Monday, April 7, 2025, 12 p.m. – 1 p.m.

Engagement and Equity

BHI-CYCLE Commons

California Quality Collaborative

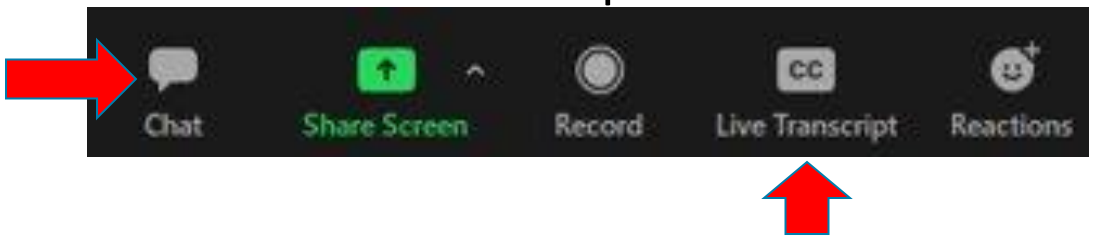
SFHN Feedback

- For those using EPIC, you could use drop downs for what is the reason you're referring to therapy. And then expand the referral drop downs to whether the patient meets any of the listed criteria.
  - It is access criteria. Screen out those that should be referred to county services.
  - Sometimes providers delete the referral criteria but try to push back.
  - LifeLong Medical Care's EPIC access criteria shared via email. Reach out to Anna for resource.
- Understanding the full workflow and what the medical providers maybe seeing on there end. Alliance team mentioned patients with positive screening had two choices – medication or BH referral. If refused medication, they received an automatic referral. Understanding that process allowed them to provide PCP education and refreshers on their role and better engage patients.
- Making sure your workflows really make sense and align with what providers are seeing in EHR.

- Finding a provider champion to bridge the gap between BH providers and PCPs. Emphasizing you are all caring for the same patients.
- Creating physician buy-in is essential. Finding site-based champions or metrics to show how well their site is doing. Using data to provide a bit of healthy competition coupled with how to improve metrics.
- Making sure your workflows really make sense and align with what providers are seeing in EHR.
- Replacing the word referral with a more approachable term that emphasizes we are all caring for the same patient. Focusing on the warm hand off and introducing another member of your team instead of an outside member.
- For residency programs, try finding champions and focus on the education piece. How is what you are doing different? How is mental health/behavioral health education different then what they are getting in other areas? Showing them how this (BH) will help them.

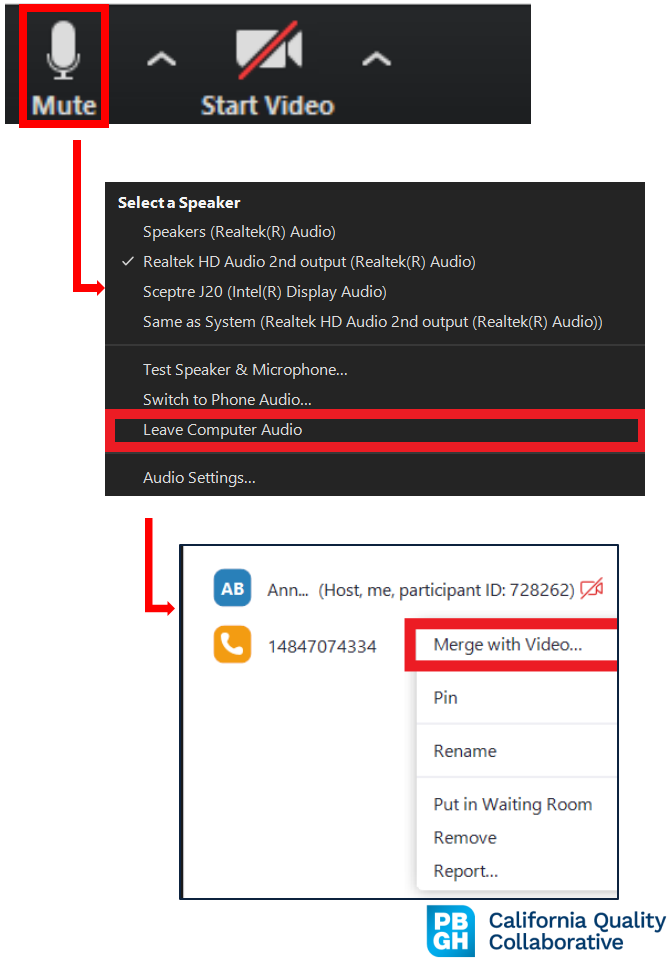
Zoom Tips

- Attendees are automatically **MUTED** upon entry
- Use the **chat box** for questions



- Request closed captioning with 'Live Transcript' button
- Welcome to update name, pronouns and organization in your Zoom name
  - Right click on yourself → Rename
- **Direct message Anna Baer** if you have any technical issues

- **If you've dialed in, please link your phone to your video/computer**



California Quality Collaborative

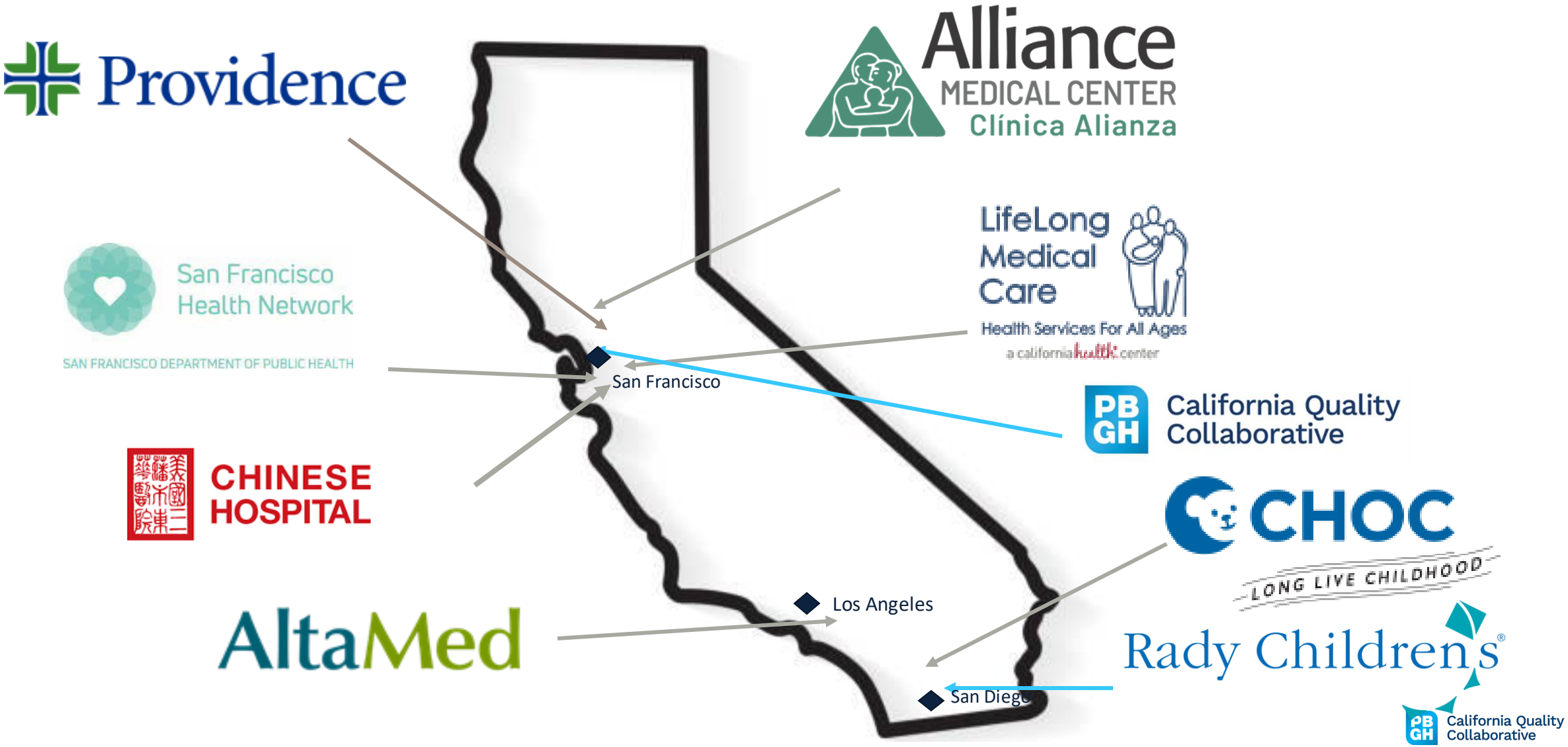
Warming Up

It has been a month since our site visit. How is everyone doing?

Come off mute or let us know in the chat!

California Quality Collaborative

Hello and Welcome!



Today's Agenda

Today, we'll:

SAN FRANCISCO HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Reflect and share advice on peer case study: San Francisco Health Network

10 - 15 min presentation +

10 min feedback

Rady Children's®

Review equity and engagement practices at Rady Children's Hospital

20 min presentation +

7 min Q&A

Share about equity and engagement at your organization

California Quality Collaborative

Engagement

San Francisco Health Network

All Teach, All Learn

Reminders

- Pose questions
- Offer suggestions
- Recommend solutions

Team Introduction: Children's Health Center

part of the
SAN FRANCISCO HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Organization Background

Name: *San Francisco Health Network, part of the SF Department of Public Health*

Org Type: **FQHC, safety-net**

Children's Health Center, ZSFG

The Children's Health Center (CHC) *@ Zuckerberg San Francisco General Hospital (ZSFG) sees roughly 40,000 visits per year through its primary, urgent, and specialty care operations, accounting for 65% of the SFHN's pediatric visits, currently serving 7000+ empaneled patients, ages birth to 24.*

EHR: **EPIC**

BHI Current State

Birth to 5 yrs: HealthySteps (through **UCSF** affiliation)

6-24 yrs: PCBH model (but insufficient, due to largely adult-focused design—A-BHVS for 12+ yrs)

BH Providers

2 Behavioral Health Clinicians (1 currently vacant, +1 BH supervisor)

1 Behavioral Assistant

6-8 HealthySteps Specialists

Current Strengths

- Enhanced chart scrubbing to promote WHO scheduling
- Partnership with PCPs to clarify PCBH services and ways to introduce BH providers in clinic.

Rachel Clee, LMFT & IF-ECMHS - *Assistant Director for PCBH*

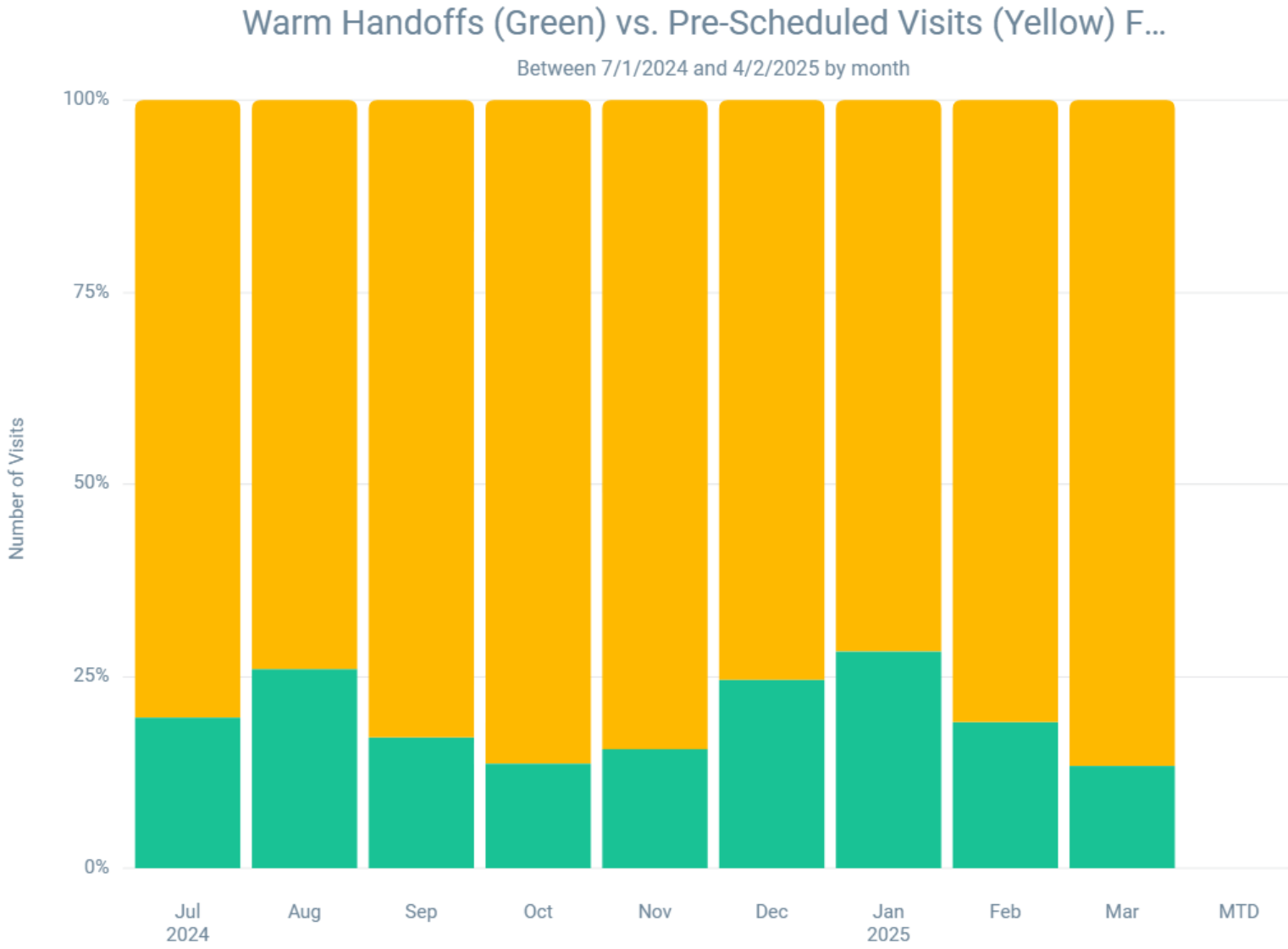
Erin Meloty – Kapella, PhD, LMFT - *BH Supervisor @ CHC*

TEAM MASCOT

What are you trying to solve?

Low WHO Rate

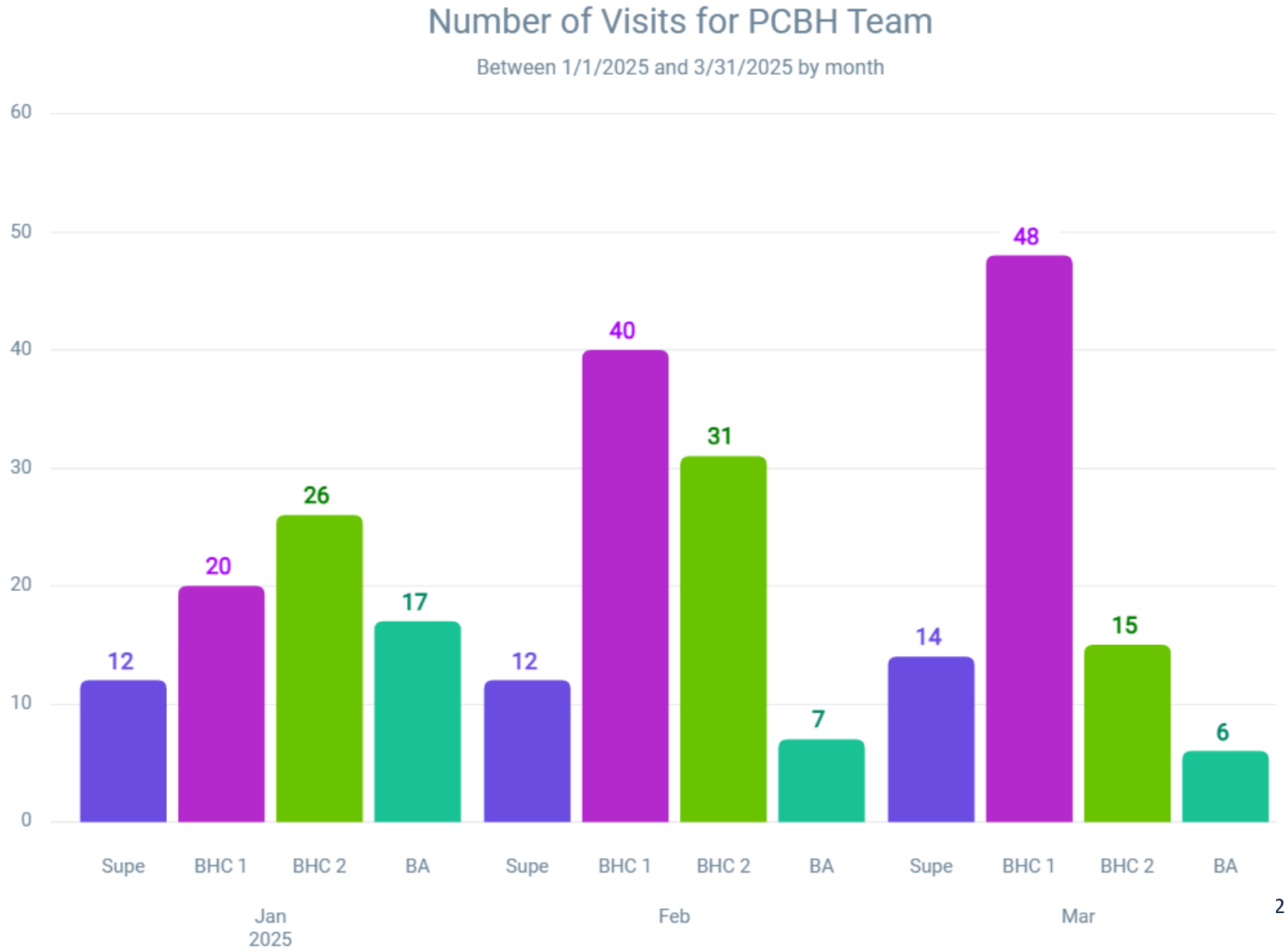
- WHO rate is **between 13.3 % and 28.2%** for the PCBH team (BHCs + 1 BA)
- Goal is **50% of visits are WHO**/BH services are provided same-day



What are you trying to solve?

Low visit volume

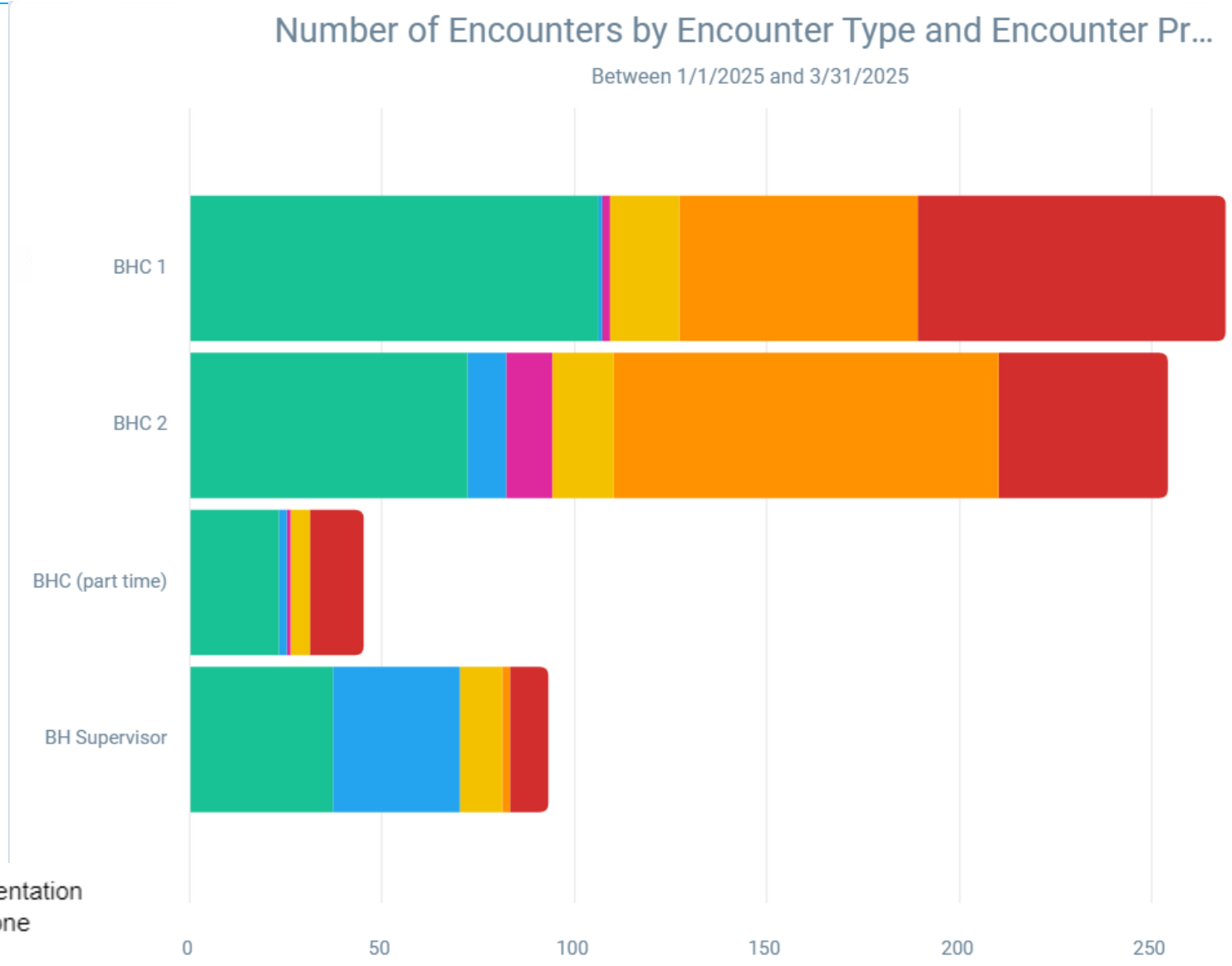
- BHCs are expected to complete **90 visits per month** (roughly 3 visits per 4-hour clinic session)
- BHCs are currently completing between **15-48 visits per month**
- No current expectations for BA



How is the team currently being utilized?

Time Spent

- Roughly **1/3 or less** is spent in pt-facing visits
- Up to 1/3 are **no-show encounters**
- Over 1/3 being utilized for **pt outreach/documentation-only** (frequently care coordination) encounters
- Referred pts are frequently high acuity/require high level of care coordination/bridge services—team operates as **Medical Social Workers**



What have you tried?

Push-ins

- BHCs tried chart scrubbing medical appt schedule to ID pts for WHO; medical providers declined

Covering other embedded clinics (e.g., such as Continuity Clinic)

- More consistent referral opportunities; did not result in visit volume/WHO increase

Educating the care team, including medical providers, on BH services (as well as limitations)

- PCBH created BH-related materials/areas for staff and pts
- BH supervisor presented at multiple meetings, including all-staff and medical provider meetings
- Incomplete/inaccurate referrals continue to be sent to WQ

Co-location

- PCBH co-located in team rooms with medical providers/HealthySteps; more consultation/presence but no increase in WHO/referrals

What would you like advice on?

How else could BH be utilized?

What else needs to happen to obtain clinic/other discipline buy-in?

How to provide team-based care when working with resident medical providers (teaching hospital/academic setting) who may only be onsite for 1 clinic per week?

We will have less space in clinic when moving from 6M to 4D—how best to utilize same-day access?

All Teach, All Learn

Reminders

- Pose questions
- Offer suggestions
- Recommend solutions

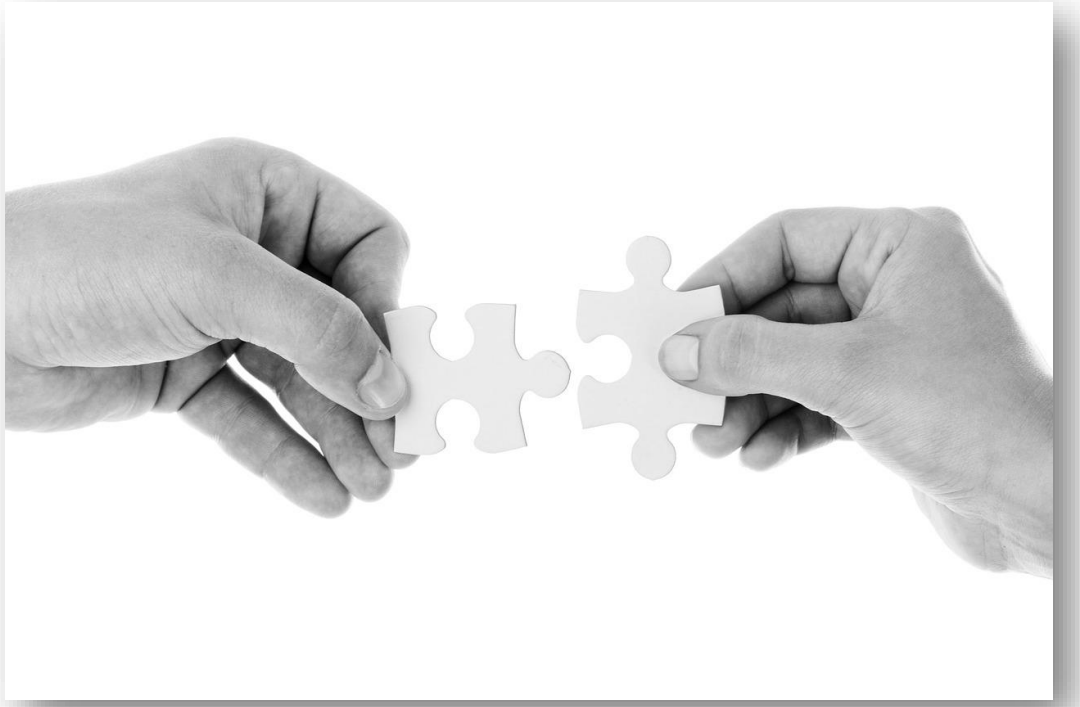
California Quality Collaborative

Rady Children's Hospital Transforming Mental Health

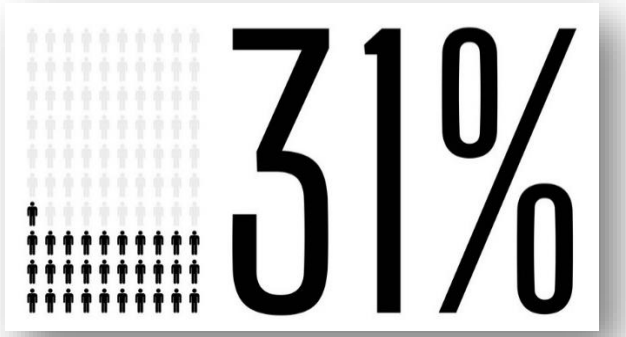
Engagement & Equity

Engagement and Equity through Integrated Care

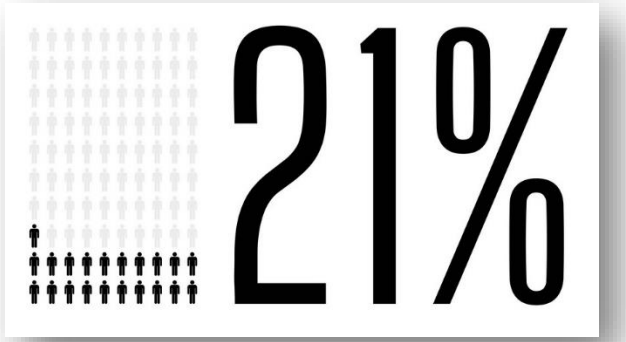
- Population health approach
- Warm Hand-Offs (WHOs) increase patient engagement in services and enhance continuity of care
- Integrated care decreases stigma



Mental Health Stigma's Impact on Accessing Care



Americans who have worried about others judging them when they told them they have sought mental health services.

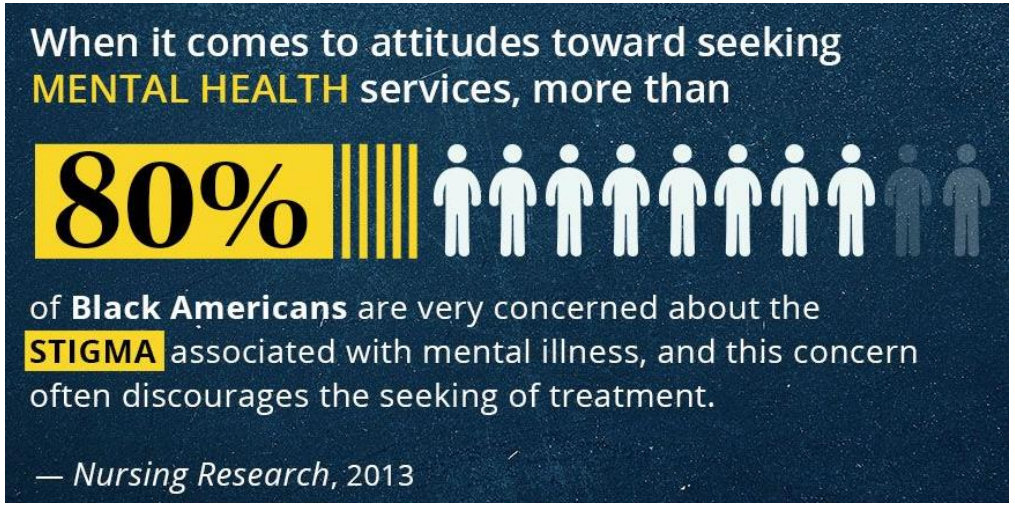


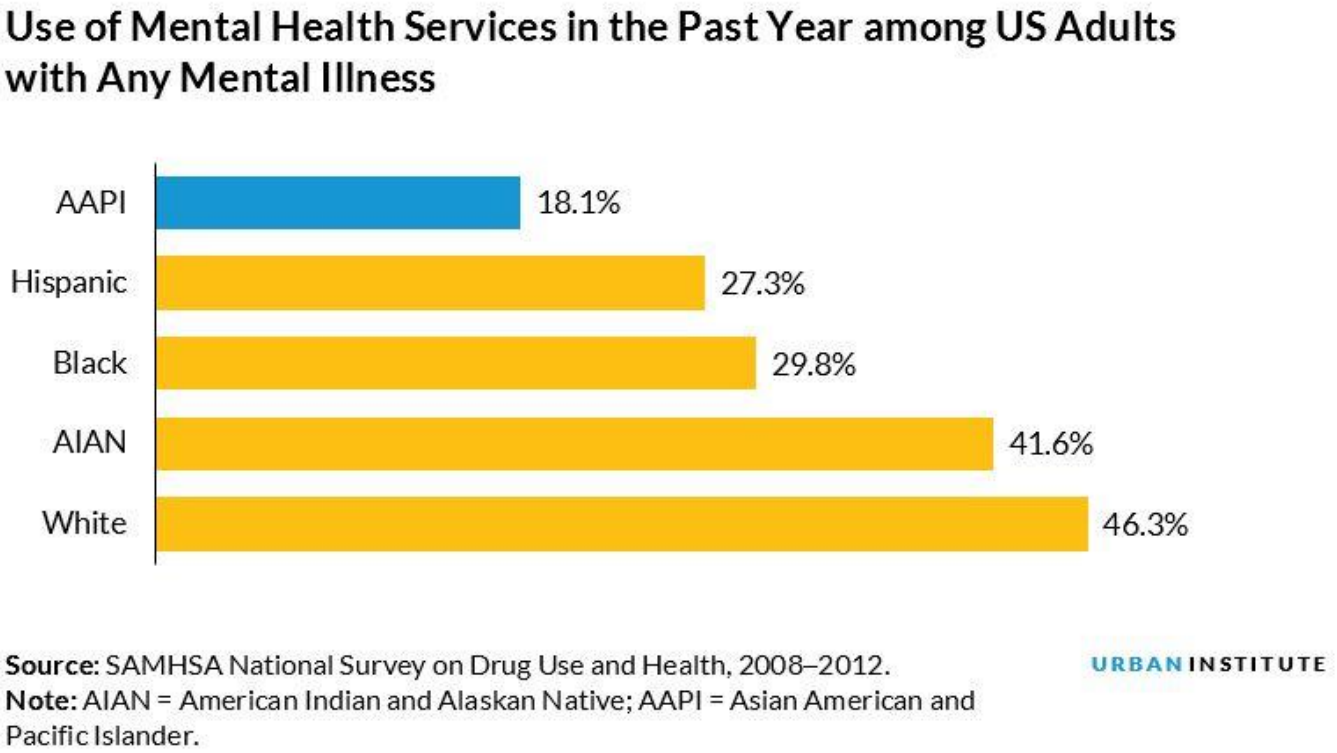
Americans who have lied to avoid telling people they were seeking mental health services.

NATIONAL COUNCIL for Mental Wellbeing

Stigma Across Demographics

Research shows that people in racial and ethnic minority groups in the U.S. are less likely than White people to seek outpatient therapy services.





Integrated Care Dismantles Mental Health Stigma

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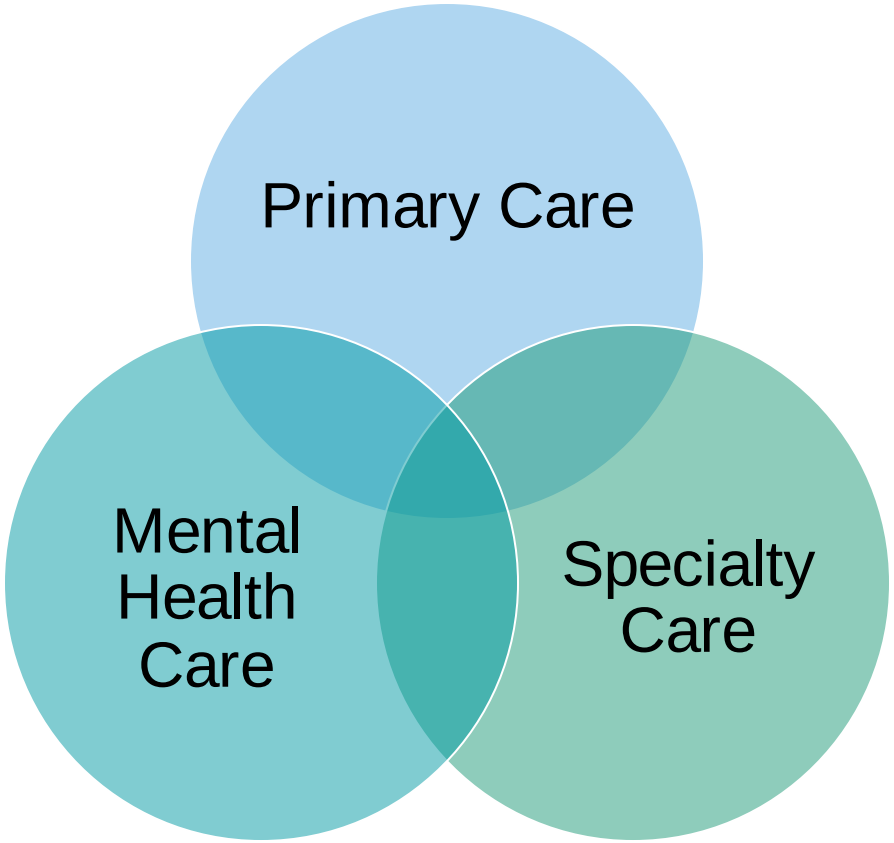


There is no health without **mental health**.

PCMHI Efforts to Increase Engagement and Equity

- Team roles in supporting equity
- Use of MIC
- Environmental inclusivity
- Flexible terminology to encourage engagement
- Research areas of focus
- Direct patient engagement

Rady Children's Focus on DEI

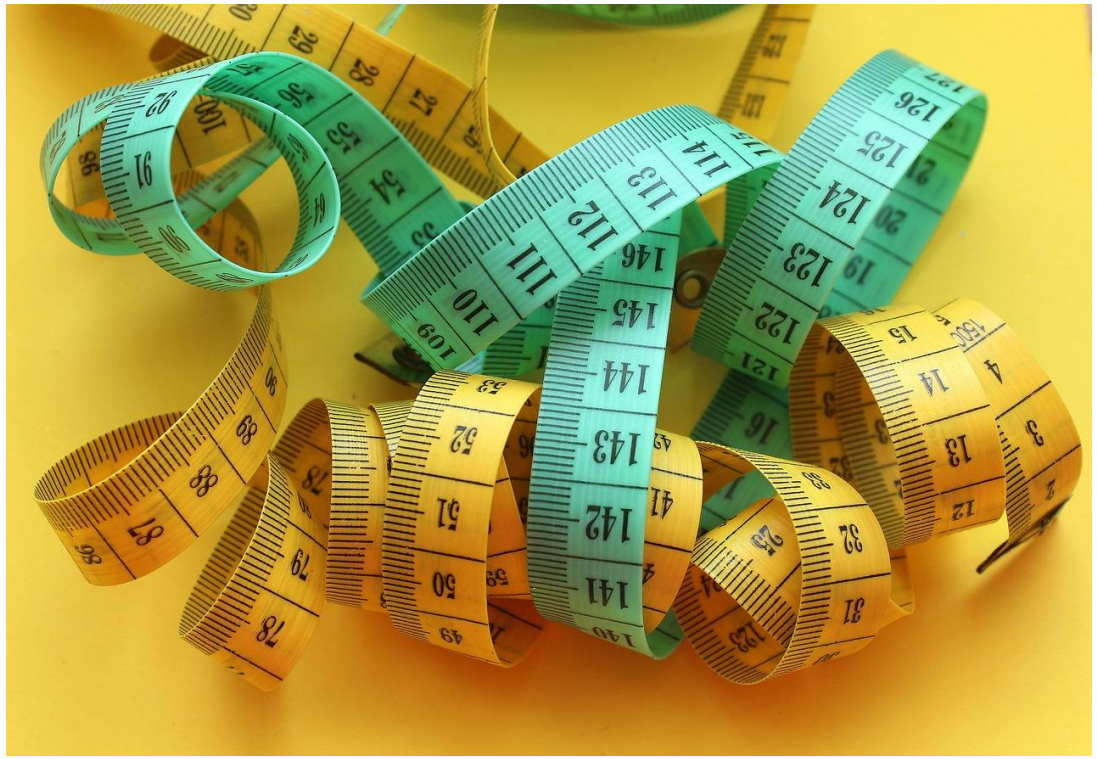
- Core values (CARES)
  - Compassion
  - Accountability
  - Respect
  - Excellence
  - Service
- DEI Council
- Team Resource Groups (TRGs)
- Impact reports

Team Role in Equity and Engagement

- Hiring diverse staff
- Hiring staff who speak the languages of our patients, primarily English and Spanish
- Ongoing DEI training for leaders
- Annual organization-wide trainings on DEI for all staff

Use of Measurement-Informed Care (MIC)

- MIC helps turn subjective patient experiences and clinician observations into objective data
- Opportunity for patients and families to provide input on the description of their symptoms
- Measurement tools:
  - GAD-7
  - PHQ-9A
  - PSC-17
  - CGI



Environmental Inclusivity

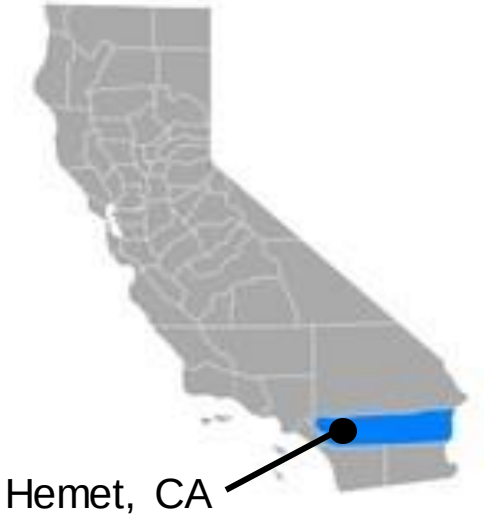
- Physically inviting space in PCP sites and Hubs
  - Signs/posters about mental health and inclusivity
  - Flyers in PCP exam rooms in both English and Spanish

Flexible Terminology to Encourage Engagement

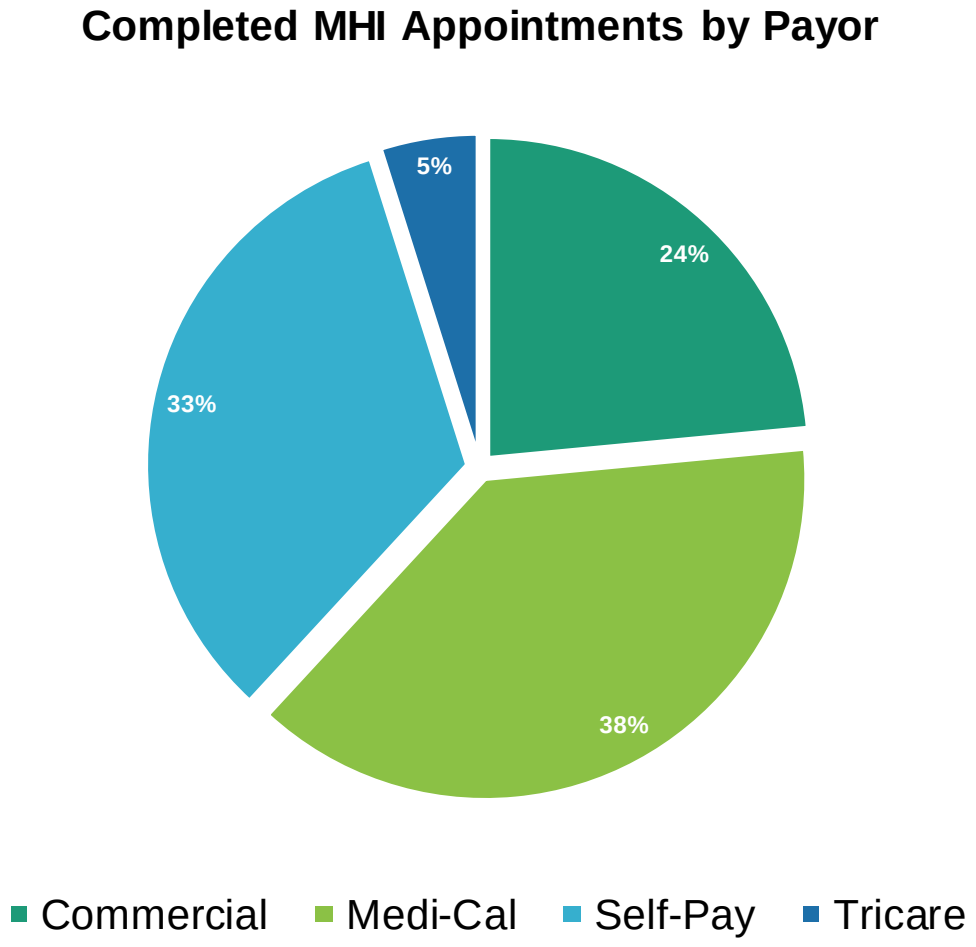
- Meeting patients and families where they are
- Adjusting program terminology based on various cultural factors that could impact mental health care
  - Utilizing “counselor” or “coach” in place of “integrated health therapist” or “psychologist” in certain contexts

Caring for Patients in Underserved Areas

- As of 2023, 11% of San Diego County residents, live below the Federal Poverty Line
- As of March 2025, 298,339 children relied on Medi-Cal insurance coverage
- The majority of patients seen by the MHI Program have Medi-Cal



Hemet Hub opened in August 2023 with the goal of providing care to an underserved community in Riverside County



Advancing Equity through Research

Children's Primary Care Medical Group

UC San Diego School of Medicine

Racial and Ethnic Differences in Time To Treatment in Behavioral Health

Jasmine R. Holt, PsyD[1]; Mario Bialostozky, MD, FAAP[1,2]; Hilary M. Bowers, MD, FAAP[4]; Jason Schweitzer, MD[1,3]; Anjali Sapkal, MBBS, MS[1]; Devin Adams, MPH[1]; Domonique Hensler, MHA[1]; Kathryn Hollenbach, PhD, MPH[1,2]

[1]Department of Transforming Mental Health, Rady Children's Hospital-San Diego; [2]Departments of Pediatrics and [3]Psychiatry, UCSD School of Medicine; [4]Children's Primary Care Medical Group

Rady Children's Hospital San Diego

BACKGROUND

- With the increased prevalence of behavioral health concerns in the pediatric population, the need for timely and easier access to mental health services is of utmost importance (Ghandour et al., 2019).
- Previous research points to racial and ethnic differences in access to healthcare in various disciplines of medicine (Marin et al., 2021; Tung, 2017). Similarly, racial and ethnic disparities in behavioral health (BH) services accessibility has been noted in the United States (Cuffe et al., 1995; Himmelstein et al., 2016; Lasser et al., 2002).
- Rady Children's Hospital - San Diego (RCHSD) and Children's Primary Care Medical Group (CPCMG) implemented a new integrated delivery system to provide behavioral and mental health care within primary care pediatric clinics.

OBJECTIVES

Examine patient racial and ethnic differences in time to BH treatment access within our integrated model. Specific time differences compared were:

- PCP appointment to referral date
- PCP appointment to warm hand-off (WHO) date
- Referral to WHO date
- WHO to initial evaluation date
- PCP appointment to initial evaluation date
- Referral to initial evaluation date

METHODS

- Random sample of children and adolescents referred by their primary care provider (PCP) to the Integrated Health Therapist (IHT) between June 10, 2020 and December 14, 2020 were evaluated.
- Day differences calculated between dates of interest.
- Day difference racial and ethnic comparisons made using Kruskal-Wallis and Wilcoxon rank-sum tests.
- Data analyzed using STATA 16.2 (College Station, TX).

RESULTS

- 347 patients referred: 47% male, median age = 11 (9, 14) years
- 9 patients lost to follow-up: 66% male; median age = 16 (8, 17) years
  - 33% Caucasian/White
  - 11% African American/Black
  - 11% Asian/Pacific Islander
  - 11% Mixed/Multiple Races
  - 33% Other
  - 22% Non-Hispanic
  - 78% Hispanic/Latino

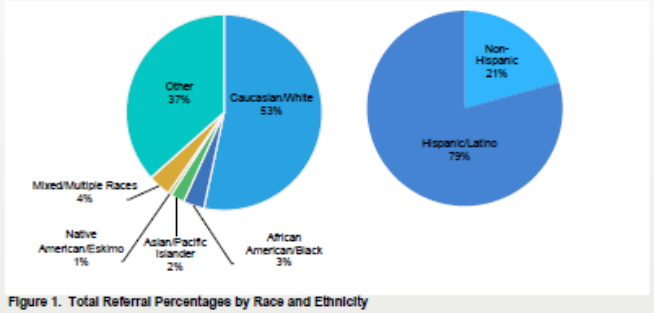
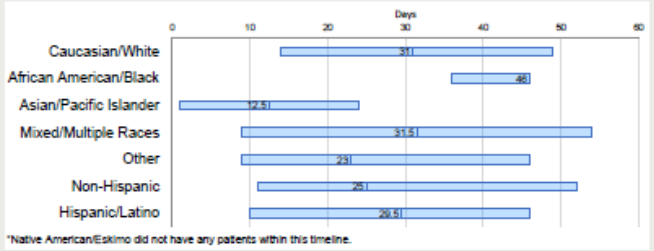


Figure 1. Total Referral Percentages by Race and Ethnicity

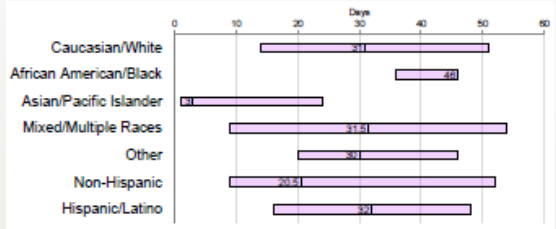
Table 1. Median (25th, 75th percentile) Program Metric Day Differences by Race and Ethnicity

	PCP Appt to Referral		PCP Appt to WHO		Referral to WHO		PCP Appt to Evaluation	
Race	n	Median Days	n	Median Days	n	Median Days	n	Median Days
Caucasian/White	160	0 (0, 0)	138	0 (0, 4)	138	0 (0, 9)	63	31 (11, 52)
African American/Black	12	0 (0, 0)	11	0 (0, 0)	11	0 (0, 0)	5	46 (36, 46)
Asian/Pacific Islander	8	0 (0, 1)	6	0 (0, 0)	6	0 (0, 0)	3	6 (1, 24)
Native American/Eskimo	1	0 (0, 0)	1	0 (0, 0)	1	0 (0, 0)	0	N/A
Mixed/Multiple Races	11	0 (0, 0)	10	0 (0, 0)	10	0 (0, 0)	2	31.5 (9, 54)
Other	118	0 (0, 0)	101	0 (0, 9)	105	0 (0, 10)	35	32 (21, 46)
Ethnicity								
Non-Hispanic	67	0 (0, 0)	59	0 (0, 6)	58	0 (0, 6)	24	22.5 (9, 52)
Hispanic/Latino	243	0 (0, 0)	208	0 (0, 3)	213	0 (0, 7)	84	32.5 (16, 49.5)



*Native American/Eskimo did not have any patients within this timeline.

Figure 2. Median Days from WHO to Initial Evaluation by Race and Ethnicity (25th, 75th percentiles represented by bars)



*Native American/Eskimo did not have any patients within this timeline.

Figure 3. Median Days from Referral to Initial Evaluation by Race and Ethnicity (25th, 75th percentiles represented by bars)

CONCLUSION

No statistically significant racial or ethnic differences were found in time to treatment based on our current time points among children and adolescents referred for behavioral health treatment within this new integrated primary care behavioral health program.

It is clinically important to note that African American children and adolescents experienced a longer delay in time to receiving their initial evaluation. Increased efforts are currently being implemented to decrease this delay. Our target goal is to have the initial evaluation occur within 14 days of referral for all patients.

Data presented here are from our two initial sites. This program is being implemented across additional clinics within the hospital system.

Further research will continue to evaluate this BH model and proactively identify and address differences in care.

REFERENCES

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Tung, E. L., Baig, A. A., Huang, E. S., Laiteerapong, N., & Chua, K. P. (2017). Racial and ethnic disparities in diabetes screening between Asian Americans and other adults: BRFSS 2012–2014. Journal of general internal medicine, 32(4), 423-429.

Stop Stigma Together Summit

- Plenary Symposium presentation, titled “Tackling the Stigma of Youth Mental Health Through Integrated Care” at the First Annual National Summit to End Stigma in June 2024

Utilizing Patient Family Satisfaction Surveys

- Survey platforms
  - REDCap: Patients
  - National Research Corporation (NRC): Parents
- Surveys are reviewed on a quarterly basis by MHI leadership and providers
- Feedback loop helps us maintain ongoing engagement with patient families

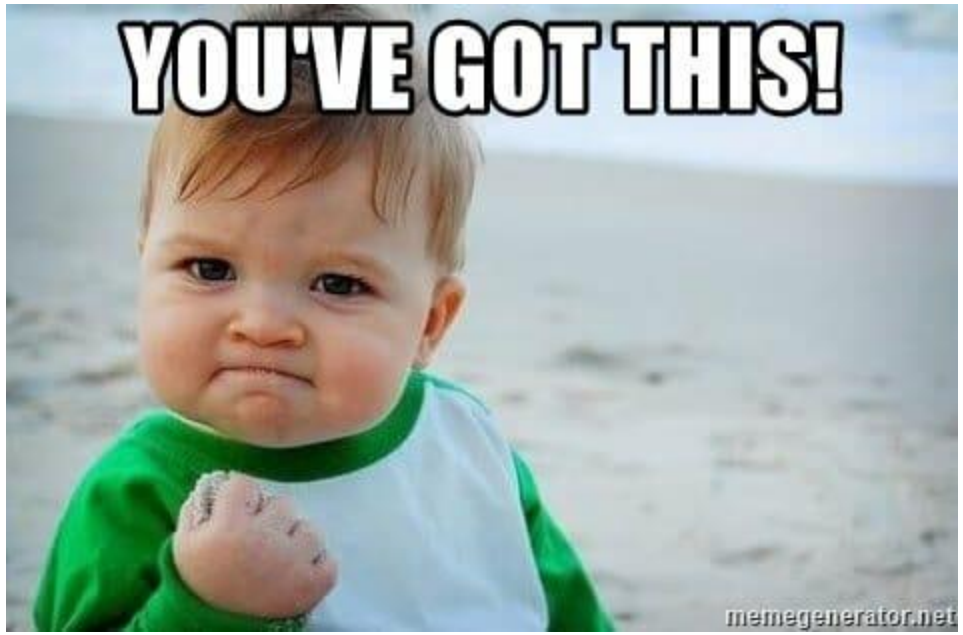
Direct Patient Engagement

Questions?

BHI – CYCLE Program Survey

Provide insights for the toolkit as well as program feedback by completing the BHI – CYCLE Program Survey today!

Responses are anonymous and due by **Friday, April 18th.**



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Feedback

1. Today's webinar was useful for me and my work *[select one]*
    - Strongly agree
    - Agree
    - Neither agree nor disagree
    - Disagree
    - Strongly disagree

2. Of the topics we covered today, what was especially helpful? *[select multiple]*

- Reflect and share advice on peer case study: San Francisco Health Network
- Review equity and engagement practices at Rady Children's Hospital
- Share about equity and engagement at your organization

BHI – CYCLE Commons | Program Timeline

Topic	Commons Webinar: Screening Mon. 1/6 (12 – 1)	Office Hour: BHI Financing and Sustainability Mon. 1/21, 12 p.m. – 12:45 p.m.	Commons Webinar: BHI Financing and Sustainability Mon. 2/3 (12 -1)	Commons Webinar: Staffing & Sustainability + Site Visit Preparation Mon. 3/3 (12 – 12:45)
Presenter	Providence			LifeLong Medical Care

Topic	In Person Site Visit – Rady Children's, San Diego March 7, 2025	By 4/18: BHI-CYCLE Program Survey	Commons Webinar: Engagement & Equity Mon. 4/7 (12 – 1)	Commons Webinar: Training and Development Mon. 5/5 (12 – 1)	Commons Webinar: Lessons Learned & Closing Mon. 6/2 (12 – 1)	CQC Public Webinar – BHI – CYCLE Successful Practices & Solutions Toolkit Wed. 9/17 (1 – 2)
Presenter			San Francisco Health Network	AltaMed	All!	

Thank you!

California Quality Collaborative