Annual Report | 2020–2021

GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL

CHILDREN'S SUBCOMMITTEE

PRESENTED TO

Wes Cole, Chair
Governor's Behavioral Health Services Planning Council

Laura Howard, Secretary
Kansas Department for Aging and Disability Services
& Kansas Department for Children and Families

Laura Kelly, Governor
State of Kansas

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<u>INTRODUCTION</u>

There is an endless list of possible areas of inquiry and research as we consider the behavioral health of children and their families from a holistic continuum of care perspective, which includes primary prevention efforts through targeted interventions for those with identified concerns. As the subcommittee worked to finish last year's work, report, and set goals, we were in the middle of the COVID pandemic and adjusting how we as individuals lived, continued our professional work, and completed the work of this subcommittee. We considered many possible topics and areas of inquiry and research including workforce concerns, impact of COVID, gaps in services, data needs and gaps, child and caregiver engagement, and coordination of our work with other subcommittees and groups.

Ultimately, we selected three topics: BEHAVIORAL HEALTH TELEHEALTH, BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID, and RACIAL DISPARITIES IN BEHAVIORAL HEALTH. We also committed to continuing our role as the advisory group for the KS Kids Map project. Using those topics as our guide we developed the following goals for our work during the 2020-2021 (state fiscal) year:

1) <u>BEHAVIORAL HEALTH TELEHEALTH:</u> Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.

2) <u>BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID</u>: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

3) <u>RACIAL DISPARITIES IN BEHAVIORAL HEALTH</u>: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.

   a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.

   b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

4) <u>KSKidsMAP Project</u>: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

This subcommittee often discusses the difficulty in having meaningful child and caregiver engagement on and with this subcommittee. We often feel disconnected from those we are ultimately making recommendations to benefit. The quote below, although it has a focus on adults and youth, is a great summary of the sentiment of our subcommittee.

“A great way to understand how to support people in the present is to invest in {asking and listening to} what people say works for them. The consumer/peer support movement has long known these issues.

Mental health resources are too complicated and often defeating, whether you are first reaching for help or have been in the system for decades. This is if there are even resources at all.

Treatment and system goals are not always aligned with the things that actually matter to people. Measures narrowly focused on diagnosis and symptom reduction can often miss what is most important to people.

We expect people to build their lives around mental health resources, as opposed to building mental health resources around people’s lives. People should have access to resources as part of their daily lives and barriers to people’s participation, whether at work or school, should be removed.

If we want to improve mental health, we need to listen to the people who most understand the system and can identify the gaps because it is their needs that are not being met.”

- Kelly Davis
  Associate Vice President of Peer and Youth Advocacy at Mental Health America

The quote above certainly highlights and encourages us to acknowledge the weakness of this subcommittee in inviting and supporting meaningful engagement with children, youth, and families. Stating this in this report will hopefully drive a focus next year and beyond to improve meaningful engagement of children and caregivers so that “our” work truly becomes the work of not just professionals doing what we think and believe is best but is driven by children, youth, and families. We invite you to connect with us and provide your feedback and voice to this effort.

Thank you for taking time to review the report and consider our recommendations. If you have questions, please contact subcommittee members or the Governor’s Behavioral Health Services Planning Council.

Summary of Recommendations

The children's subcommittee chose three topics to focus on this year and continues to serve as the advisory group for the KSKidsMAP Project. Below are the goals we set for this year and the summary of recommendations for each of those goals.

1) BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.

Recommendations:

- Support investments in digital infrastructure to increase access to Telehealth.
- Support providers in the provision of Telehealth with specific populations, situations, and appropriate use within the continuum of care, including to youth in crisis or awaiting placement.
- Ensure inclusive and equitable access to telehealth services, irrespective of provider codes, site, or diagnosis.

2) BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

Recommendations:

- Public education campaign about the effects of isolation and loneliness including the brain science behind it.
- Equip educators, school districts, and early childhood professionals to participate in preventative, family supportive strategies to intervene in child maltreatment and not just reporters of child maltreatment. The state should support and fund efforts to equip teachers with the knowledge, tools, and resources they need.
- Support and expand peer groups and the connection they provide in mitigating the effects of isolation. We hear several examples of how peer groups were effective in combatting isolation during the pandemic.
- Promote and invest in peer support and/or other locally driven communities and support groups where people take care of each other.
- Consolidate COVID response and resource information in a central location where people can easily find it.
- Medicaid Expansion would address many of the safety net issues.

- Support and/or fund specialized training for clinicians in dealing with depression and anxiety
- Support and/or fund ways for providers to meaningfully engage with parents
- Support and/or fund expanded treatment for very young children.

Several recommendations from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature align with or support our recommendation (see Resources & Links section at the end of this report), specifically:

- Community Engagement Recommendation 3.1 Crisis Intervention Centers. Utilize state funds to support the expansion of crisis centers around the state.
- Community Engagement Recommendation 3.4 Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and cooccurring conditions.
- Prevention and Education Recommendation 4.2 Early Intervention. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.
- Prevention and Education Recommendation 4.4 Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention).

3) RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.

   a. Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.

   b. Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

Recommendations:

- All state agencies should prioritize improved data systems to collect and report on service data reported with racial disparities and equity in mind.
  - Support providers in providing data into those new data systems
  - Engage stakeholders, especially trusted local community leaders, providers and families, in building data systems.
- Hire a dedicated position to coordinate and provide accountability.

- One recommendation from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature aligns with or supports our recommendations specifically: Data Systems Recommendation 7.5 Cross-Agency Data (SI): Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.

4) KSKidsMAP Project: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

- Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.
- Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
  - Use of Medicaid Administrative match allowed for provider training activities
  - Managed Care Organization and/or commercial insurance
  - State general funds line item
  - Blended/braided funding across state agencies (e.g., KDADS, KDHE)
- Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.
- Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists. KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU's Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.
- One recommendation from The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature align with or support our recommendations specifically: Treatment and Recovery Recommendation 5.3 Frontline Capacity. Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.

HIGHLIGHTS OF PROGRESS

Our role is to make recommendations regarding improvements to behavioral health services for Kansas children and their families. Our work often focuses on "what's wrong" or "not working right." We realize that we need to model as a subcommittee the strengths-based approach we hope the state supports and Kansas providers use when working with children and their families. With that goal in mind, we are highlighting some of the positive work we know happened and is happening in Kansas this past year.

- The Kansas Legislature, through the Special Committee on Kansas Mental Health Modernization and Reform, has worked to understand and make recommendations regarding the Mental Health system in Kansas. We are hopeful about increased focus on improvements in mental health for Kansans.
  - Report of the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature. Special Committee on Kansas Mental Health Modernization and Reform. January 2021. http://www.kslegresearch.org/KLRD-web/Publications/CommitteeReports/2020CommitteeReports/ctte_spc_2020_ks_mental_health_modern_1_complete_report.pdf
- KDADS has worked for several years, including this year, to improve the wait time and waiting list for PRTF beds. This has included working with providers to increase the number of available beds and new specialty beds. We also appreciate KDADS promise of continued work on this.
- Members of the subcommittee have personally seen the impact that state-level multidisciplinary team meetings have had in difficult cases. Specifically, we wish to thank Gary Henault and Joe Winslow and their dedication to participating in MDT meetings for difficult cases that are referred to them. We would encourage others to do the same, and perhaps encourage the state to put more resources (dedicated staff time) into these types of activities.
- We are seeing evidence of a positive culture shift within and between state agencies: state personnel are approachable, staff are listening to providers, and as a result we see better partnerships and collaboration. This has resulted in system improvements to minimize silos and fragmentation. For example, DCF has invested in the creation of and hiring of a Director of Medicaid and Children's Mental Health, state agencies are sharing updates and data that they have available.
- KDADS is leading progress on review of direct provider training and manuals.
- The state was commitment and dedicated work on the Federal mandate.
- We continue to be amazed by the learning and the progress that has been made with the HRSA funded KSKidsMAP project. Specifically, we have seen great success in improving skills and abilities of pediatricians and other primary care clinicians in meeting behavioral health needs of children and families, and we look forward to seeing continued growth and sustained support of this project.
- The Psychotropic medication workgroup has made progress in a short period of time.

- KDADS's swift response to new disaster relief grant funding provided free training to parents and professionals.
- We are also encouraged by the work to initiate mobile crisis response.
- The work of the School Mental Health Initiative continued this year, increasing partnerships. Availability and accessibility of services has increased through these collaborative efforts and has helped leverage knowledge capacity of professionals.
- Community Mental Health Centers are working with the state on innovative and new ways to meet the needs of children and families.
- The state has supported continued access to telehealth, with reasonable recommendations in place.

2020-2021 Goals & Accomplishments

<u>Goal #1 - BEHAVIORAL HEALTH TELEHEALTH: Further explore telehealth and make recommendations about its use related to behavioral health services: during a pandemic and under regular circumstances.</u>

We used information from professionals and the agencies those professionals represent on this subcommittee to inform the following summary of information related to this goal.

<u>Benefits of Telehealth:</u>

- More frequent meetings
- Better attendance at scheduled meetings
- Improved access for clients and providers
- Safer environment, without exposure to COVID and other illness
- Potential reduction in stigma

<u>Limitations/Barriers of Telehealth:</u>

- Many providers went to 100% Telehealth, losing in-person human interaction.
- Participants cannot see the non-verbal communication (i.e., wringing hands, balled up fists)
- Provider is not able to use other senses to assess client (i.e., client smelling like alcohol or other substances).
- Tough to keep attention of young children, can only use talk therapy and not play therapy.
- Confidentiality of sessions is difficult to ensure people are in the car or in public places like stores, or if they are in a private location there may be other people in the room.
- Privacy may not be easy to ensure, in certain home situations
- Tough or maybe impossible to thoroughly assess to make some diagnoses via Telehealth (e.g.., autism)
- Access to technology due to cost or lack of availability in some areas does not make Telehealth an option for some providers and families.
- Some families are uncomfortable with or fearful of technology

<u>Systemic Issues</u>:

- Reimbursement rate to the clinician was less for Telehealth prior to the COVID pandemic
- Limitation in origination sites prior to the COVID pandemic
- Could not access across state boundaries prior to the pandemic
- Professionals from other states providing care to clients in our state and hospital settings during the COVID pandemic, but without awareness of local resources or the ability to liaise with local professionals
- Telehealth should be a tool to use, but not the only tool
- Technical problems resulting in missed sessions or leaving a session
- Cyber security concerns
- Increases in fraud cases

In summary, Telehealth is an appropriate and effective treatment option for some populations and situations, however it is not a replacement for person-to-person contact. Telehealth makes observation of non-verbal cues at the best challenging, if not impossible. Telehealth is a great resource for reaching rural and frontier areas where transportation barriers and access to providers may be a challenge. It is also a good resource for clients who may miss appointments or otherwise have a history of failing to attend appointments. It must be noted, that although Telehealth has resulted in fewer missed appointments for many, the appointment duration is often shorter, resulting in the need for more frequent appointments and adjusting the work to more frequent and shorter appointments. Adults and young adults have a higher success rate with compliance; however, adolescents and small children are extremely difficult to keep engaged and working.

Even with the best of technology, there can still be digital connectivity issues, and there is always the option available to clients to turn off their camera or leave sessions when the conversation becomes difficult.

There is also a concern and need to monitor the use of Telehealth as there is a push for nationwide Telehealth and an increase in practitioners providing care from outside of the state. Although this may be a temporary solution to the lack of providers and increase access initially, it does not solve workforce or other access/barriers to in-person behavioral health treatment and services for our state.

Recommendations:

- Support investments in digital infrastructure to increase access to Telehealth.
- Support providers in the provision of Telehealth with specific populations, situations, and appropriate use within the continuum of care, including to youth in crisis or awaiting placement.
- Ensure inclusive and equitable access to telehealth services, irrespective of provider codes, site, or diagnosis.

Goal #2: BEHAVIORAL HEALTH IMPACT AND LEARNING FROM COVID: The impact of COVID has affected children and families differently. We will look beyond the initial distress and treatment, to make recommendations regarding the need to increase family/community protective factors, like resiliency and connectedness.

Safety Net – One of the issues that became very apparent during the pandemic was the need for a secure and adequate safety net in our communities. Due to the pandemic, many people became dependent on their community's safety net for survival. This includes things like:

- Food
- Housing/safety
- Access to health care
- Human connection
- Financial assistance/employment

Providers and subcommittee members have reported several instances of children literally disappearing from everyone's radar. Isolation is a strong predictor of child maltreatment and the impact of loneliness on people's well-being has worsened during the pandemic. Schools that serve as the safety net for many children were unavailable. When thinking about the basic needs and higher-level brain functions, like learning, making sure people's basic needs are taken care of must come before other needs can be addressed. These overlapping situations increase our concerns for the behavioral health of Kansans, especially children and their families.

Clinical Resources – In retrospect, we now know what behavioral health issues would become prominent for children and caregivers during the pandemic. We should bolster the system by addressing issues such as specialized training for clinicians in dealing with depression and anxiety, ways to meaningfully engage with parents and continuing to expand ways to treat very young children.

Recommendations:

- Public education campaign about the effects of isolation and loneliness including the brain science behind it.
- Equip educators, school districts, and early childhood professionals to participate in preventative, family supportive strategies to intervene in child maltreatment and not just reporters of child maltreatment. The state should support and fund efforts to equip teachers with the knowledge, tools, and resources they need.
- Support and expand peer groups and the connection they provide in mitigating the effects of isolation. We heard several examples of how peer groups were effective in combatting isolation during the pandemic.
- Promote and invest in peer support and/or other locally driven communities and support groups where people take care of each other.

- Consolidating COVID response and resource information in a central location where people can easily find it.
- Medicaid Expansion would address many of the safety net issues.
- Support and/or fund specialized training for clinicians in dealing with depression and anxiety
- Support and/or fund ways for providers to meaningfully engage with parents
- Support and/or fund expanded treat very young children.

Several recommendations from *The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature* align with or support our recommendation (see Resources & Links section at the end of this report), specifically:

- Community Engagement Recommendation 3.1 Crisis Intervention Centers. Utilize state funds to support the expansion of crisis centers around the state.
- Community Engagement Recommendation 3.4 Community-Based Liaison. Fund and improve resources for community-based liaison to facilitate connection to treatment and support services (e.g., community mental health services) upon re-entry as a component of pre-release planning and services for justice-involved adults and youth with substance use disorder (SUD) and cooccurring conditions.
- Prevention and Education Recommendation 4.2 Early Intervention. Increase access to early childhood mental health services by including additional language in the Medicaid state plan to explicitly cover the cost of early childhood mental health screening, assessment, and treatment.
- Prevention and Education Recommendation 4.4 Behavioral Health Prevention. Increase state funds for behavioral health prevention efforts (e.g., SUD prevention, suicide prevention).

Goal #3 - RACIAL DISPARITIES IN BEHAVIORAL HEALTH: Discuss racial disparities and cultural considerations related to behavioral health services in Kansas.

a) Request and review state data to determine if there are racial disparities in access to care. Based on findings, there could be recommendations around outreach, stigma reduction efforts, etc.

b) Review the Culturally and Linguistically Appropriate Services (CLAS) standards that are required for cultural awareness staff training and consider possible recommendations.

Staff from KDHE presented data available in Kansas regarding racial disparities and equity. Data sources included:

1. **National Violent Death Report System (NVDRS)**: State-based surveillance system that gathers comprehensive information to fully characterize incidents
2. **Kansas Hospital Association (KHA) discharge databases**: includes data on emergency department visits (EDV) and hospitalizations
3. **Kansas Communities That Care (KCTC) Student Survey**: 6th, 8th, 10th, 12th grades
   - http://kctcdata.org/
4. **Kansas Youth Risk Behavior Survey (YRBS)**: 9th, 10th, 11th, 12th grades
   - https://yrbs-explorer.services.cdc.gov/#/
5. **Kansas Attorney General's Youth Suicide Prevention Task Force** (2018 Task Force Report)
6. **State Child Death Review Board** (2020 Annual Report)

Although there is data available it often has challenges or limitations due to not being collected at all or small sample sizes limiting the ability to draw conclusions or generalize. We are left with many questions and possible next steps.

- Identify and share statewide (and other) reports on mental health service utilization
  - KDADS and MCOs for Medicaid population
  - Association of CMHC
  - BSRB for percentage of providers by race
- Identify trends or gaps with services and provider availability based on data gathered
- Identify what is the Culturally and Linguistically Appropriate Services (CLAS) Program data points and identify if there is any participation in CLAS by any Kansas state agency.
- Then ask for current measures monitored and if any reports exist to review population served/ included.

Recommendation:

- All state agencies should prioritize improved data systems to collect and report on service data reported with racial disparities and equity in mind.
  - Support providers in providing data into those new data systems
  - Engage stakeholders, especially trusted local community leaders, providers and families, in building data systems.
- Hire a dedicated position to coordinate and provide accountability.

- One recommendation from *The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature* align with or support our recommendations specifically: Data Systems Recommendation 7.5 Cross-Agency Data (SI): Encourage state agencies to develop policies that improve their ability to access and review cross-agency data for making service and program decisions based on a thorough, shared needs assessment.

Workgroup #4 -KSKidsMAP Project: Use dedicated time during meetings to discuss the KSKidsMAP project, and more intentionally serve as an advisory group.

Throughout the year meetings were used to provide us updates on the project and KDHE staff used meeting time via breakout sessions to review data and collect feedback on the data, planned activities, and next steps.

KSKidsMAP Summary:

In an effort to address the Mental Health Professional Shortage Areas, specifically child and adolescent psychiatrists and psychologists, and the under-identification of children and adolescents with behavioral disorders, HRSA administers cooperative agreements for *Pediatric Mental Health Care Access Programs.* The Kansas program, KSKidsMAP, is a partnership between KDHE's Bureau of Family Health and KUSM-Wichita Departments of Pediatrics and Psychiatry and Behavioral Sciences. HRSA funding ($445,000 annually) and 20% ($89,000) non-federal match will support KSKidsMAP from July 2019 through June 2023.

The shortage in mental health professionals, and other factors, including accessibility and lack of stigma, means many families seek treatment in the primary care setting. KSKidsMAP partners with pediatric primary care physicians and clinicians (PCPs) to expand their scope of practice to integrate mental health care. To achieve this, KSKidsMAP established a pediatric mental health team that includes two board-certified child and adolescent psychiatrists, a board-certified child and adolescent psychologist, a board-certified pediatrician, and a licensed social worker/care coordinator. The team offers support via toll-free consultation line, an ongoing TeleECHO Clinic, and PCP wellness activities.

From July 1, 2019 to March 31, 2021, KSKidsMAP has accomplished the following:

- Enrollment of 105 PCPs who serve patients in 59/105 (56%) Kansas counties
- Received 193 calls or emails to the consultation line encompassing 248 inquiries
    - PCPs can contact the consultation line for more than one reason at a time
    - Case consultations are the most requested KSKidsMAP service (28.6%) followed by requests for practitioner toolkits (21.4%)
    - Of the enrolled PCPs, 66.7% have utilized the consultation line
- Trained 73 PCPs through the KSKidsMAP TeleECHO Clinic

Children's Subcommittee as KSKidsMAP Advisory Council:

Most meetings focused on strategies for sustainability beyond the lifespan of the grant (June 2023). KSKidsMAP is currently working on an infographic and an impact paper to highlight the importance of the project. The Children's Subcommittee will assist by providing feedback and sharing ideas for important information to include (e.g., system cost savings). Once finalized, both resources could be used when initiating sustainability discussions with key stakeholders.

The Children's Subcommittee has identified the following sustainability ideas: use of Medicaid admin funds to support training/workforce development, MCOs, commercial insurance, SGF

line item, and blended/braided funding from state agencies (e.g., KDHE, KDADS). There was also a *Frontline Provider* recommendation included in the Mental Health Modernization and Reform Committee's Report furthering supporting the need to sustain the program.

<u>Recommendations:</u>

The following recommendations are proposed to promote policy, programs, and systems which support access to psychiatric care for Kansas youth:

- Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.
    - Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
        - Use of Medicaid Administrative match allowed for provider training activities
        - Managed Care Organization and/or commercial insurance
        - State general funds line item
        - Blended/braided funding across state agencies (e.g., KDADS, KDHE)

- Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.
    - Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists. KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU's Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.

One recommendation from *The Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature* align with or support our recommendations specifically: Treatment and Recovery Recommendation 5.3 Frontline Capacity. Increase capacity of frontline healthcare providers (e.g., pediatricians, family physicians and OB-GYNs) to identify and provide services to those with behavioral health needs.

Other Recommendations

Throughout the year we received updates and had many discussions which resulted sometimes in follow-up and/or sharing of information. As a result, we identified other recommendations that do not fall within our identified goals for the year. These recommendations are summarized here.

- Continued focus on improvements to parent engagement (information, resources, training, supports, services, etc.) throughout the continuum of care. Information provided to parents should be accessible, clear, timely, and accurate. A greater focus on parent engagement and information about resources is vital to prevention, early intervention, and successful service provision.
- State agencies should continue collaborating to identifying gaps in the continuum of care. Some possible areas of focus include:
    - consider looking into the lack of resources and services for youth who experience sexual reactive disorders.
    - continue to work on PRTF waiting lists
    - consider looking at children who need more than a PRTF but are not eligible for long term care
    - consider the IDD population, especially those with dual diagnosis mental health and IDD.
    - Consider the need for more foster homes, especially specialized or therapeutic foster homes
- We recommend fully funding the IDD Waiver.
- Allow an exception for children who are at risk and may not have health equity due to telehealth and issues due to COVID treatment limitations for children. Or at least have a conversation about why or why not to have exceptions for meeting CAFAS requirements due to extenuating circumstances.
- ACEs screenings should not be used unless it is to inform services and treatment and in coordination with a resiliency and/or strengths-based perspective.
- The state should add partial hospitalization and intensive outpatient services to the state plan – and look at lessons learned from the PRTF Demonstration project as they do so.
- Support for recommendations from the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature:
    - Treatment and Recovery Recommendation 5.1 Psychiatric Residential Treatment Facilities. Monitor ongoing work to improve care delivery and expand capacity at Psychiatric Residential Treatment Facilities (PRTF) to meet the needs of youth for whom a PRTF is medically appropriate, such as through reductions in the PRTF waitlist and a focus on reintegration and discharge planning, including with schools.
    - Community Engagement Recommendation 3.3: Foster Homes: The State of Kansas should invest in foster home recruitment and retention by increasing funding for supplemental training on behavioral health needs and providing additional financial incentives to support serious emotional disturbance (SED) youth.

- Workforce Recommendation 1.4: Workforce Investment Plan: The State of Kansas should make a long-term investment plan for the behavioral health system workforce by increasing funding for training, recruitment, retention, and support to effectively attract and retain high-quality staff. Specific steps include:
  - Develop a career ladder for clinicians, such as through the development of an associate's-level practitioner role and
  - Take action to increase workforce diversity, including diversity related to race/ethnicity, LGBTQ and the ability to work with those with limited English proficiency.
- System Transformation Recommendation 9.5 Family Psychotherapy. Enable utilization of procedure code 90846 in Medicaid as a tool to support youth in foster care, as well as any child accessing care in a Psychiatric Residential Treatment Facility.

2021 - 2022 Goals

Goal 1: Children with Dual Diagnoses

Explore* and identify the need and gaps in services for Dually Diagnosed children (IDD/MH; ASD/BH) including workforce issues such as lack of training and availability of providers, funding, system involvement and limits.

*Clarification of the role of CMHCs, CDDOs, consider recommendations from the Special Committee on Mental Health Modernization and Reform.

Goal 2: KSKidsMAP

- Continue to serve as the advisory group for the KSKidsMAP Project
- Make progress on the recommendation to sustain the project by continuing to research and identifying opportunities or actions for the committee or others to take to sustain the project.

Goal 3: Continuum of Care & Parent and Community Engagement

Explore how Community Mental Health Centers, Federally Qualified Health Centers, Psychiatric Residential Treatment Facilities, Qualified Residential Treatment Program are engaging the community to educate and collaborate with primary care providers, caregivers and parents, schools, and other agencies.

Note about this goal: we are concerned about making recommendation regarding prevention to raise the awareness and information available to parents before behavioral health needs are present to increase early access to services and supports. We are also interested in what gets and keeps parents engaged in treatment and care of their child.

RESOURCES & LINKS

- *"A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities."* National Committee for Quality Assurance. December 2016. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf (Last accessed July 7, 2021)

- *"Improving Cultural Competency for Behavioral Health Professionals."* U.S. Department of Health & Human Services. https://thinkculturalhealth.hhs.gov/education/behavioral-health

- *"Education and Mental Health During COVID-19,"* Infographic from the National Federation of Families, https://files.constantcontact.com/fa3e9a0a001/fc8696d3-443a-41f8-b8c9-0bf682a9ac59.pdf (Last accessed July 7, 2021)

- Report of the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature. Special Committee on Kansas Mental Health Modernization and Reform. January 2021. http://www.kslegresearch.org/KLRD-web/Publications/CommitteeReports/2020CommitteeReports/ctte_spc_2020_ks_mental_health_modern_1_complete_report.pdf or http://www.kslegresearch.org/KLRD-web/Publications/CommitteeReports/2020CommitteeReports/ctte_spc_2020_ks_mental_health_modern_1_complete_report.pdf
  - Special Committee on Mental Health Modernization and Reform Working Groups, February 2021. https://www.khi.org/policy/article/MHMR-2021

APPENDIX: CHILDREN'S SUBCOMMITTEE CHARTER

GBHSPC
CHILDREN'S SUBCOMMITTEE
CHARTER

GBHSPC Subcommittee Charter	
Subcommittee Name:	Childrens Subcommittee
Context:	The Children's Subcommittee generates recommendations for the GBHSPC regarding the behavioral health system of Kansas as it relates to Kansas children and their families. The GBHSPC reviews not just this subcommittees recommendations but other existing subcommittees and presents all Behavioral Health recommendations to the Secretary of KDADS and the governor. It is acknowledged that although the priority focus of the GBHSPC are the SPMI and SED target populations (Federal law 102-321), the work of the subcommittee is to be conducted with the whole system and all Kansas citizens with behavioral health needs in mind.
Purpose:	The Children's Subcommittee is devoted to the behavioral health needs of children and their families. The subcommittee examines and makes recommendations to improve the array of behavioral health services offered to children and their families through Kansas Community Mental Health Centers (CMHC), substance use treatment providers other children's service systems and collaboration between systems of care such as Psychiatric Residential Treatment Facilities (PRTF), hospitals, juvenile justice services and schools. We: ▪ Identify strengths and needs. ▪ Make informed recommendations. ▪ Use subcommittee member networks to address identified needs and influence change.
Vision:	That all Kansas children and their families will have access to essential, high-quality behavioral health services that are strengths-based, developmentally appropriate, and culturally competent.
Mission:	To promote interconnected systems of care that provide an integrated continuum of person- and family-centered services, reflective of the Children's Subcommittee vision and values: ▪ *Interconnected Systems* *The integration of Positive Behavioral Interventions and Supports and School Mental Health within school systems to blend resources, training, systems, data, and practices in order to improve outcomes for all children and youth.*[i]

- *Systems of Care*
  A spectrum of effective, community-based services and supports that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to enhance functioning at home, in school, in the community, and throughout life.[ii]

- *Integrated Services*
  Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.[iii]

- *Continuum of Care*
  - ✓ *Across the Lifespan – From birth to age 22.*
  - ✓ *Across Levels of Intensity – Preventative (Tier 1), targeted (Tier 2), intensive (Tier 3).*

- *Person & Family-Centered Planning*
  A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person- and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities, preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.[iv]

Intensive supports/intervention:
for children and their families who are in crisis or at risk
"Individual"

Targeted & Preventative supports/intervention:
for commuity, providers, staff, children and their families, etc. with identified needs, risks, etc.
"Targeted Individuals & groups"

Preventative & Universal Supports/Intervention:
for everyone (state, community, agency, school, etc.)
"Statewide-Communitywide-Agencywide-School Wide"

Values:	The Children’s Subcommittee will use the following values to guide their purpose: ▪ Use data from multiple sources to ensure an accurate picture of the target population ▪ Promote person and family-centered planning ▪ Ensure all recommendations are supported by evidence ▪ Maintain collaborative and inclusive networks ▪ Listen and respect the voices of those we serve

GBHSPC Approval	
Name	**Signature**
Click here to enter text.	
Click here to enter text.	

Charter Effective Date: 05/08/2017

[i] http://www.midwestpbis.org/materials/interconnected-systems-framework-isf
[ii] https://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf
[iii] http://www.integration.samhsa.gov/about-us/what-is-integrated-care
[iv] https://www.samhsa.gov/section-223/care-coordination/person-family-centered

APPENDIX: CHILDREN'S SUBCOMMITTEE MEMBERS

- Erick Vaughn — *Chair*, LMSW, Executive Director, Douglas County CASA
- Rachel Brown — *Chair-Elect*, MBBS, KU Dept of Psychiatry and Behavioral Sciences, Professor and Chair, Residency Program Director
- Nancy Crago — *Past-Chair*, LSCSW, Director of Psychosocial Rehabilitation, Family Service and Guidance Center
- Laura Hattrup — *Secretary*, LSCSW, State Trainer, Kansas Technical Assistance System Network
- Amanda Aquila-Gonzalez — Kansas Department for Health & Environment, KSKidsMAP
- Annemarie Arensberg — CEO at Lake Mary Center
- Anthony Bryan — Director of Risk Management and Corporate Compliance at Family Service and Guidance Center
- Ashley Grill — *GBHSPC Liaison*
- Brenda Grove — *Parent Representative*, GBHSPC
- Brian Dempsey — Attorney at Kansas Department of Education
- Charlene Jostes — Parent & Affiliate Development Specialist at NAMI Kansas
- Charlie Bartlett — *KDADS Liaison*
- Chelle Kemper — Special Education Director
- Debra Garcia — *KDADS Liaison*, Kansas Department for Aging and Disabilities Services, Children's Community & Inpatient Program Manager
- Gary Henault — *KDADS Liaison*, Kansas Department for Aging and Disabilities Services, Director of Youth Services
- Gianna Gariglietti — President at Lakemary
- Jeff Butrick — Service Manager at Kansas Department of Corrections-Juvenile Services
- Kellie Hans-Reid — Foster Care Coordinator, Aetna Better Health of Kansas
- Kelsee Torrez — Maternal & Child Health Behavioral Health Consultant, KDHE
- Kevin Kufeldt — LCPC, Program Manager, ACT Residential Treatment, Johnson County Mental Health
- Laura Nichols — Assistant Principal at Topeka West High School
- Melinda Kline — Prevention and Protection Services Deputy Director, DCF
- Natalie Sollo — Director of Ambulatory Division, KUMC Pediatrics
- Pamela Cornwell — Saint Francis Community Services
- Rick Gaskill — Executive Director, Sumner Mental Health Center
- Sandra Berg — Executive Director, UnitedHealth Group
- Sherri Luthe — *Parent Representative*, Recovery and Resiliency Manager at OptumHealth Division of United Health Care

Project Impact Paper

ACKNOWLEDGEMENTS

This report was prepared by KSKidsMAP staff: Amanda Aguila Gonzalez, MPH; Rachel Brown, MBBS; Kari Harris, MD; Nicole Klaus, PhD; Polly Freeman, LBSW MSW; Cari Schmidt, PhD; Ashley Hervey, Med; and Kelsee Torrez, MPA with contributions from the Kansas Governor's Behavioral Health Services Planning Council's Children's Subcommittee.

STATEMENT OF NEED

Mental disorders among children and adolescents age 0 to 21 years (hence, youth) are on the rise across the country. In Kansas, one in five youth meet criteria for a diagnosis, and more than 35,000 are severely impaired as a result.[1] The COVID-19 pandemic has impacted youth who are at risk due to developmental age, educational status, economic underprivilege or pre-existing mental disorders.[2]

Many youth identified as at risk or diagnosed with a mental disorder as defined by Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5),[3] receive no treatment. Those who receive treatment often experience long waits to access care.[4,5] Waiting lists to see a mental health professional can be three months to a year.[6,7] Just over 10% of U.S youth receive any treatment from a mental health professional, far fewer than the number living with a mental disorder.[8]

Youth who do not receive effective treatment for their mental disorders are significantly disadvantaged compared to their healthy peers. Mental disorders interfere with the ability to participate in age appropriate academic and social activities. Youth with mental disorders have lower grades and are less likely to graduate high school or to be college or work ready.[9,10] Without effective management and follow up of their disorders, prognosis in adult life is worse. Delayed diagnosis and inadequate treatment

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[1] O'Connell, ME., Boat, T., & Warner, KE. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. National Research Council. Institute of Medicine. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions. Washington (DC): National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK32776/

[2] Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry Research*, *293*, 113429. https://doi.org/10.1016/j.psychres.2020.113429

[3] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

[4] Henry J. Kaiser Family Foundation (KFF). (2018). Percent of Children (ages 3-17) Who Receive Any Treatment or Counseling from a Mental Health Professional. Retrieved from https://www.kff.org/other/state-indicator/child-access-to-mental-health-care/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[5] Mentalhealth.gov. (2017). Mental Health Myths and Facts. Retrieved from https://www.mentalhealth.gov/basics/mental-health-myths-facts

[6] Sullivan, K., George, P., & Horowitz, K. (2021). Addressing National Workforce Shortage by Funding Child Psychiatry Access Programs. *Pediatrics, 147*(1): e20194012. https://doi.org/10.1542/peds.2019-4012

[7] Steinman, KJ., Shoben, AB., Dembe, AE., Kelleher, KJ. (2015). How long do adolescents wait for psychiatry appointments? *Community Mental Health Journal, 52*(7): 782-789.

[8] KFF (2018). Percent of Children (ages 3-17) Who Receive Any Treatment or Counseling from a Mental Health Professional.

[9] Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2015). Leaving school without qualifications and mental health problems to age 30. *Social psychiatry and psychiatric epidemiology*, *50*(3), 469–478. https://doi.org/10.1007/s00127-014-0971-4

[10] Dalsgaard, S., McGrath, J., Ostergaard SD., et al (2018). Association of Mental Disorder in Childhood and Adolescence with Subsequent Educational Achievement. *JAMA Psychiatry,* 1;77(8):797-805. https://www.doi.org/10.1001/jamapsychiatry.2020.0217

lead to increased disability and poorer functioning in adulthood with higher likelihood of un/under employment, incarceration, and higher health care costs for both mental and physical health.[11] The life expectancy of adults with mental disorders, including anxiety and depression, is significantly shortened.[12]

The financial costs of untreated mental disorders are also significant. In 2009, the National Research Council and the Institute of Medicine estimated the total cost of mental, emotional, and behavioral services to be close to $250 billion a year, including lost productivity, criminal behavior, and cost of health services.[13] This is likely an underestimate as the Kaiser Family Foundation has reported a 3% increase in the cost per case to treat mental disorders between 2000 and 2012.[14]

Along with rising mental and behavioral health problems in youth, there is a national shortage of mental health professionals, especially those with the greatest expertise, child and adolescent psychiatrists and psychologists.[15] Kansas needs more than 400 child and adolescent psychiatrists to support the population but currently has approximately 60, the majority of whom work in the northeast region of the state.[16]

There is a chasm between the number of youths needing treatment and the availability of child and adolescent psychiatrists and psychologists and other professionals with expertise in evidence-based treatment for mental disorders. This shortage means many families seek treatment in the primary care setting. Primary care physicians and clinicians (PCPs), especially pediatricians, family physicians, physician assistants and nurse practitioners, are being called on to manage the mental disorders of youth.

PCPs play an important role in the overall health and wellbeing of youth. PCPs see patients from birth through adolescence and into adult life. Because of their role in a child's life, PCPs are uniquely positioned to implement psychosocial screenings, provide assessments, diagnose, and treat less complicated mental disorders themselves. Professional organizations, such as the American Academy of Pediatrics (AAP), are recommending psychosocial screening and assessment for mental disorders be integrated into the pediatric workflow,[17] and a number of other policy and position papers support these initiatives.[18] In addition, recommendation 5.3 of the Special Committee on Mental Health Modernization and Reform report to the 2021 Kansas Legislature specifically addresses the need to

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[11] Patton GC., Coffey, C., Romaniuk, H., et al (2014). The Prognosis of Common Mental Disorders in Adolescents: a 14-year Prospective Cohort Study. *Lancet*, 19;383(9926)1404-11. https://doi.org/10.1016/S0140-6736(13)62116-9

[12] Rehm, J., Shield KD. (2019) Global Burden of Disease and the Impact of Mental and Addictive Disorders. *Curr Psychiatry Rep* 7;21(2):10. https://doi.org/10.1007/s11920-019-0997-0

[13] O'Connell, ME., Kelly, BB., Keenan, W., & Kasper, MA. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Youth People: Progress and Possibilities. Report Brief: A Focus on Costs and Benefits. The National Academies. Retrieved from https://www.nap.edu/resource/12480/Prevention-Costs-Benefits.pdf

[14] Kamal, R. (2017). What are the current cost and outcomes related to mental health and substance use disorder? Health System Tracker. Peterson-Kaiser Family Foundation. Retrieved from https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-start

[15] Kansas Department of Health and Environment (KDHE). (2019). Health Professional Underserved Areas Report: Kansas Primary Care and Rural Health. Kansas Department of Health and Environment. Retrieved from https://www.kdheks.gov/olrh/SD_overview.htm

[16] SAMSHA. (2020). Behavioral Health Workforce Report. Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf

[17] AAP. (2020). Bright Futures Implementation Tip Sheet. American Academy of Pediatrics. Retrieved from https://brightfutures.aap.org/clinical-practice/Pages/default.aspx

[18] Zuckerbrot, R. A., Cheung, A., Jensen, P. S., Stein, R., Laraque, D., & GLAD-PC STEERING GROUP (2018). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. *Pediatrics*, *141*(3), e20174081. https://doi.org/10.1542/peds.2017-4081

increase the capacity of frontline health care providers to offer services to those with behavioral health needs.[19]

Unfortunately, most PCPs have little training in pediatric psychiatric care. While screening is recommended universally and easily implemented in primary care, thorough assessment, diagnosis, and treatment of mental disorders in youth are an entirely different matter. The training of pediatricians and family physicians includes little education in how to evaluate youth presenting with emotional and behavioral problems that may be the symptoms of mental disorders. The training of nurse practitioners and physician assistants is even more limited. As such, many children presenting in primary care go undiagnosed, untreated and without services and accommodations that would benefit them.

In response to the combination of increased need and specialty shortage, a number of states have developed models of care to provide ongoing education and support for PCPs as they expand their ability to take care of youth with mental disorders. These models include Pediatric Mental Healthcare Access (PMHCA) programs also referred to as Child Psychiatry Access Programs; Kansas' KSKidsMAP is an example. The program's impact and growth since 2019 have been significant; by empowering PCPs to provide pediatric psychiatric care in their own clinics, access for youth to this limited resource is improved. The program will be described in detail below.

CURRENT EFFORTS

Integrated Care Models

The shortage in pediatric mental and behavioral health experts is not exclusive to Kansas. Many clinics have used practice models that integrate primary and mental health care to improve patient outcomes and satisfaction at a lower cost by addressing common behavioral health problems (e.g., depression, anxiety, attention deficit hyperactivity disorder). PMHCA programs support integrated care practice models by offering training and consultations to PCPs. Programs like KSKidsMAP work to improve the expertise of PCPs in assessing, diagnosing, treating, and referring youth with mental disorders. By empowering PCPs to provide mental health care in their own clinics, access to care for youth is improved. PMHCA programs increase PCPs' ability to provide mental health care as part of overall comprehensive health care to their patients and are valued by PCPs as an extension of primary care.[20]

KSKidsMAP Program

KSKidsMAP is a partnership between the Kansas Department of Health and Environment (KDHE) and the University of Kansas School of Medicine-Wichita, Departments of Pediatrics and Psychiatry and Behavioral Sciences. Established in 2019, KSKidsMAP partners with PCPs to expand their scope of practice to integrate mental health care. The program relies on the availability of highly trained mental health professionals and a pediatric primary care liaison to provide advice on screening, accurate diagnostic and assessment tools and practices, and evidence-based treatments and resources.

The professionals who make up the KSKidsMAP Pediatric Mental Health Team (PMHT) include:

- Two board-certified child and adolescent psychiatrists
- Board-certified child and adolescent psychologist

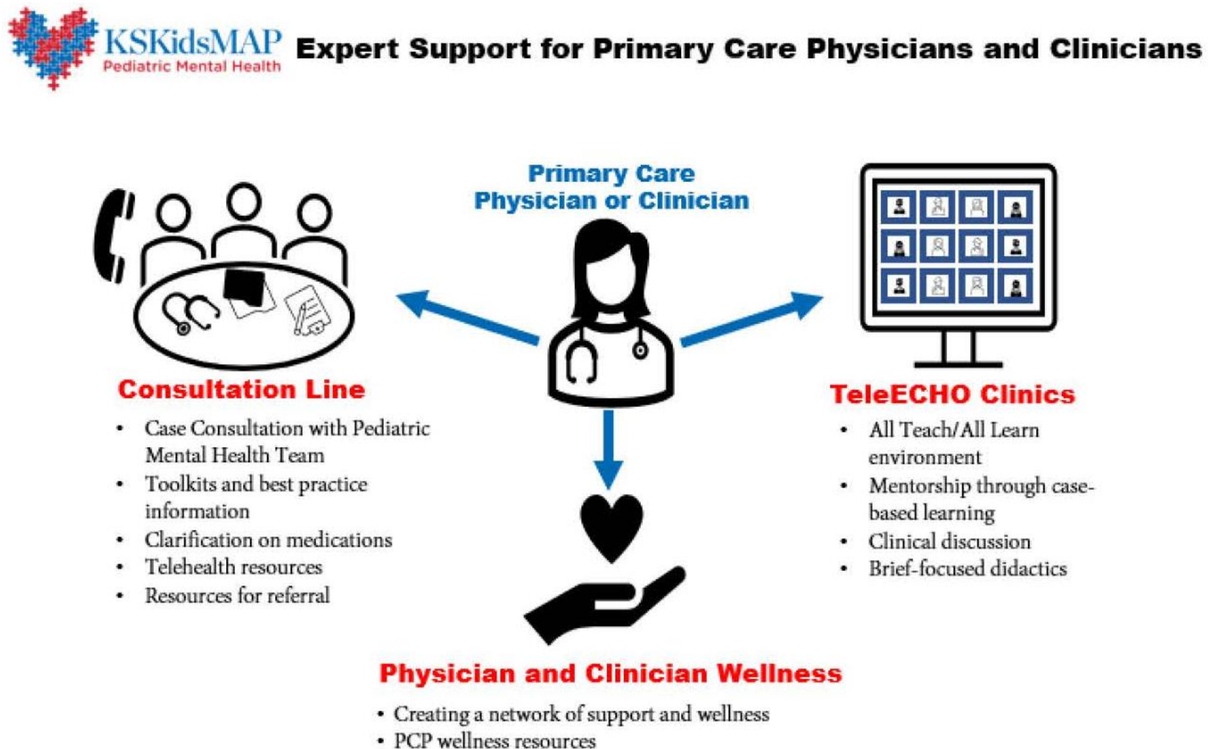
[19] Kansas Health Institute. (2021). Report of the Special Committee on Kansas Mental Health Modernization and Reform to the 2021 Kansas Legislature. Retrieved from http://www.kslegresearch.org/KLRD-web/Publications/CommitteeReports/2020CommitteeReports/ctte_spc_2020_ks_mental_health_modern_1_complete_report.pdf

[20] Sarvet, et al. (2010). Improving access to mental health care for children: the Massachusetts CPAP. *Pediatrics*, *126*(6), 1191–1200.

- Board-certified pediatrician with experience in adolescent medicine and mental health
- Licensed Social Worker Care Coordinator

KSKidsMAP works directly with the PCP, providing tailored resources to ensure confidence in delivering evidence-based mental health care to youth in their practice. KSKidsMAP has multiple program components led by their team, including an ongoing TeleECHO Clinic, a Consultation Line, and wellness resources (Figure 1), to support the PCP who is managing youth with mental disorders.

Figure 1. Expert Support for the Primary Care Clinician Working in Pediatric Mental Health



KSKidsMAP offers multidisciplinary expertise through the KSKidsMAP Consultation Line and KSKidsMAP TeleECHO Clinic. These two components of KSKidsMAP allow PCPs to have an ongoing telementoring relationship with experts as they manage patients. In addition, the TeleECHO Clinic provides ongoing learning through a community of PCPs who can share expertise with and learn from each other. This concept is fundamental to the program because it allows the entire KSKidsMAP network to learn from a single case, thereby moving knowledge (not patients), and disseminating best practices throughout the community. As PCPs participate in KSKidsMAP, their skills and confidence expand, and they are able to manage patients more effectively in their practices with similar conditions.

KSKidsMAP Physicians and Clinicians

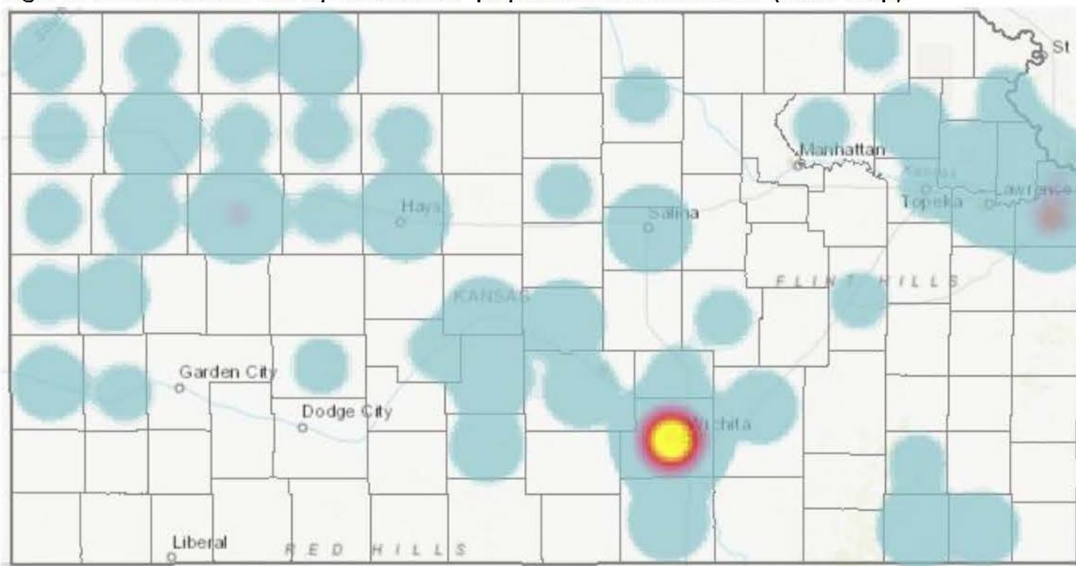
Since inception (December 2019 - April 2021), a total of 115 PCPs have enrolled in KSKidsMAP (Table 1). Participating PCPs indicated serving patients in 60 (57%) of 105 Kansas counties (Figure 2).

Table 1. KSKidsMAP Network

Physician/clinician Type	N (%)
Physician	70 (60.9%)
Nurse Practitioner	26 (22.6%)
Behavioral Health Clinician	6 (5.2%)
Social Worker	4 (3.5%)
Physician Assistant	3 (2.6%)
Registered Nurse	3 (2.6%)
Other	3 (2.6%)
Total	**115 (100.0%)**

Of the PCPs enrolled, 66.7% (n=70) have utilized the Consultation Line and 69.5% (n=73) have been trained through the KSKidsMAP TeleECHO Clinic.

Figure 2. Counties served by KSKidsMAP physicians and clinicians' (Heat Map)



*Note: Circles with red and yellow marks denote high numbers in the given area

KSKidsMAP Consultation Line

An enrolled PCP may contact the KSKidsMAP Consultation Line by phone or email to connect with the Social Work Care Coordinator. Inquiries by the PCP can be patient-related or personal-wellness centered. The Care Coordinator gathers information regarding the PCP's specific need and responds to requests for patient- and wellness-focused resources and referrals. She consults with the wider Pediatric Mental Health Team for specific patient related questions. Case consultations are offered within 72 hours of the first inquiry. After a videoconference, the PCP receives a summary of the case with written recommendations and a tailored list of resources.

Between December 2019 and April 2021, KSKidsMAP supported care for pediatric patients across Kansas with a total of 222 contacts regarding 292 specific inquiries. Case consultation (29.1%, n=85) is the most requested KSKidsMAP support service, followed by mental health toolkits/website resources (22.9%, n=67). Other inquiries include requests for mental health resources for referral (18.5%, n=54),

community resources (10.3%, n=30), telehealth resources (0.3%, n=1), and physician wellness resources (18.8%, n=55).

Of the total consultation inquiries (N=292), 61.6% (n=180) requested assistance addressing specific mental disorders. Of these, 27.2% (n=49) indicated a focus on attention deficit hyperactivity disorder, followed by anxiety (23.3%, n=42), depression (13.9%, n=25), and autism spectrum disorder (13.9%, n=25).

TeleECHO Clinic

Launched in April 2020, the KSKidsMAP TeleECHO Clinic is an ongoing virtual clinic that meets twice a month for case consultation and didactic learning on youth mental health needs in primary care settings. The TeleECHO Clinic offers a platform for PCPs to share de-identified cases and receive input and support from other PCPs and the KSKidsMAP Team. Case-related feedback from the TeleECHO Clinic is summarized and packaged with additional recommendations from the Team, toolkits, and local resources. These case recommendations are made available to all TeleECHO Clinic participants. Approximately 10-15 PCPs attend each session.

Brief didactics are also included in the TeleECHO Clinics. Thus far, PCPs have received education on screening, diagnosis, and treatment for depression, anxiety, and attention deficit hyperactivity disorder. PCPs have also received education on pharmacologic and non-pharmacologic interventions for sleep, monitoring, follow up, and when to refer for additional mental health services. Lastly, physician wellness, and COVID-19 implications for mental health and returning to school have also been explored through TeleECHO Clinic education.

Physician and Clinician Wellness

Integrating mental health care and providing support for youth with mental disorders can increase the stress PCPs experience. In addition to integrating wellness concepts and resources in the KSKidsMAP TeleECHO didactics and Consultation Line supports, the KSKidsMAP program has partnered with programs to offer wellness sessions for enrolled PCPs and to support development of a wellness culture within their clinics.

Other KSKidsMAP activities

During the first 22-months of the program, the KSKidsMAP team has conducted a multisite quality improvement project to increase adolescent depression screening during well visits, developed policies and procedures for clinical recommendations, created a statewide database for mental health resources and toolkits, and developed and broadly distributed a quarterly newsletter. In addition, participating PCPs have received continuing medical education credits and maintenance of certification credits required for licensure and board certification.

KSKidsMAP Participant Highlights

PCPs who utilized the Consultation Line and/or participated in the TeleECHO Clinic provided positive feedback regarding the benefit of resources and discussion in increasing their ability to treat youth within their own practices. During the TeleECHO Clinic discussion one physician from a rural practice shared,

> *"KSKidsMAP provides the extension of care of a pediatric medical home with the psychiatric expertise to provide the best mental health care to children under one roof."*

Another physician said,

> *"KSKidsMAP fills a long-standing void in pediatric care as the prevalence of mental health is increasing with the changing social structure dynamics of modern times. The program helps to manage complicated [psychiatric illnesses and other mental and behavioral health problems] in children, since most pediatricians do not have the support of a mental health team in their realm of pediatric practice. During all these years in practice, we could not get the help which is currently being provided by the team in KSKidsMAP."*

SUSTAINABILITY

KSKidsMAP is one of many programs across the nation working to increase access to pediatric mental health care by building capacity in primary care. These programs have shown success on the large scale but all face challenges with sustained funding. Kansas is no different. KSKidsMAP is in year two of a 4-year HRSA grant that expires in June 2023. Beyond 2023, the future of KSKidsMAP, and access to care for youth currently benefiting from the program, is uncertain. Pediatric mental health care takes time and effort beyond typical pediatric health care; KSKidsMAP needs financial support for infrastructure and for the dedicated time of the expert Pediatric Mental Health Team. Without funding, the program will not survive beyond the grant period, and the opportunity to educate and support PCPs in providing quality care to youth suffering from mental disorders will be lost.

Other PMHCA programs across the country have been partially successful in addressing the financial sustainability barrier. The most successful initiatives rely on the engagement of legislators and on partnerships with state health departments and Medicaid leadership. Examples include implementing billing codes for physician-to-physician consultation reimbursement (North Carolina Psychiatry Access Line) or obtaining state budget allocation for program funding (Missouri Child Psychiatry Access Project). Maryland Behavioral Health Integration in Pediatric Primary Care is funded through both state line items and federal funding. Specifically, Maryland's Department of Health Behavioral Administration funds the consultation line, training, social work co-location, and resource and referral networks, while HRSA funds care coordination, ECHO clinics, telepsychiatry and tele-counseling services. Other options for sustainability include private sector support, community foundation support, and improved reimbursement for interprofessional collaboration around specific patient needs.

RECOMMENDATIONS

The following recommendations are proposed to promote policy, programs, and systems which support access to psychiatric care for Kansas youth:

1. **Make pediatric primary care workforce development opportunities (i.e., training, technical assistance) widely available. These efforts will ensure** gap-filling treatment services in mental health shortage areas are high-quality services that follow mental health best practices.
    a. <u>Fully fund a statewide child psychiatry access program (e.g., KSKidsMAP) to lead these activities</u>. Funding the KSKidsMAP Expert Team would allow the psychiatry access program services to continue beyond the lifespan of the federal grant award (June 2023). Options to explore should include:
        - Use of Medicaid Administrative match allowed for provider training activities
        - Managed Care Organization and/or commercial insurance
        - State general funds line item

- Blended/braided funding across state agencies (e.g., KDADS, KDHE)

b. Revise payment policies within managed care to ensure appropriate payments are available. Policies should apply to both direct mental health services in primary care and for physician-to-physician consultations.

2. **Fund initiatives that enhance the number of highly trained professionals, including child and adolescent psychiatrists and child psychologists.** KSKidsMAP, and similar programs, require teams with the highest levels of training and expertise – board certified child and adolescent psychiatrists and psychologists. KU's Department of Psychiatry and Behavioral Sciences trains general psychiatrists and child psychologists in accredited community-based programs. Community partnerships have been established that could support a two-year focused child and adolescent psychiatry fellowship training program, given appropriate financial resources.

CONCLUSION

More than 20% of Kansas youth experience mental disorders and there is a grave shortage of specialists to care for them. KSKidsMAP is one effective solution. The program decreases barriers to mental health care access in Kansas because it builds capacity in primary care, allowing more youth to receive quality mental health care closer to home and by the PCP with whom they already have a trusting relationship. Youth and families are spared long wait times to see mental health experts and long drives to access this specialty care. In addition, by decreasing long-distance appointments, youth are able to remain in school and parents at work, thus benefiting the economy. By supporting PCPs to manage less complex mental disorders in primary care, this model also allows experts in child and adolescent psychiatry and psychology to see youth with more complex mental disorders. With more than 100 enrolled PCPs from over half of Kansas counties, KSKidsMAP has indirectly reached 3,400 children, adolescents, and their families in Kansas over the first 22 months of the program. The KSKidsMAP network continues to grow as does the comfort, knowledge, and skills of the PCPs who participate in the program.