support case management ● Only supports master's level prepared and licensed mental health providers ● Only provides services in the clinic setting 	Cons <ul style="list-style-type: none"> ● Requires high levels of functional impairment for funding (no early identification encouraged) ● Burdensome administration and documentation requirements for funding



These public policy barriers make it difficult if not impossible for willing agencies to provide the full array of services as early as possible for children and families in need. If integration of behavioral health service in primary care settings is to be fully realized, there must be new administrative mechanisms that allow for the efficient and flexible provision of needed services at the time and place the need is identified.



Project specific accomplishments and lessons learned

Each of the projects experienced their own successes and challenges. We now delineate goals established by H3 South and H3 West and the progress made toward achieving those goals, as well as specific challenges encountered.

H3 South

MFS partnered with Mile Square to implement the H3 South project in Englewood, a community on the South Side of Chicago with high rates of poverty, unemployment, infant mortality, food insecurity, violence and other social vulnerabilities.

H3 South set the following goals when implementing their H3 model:

- Establish a strong coalition of local stakeholders to serve as program advisors
- Employ highly trained integrated service providers
- Provide a continuum of care beyond primary and behavioral health to meet a family's comprehensive needs
- Improve child and family general and behavioral health through integrated care
- Create a sustainable program model
- Increase access to trauma-informed care
- Decrease stigma related to mental health services
- Address social determinants of children's health

With the exception of financial sustainability, H3 South was successful in temporarily meeting all of the above goals while receiving support from the ILCHF grant. This was evident through reports by all levels of system stakeholders. Ultimately, the currently available public funding mechanisms — Medicaid and FQHC funding — were inadequate to sustain the model.

H3 South served 2,930 unduplicated children with their H3 model over the course of the five-year project. Ninety-three percent of the children were African American, 1% were Hispanic, 1% were white and 5% were other. The population of children seen by H3 South was young; the average age of the children served was 4.3 years with 70% of the children below age three. Per child, there was an average of two to three in-person contacts with an H3 care team member over the last four years of the project. Each child and family received an average of four community referrals. The most common areas of need addressed by the FRD were housing, food assistance and education advocacy.

H3 South used the Pediatric Symptom Checklist (PSC) to screen all children over age three for mental health and social-emotional difficulties. At the first screening, 29% of children in this age group screened positive for problems. H3 South used the Ages and Stages Questionnaire for children below age three and 2% of these children screened positive for problems.

H3 West

Erie partnered with C4 to implement H3 West within the Erie Family Health Center located in the West Town community on the West Side of the city. The health center serves a predominantly Hispanic population, which is challenged by the same social factors impacting H3 South, including poverty and other social vulnerabilities complicated by issues associated with immigration status.

H3 West had the following goals in implementing their H3 model:

- Achieve a fully integrated system that expands access to both behavioral and primary healthcare through a no-wrong-door approach
- Implement seamless cooperation between primary and mental healthcare so the consumer sees no difference between providers
- Promote shared training between providers that increases staff comfort with integrated care and ensures use of best practices
- Establish an integrated model that can be sustained and replicated financially, functionally and situationally
- Move integrated care into the community culture by continuously seeking input and participation from community members

H3 West was successful in achieving these goals during the period of full grant funding. It was ultimately successful in achieving and sustaining parts of its care model, though not in the way originally expected.

H3 West developed a care model that involved BHCs who were originally hired through C4. The BHC staff assisted with the mental health screening and provided brief mental health interventions for up to eight sessions. If it was clear that a child's need would exceed eight sessions, the family was linked with a C4 longer-term mental health professional. H3 West hired an IHA who provided case-management functions in linking families to services. The Erie and C4 partnership initially involved utilizing senior-level mental health experts—including a psychiatrist—to provide consultation to the H3 West medical and BHC staff.

C4 experienced financial problems early in the project, which led to its temporary closure. When this happened, Erie hired the C4 BHC staff directly into its organization. This changed the culture related to mental health at H3 West significantly; BHC staff were wholly integrated into the FQHC. Unfortunately, this situation also limited the options for service array and changed sustainability as the BHC staff services could no longer be billed to Medicaid through the CMHC. H3 West has eliminated the three BHC positions that were solely dedicated to the pediatric population during the time of grant funding and changed the model so that there are four BHCs who support both the pediatric and adult clinic populations. This has been accomplished using FQHC funds and Medicaid billing, supplemented with general fundraising by organization. H3 West did not sustain the IHA case management role.

Of the 11,549 children served, 37% were below age five, 48% were ages 5 to 13, and 15% were ages 14 to 18. Forty-seven percent of the affiliated parents or caregivers spoke Spanish as their primary language. Eighty-five percent of the patients identified as Hispanic or Latino. Eighty-four percent of the patients had either Medicaid or no insurance coverage. H3 West serves a large population of families for whom immigration documentation is a concern.

H3 West screened 11,549 children over the age five, utilizing the PSC as well as the Ages & Stages Questionnaires: Social-Emotional (ASQ-SE) for children below age five. Approximately 10% of children screened positive on the PSC for mental health problems. The rate of positive screens with the ASQ-SE was so low that H3 West stopped utilizing it for children below the age of three at the close of the project in December 2018.



Conclusion

Much has been learned over the past five years about integrating mental health services into pediatric settings in FQHCs. Both sites put considerable thought into planning the implementation of service provision and the context within which those services were provided. Based on their experiences, the sites offer the following ideas on ways to improve the model:

Potential improvements in mental health service integration models

Add family-based interventions. Through H3, the sites identified frequent service needs for multiple generations of the family and noted that family problems impact the child. Parent mental health concerns, including depression, impacted both their parenting behaviors and their ability to follow through with recommended services for children. Responding to the holistic needs of the family is seen as critical to the wellbeing of children. H3 sites did not consistently have the resources to provide these interventions to multiple family generations.

Medicaid policy. During the period of this project, Illinois adopted a new managed Medicaid program in which many families participating in H3 were required to enroll. The myriad enrollment requirements were confusing. As a result, many H3 participants either lost Medicaid coverage or were required to change providers. Mile Square was not a provider for some of the managed care networks, which meant that some families were confused when they couldn't be served in H3 and numbers of patients in the pediatric clinic dropped significantly. Illinois is now addressing some of these barriers to care that families are facing related to Medicaid enrollment.

Difficulty obtaining data. Erie and Mile Square are each part of separate larger provider systems. It took both sites considerable time before they were able to get service data out of their electronic record systems. The ability to do so earlier may have aided in quality improvement efforts.

Sustainability. Both sites recognized that the level of clinical need was generally low and could be best addressed with a brief and immediate intervention. Ultimately, the services were primarily funded with FQHC funds, which came with fewer administrative barriers. However, FQHC funds cannot be used to support home-based services, flexible provider credentials or case management, all of which are important to better meet family needs. Either adding these services to the FQHC reimbursement structure or reducing the administrative Medicaid billing burden would allow this to be achieved.

Project development process. The H3 project provided a significant learning environment at both sites. Both sites designed their own models at the start of the project.

A pre-existing process model for integrating care, which could be followed and then adapted, would have been helpful at the start of the project. Fortunately, in the ensuing years these models have been developed and are available through the Substance Abuse Mental Health Services Authority. Additionally, Michelle Duprey, LMSW, has authored a primer on integrated care, which is available here: <https://www.integration.samhsa.gov/integrated-care-models/Pediatric-Integrated-Health-Care-Implementation-Model.pdf>.

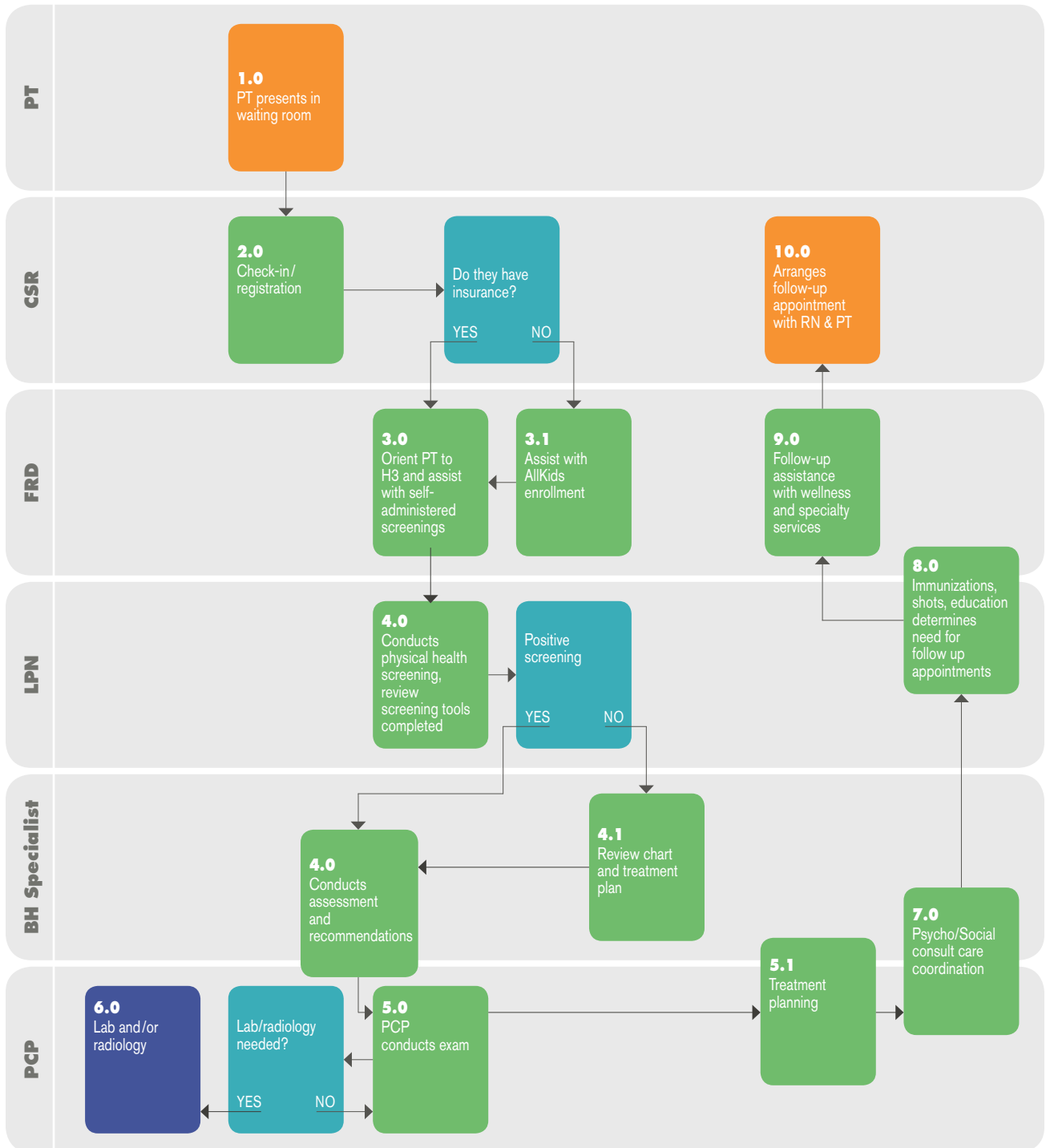
Political influences on the clinical environment influences. During the course of the H3 projects, U.S. immigration policies impacted immigrant parents' comfort in acknowledging problems and getting services for their children. Removing these concerns would result in earlier identification and intervention for children and families in need.

The teams at Erie and Mile Square continue to work every day to improve the health of the children and families they serve. Working to fully integrate mental health services into their pediatric practices where no such services were previously available is complex and difficult work. However, through grant funding that created the time and opportunity to do this work, these systems have been changed and, in some ways, sustained.

We encourage those practitioners who have not yet moved to an integrated model or who are in the midst of a transition to this model to contact ILCHF or our grantee partners to learn more about this journey. We also encourage those who administer, create or amend rules associated with the funding of these structures to talk to us or our grantee partners to better understand the barriers to providing these vital services in order to engage in improved rulemaking. Together we can continue to improve the health of Illinois' children.

Appendix A

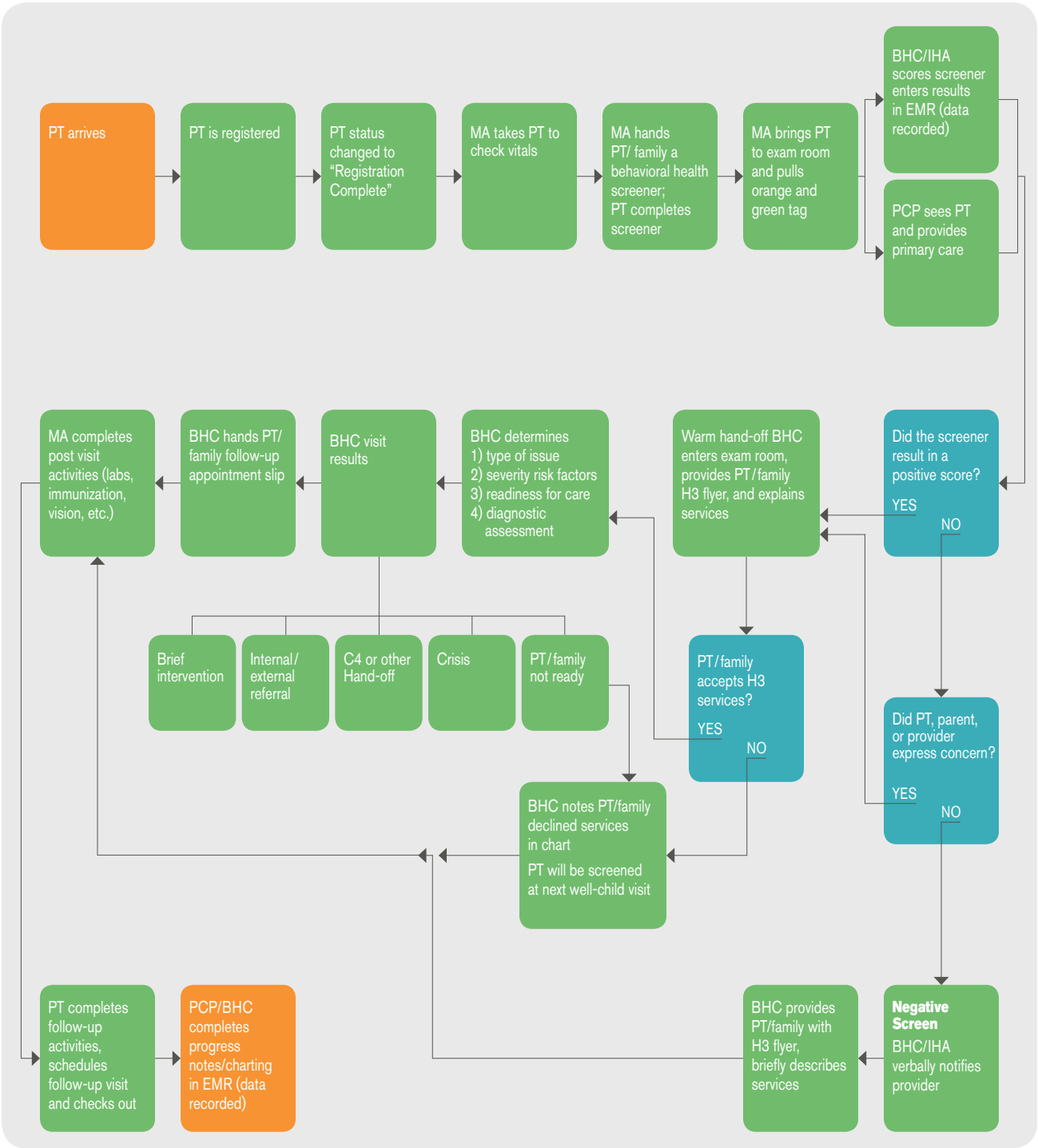
H3 SOUTH WORKFLOW



BH BEHAVIORAL HEALTH
CSR COMMUNITY SUPPORT RESOURCE
FRD FAMILY RESOURCE DEVELOPER
LPN LICENSED PRACTICAL NURSE
PCP PRIMARY CARE PHYSICIAN
PT PATIENT

■ START/END POINT IN WORKFLOW PROCESS
 ■ WORKFLOW PROCESS STEPS
 ■ DECISION
 ■ SEPARATE PROCESS

H3 WEST WORKFLOW



- BHC** BEHAVIORAL HEALTH CONSULTANT

EMR ELECTRONIC MEDICAL RECORD

IHA INTEGRATED HEALTH ASSOCIATE

MA MEDICAL ASSISTANT

PCP PRIMARY CARE PHYSICIAN

PT PATIENT
- START/END POINT IN WORKFLOW PROCESS

WORKFLOW PROCESS STEPS

DECISION

SEPARATE PROCESS

Appendix B

Acknowledgements

The foundation is grateful to and celebrates the grantees and stakeholders of H3 for the work they do every day to improve children’s mental health in Illinois. The extent of the system improvement and overall learning from H3 is a result of their hard work and candor in sharing insights into what went well, as well as what was challenging. We would like to specifically acknowledge the leadership of the following individuals at each H3 organization:

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Metropolitan Family Services	Mile Square Health Center
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Endnotes

- 1** Illinois Children’s Mental Health Partnership FY2017 Annual Report to the Governor (<http://icmhp.org/wordpress/wp-content/uploads/2018/02/ICMHP-Annual-Report-FY2017-.pdf>)
- 2** Illinois Children’s Mental Health Partnership FY2017 Annual Report to the Governor
- 3** ‘Already in crisis:’ Report says Medicaid funding shortfalls causing nursing homes to close (<https://www.nwherald.com/2019/04/18/already-in-crisis-report-says-medicaid-funding-shortfalls-causing-nursing-homes-to-close/a8ukvph/>)
- 4** U.S. Census Bureau QuickFacts: Illinois (<https://www.census.gov/quickfacts/IL>)
- 5** Whitney, D. & Peterson, M. ‘US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care in Children’. *Journal of the American Medical Association Pediatrics*. 2019;173(4):389-391
- 6** Illinois Children’s Mental Health Partnership FY2017 Annual Report to the Governor
- 7** Illinois Criminal Justice Information Authority (<http://www.icjia.state.il.us/articles/child-and-youth-exposure-to-violence-in-illinois>)
- 8** Illinois Children’s Mental Health Partnership FY2017 Annual Report to the Governor



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