Appendix B

The Partnership Access Line Establishing an Empirically Based Child Psychiatry Consultation Program for Washington State: Background, Program Description, and Measures

The Partnership Access Line

Establishing an empirically based child psychiatry consultation program for Washington State: Background, Program Description, and Measures

Program Update

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Background

The Partnership Access Line is a consultation and education service designed to help primary care providers throughout the state to deliver more rapid, accessible and evidence based mental health treatments. The program was created based on a perceived need from the public, from the state agencies and from the state legislature that the psychiatric care of Medicaid children had shortfalls which could be addressed by providing child mental healthcare support for primary care providers.

Concerns about the system as usual were many fold. It has been noted that medications were being given to children with an ever increasing frequency for emotional/behavioral disorders, both nationally and locally here in Washington. Nationally, investigators have found two to three fold increases in prescriptions for most psychiatric medications in children over a recent 10 year period,[1] as well as a significant increase in use of psychopharmacology in preschool children.[2] In Washington State these trends are no different. Even very strong psychiatric medications have been used more and more often with young children. It has been reported that 10% of all adolescents, and as high as 34% of all children and youth in certain high risk populations (children in foster care) are now receiving psychiatric medications.[345] Between 2004 and 2007 with Washington Medicaid the number of children taking atypical antipsychotics has risen 25%, and the associated per unit costs from this medication class have risen 38%.[6]

Inadequate treatment of child mental health problems is a significant public health concern. Functionally impairing emotional or behavioral disorders occur in approximately 20% of youth in the United States,[7] and occur in even higher rates (44%) for youth in foster care.[8] Untreated mental health disorders are associated with poor childhood outcomes such as suicide, juvenile delinquency, school violence, and educational failure, and poor adult outcomes such as school failure, poor employment opportunities and poverty.[1,9,10,11,12]

The Partnership Access Line is designed to address all five of the recognized barriers to primary care providers delivering quality mental health care, as published by the American Academy of Pediatrics:

- a lack of mental health training/knowledge
- a lack of time to dedicate to caring for mental health issues
- a lack of sufficient reimbursement
- a lack of knowledge about local resources
- insufficient referral feedback from local mental health specialists[13]

Arguably one of the greatest barriers to Medicaid children receiving quality mental health care is access to child mental health specialists. Washington State has far fewer child psychiatrists than it needs, with its number of child psychiatrists calculated to be 6.6 per 100,000 youth. This number is well below the national average of 8.7 and also well below an estimated need of 14.4 in an ideally designed managed care utilization system.[14] Rural access to child psychiatry is comparatively abysmal compared to urban centers, so the rural areas of the state have the greatest need for such access. At its core, the Partnership Access Line is a program designed to create rapid access to child psychiatric specialists that are otherwise inaccessible.

Program

In April 2008 the Partnership Access Line opened for service, employing one FTE of child psychiatry time, and marketing to DSHS Region 6. In June 2008 the program was asked to expand its service to DSHS Region 1. As part of that expansion, a second FTE of child psychiatrist time was then assigned to the PAL program (this second FTE was subsequently removed in July 2009 due to budget constraints). In November 2008 the Partnership Access Line opened a satellite office in Spokane to ensure a high level of service to the East side of the state as part of the Region 1 expansion.

The Partnership Access Line

The planning group's working assumption was that the ideal consulting experience from a PCP's perspective would be a child psychiatrist who is immediately available to offer curbside advice whenever it is needed. Physically locating a child psychiatrist in every practice of the state was of course not an option, so the Washington Partnership Access Line (PAL) was designed to approximate that immediately available experience in as resource efficient a manner as possible. Immediate telephone availability of a PAL consultant provides the experience of rapidly accessed consultation to as many practices as possible with as few child psychiatrists as is necessary. By ensuring that phone availability is rapid (rather than via a scheduled phone appointment, or only available during very restricted hours) we make a major investment in encouraging providers to call the program repeatedly over time, by giving them immediate responses for their questions. Rapid phone availability also provides an opportunity to shape the patient's treatment plan before that child patient leaves the PCP's office that same day.

The PAL Consultation Process

Each consultation begins by the PCP calling a toll free number that is answered by the program assistant. The assistant records basic information such as name of provider calling, name of patient and patient's date of birth. A child psychiatrist, affiliated with Seattle Children's Hospital, is on duty for the PAL service and is then called or paged. The PAL consultant and the PCP are connected and discuss the PCP's consultation question. Occasionally, if a PCP has a resource-specific question, they may be connected to a PAL social worker directly, upon request. The PAL psychiatrist or social worker who handles the call is commonly referred to as the "PAL consultant". If the PAL consultant is not available immediately, the PCP will receive a call back typically within 10 to 20 minutes (an accessibility that is virtually unheard of without such a system).

The nature of the conversation between PCP and PAL consultant is best characterized as a "curbside consult," in style, but in substance it offers much more than a simple curbside discussion. PAL consultants have to hold their advice to a high evidence based standard, using regular consultation group meetings to review currently available evidence based assessment and treatment information, and to assure consistency across consultants. Careful documentation of the telephone discussions allows other members of the PAL team, such as our social worker, to

provide additional assistance to the child's provider. Consultant recommendations are referenced to a child mental health care guide developed specifically for this program, a guide which is also distributed to PCPs (and available at www.palforkids.org).

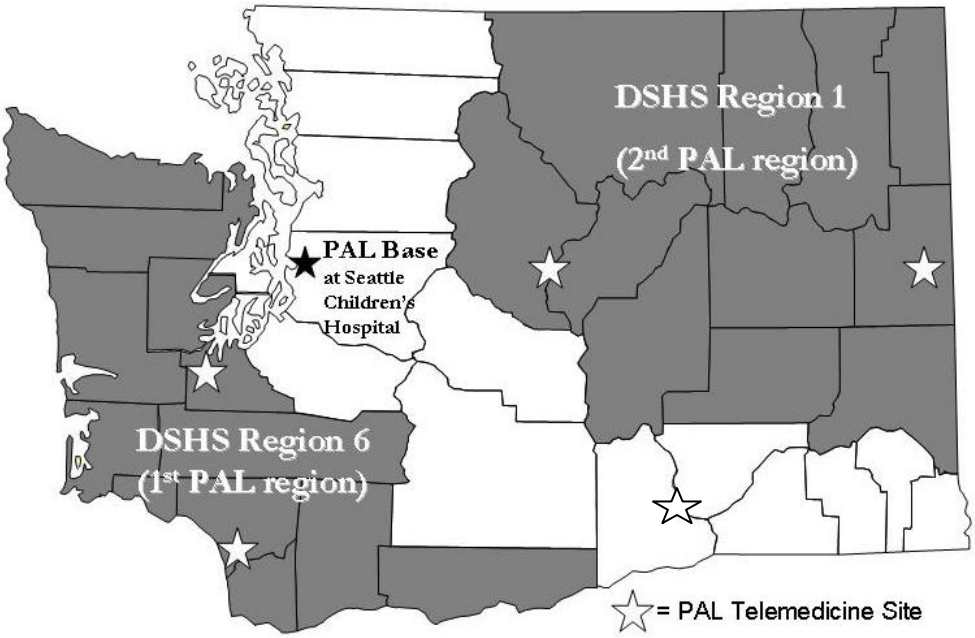
The 70 page long care guide, which was coordinated by Dr. Hilt, contains care algorithms, medication tables, patient handouts, and rating scales tailored to child mental health care in a primary care practice. This care guide was developed with expert input from Washington State academic child psychology and psychiatry specialists and from state policy makers; it is also endorsed by the Washington State Department of Social and Health Services, Children's Administration, DSHS Regional area medical directors, and the Washington State Chapter of the American Academy of Child and Adolescent Psychiatry. Preparation of the care guide was a core work product of the PAL program, necessary before the program could open its doors for business.

If a PCP requests a full consultation assessment during their phone conversation with the PAL consultant, then the PAL psychiatrist has the option of conducting a telemedicine or in-person evaluation of the patient. Full consultation appointments are rapidly available, and may occur as quickly as the next day if feasible for the family. The decision about whether to schedule a full consult visit is decided jointly by the PCP and PAL phone consultant. Consult appointments may occur in person, or via telemedicine at a clinic site more convenient to the family (see figure 1). PAL consultants never write prescriptions for the children who are seen for full appointments—this is essential for ensuring care remains coordinated within the child's medical home. The PAL consultant's role is to support the PCP in their work with the child, and/or to help advocate for the most appropriate long term local mental health specialty care to be engaged on behalf of the child.

PAL consultants provide same day verbal or written feedback to the referring PCP after a consult visit, as well as a formal consultation report mailed to the provider as quickly as possible. Ongoing care remains with the PCP, or (when applicable) with a local mental health provider. Providers may call repeatedly about the same patient, and in this way can get ongoing support for individual cases. It has now become a regular occurrence (about 10% of our calls) that we talk to a PCP repeatedly about the same child and provide longitudinal care assistance. On some occasions we have been called by two different providers on different occasions about the same child, placing the PAL program in a unique role of providing the child with some additional care continuity as the family moves around from practice to practice.

One of the two PAL social workers will create an individualized referral plan for a patient if they may benefit from further mental health evaluation or a new ongoing care relationship within the child's own community. This plan is then directly communicated to the PCP's office. An example of a typical social work consultation might be a referral for an empirically supported treatment such as Parent Child Interaction Therapy for children with externalizing disorders. The PAL social worker maintains a large database of community referrals and empirically supported treatments available throughout Washington State.

Figure 1. Areas Contracted for Coverage by PAL



Another key component to the PAL program are community outreach education efforts such as full-day continuing medical education conferences or other local lectures on child mental health topics at no cost to PCP's in Washington State. These outreach efforts include topics that are germane to best practice assessment and treatment of mental health disorders in children, as well as education about community resources and use of the PAL program. Presenters at these educational efforts have included PAL consultants, University of Washington based experts, and the Eastern WA area health education director.

To maintain rapid PAL consultant availability, any given PAL consultant on duty is not given any more than two in-person consultations per day long shift. That way the PAL consultant has time available to quickly catch up on PCP phone calls that may arrive during their in person consultation assessments. When the program had two child psychiatrists on duty at any given time, this enabled us to triage PCP calls to the most available PAL consultant at the moment the PCP reached out by phone to the program. The PAL consult program does not bill insurance for in person consultation services for Medicaid clients, because as a Medicaid-funded program the consultant's time has already been pre-purchased by the state.

Case example, demonstrating how the PAL program works

A typical example of a PAL case involves only phone contacts. In one situation, a provider called one day to review the care of a 6 year old boy who was taking risperidone (an antipsychotic) and clonidine for "bipolar disordered" behavior that the PCP described as "all over the place," involving emotional meltdowns. The risperidone dose had been pushed up over time to the point of heavy sedation and things were still going poorly, at which point the provider

called PAL. The PAL consultant learned that before the risperidone was initiated, there had been a failed trial of methylphenidate that had caused significant side effects of low appetite and increased aggression.

A collaborative plan was made to have Vanderbilt behavior scales completed at home and school to better assess the current externalizing problems, and to start weaning the child off the risperidone since there was a lack of benefit. The PAL social worker assisted the provider's office with locating therapists and after school resources for this child. During a second PAL phone discussion with the same provider it was noted that aggression had increased after stopping the risperidone (when the risperidone sedation was gone) and that the Vanderbilt scales strongly supported an ADHD problem. The PAL consultant recommended that the child receive a cautious trial of dextroamphetamine for ADHD since some children respond much better to one stimulant than another. Further inquiry at that time revealed this child had expressive language delays which had not been previously identified, so a speech evaluation and therapy plan was facilitated to occur at his school. His teacher revealed the child was easily overwhelmed by the other students, and so he and his teacher decided to move his desk slightly away from the other children during times of increased activity. The PCP called PAL a third time, this time just to report that the medication and environmental changes were all working out very well for the child. The PAL program social worker continued to work with the PCP's office to facilitate this family's pursuit of behavioral management therapies in their area.

The case above exemplifies how it is possible for simple phone contacts with a PAL consultant to enhance evidence based mental health practice within a collaborative care framework.

Program Goals

Succinctly put, the PAL program designers hoped the PAL program will improve child mental health care access, quality, and outcomes. The primary measured goals of the program are looking to: (1) demonstrate overall feasibility and PCP satisfaction with the program, (2) demonstrate changes in PCP knowledge about assessment and treatment of child psychiatric disorders, (3) demonstrate any impacts on PCP prescriptive practices, (4) demonstrate a preference for steering children into non-medication evidence based practices, and (5) demonstrate changes in symptomatic and functional outcomes of children who are exposed to the PAL program.

Evaluation Plan

Since the PAL program is predicted to have a multi-layered impact on regional child mental health care delivery, a complex evaluation plan is needed to capture the full range of impacts. Primary data (e.g., surveys) are being collected from PCPs who utilize the PAL program. Data on each individual call are recorded on a secure Microsoft Access database, to allow tracking of calls, call topics and overall program utilization. Secondary data is planned to be obtained from the Washington State DSHS Medicaid claims, mental health, and Children's Administration (i.e., child welfare) databases. These secondary data will be utilized to investigate PCP and child level outcomes and will allow for evaluation of outcomes to

comparison groups of non-participating PCPs and children. The initial study plan also involved an IRB approved procedure for interviewing guardians of children impacted by the PAL program—however that procedure had to be dropped in May 2009 due to inability to enroll a sufficient number of families through what was a too complicated consenting procedure.

Research Sample

All PCPs who provide care for Medicaid funded children in the predominantly rural Regions 1 and 6 of Washington State are eligible to participate in the evaluation study. (Figure 1) PCPs are defined as pediatricians, family practice physicians, physician assistants, and nurse practitioners who provide primary health care to children. Through database and internet searches, the PAL program has been able to identify a total 1042 PCPs combined in the two intervention regions. Parents and foster parents of children who receive a PAL consultation and whose care is Medicaid funded were also originally planned to become direct participants in the study. However, experience has been that utilizing the Washington State IRB approved procedure for contacting families was terribly cumbersome, and despite best efforts was unable to achieve receipt of feedback from any significant percentage of children potentially benefiting from the service. In May of 2009 this family interview procedure was officially dropped due to failure of the IRB approved procedure to generate any significant amount of data.

Evaluation Procedure

Institutional review board (IRB) approval was obtained from the Washington State IRB in May 2008, with primary data collection beginning at that time. PCPs in Region 1 and 6 were recruited to participate in the study via direct mail invitations and consenting. PCP's are also informed about the research program if they attended one of our PAL educational sessions. PCPs are clearly informed that they are not required to participate in PAL research in order to utilize the PAL clinical service, as also stipulated by the IRB.

After stopping the IRB research procedure for family contact in May 2009 (as described earlier), the PAL team in June initiated its own quality improvement follow up procedure with families who received consultation appointments. For this, families are called by the PAL team 1 month and 3 months following a consult appointment to inquire about the child's current clinical condition and experience with seeking care in their local system. This new QI follow up procedure has been much better accepted by families, but it is too soon to interpret results at time of this writing.

PCP satisfaction and feasibility are being measured via surveys completed after the 1st, 2nd, 5th and subsequent 5th telephone consultations and after every telemedicine consultation. These satisfaction tools include 12 (telephone consultation) and 15 (telemedicine/in person consultation) Likert scale items and one qualitative item. Feasibility of the PAL program will also be measured by assessing the percentage of eligible providers who participate in the program, as well as the overall frequency of provider consultations. Process measures of the nature of each consultation call will demonstrate the type of work being performed.

PCP perceived child psychiatry knowledge will be evaluated utilizing the Mental Health Resource and Self-Assessed Confidence Survey, a measure created for this study. This tool includes 49 items assessing provider demographics, perceptions about the mental health system and resources in their community, and perceived knowledge and comfort about psychiatric assessment and treatment. It includes both quantitative and qualitative items. This measure will

be administered to all eligible providers prior to implementation of the PAL program via a general mailing. In order to assess changes in perceived knowledge after PAL consultations this measure will be re-administered after the 1st, 5th, and every 5th subsequent Medicaid funded consultation. Comparisons between pre and post-consultation knowledge will be conducted to investigate the impact of the PAL program on PCP perceived knowledge.

It is planned that PCP level administrative data will be utilized to investigate the impact of PCP program participation on PCP prescriptive practices. These outcomes will include: average number of psychiatric medications prescribed, number of children receiving psychotropic polypharmacy, and number of children receiving within class polypharmacy. Outcomes will be investigated for one year before and after program utilization to investigate within subject change. Between subject change will be investigated by utilizing a matched group of PCPs who did not participate in the program. Data will be gathered from these providers for a corresponding two year time period. PAL consultant recommendations for medication changes will be compared to DSHS database record of actual prescription fills. Other administrative data to be assessed will include inpatient and outpatient psychiatric utilization, psychiatric diagnosis, number of foster care placements, number of child protection service referrals, psychotropic medication prescribed, and medication adherence. This administrative level data analysis is currently being negotiated for how best to conduct it.

PAL consultant advice with every phone or in person consultation contact is being carefully recorded with a unique record for each call. PAL consultants review each others' de-identified PAL consultation notes on a regular basis to maintain an active peer review process amongst the consultants. Advice will be catalogued, and compared to accepted care standards, such as whether or not a non-medication treatment like CBT is recommended for an adolescent with depression.

Feasibility

The first element of establishing program feasibility was to ensure that our assumptions about the needs of the practice community were correct. The baseline experience of practicing PCPs was assessed with a detailed survey completed by PCPs at the time they enrolled with the UW as a PAL study provider. At the time of last analysis, 253 baseline assessment surveys have been received out of a possible total of 1042 PCP's practicing in DSHS Regions 1 and 6.

With this survey, it was confirmed that mental health care access is relatively a greater problem for Medicaid clients than for privately insured children, though both populations have significant issues have major problems with access.

- Only 21% of PCPs stated they can access a child psychiatrist for Medicaid children when one is needed
- only 31% of PCPs stated they can find a child therapist for Medicaid children when one is needed

- only 23% of PCPs felt that with existing resources that they can usually meet the needs of children with psychiatric problems

These results confirmed the original assumption that there was a tremendous need to enhance the current care system through providing support to primary care providers. The specific survey questions which pertained to mental health resources are presented below along with summarized responses by the PCPs participating in the survey:

PAL Baseline Needs Assessment of Regions 1 and 6

Mental Health Resources (1= Strongly Disagree, 5= Strongly Agree)	**Strongly Disagree/Disagree**	**Strongly Agree/Agree**	**Mean (SD)**
With existing resources I am usually able to meet the needs of children with psychiatric problems.	53%	23%	2.6 (1.1)
When I want to, I can consult with a mental health specialist about my child patients within a reasonable period of time.	62%	23%	2.4 (1.1)
I have an established relationship with a mental health specialist, who helps me care for my child patients.	58%	26%	2.5 (1.2)
When I need to, I can make referrals to therapists skilled in cognitive behavior therapy (CBT).	53%	26%	2.6 (1.1)
For my MEDICAID patients I can find a therapist/counselor when needed.	46%	31%	2.7 (1.1)
For my MEDICAID patients I can find a psychiatrist when needed.	67%	21%	2.2 (1.1)
For my PRIVATE INSURANCE patients I can find a therapist/counselor when needed.	26%	51%	3.3 (1.0)
For my PRIVATE INSURANCE patients I can find a psychiatrist when needed.	45%	38%	2.8 (1.2)

We further asked PCPs on the same baseline survey to simply tell us what they felt was the most important need to be addressed in child mental health. Specifically, the question we posed was, "**What are the biggest challenges in finding mental health specialist resources for your child patients?"** Some of the typical responses included:

> "Getting patients in to a psychiatrist also finding a counselor that actually makes a difference in the child and parent functioning"

> "There are only a couple counselors who are good with children/adolescents and they are booked out for months. I can refer, but this requires travel in typically dysfunctional families and therefore low compliance"

> "Even available counselors are difficult to access. Most available counselors don't manage needs at all."

> "Not very user friendly. Rarely feedback from mid-levels. Psychiatry- unable to directly refer. (For welfare which is 90% of practice.)"

> "Not enough child psychiatrist, Insurance limitations, listing of providers-- not sure who to call sometimes."

> "Insufficient resources. There are 2 ARNP's in the county and no psychiatrists. Evals are done but due to backlog in school system, only the most severe get any treatment."

> "For severely ill patients (acute psychosis) I can't get someone (child) to see a psychiatrist for months."

Overall, the results of our baseline survey of PCPs confirmed our original assumption that the state's existing care system has not been able to adequately to meet the mental health care needs of Medicaid children, as assessed by the perspective of the state's primary care providers. It appears that a more easily accessed mental health specialist resource like PAL is in fact well matched to what primary care providers say they need and want.

A second core element of feasibility of the program is showing that it is actually possible to hire child psychiatrists to work on the program. Child psychiatrists are an extremely scarce resource in this state. Without the ability to staff the program with experienced child psychiatrists, the program could not exist, however the PAL program had no difficulty with recruiting skilled consultants to participate.

A third early measure of the PAL program's long term feasibility is the overall utilization of the program by PCP's. Changing PCP behavior to reach out to a mental health consultant during the course of a busy work day is a major hurdle. The potential barriers to making that phone call are numerous, including lack of familiarity with the program, lack of time for making a call, and lack of willingness to do something different than their usual practice pattern. We utilized a multifaceted marketing approach of face to face meetings, local CME outreach, repeated direct mailings, phone calls and fax communications to raise awareness about the program. Our initial experience has shown us that face to face meetings between PAL consultants and PCPs, or positive recommendations from respected colleagues seem to be the most effective strategies behind increasing PAL program utilization by PCP's.

Unfortunately arranging face to face meetings between a PAL consultant and local primary care providers is not easy, in large part because it is a ~2 hour drive for a PAL consultant to reach the nearest edge of one of our intervention regions (Figure 1). This makes it difficult for us to informally drop by a practice to do a meet and greet. To improve our efficiency with such face to face meetings, effort was made to meet with whole practices at once, usually organized around providing them with a mental health educational talk of the local practice's preference. Also we organized having PAL consultants provide presentations at local institutions to give CME category 1 or 2 education as another way of establishing professional collaborations. (See Appendix 2 for samples of PAL presentations) Organized presentations have occurred at the

following dates and locations so far, which represent face to face meetings with about 1/4 of the providers in our intervention regions.

PAL Presentation History

3/13/08 Salmon Creek Hospital	Vancouver	10 providers
4/3/08 Northwest Pediatric Center	Centralia,	11 providers
4/9/08 Jefferson Memorial Hospital	Pt. Townsend	5 providers
4/22/08 St. Peter's Hospital	Olympia	18 providers
5/7/08 Vancouver Clinic	Vancouver	13 providers
5/19/08 Child and Adolescent Clinic	Longview	10 providers
6/14/08 Sacred Heart Children's Hospital	Spokane	18 providers
6/19/08 Mark Reed Hospital	Olympia	9 providers
7/12/08 WCAAP board meeting	Leavenworth	14 providers
7/16/08 Cowlitz Family Health Center	Longview	16 providers
7/22/08 SW Washington Medical Center	Vancouver	13 providers
8/4/08 Olympic Medical Center	Port Angeles	3 providers
10/4/08 Sacred Heart Medical Center	Spokane	27 providers
10/6/08 Jefferson Hospital	Port Townsend	3 providers
11/11/08 Jefferson Hospital	Port Townsend	7 providers
11/15/08 Sacred Heart Medical Center	Spokane	44 providers
12/9/08 Seattle Children's Hospital	Seattle	9 providers
1/31/09 SW Washington Medical Center	Vancouver	54 providers
2/28/09 St. Peter's Hospital	Olympia	44 providers
4/25/09 Olympic Medical Center	Port Angeles	12 providers
		(340 in all)

Initial utilization of PAL was low in the first several months of the startup phase, at the rate of around one phone call per day. As we got stronger word-of-mouth spread within local practice communities, utilization has significantly improved. The initial low utilization was an unavoidable part of the program's design. This is because the PAL program requires rapid availability of a child psychiatrist to give the PCP a positive clinical experience from calling the program; otherwise it is unlikely that the PCP will choose to call again in the future. For this reason it was essential to build up our consultation capacity long before overall program utilization would keep an assigned child psychiatrist busy with work on the PAL program.

Recent utilization trends have shown this strategy of providing an early positive experience with rapidly reaching the PAL consultant is now working. Call volumes grew throughout the 15 months of the Program with the expected slowdowns around Christmas and summer.

Figure 2: Utilization of PAL program over time

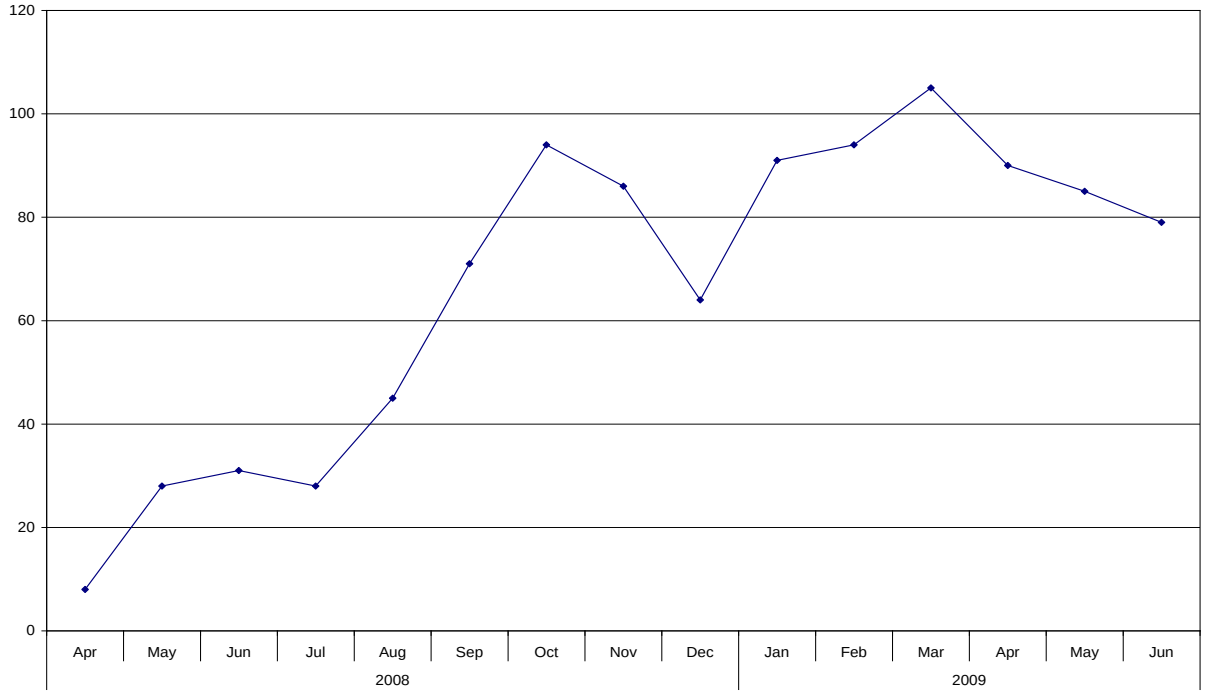
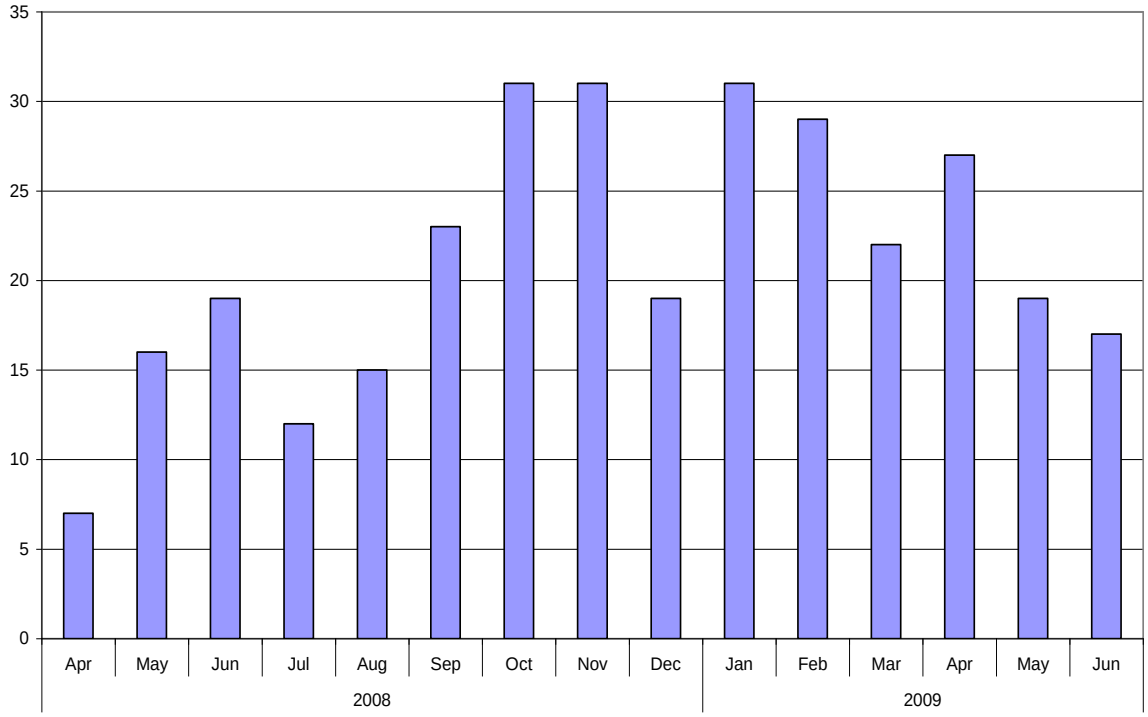


Figure 3: Number of Providers Using PAL for First Time

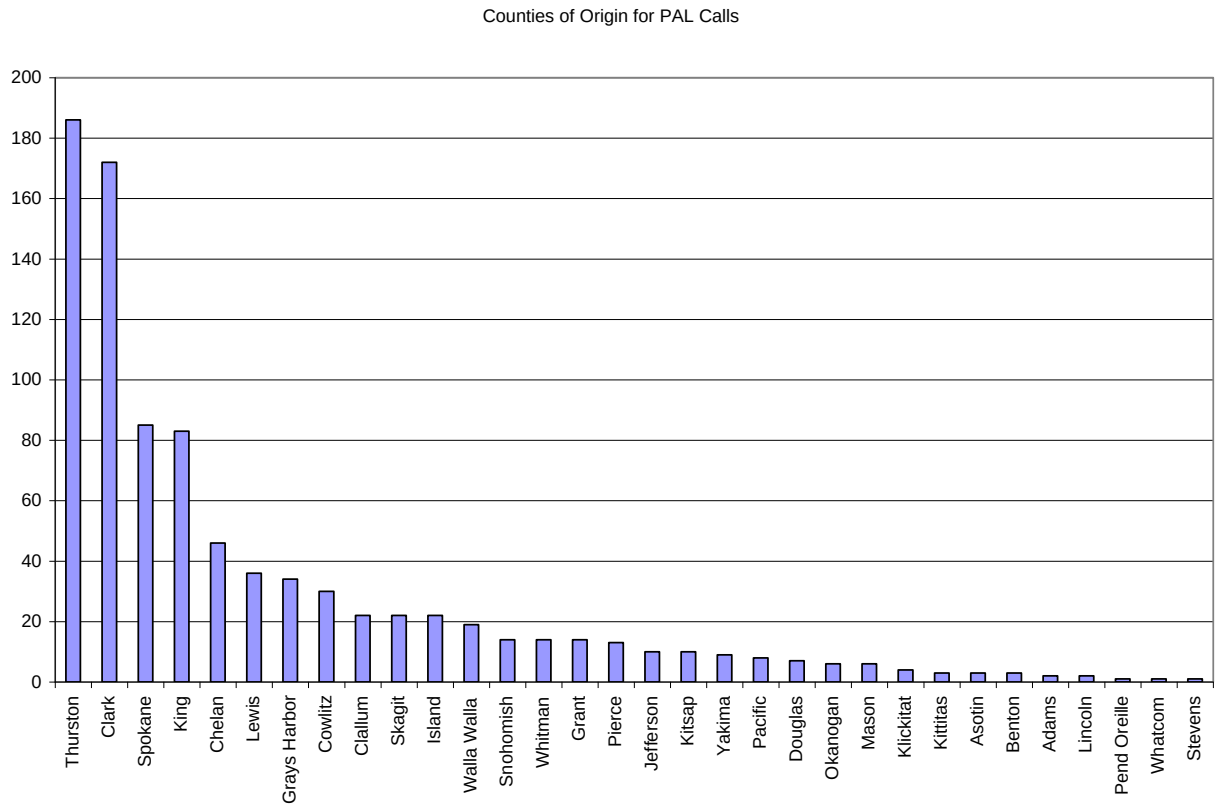


PAL call response times:

The goal of the PAL program is for the Psychiatrist to be able to take the call immediately when the call comes in. In the first 15 months of the program we were able to transfer a PCP directly to the consultant about 1/3rd of the time. Often the consultant might be on another call, with a patient, or away from their desk. More than half of the time the consultant was able to return the PCP's call within 30 minutes often within 5 minutes.

PAL call sites of origin:

The PAL program has only been marketed to providers in DSHS Region 1 and 6, because these are the two state regions where the program has been contracted to provide service. However some calls have come to us from outside of these regions as well, due to word of mouth spread about the program. The PAL team has decided that unless the phone line becomes too busy to provide a high level of service to our contracted regions, that we will offer the same service to our out of area callers. The following is a graph showing the counties of origin for calls to the PAL line.



Full Consult Appointments

The PAL program has provided a total of 54 in person consultations through the end of June, which means one full consultation occurs for approximately every 15 PCP calls to the PAL program. This experience seems to confirm that consultation phone contacts with a child psychiatrist are providing the major part of the value of the PAL program overall; the telephone discussions are providing the majority of the program's value. Telemedicine was an important mechanism for how our in person full consultations were occurring, in that 33 of the 54 consultation appointments occurred with use of telemedicine. The PAL program has used Telemedicine sites in Wenatchee, Longview, Olympia, Richland and Spokane.

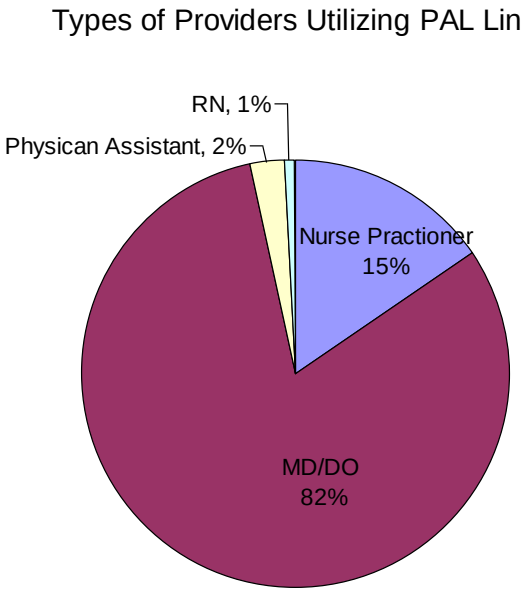
Advantage of having more than one PAL consultant on duty

The PAL program had two child psychiatrists available daily between July of 2008 and June of 2009, and during that time it was noted that these two providers offered a distinct program availability advantage to having just one psychiatrist on duty at a time. For instance, an essential component of the PAL program is that the PAL child psychiatrist needs to perform some patient consults with DSHS children either in person or with telemedicine. These appointments each last at least 60 minutes in duration. If another PCP calls the program while the PAL consultant is tied up performing an in person consultation, then it may be 30-60 minutes until the PCP can get a call back from that PAL consultant. If there is a second PAL consultant on duty, work schedules can be arranged such that a rapid phone response is always possible when the PCP calls. Running a PAL hotline consultation system that is busy enough to justify

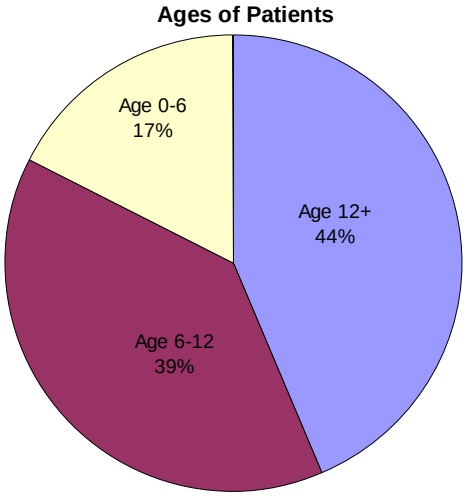
having 2 FTE of child psychiatry time assigned to it thus offers superior service than a system half that size with only one FTE of child psychiatry time assigned. The PAL care delivery process is thus improved through economy of scale.

Nature of the calls

Who calls: 82% of calls to PAL come from DO's and MD's. 15% of calls have come from nurse practitioners, and 2% have come from physician assistants.



Subjects of the calls: 17% of calls are about children less than 6 years of age, 39% about children aged 6-12, and 44% are about children over 12 years of age. Therefore over half of our consultation work involved pre-pubertal children.



DSHS status: Despite the fact that primary care providers are invited to have a phone consult with the PAL program about any child they see in their practice, most calls to the PAL line are about DSHS clients.

- 59% of calls to the PAL program have been about DSHS clients
- 37% of all of the state's children are enrolled in Medicaid[15]

We expected that the phone call frequencies as sorted by insurance coverage would fairly closely match the prevalence of insurance plan enrollment in the community—after all, this is the pattern observed with the similar Massachusetts' MCPAP statewide consult program. Instead the frequency of Medicaid client calls was nearly twice the rate we anticipated. This difference may be because there is a greater perceived need for additional assistance with Medicaid clients over insured clients (i.e. they are "sicker") in our state, or because providers have a higher rate of dissatisfaction with existing Medicaid systems in our state as compared to private insurance care systems). The fact that full consultation visits are only available in the PAL program for children with Medicaid coverage is not likely the reason, because only about 1 in 15 phone calls results in a full consultation.

Severity of child problems: PCPs are observed to call the PAL program for consultations on children with quite significant mental health problems. For instance in the month of October, the mean Children's Global Assessment Scale (CGAS) score for patients about whom a PAL phone consult occurred was 48, and the mean number of mental health diagnoses was 2.5. Using the WA State access to care standards cutoff of a CGAS score of less than 60 (which indicates the presence of a functional impairment serious enough to be eligible for RSN services), our records indicate that 86% of the time in October calls to PAL occurred about children who are functionally impaired enough to be eligible for RSN services.

PCPs most often stated that they decided to call PAL because they wanted to review the use of a psychiatric medication with a child psychiatrist.

- Overall, 69% of calls to the PAL line through October 2008 have occurred because the PCP wanted to review use of a psychiatric medication (186 out of 269 calls).
- 21% of the medication-focused calls involved a discussion about an antipsychotic medication.
- 52% of the time that an antipsychotic medication was mentioned by the PCP during a PAL call, that particular antipsychotic was recommended to be either stopped or reduced in dosage
- 26% of the time when calls were focused on an antipsychotic medication, the PAL consultant recommended either a dose increase or to go ahead with the provider's existing plan to start an antipsychotic medication.

These numbers above were important for us to monitor, because the intended philosophy of the PAL program is a conservative approach to psychiatric medication use in children, as supported by good evidence based practice. So far, following these parameters regarding use of the potent antipsychotic agents has led us to recommend them to be stopped or reduced in dosage at about twice the rate that we endorse their startup or increase in dosage.

Ensuring children are engaged with non-medication treatments

46% of the time when a PCP called with a limited focus of discussing how to manage a child's medication, the phone call ended with the child psychiatrist recommending the child

engage in an evidence based psychosocial treatment (such as cognitive behavioral therapy). The PAL program feels this statistic is very important as it shows our consultants are frequently turning a *medication only* question by a PCP into an educational discussion about the available non-medication approaches to managing behavioral health problems. (Note that this percentage of 46% does not include those children who are already receiving evidence based psychosocial interventions. Overall the percent of PAL consult children who are either already receiving an evidence based psychosocial treatment or being recommended to start one would be significantly higher.)

Our interpretation of the statistics on consult outcomes overall is that the PAL consultants are showing PCP's how to practice good evidence based medicine, and showing PCP's how to be appropriately conservative about the decision to prescribe psychiatric medications to children.

Costs

A cost analysis performed in 2008 noted the following: 27% of PAL calls received through the month of October 2008 resulted in a recommendation to stop, decrease, or change a medication. We compared the Medicaid Average Daily Costs of the medications that the patients were currently prescribed to the cost of following the PAL recommendation. For the 269 consultations done between April and October of 2008 the potential savings were between $75K and $110K for 12 months of medication (the savings range is due to generic versus brand name Medicaid costs). **Projected annualized medication savings based on current call volumes and assuming the same rate of savings would be between $290K and $425K per year.**

Another cost savings of the PAL program is that some specialist evaluation appointments (CPT codes 90801 or 99205) are no longer required in the community after a PAL consultation is utilized. 61% of PCPs who called during the month of October reported that their referral question had been fully answered by the PAL consultant, and that there remained no need for a psychiatrist visit. Given a call volume of ~20 calls per week, 64% of which are calls on Medicaid clients, this projects to an additional annualized Medicaid specialist appointment cost savings of between $42K and $57K per year.

Results of Research Evaluation to Evaluate Provider and Child Outcomes

Michael McDonell, Ph.D.
Eric Trupin, Ph.D.
Division of Public Behavioral Health and Justice Policy (PBHJP)
Robert Hilt, MD

Executive Summary

Faculty at PBHJP in collaboration with the PAL clinical team, have conducted a research evaluation of the PAL program utilizing primary care provider and family survey data. Overall pre-PAL primary care provider (PCP) needs surveys indicated a lack of confidence in providing mental healthcare to children in a primary care setting, as well as a perceived lack of access to specialty mental health care providers, particularly for Medicaid covered children. Post-PAL PCP survey results suggested high levels of physician satisfaction with the PAL program, as well

as increases in physician confidence in providing psychiatric treatment and accessing psychiatric resources. Parent surveys indicated an overall decrease in child mental health symptoms from 1 to 3 months after PAL consultations.

Highlights of the evaluation are summarized here and described in greater depth throughout this document.

PCP SURVEYS:

Pre-PAL Needs Assessment

- 299 PCPs returned pre-PAL needs assessment surveys
- Results indicated:
    - PCPs had relatively low levels of confidence in managing psychiatric illness in primary care
    - Confidence was lowest for managing challenging mental health problems (prescribing atypical antipsychotics, managing youth with severe behavioral problems)
    - PCPs who provided care to higher numbers of pediatric patients with psychiatric disorders reported higher levels of confidence in management of youth with psychiatric disorders.
    - 90% of PCPs reported that access to adequate behavioral health specialty care was one of their biggest concerns regarding mental health care for their patients
    - Overall, increasing provider confidence/knowledge in managing psychiatric disorders and increasing access to specialty care should be main objectives of PAL.

Post-PAL PCP Surveys:

PCP Satisfaction

- 153 satisfaction surveys were received from 91 PCPs
- Results indicated:
    - Very high levels of PCP satisfaction
    - PCPs were most satisfied with the quality and helpfulness of PAL consultation
    - PCPs reported that PAL increased mental health access for their patients
    - Satisfaction increased after multiple PAL consultations
    - Providers who reported few community resources had significantly higher satisfaction with PAL
    - Areas of improvement include providing more timely written feedback and increasing availability of consultations outside of typical business hours

Changes in Confidence and Community Resources

The initial pre-PAL needs survey was administered again after the 1st, 5th, and subsequent 5th PAL consultation to investigate changes in provider confidence and community resources after PAL consultations

- 122 surveys were received from 99 providers
- 37 providers completed a pre and post-PAL survey allowing for comparisons
- Results indicated:

- PAL users reported higher levels of confidence and resources, when compared to non-users (those who only completed the pre-PAL survey)
- No statistically significance increase in confidence or resources were observed in the 37 providers who completed a pre and post-PAL survey.

CHILD OUTCOMES:
We attempted to contact parents or foster parents of all children who received a PAL consultation in order to assess mental health care and changes in psychiatric symptoms 1 and 3 months after a PAL consultation. We experienced significant challenges obtaining parent contact information and obtaining parental consent to participate in the study. Due to these challenges we completed 40 parent interviews with 31 parent respondents

- Results indicated:
  - Statistically significant decreases in psychiatric symptoms in youth from 1 to 3 months post-PAL consultation
  - PAL consultations lead to access to mental health treatment, with 80% of youth being prescribed psychotropic medication and 60% receiving psychotherapy.
  - 83% of parents reported that their child's psychotherapy was clearly or somewhat helpful

Results of Research Evaluation to Evaluate Provider and Child Outcomes
Detailed Study Results

PHYSICIAN SURVEYS

PAL NEEDS ASSESSMENT
All primary care providers (PCPs) who provide care to children in regions 1 and 6 in Washington State were recruited to participate in a pre-PAL assessment of provider perceived mental health knowledge and resources. The 49 item Mental Health Perceived Knowledge (MHPK) survey was mailed to 970 eligible providers. Incentives for participation, reminder phone calls, and second mailings were all used to increase return rates, as these techniques have been effective in previous surveys of physicians. We received completed surveys from 297 providers, 31% of the eligible sample.

Description of the MHPK
The MHPK is a 49 item survey created for purposes of this evaluation that includes assessments of provider demographics, community resources, and confidence about the management of psychiatric issues in children, including assessment and medication management. Questions about community resources and management of psychiatric disorders included quantitative Likert ratings, as well as qualitative items. A psychometric study of this tool was conducted utilizing the 297 surveys received and indicated that the tool has excellent internal consistency. Results also suggested 4 meaningful subscales that can be used to summarize the needs of

providers who are eligible to utilize the PAL service. Subscales included community resources, confidence in management of challenging mental health problems (bipolar disorder, serious externalizing disorders, use of atypical medications), confidence in management of internalizing disorders (depression/anxiety), and confidence in management of ADHD.

MHPK Results

Providers who responded to the survey tended to be medical doctors (n = 223, 75%) and identify themselves as having a specialty in family medicine (n = 203, 69%) or pediatrics (n = 88, 30%). The majority of providers had been practicing medicine for 6 years or longer, with 43% (n = 127) practicing for 16 or more years, 39% (n = 114) practicing for 6-14 years, and 18% (n = 54) for 5 or fewer years. Experience providing care to children and children with psychiatric disorders varied by specialty, with pediatricians providing care to greater numbers of children, relative to family practitioners. Sixty percent of pediatricians reported seeing greater than 25 foster care youth annually, while 78% percent of family medicine providers reported seeing 15 or fewer foster care youth annually, with 41% reported seeing 5 or fewer a year.

Total and subscale scores are reported in Table 1. Ratings are based on a 1 to 5 scale with 1 indicating a lack of confidence, 3 indicating neutral/unsure confidence, and 5 indicating high confidence. Total and subscale scores fell within the Somewhat Not Confident to Neutral/Unsure Confident range, suggesting low levels of confidence in managing psychiatric issues in children. When subscales are investigated, providers reported less confidence managing challenging psychiatric issues, such as using atypical medications, managing bipolar disorder, treating autism, and treating difficult behavior problems. Providers appeared most confident in managing internalizing disorders and ADHD.

Table 1. MHPK total and subscale scores.

	Mean	Standard Deviation
Total MHPK score	2.8	0.5
Challenging psychiatric problems subscale	2.4	0.7
Internalizing disorders subscale	2.9	0.7
ADHD subscale	2.9	0.7
Community resources subscale	2.6	0.8

MHPK Correlations with Provider Demographics

Table 2 displays the means for important provider demographics. Bolded means and standard deviations indicate statistically significant differences. Pediatricians reported significantly higher confidence overall and with managing ADHD, relative to family practitioners. Physicians also reported higher overall confidence, relative to other practitioners. Years in practice were not associated with differences in overall or subscale confidence or perception of community resources.

Table 2. MHPK differences by PCP demographic variables.

	Total Score	**Challenging Diagnoses**	**Internalizing Disorders**	**ADHD**	**Resources**
Provider Specialty					
Pediatrics n=88	**Mean: 108.60 SD: 18.25**	Mean: 2.55 SD: .75	Mean: 2.95 SD: .71	**Mean: 3.47 SD: .50**	Mean: 2.82 SD: .72
Family Practice n=203	**Mean: 98.73, SD: 18.43**	Mean: 2.37 SD: .68	Mean: 2.94 SD: .68	**Mean: 2.72 SD: .70**	Mean: 2.53 SD: .79
Provider Degree					
MD/DO n=223	**Mean: 102.51 SD: 18.72**	Mean: 2.43 SD: .70	Mean: 2.96 SD: .68	Mean: 3.01 SD: .71	Mean: 2.62 SD: .79
Other n=74	**Mean: 98.46 SD:19.46**	Mean: 2.37 SD: .72	Mean: 2.88 SD: .75	Mean: 2.70 SD:.79	Mean: 2.58 SD:.72
Years in Practice					
<5 n=54	Mean: 101.76 SD: 14.02	Mean: 2.32 SD: .53	Mean: 2.99 SD: .63	Mean: 2.93 SD: .73	Mean: 2.70 SD: .71
6-15 n=114	Mean: 100.93 SD: 19.38	Mean: 2.38 SD: .73	Mean: 2.96 SD: .73	Mean: 2.97 SD: .63	Mean: 2.53 SD: .77
16+ n= 127	Mean: 102.30 SD: 20.23	Mean: 2.49 SD: .74	Mean: 2.93 SD: .68	Mean: 2.93 SD: .82	Mean: 2.64 SD: .79

We also investigated the relationship between PCP confidence and resources and the number of children seen by a provider, the number of children in foster care seen by a provider, and the number of children seen with psychiatric difficulties by a provider and found that the number of children seen by a provider was significantly associated with provider confidence. Regardless of specialty or degree, providers who reported seeing more children reported more confidence in managing psychiatric disorders in their patients.

Qualitative MHPK Results

Qualitative items assessed issues related to community mental health resources, as well as overall feedback regarding PCPs treatment of psychiatric disorders in youth. Figures 1 and 2 categorize these responses into meaningful groups. Access to care was by far the most common response with 90% of responses indicating that access to care (either restrictions to who may access care and lack of resources) was one of the biggest challenges for obtaining care for their patients. Importantly, only 11% of responses indicated that quality of mental healthcare was an issue for their patients. Examples of typical responses were:

- Not enough therapists, No psychiatrist in our county, Child psychiatrist is 75-100 miles away.
- Serious shortage of child psychiatrists and counselors skilled in working with kids, compounded by the refusal of most to take Medicaid
- They often do not see children. There are not enough psychiatrists to manage the complex children.

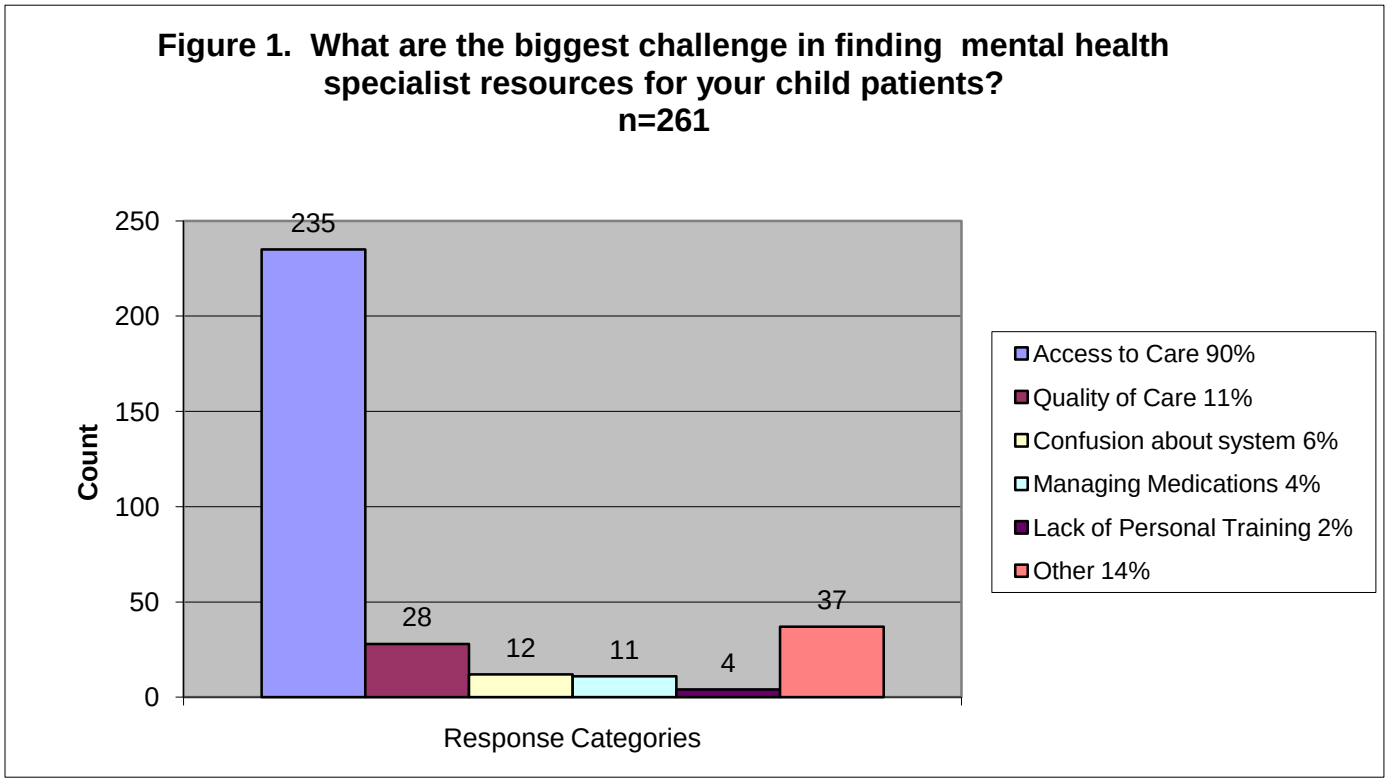
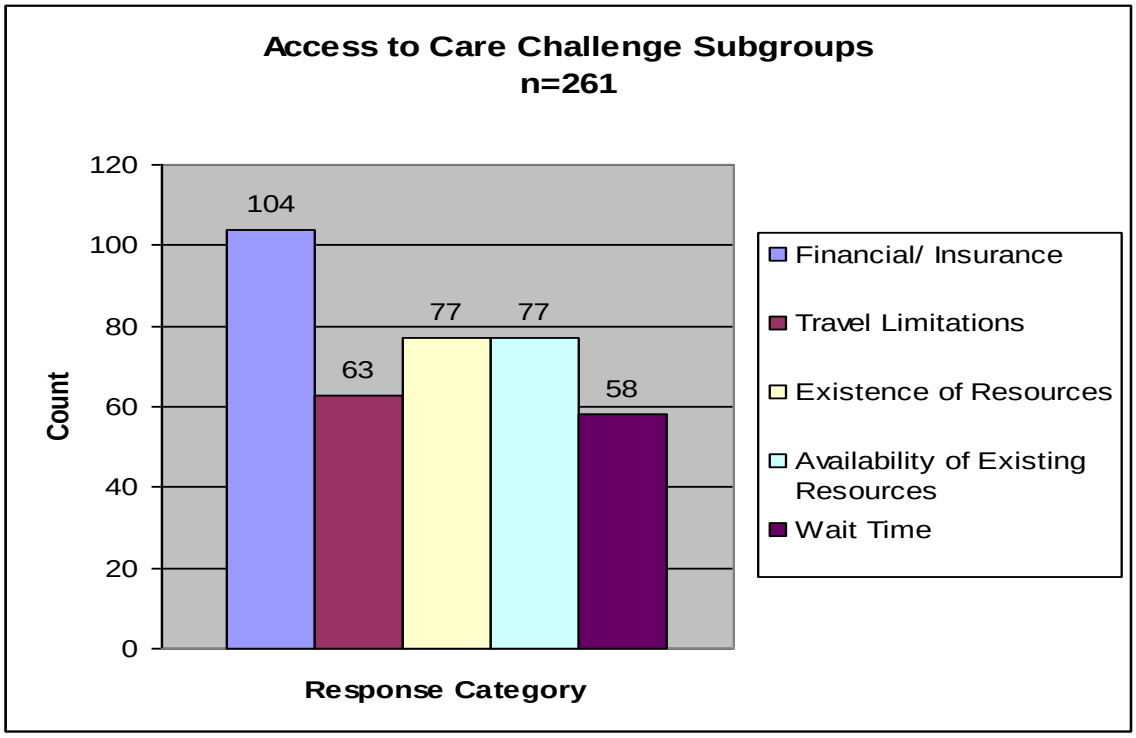


Figure 2 provides a summary of specific access to care concerns of providers. Either patients' lack of insurance for mental health care or difficulty finding providers who accept this insurance were PCPs most frequent concerns, followed by issues regarding the actual existence of a mental health resource (e.g., no child psychiatrists) or access to that resource (e.g., no child psychiatrist are taking new patients), travel limitation of patients/families, and wait time.

Figure 2. Access to care challenges reported by PCPs



PAL USER SATISFACTION

All providers who were eligible for study participation (providers in regions 1 & 6) were asked to complete a satisfaction survey after every 1st, 2nd, 5th, and subsequent PAL phone consultations and after every PAL in-person or telemedicine consultation. 153 satisfaction surveys were received from 91 providers. Satisfaction scales consisted of a set of statements, related to the quality and feasibility of PAL consultations. Respondents rated each satisfaction statement based on a Likert scale of 1 *Strongly Disagree* (not satisfied) to 5 *Strongly Agree* (satisfied). Responses of 4 or 5 indicate satisfaction with the PAL program. Total satisfaction scores were created by averaging satisfaction ratings across the survey items. Overall scores suggested that satisfaction for in-person (Mean = 4.7, SD = 3.2) and telephone consultations (Mean = 4.7, SD = 3.8) were high. Tables 3 and 4 summarize average satisfaction ratings of the 133 telephone and 20 in-person/telemedicine satisfaction surveys received. All items had an average satisfaction of 4 or greater, indicating satisfaction across multiple facets of the PAL program (e.g., increased access, effectiveness of the consultation, feasibility with current practice). Investigation of specific telephone satisfaction items suggest that PAL increases access to mental health resources, provides quality consultations, and that the service is easily and efficiently accessed by providers. While still above an average score of 4 (Agree/Satisfied), results of the telephone satisfaction survey suggests areas for improvement in terms of quick feedback to providers and the speed of obtaining specialty mental health care for patients.

Table 3. PAL provider telephone item satisfaction (133 surveys received).

Telephone Satisfaction Items:	Mean (SD)
1. The program makes consultation services more available to my patients.	4.8 (0.4)
2. I could understand the program consultant's recommendations.	4.8 (0.4)
3. The program is effective for an initial consultation.	4.7 (0.5)
4. The program is/would be effective for follow-up consultations about my patients.	4.5 (0.6)
5. My patient(s) received specialty consultation services sooner because of the program.	4.4 (0.9)
6. The telephone assessment by the program consultant helped me to manage my patient's care.	4.7 (0.5)
7. I feel that the program brings needed mental health experts to my practice.	4.8 (0.4)
8. I am satisfied with the overall quality of the program's consultation regarding my patient(s).	4.8 (0.4)
9. I would be willing to refer patients to a specialist using this program again in the future.	4.8 (0.5)
10. This program helps me to increase my own skills in the mental health care of my patients.	4.6 (0.6)
11. I reached the consultant quickly when I called.	4.9 (0.4)
12. Calling the consultant fits well within my daily practice.	4.6 (0.7)

In terms of in-person and telemedicine consultations, results of item level satisfaction indicate that providers believe that PAL consultations increase the availability of specialty care. Responses also suggest that providers believe that PAL provides high quality consultations and that providers plan on utilizing this service in the future. Although still in the Agree (Satisfied) range, satisfaction survey responses suggest potential improvements in proving faxed reports in a

timely manner, as well as more directly improving provider's knowledge regarding appropriate mental health referrals, diagnosis, and treatment.

Table 4 PAL provider telemedicine/in-person item satisfaction (20 surveys received).

Telemedicine/In-person Satisfaction Survey Items:	Mean (SD)
1. The program makes mental health consultation services more available to my patients.	5.0 (0.0)
2. Patients and/or their parents feel that it is acceptable to receive consultation services using the program.	4.6 (0.6)
3. I received the faxed consultant's report in a timely manner.	4.4 (1.2)
4. The dictated consultant report was helpful to me.	4.7 (1.0)
5. I could understand the program consultant's recommendations.	4.7 (0.6)
6. The program is effective for initial consultations of patients.	4.9 (0.5)
7. The program would be useful for follow-up consultations.	4.7 (0.5)
8. My patient(s) received specialty consultation services sooner because of the program.	4.8 (0.5)
9. The assessment of my patient(s) by the program consultant helped me to manage my patient's care.	4.7 (0.7)
10. I feel that the procedures necessary for clinical assessment of my patient(s) are available through the program.	4.6 (0.6)
11. I am satisfied with the overall quality of the program's consultation regarding my patient(s).	4.9 (0.4)
12. I would be willing to refer patients to a specialist using this program again in the future.	4.9 (0.2)
13. This program helped me increase my own skills with making mental health *referrals* for my patients.	4.5 (0.6)
14. This program helped me increase my own skills in *diagnosing* mental health problems with my patients.	4.2 (0.9)
15. This program helped me increase my own skills in *treating* mental health problems with my patients.	4.4 (0.7)

Satisfaction Changes after Repeated PAL Utilization:

Because phone satisfaction surveys were administered after the 1st, 2nd, 5th and subsequent 5th PAL consultations, we were able to investigate changes in satisfaction after repeated use of the PAL program. Results indicated significantly higher satisfaction with PAL services after repeated use of the PAL program. As might be expected, satisfaction scores were significantly higher for providers who utilized the PAL service 3 or more times, compared to those used the service for the first time.

Correlates of PAL Satisfaction:

PAL satisfaction was consistent across regions, provider specialty, and provider profession/degree (MD vs. ARNP, etc.). Providers who treat higher numbers of children and foster children reported higher satisfaction with PAL telephone consultations. Another interesting finding was that providers who reported fewer resources in their community reported higher satisfaction with PAL consultations. Only provider years of practice significantly

correlated with PAL telemedicine/in-person satisfaction. Less experienced providers appeared to be more satisfied with PAL telemedicine/in-person consultations.

Qualitative Provider Satisfaction Responses

Each satisfaction survey had a qualitative item asking for comments about the PAL program. There were 64 qualitative responses to satisfaction surveys. Seventeen of these responses were general statements of satisfaction such as, "thank you, thank you, thank you" or "fantastic program." There were two responses that indicated some difficulty finding the time in their schedule to access the PAL services, as well two responses requesting more expedient written feedback after PAL consultations. All other responses were very positive and centered around the increased access that is provided by PAL, as well as the quality of PAL consultations.

Other specific responses included:

PAL meets a need where resources are limited:

- Excellent! Very helpful to me, a primary care pediatrician, isolated 1 hour north of Spokane in a rural setting. Please keep the services available!!! Thanks :)
- This program is a godsend in an area where there are no resources available for Medicaid and uninsured patients where even the resources for the insured are scarce.
- Fabulous! Very necessary service otherwise in Spokane patients would get NO mental health services. In spite of how things look or sound on paper, there is defacto no access.
- So helpful. We have so few resources and receive so little training that this is just invaluable. I think too, being able to provide parents with a quick answer (like that day) results in better outcomes than just sending them out to "follow up with a psychiatrist" which they may or may not do.
- Thank you SO much for this service. This is exactly what our rural practice needs! I hope it is permanent.

Overall quality of the consultation and ease of access:

- The phone call was extremely helpful. I will highly recommend to my colleagues.
- My experience using the PAL line was excellent--thoughtful recommendations, list of therapists with expertise specific to my patient, and advice about medications. I was not comfortable initiating medication for my patient until speaking with a psychiatrist--she was able to start treatment much more quickly with the PAL line assistance.
- It was so helpful and the doctor was so nice to talk to! She didn't make me feel like an idiot like some specialists do.
- It was a very helpful experience, educational for me and my partners, and helpful for my patient. Thank you for being available.
- I was really impressed with this service, the speed and the recommendations were very helpful. Thanks!
- I love this program. I have gotten quick consultation on kids that would have waited a long time. Also they are very thorough.
- Helpful, convenient, thorough. I was able to ask all my most basic questions without being made to feel inadequate.
- Dr. Hilt was extremely helpful in giving guidance and faxing informational resources to my office!

CHANGES IN PAL USER TREATMENT CONFIDENCE AND RESOURCES

Provider self-perceived knowledge regarding psychiatric care was assessed after the 1st, 5th and subsequent 5th PAL consultation, using the MHPK survey. We received 122 post-PAL MHPK surveys from 99 providers. As of May 15, 2009, 37 providers had completed both a pre and post-PAL MHPK survey, allowing for within provider comparisons. In order to provide a general description of provider confidence and resources before and after PAL consultations overall and subscale scores of the 122 post-PAL MHPK surveys were compared to the 297 MHPK surveys received prior to implementation of PAL (i.e., a pre- post-PAL comparison of all surveys received). Results indicated significantly higher levels of overall confidence in treating psychiatric disorders, resources, internalizing disorder confidence, and ADHD confidence by providers who completed the MHPK after utilizing PAL, relative to those who completed surveys before PAL implementation. This suggests that PAL utilizers have higher levels of confidence and knowledge managing psychiatric disorders and believe they have more mental health resources in their community, relative to those who completed these surveys before PAL. Changes in MHPK total and subscale scores were investigated among the 37 providers who completed both a pre- and post-PAL implementation survey. While no statistically significant differences were observed, there was an overall trend toward statistical significance for confidence in managing internalizing disorders. Results of this analysis may be limited by a lack of statistical power (i.e., too few PCPs completed surveys before and after PAL), as the effect of a brief PAL consultation is not likely to result in a large change in provider knowledge regarding mental health care.

CHILD OUTCOMES

Thirty-one parents or foster parents completed a parent report interview 1 month or 3 months after a PAL consultation. Nine parents completed this interview at both 1 and 3 months post-consultation. The process of recruiting these families were 1)obtaining contact information for each family from primary care providers, 2)contacting these families by telephone to inform them of the study, and 3) then obtain, through the mail, their signed, informed consent for study participation. Only after all these steps were completed were we able to schedule and conduct a parent interview.

This interview included a parent report of current mental health treatments received, description and rating of severity of 3 child specific mental health concerns (presenting problems), and ratings of 12 typical symptoms of mental health disorders. Results suggested declines in primary concerns, as well as overall mental health symptom scores from 1 to 3 months post-PAL consultation. Paired samples t-tests indicated statistically significant decreases in severity of the first two child specific mental health concerns, as well as overall mental health symptom severity, suggesting that PAL may have had a positive impact on mental health symptoms.

In terms of treatments received, parents reported that their child was prescribed psychotropic medication on 32 (80%) of 40 completed interviews. Forty-four percent (n=14) of those prescribed medication were prescribed more than one psychotropic medication. Stimulant and antidepressant medications were the most commonly prescribed, with 6 (19%) parental responses indicating that their child is currently prescribed an atypical antipsychotic. Sixty percent (18/31) of parents reported that their child was receiving psychotherapy of some kind after their PAL

consultation. When asked to name the specific type of psychotherapy, most replied that the therapy their child received had no specific name (n=11). Specifically named psychotherapies included behavior therapy (n=1), CBT (cognitive behavioral therapy, n=1), biofeedback (n=1), and play therapy (n=1). Twelve (39%) of parents reported that they had difficulty accessing psychotherapy for their child. A lack of funding for treatment and a lack of available clinicians were listed as difficulties in accessing psychotherapy services. Sixty-one percent (n=11) of parents rated their child's psychotherapy as clearly helpful, while 22% (n=4) rated psychotherapy as somewhat helpful, and 17% rated psychotherapy as not helpful (n=4).

Feedback on the PAL care guide

The PAL child mental health care guide prepared for and maintained by this program has been endorsed by the state chapter of the American Academy of Child and Adolescent Psychiatry, and has been distributed by mail to all 1022 primary care providers in DSHS Regions 1 and 6. A total of 1400 care guides have been printed and distributed overall, due to additional copies being requested by providers during conferences and meetings. Other organizations have taken notice of this work—we have been informed recently that the primary care providers at Madigan are adopting use of the care guide, have been informed that it is being distributed by training physicians at UW, and have been told that other locations like the state of Oregon are now reviewing it for adoption there. As of August 2009, the entire care guide has been downloaded from the PAL program website 271 times. Subsections of the care guide (such as ADHD or depression care sections) have been downloaded 2719 times.

Conclusion

Washington is the first state to replicate and adapt the MCPAP child mental health consult program in order to provide easily accessed child mental health care assistance to state primary care providers. Washington's Partnership Access Line (PAL) provides rapid child mental health consultation and resource connection assistance to primary care providers over a very large geographic area, with an emphasis on providing service assistance to the state's Medicaid population. PAL has an extensive evaluation effort currently underway designed to evaluate the impact of the program on important PCP and child outcomes. Early evaluation results of the PAL program have shown promising results in terms of utilization and overall feasibility of the program design, high PCP satisfaction with the service, and clinical markers of service provision indicating that non-medication strategies are being appropriately emphasized in the treatment of children.

Appendix 1:

Partnership Access Line Staff

Program Direction:

Robert Hilt, MD*, PAL Program Director,* is an attending psychiatrist at Seattle Children's Hospital and Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, School of Medicine. His work focuses on consultation psychiatry with primary care and hospital physicians. His clinical and research interests include psychiatric systems of care, improving child psychiatric emergency services, and developing and studying care systems for psychiatric consultation to primary care. His teaching interests include a variety of child psychiatric topics likely to be encountered by a referring clinician, with experience lecturing to medical students, residents and attending physicians in many areas. He is a member of the American Academy of Child and Adolescent Psychiatry (AACAP) and sits on its Committee on Collaboration with Medical Professions. He is a fellow of the American Academy of Pediatrics, and has experience working as a practicing pediatrician. He was awarded membership in the Alpha Omega Alpha honor society, and has received the AACAP Outstanding Child Psychiatric Resident Award. He is board certified in both adult and child psychiatry.

Jim Myers, MBA*, PAL Administrative Director,* is the Business Director for Psycho-Social Services at Seattle Children's Hospital. He has an MBA from the Kelly School of Business at Indiana University and has worked in the Healthcare Administration for over 10 years. He is a member or the American College of Healthcare Executives and the Healthcare Financial Management Association

Clinical PAL Consultants:

Alison Golombek*,* ***MD****,* is a clinical psychiatrist at Seattle Children's Hospital. She received her undergraduate degree from the University of California, Berkeley and then attended The Ohio State University, College of Medicine. She completed both her medical residency and fellowship at the University of Washington. She is a LEND (Leadership Education in Neurodevelopmental and Related Disabilities) fellow, one of the few psychiatrists honored with this distinction by the University of Washington. Her history in pediatric medicine lends itself to a long-standing interest in the relationship between pediatric medicine and psychiatry, including dealing with autism spectrum disorders and other neurodevelopmental diagnoses. Her current clinical interests include treating medically complicated children with psychiatric symptoms, as well as supporting the medical community at large through consultation psychiatry.

Kari Hancock, MD, is a clinical psychiatrist with Seattle Children's Hospital, who is located in Spokane, Washington. She attended the University of Washington for her undergraduate degree and received her MD from the University of Hawaii, John A. Burns School of Medicine. She acted as chief resident in the Spokane Advanced Clinician Track through the University of Washington and she also completed her fellowship through the University of Washington,

located at Seattle Children's Hospital. Since October of 2007, she has practiced as an outpatient child and adolescent psychiatrist at Spokane Mental Health, where she also served as a University of Washington psychiatry residency supervisor. Her professional memberships include the American Medical Association, the American Academy of Child and Adolescent Psychiatrists, and the American Psychiatric Association.

Brent Collett, PhD, is an attending psychologist at Seattle Children's Hospital and Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, School of Medicine. Working in Seattle Children's Early Childhood Clinic, he is involved in evaluation and treatment of children from birth to age 5 and their families, particularly children who have complex medical conditions (e.g., craniofacial anomalies) in addition to developmental, behavioral or psychiatric problems. His research is primarily in the area of pediatric psychology and includes studies of children with craniofacial anomalies and survivors of childhood cancer. Collett also maintains an active research interest in the developmental psychopathology of disruptive behavior disorders. His teaching activities include supervision of child psychiatry fellows and psychology interns in the Early Childhood Clinic and didactic teaching related to early-onset behavior problems and normative preschool-age development.

Carol Rockhill, MD, PhD, MPH, is an attending physician at Seattle Children's Hospital. She is an Acting Assistant Professor at the University of Washington. She earned her MD and PhD at the University of Illinois, Champaign-Urbana campus, as part of the Medical Scholars Program. She earned her MPH at the University of Washington, School of Public Health. She has completed residency training in General Psychiatry, and fellowship training in Child and Adolescent Psychiatry, both at the University of Washington. Her clinical interests include major depression in children, especially when complicated by another diagnosis such as oppositional defiant disorder. She was selected for participation in the Child Health, Intervention, and Prevention Services Summer Research Institute program, funded by the National Institutes of Mental Health, in April of 2007.

Christopher Varley, MD*,* is an attending psychiatrist in the outpatient psychiatry clinic at Seattle Children's Hospital where he has developed a service for complex attention deficit hyperactivity disorder. He is Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, School of Medicine and is training director for the Division of Child and Adolescent Psychiatry. He is consulting psychiatrist for the Gateway Center for Human Services in Ketchikan, Alaska. His clinical interests include disruptive behavior disorders and complex psychopathology in children and adolescents and psychopharmacology.

PAL Staff:

Catherine Bradley, BA*, PAL Program/Admin. Assistant*

Catherine received her Bachelor of Arts in Psychology from the University of Washington, and went on to work at the University of Washington as a research assistant for a study about children's fear of the dentist. She began work at Seattle Children's Hospital in June of 2005 as a Pediatric Mental Health Specialist on the Inpatient Psychiatry unit where she established, created the curriculum for, and taught a sibling support group for siblings of inpatients. She continued as an inpatient staff until taking the position of PAL Program/Admin. Assistant in April of 2008.

***Lauren Kimball, MSW**, PAL Consultation Social Worker*
Lauren received her Master's in Social Work from Simmons College in Boston, Massachusetts. She had two clinical internships working with homeless young adults and opiate-addicted clients receiving methadone maintenance. She then moved to San Jose, California and worked with severely emotionally disturbed adolescents in a locked community treatment facility. She began working at Seattle Children's in late April 2008 with the PAL program. Her clinical interests include the relationship between addiction and trauma, major depression with psychotic features, and working with runaway children. Lauren is a member of the National Association of Social Workers and is a Washington State Registered Counselor.

***Jessica Andregg, MSW**, PAL Consultation Social Worker*
Jessica received her Master's in Social Work from Walla Walla University in Washington. She previously worked for the Washington State Department of Children and Family Services in Walla Walla and as a substitute teacher in several Washington School Districts. Jessica is bilingual and has done outreach work in the Latino Community.

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Eric Trupin, Ph.D. is Professor and Vice Chair in the Department of Psychiatry & Behavioral Sciences of the University of Washington School of Medicine in Seattle, Washington. He is a child psychologist. Dr. Trupin is currently the Director of the Division of Public Behavioral Health and Justice Policy. This Division maintains a wide range of clinical, research and training programs primarily focused on implementing evidence based behavioral health practices to improve outcomes for children and adults. In 2007 the Washington State Legislature established an Evidence Based Institute within his Division.

Michael McDonell, Ph.D., is an Acting Assistant Professor in the department of Psychiatry and Behavioral Sciences UW SOM and conducts research and clinical activities at both Harborview Medical Center (CHAMMP) and at the Division of Public Behavior and Justice Policy (PBHJP). Dr. McDonell's clinical and research training has focused on youth and adults served in the public mental health system. He is also an attending psychologist in the Center for Foster Care Health, Department of Pediatrics, Harborview Medical Center. In this primary care setting, he conducts psychological consultation and short term treatment for youth in foster care. His current interests focus on investigating the adaptation of current empirically supported psychosocial interventions and engagement strategies for youth (e.g., youth with early onset serious mental illness, youth in foster care) who are transitioning from the adolescence to adulthood, with a focus on preventing long term disability in these populations.

Appendix 2
Sample PAL Presentation Outlines

Partnership Access Line Educational Event
Sacred Heart Children's Hospital
Saturday, October 4th, 2008

8:00-8:30 AM	**Registration & Refreshments**
8:30-8:45 AM	**Introduction & Welcome**
8:45-9:15 AM	**The Partnership Access Line: How We Propose to Help You Here** Robert Hilt, MD and Lauren Kimball, MSW
9:15-10:15 AM	**Autism Spectrum Disorders: A Review and Update** Kari Kawakami, MD
10:15-10:30 AM	**Break**
10:30-11:45 AM	**Orientation to Evidence Based Psychosocial Therapies in Youth** 1. What should happen when referring to the therapist? 2. What to do if there is no "evidence based therapy" available Christopher Blodgett, PhD
11:45-12:45PM	**Buffet lunch**
12:45-1:45 PM	**Childhood Bipolar Disorder:** What you need to know about the great debate Robert Hilt, MD
1:45-2:30PM	**Rating Scales: brief measures that can make a difference** Christopher Blodgett, PhD
2:30-2:45	**Break**
2:45-3:30 PM	**Sleep problems in children: the art and science of management** Robert Hilt, MD and Kari Kawakami, MD
3:30-4:15 PM	**Going 'mental' in primary care:** How do you approach the difficult topics in your office? Robert Hilt, MD, Kari Kawakami, MD, Christopher Blodgett, PhD.
4:15 PM-4:30PM	**Wrap up, then adjourn**

Partnership Access Line Educational Event
Sacred Heart Children's Hospital
Saturday, November 15th, 2008

8:00-8:30 AM	Registration & Refreshments
8:30-9:30 AM	**Interpreting data based warnings in child psychopharmacology: Stimulants and SSRI's** Robert Hilt, MD
9:30-10:30 AM	**Anxiety Disorders in Children** Christopher Blodgett, PhD
10:30-10:45 AM	Break
10:45-11:15 AM	**Obsessive Compulsive Disorder** Lee Carlisle, MD
11:15-12:15PM	**Disruptive Behavior Disorders; Diagnosis and Treatment** Lee Carlisle, MD
12:15-1:15 PM	Buffet Lunch
1:15-2:15 PM	**Addressing Substance Abuse in the Primary Care Setting** Leslie Walker, MD
2:15-3:15 PM	**Depression in Children and Adolescents** Elizabeth McCauley, PhD
3:15-3:25 PM	break
3:25-4:25 PM	**ADHD: an update and approach to the complicated patient** Robert Hilt, MD
4:25-4:45 PM	**Partnership Access Line Services Update, and Q & A Suggestions for the Future** Robert Hilt, MD and Catherine Bradley, PAL program assistant
4:45PM	Adjourn

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[15] Source: DSHS 2008 data of 570,239 children who are either fee for service eligible or in managed care (Healthy Options)