Caring for the Whole Child: Final Narrative Report

June 2002

Prepared By:

primary care coalition

For the Health Resources and Services Administration

Table of Contents

Annotations and Abstract

Annotation

The likelihood of trauma exposure among participants in the Care for Kids (CFK) program is high, but available behavioral health resources were limited prior to this project. The Caring for the Whole Child project was designed to identify CFK kids with behavioral health problems and refer them to integrated behavioral health services financed by CFK. Project aims also include provider training to improve behavioral health screening and/or services as well as community advocacy for ongoing behavioral health services for CFK participants. The project provided behavioral health services to more than 400 children, established a sustainable source of funding for these services, and began an ongoing learning collaboration among behavioral health providers serving CFK participants.

Key Words

Latino adolescents, Latino children, integrated behavioral health, depression screening in pediatric primary care, PHQ2, PHQ9, pediatric behavioral health

Abstract

Project Title: Caring for the Whole Child
Project Number: H17MC30730
Project Director: Marisol Ortiz, Director of Client Services
Grantee Organization: Primary Care Coalition
Address: 8757 Georgia Ave, 10th Floor, Silver Spring, Maryland 20910
Phone Number: (301) 628-3442
E-mail Address: Marisol_ortiz@primarycarecoalition.org
Home Page: www.primarycarecoalition.org
Project Period: March 2017 – February 2022
Total Amount of Grant Awarded: $250,000

PROGRAM PURPOSE AND MCH RELATIONSHIPS: In 2014, Montgomery County, Maryland began welcoming large numbers of children arriving as unaccompanied minors. Many faced violence in their home countries, family separation, and difficult journeys here, only to face the ongoing challenges of resettlement in an unfamiliar environment and family reunification. These children were rapidly expanding enrollment in the Care for Kids (CFK) program, a public-private partnership providing access to primary and specialty care for Montgomery County children living in low-income households who did not qualify for other state or federal healthcare assistance programs. Despite a growing population at risk for behavioral health problems, the CFK program did not offer access to behavioral health services. Caring for the Whole Child was conceived to fill that gap—connecting CFK participants at four safety-net clinic partner sites with affordable and integrated behavioral health care.

The program addressed the Healthy Tomorrows mental health funding priority and involved input from both the AAP Maryland Chapter and Maryland Title V Maternal and Child Health Bureau.

GOALS AND OBJECTIVES: Program goals and objectives were revised twice over the course of the project to reflect lessons learned from program experience and ideas for improvement. Final goals included identifying CFK participants with behavioral health concerns through routine behavioral health screening during primary care medical visits (objectives: increase screening; educate stakeholders for better identification of children's behavioral health challenges), involving stakeholders in the development of revised strategies and tests of change for service improvement (objectives: hold routine learning collaborative meetings, engage patients and parents in project feedback), and developing community support for CFK behavioral health services (objective: secure sustainable funding). Progress was made toward all goals and objectives, though not all metrics were achieved, particularly during the pandemic.

METHODOLOGY: The project was designed as an extension of existing primary care services for uninsured children, replicating a successful model of integrated behavioral health services established among an adult population with similar income constraints and lack of health insurance. Project implementation sought to support universal behavioral health screening in the primary care setting to support referral to integrated behavioral health services, including process improvement to assure adequate screening, and advocacy to support sustainable funding of behavioral health services for this pediatric population.

EVALUATION: Both quantitative and qualitative analyses were used to understand the effectiveness of the implementation process and the impact of services on CFK participants. Metrics included data on the prevalence of behavioral health screening among the patient population, the prevalence of behavioral health concerns, treatment effectiveness, and feedback on remaining barriers to treatment access. Early achievement of sustainable local funding for behavioral health services shifted project focus from demonstration of the need for behavioral health services to exploration of the best pathways to identify and meet patients' behavioral health needs.

RESULTS: CWC achieved a sustainable level of County funding by the end of year 2 to provide behavioral health services to all CFK participants, and these services have continued past the grant period. Work to improve screening processes and service utilization was more mixed, particularly as the COVID pandemic upended service delivery and limited capacity for process improvement. However, the percentage of adolescent CFK medical visits at which participants are screened for behavioral health needs has risen over the course of the grant. Behavioral health providers also chose to continue participating in collaborative meetings beyond the life of the grant to continue a shared approach to tackling service delivery problems and identifying additional resources. PCC will use the behavioral health experience to support advocacy for a

quality assurance role in the CFK program, which would help continue to address process improvement concerns around screening and service delivery.

PUBLICATIONS/PRODUCTS The project produced annual Care for Kids reports during the grant period, which included updates on the CWC experience. It also produced brochures and rack cards—in English and Spanish—to educate patients and parents about behavioral health symptoms and the services available. In addition, the project produced a detailed report on patient and parent focus group feedback and an evaluation report from the initial year of project data.

DISSEMINATION OF RESULTS Dissemination activities have focused on progress updates to the Montgomery County Department of Health and Human Services, which provides the funding for CFK, including behavioral health services, and the Montgomery Cares Advisory Board, which exists in statute as the advisory board overseeing County-funded programs that serve uninsured residents—including Care for Kids. PCC is also planning to convene a learning journey around the ways different communities have supported newly-arrived children and families, including the CWC experience.

Narrative

Project Purpose and MCH Relationships

Problems Addressed

This project's overarching goal was to ensure that uninsured children living in Montgomery County and enrolled in Care for Kids have access to behavioral health screening and needed treatment.

Pediatricians and child development experts agree that traumatic events in childhood can affect an individual's health and wellbeing throughout life. Immigrant children, especially those who come to the United States fleeing violence, have almost certainly experienced multiple traumas in their home countries, on the route to the United States, in detention, and, quite possibly, during their daily life as they adapt to a new culture. The best way to help these children is to identify those in need of support and to provide it as soon as possible.

Effective screening methods exist to identify children at risk for negative outcomes, as do evidence-based behavioral health treatments that can help them recover from traumatic experiences. Because all these children will be seen by a pediatrician at some point, and because pediatricians are uniquely positioned to guide families toward the care they need, primary care visits are an optimal point for this screening.

The Primary Care Coalition (PCC) administers the Care for Kids program, a public-private partnership to provide health care access for children living in Montgomery County whose households earn less than 250% of the federal poverty level and who do not qualify for other state or federal health care programs.

Caring for the Whole Child was designed to address the behavioral health needs of CFK children with a focus on adolescents. All CFK enrollees are foreign-born immigrant children with

immigrant parents. Many are new immigrants who crossed the border unaccompanied, were detained by the border authorities, and released to family members in Montgomery County. These new immigrant children are fleeing violence in home countries of Central America. The number of children enrolled in CFK doubled in size between FY13 and FY17, due largely to increasing numbers of unaccompanied minors being reunited with family members in the County. Over the course of the five-year pilot, CFK enrollment grew from 4,800 to over 7,000 children actively enrolled per year. In FY21 the program enrolled 794 new children, 523 (65.8%) from the recent influx of unaccompanied minors. Many have experienced violence and trauma that no child should have to endure.

At the time of our grant application, behavioral health care was not covered through CFK, making available resources for some of our most vulnerable immigrant children very limited. Primary care providers could refer children with very serious or urgent behavioral health needs to CFK for case management. CFK could refer children to the county's Child and Adolescent Mental Health Program (CAMH)—where the wait time for services could be as long as three to four months—with the county Crisis Center as an interim option for urgent problems.

With the Caring for the Whole Child (CWC) project, PCC partnered with four safety-net clinics that treat CFK children: Catholic Charities Medical Clinic, CCI Health & Wellness Services, Holy Cross Health Center Germantown, and Mary's Center for Maternal and Child Health. Together, these clinics served 37% of CFK participants in the first year of program evaluation (April 2017-March 2018) and were serving 75% of CFK enrollees by March 2022. Each of these clinics offers a medical home for well and sick care by pediatricians and other pediatric primary care providers. They also offer behavioral health services on-site staffed by licensed mental health professionals.

MCH Priorities and Collaborations

The Caring for the Whole Child (CWC) project addresses behavioral health/mental health area of interest to HTPCP.[1] CWC enjoys productive collaborations with several state and local programs. Both the Maryland Title V Maternal and Child Health Bureau (MCHB) and the Maryland Chapter of the American Academy of Pediatrics (AAP) were contacted when planning the project and representatives from each served on the Year 1 CWC Community Advisory Board. Representatives from both AAP Maryland and the MCHB also participated in the June 2018 technical assistance visit.

Since 2008, the MCHB Office for Genetics and People with Special Health Care Needs has funded a CMS Specialty Care Coordinator at PCC to enroll Montgomery and Prince George's County children in the CMS program. This position is a member of the CFK team working under CFK management. The CMS Coordinator helps both CFK families and other low-income parents with ill children complete applications for the program and coordinates specialty medical care for children.

PCC included leadership from the AAP Maryland Chapter in CWC project planning, and some pediatricians serving CFK children are AAP members.

Goals and Objectives

Caring for the Whole Child (CWC) has an overall goal of establishing access to behavioral health services, including services that are integrated into the primary care setting, for uninsured children and adolescents living in Montgomery County. Using the Bright Futures Recommendations for Preventive Pediatric Health Care as a guide, the project seeks to achieve

[1] Healthy Tomorrows Funding Opportunity Announcement for Fiscal Year 2017, page 1.

regular and universal behavioral health screening among adolescents and provide comprehensive behavioral health treatment for common mental health disorders among children and adolescents enrolled in Care for Kids (CFK).

PCC adjusted project goals and objectives over the five grant years to reflect lessons learned and ideas for improvement. Despite these refinements, goals and objectives throughout the project fell into the same main categories:

- Screening for child and adolescent behavioral health needs and connection to services
- Provider training and process improvement
- Advocacy for sustainability

Taken together, these goals were designed to identify children and adolescents with unmet behavioral health needs and connect them to accessible, appropriate care; promote collaboration with providers to improve the availability and delivery of services; and conduct advocacy with public and private funders to ensure that sufficient services to meet the need would be available beyond the life of this grant. These goals reflected the realities of implementing a pilot program among a population that was fluid in size and—potentially—need, along with PCC's history of leveraging pilot funding into long-term public-private partnerships.

As of March 2020, project goals and objectives included the following:

Table 1 CWC Goals and Objectives as of 2020

<table>
<tr><td>Goal 1: Identify CFK participants with depression and other common behavioral health problems during medical visits at all CFK sites.</td><td>Objective 1A: Increase behavioral health screening of CFK adolescents from 61% in Year 1 to at least 90% by Year 5.

Objective 1B: Improve identification of CFK participants' behavioral health needs through annual parent or participant education outreach.</td></tr>
<tr><td colspan="2">Results:

Screening results were mixed, with modest success in increasing the number of medical visits that included behavioral health screening (from 40% in evaluation year 1 to 46% in evaluation year 5) but no progress in increasing the percentage of active CFK patients receiving behavioral health screenings. Our evaluation years ran from April through March, and both screening measures reflect a dip in year 3, the last month of which may have been impacted by the outbreak of COVID-19. The project's ability to continue screening patients at comparable rates during the pandemic—and even gaining ground on visit screening—suggests progress in promoting a culture of screening at partner primary care clinics.

Clinic staff received Mental Health First Aid training in grant year 2 (29 staff trained), and patients and parents began receiving educational materials in grant year 2. Following an initial mailing at the end of grant year 2, the primary means of distribution was during the enrollment/re-enrollment process, when participating families receive CFK program information and ID cards. Because our patient population is relatively mobile, we felt this was the best strategy to ensure materials actually reached patients. However, new and renewal enrollments dropped substantially during much of 2020 and 2021, when the county offices that accepted CFK applications were generally closed. To ensure continuity of health care access, the County added an additional year of enrollment to each CFK participant whose enrollment was expiring before June 30, 2021. CFK staff sent behavioral health materials to 81% of active CFK participants in year 3 (4/1/2019-3/31/2020), when there were 3,385 new and re-enrolled participants, but only 21% in year 4 (4/1/2020-3/31/2021), when there were 1,094 new and re-enrolled participants. Outreach rates were recovering in year 5 (4/1/2021-3/31/2022), when there were 2,996 new or re-enrolled participants, and 60% of active participants were sent outreach materials. We also distributed brochures and rack cards to partner clinics for use in waiting rooms and exam rooms as appropriate.</td></tr>
<tr><td>Goal 2: Involve clinical and community stakeholders in CWC process improvement and service expansion efforts.</td><td>Objective 2A: Form a learning collaborative among pediatric primary care and behavioral health providers to share information and identify training needs to connect CFK patients with appropriate behavioral health services.

Objective 2B: Utilize input of experts, parents, and participants to increase quality and utilization of services.</td></tr>
<tr><td colspan="2">Results:

The learning collaborative received regular engagement from clinic behavioral health providers, ultimately generating ideas for alterations to the project, resource sharing among participants, and an ongoing commitment to collaborate beyond the life of the grant via</td></tr>
</table>

<table>
<tr><td colspan="2">participation in existing meetings for behavioral health leaders serving Montgomery Cares patients. These meetings currently occur approximately every quarter, with plans to adjust the meeting schedule as needed. Combining these groups will allow providers to address behavioral health issues across the lifespan.

Determining the best way to engage patients and parents was an ongoing challenge. Offering participation incentives like gift cards did not work consistently, nor did the ability to meet virtually during the pandemic. We abandoned the group model altogether for our final outreach cohort, opting instead to conduct one-on-one virtual meetings with individual patients and parents. This method offered a high level of participation—likely because we were able to tailor timing to each family's schedule.</td></tr>
<tr><td>Goal 3: Build community support for sustainable behavioral health services provided through CFK.</td><td>Objective 3: Beginning in year 1, CWC will pursue non-HRSA funding for the project. By year 5, secure funding will be in place to support ongoing behavioral health services for CFK children.</td></tr>
<tr><td colspan="2">Results:

The project achieved a sustainable level of funding through the Montgomery County Department of Health and Human Services by the end of year 2, offering a stable funding match for the duration of the grant period and an ongoing funding source to maintain behavioral health services for this patient population. In addition, Montgomery County has allocated additional funds for behavioral health in school-based health and wellness centers, many of which are the primary care home for CFK enrolled children not assigned to clinics participating in the CWC pilot.</td></tr>
</table>

See Appendix 1 for the complete list of project goals and objectives. Appendix 2 includes additional performance data by evaluation year.

Methodology

Caring for the Whole Child pursued the following broad categories of activities:

- Creating screening and referral workflows at partner clinics
- Using screening data to understand the level of need
- Identifying and testing additional interventions
- Training providers and clinic staff to better identify behavioral health needs and provide trauma-informed care
- Coaching around screening process improvement
- Advocating with Montgomery County and private funders

The project was an effort to replicate a successful model for behavioral health care access among low-income, uninsured adults in Montgomery County to serve children with similar vulnerabilities by race/ethnicity, income, and immigration status. It benefited from the expertise of PCC's Director of Client Services, who manages the CFK program, and PCC's Director of Behavioral Health Programs—both working on the project as an in-kind contribution. The project specifically piloted expansion of existing service networks as an efficient way to provide services that are convenient, affordable, and culturally appropriate for our patient population.

The overall cost to the Health Services and Resources Administration was just over $150,000, and that amount has been leveraged to secure nearly $70,000 annually in county funding for behavioral health visits. We will continue to monitor service utilization and advocate for increased funding support as needed, though county funds are currently sufficient to meet service demand. The range of behavioral health services offered includes psychotherapy, psychiatry, and substance abuse counseling.

Evaluation

Our evaluation methodology combined quantitative and qualitative data collection/analysis to develop a comprehensive picture of the need for behavioral health services among our patient population and the ability of this service model to meet it. Our quantitative data analysis evaluates the number of documented screens, positive screens, and behavioral health visits referred patients receive, as well as measures of symptom improvement. The project considers these data for outcome evaluation of the project's screening and behavioral health services. Process evaluation considers the learning collaborative and patient/parent advisory board meeting notes, communications schedule, and project report availability as landmarks for engagement and advocacy efforts. The amount of sustainable funding achieved is the outcome measure for project communications and reporting, while strategies generated by the learning

collaborative and patient/parent advisory board meeting input are considered relative to clinical and service utilization measures.

PCC completed an evaluation report for the first full year of project data—for the period April 2017 – March 2018—and developed measures for behavioral health screening and service utilization. Results demonstrated that behavioral health screening, positive screens for behavioral health concerns, and utilization of behavioral health services were all lower than anticipated. Partner clinic representatives are confident that the need for these services is real, but that patients are not being identified or engaging in services at the level we had hoped.

Discussions with partner clinic representatives and Healthy Tomorrows technical assistance providers led to significant revisions in the project approach designed to better identify children and adolescents who would benefit from behavioral health services and to address any barriers patients face to actually using those services.

The addition of behavioral health as a service requirement in the CFK contract and related appropriation of funds has also impacted this project's focus. Initially, the pilot was designed to demonstrate the need for behavioral health services among CFK adolescents in Montgomery County—which has seen a substantial increase in residents recently arrived from Central America whose early years and journeys here likely exposed them to significant trauma and make them more likely to have behavioral health service needs. Approved county funding combined with low service utilization, however, has meant that growth in direct services funding has outpaced our ability to increase behavioral health screening rates, identify patients in need of behavioral health services, and improve referral processes.

The result has been an increased focus on understanding the best pathways to identify behavioral health needs among CFK children and adolescents and connect them with genuinely accessible care. It has also meant substantial budget adjustments to fund multiple mini pilots of

related training and assistance so that we leveraged our more time-limited funding stream from the Healthy Tomorrows grant to maximize the long-term effectiveness of local government funding.

Results/Outcomes

Lessons Learned

The evolving project goals and objectives reflect a multitude of lessons learned, primarily with regard to service demand and process improvement strategies.

When PCC applied for funding through the Healthy Tomorrows Partnership for Children Program, we anticipated overwhelming behavioral health needs simply waiting for a service opportunity. “If you build it, they will come,” in pop culture speak. There was very limited literature on the prevalence of behavioral health needs in pediatric populations, but it was clear that many of our participants had significant trauma exposure that could be associated with behavioral health needs. The reality we found was more complicated.

CFK participants were initially slow to utilize behavioral health services. With approval from HRSA, we conducted 2017 focus group sessions among CFK children and parents to find out why. In those sessions, CFK children and parents agreed that there were behavioral needs in the community, but they also revealed significant levels of stigma around behavioral health services among parents, in particular. Providers also worried that the $15 co-pay families paid with each behavioral health visit was a significant barrier among a very low income population.

PCC implemented multiple tests of change to address these barriers, including sending outreach materials to participant families, reimbursing clinics for co-pays as well as services rendered so that there would be no cost to families, and training patient-facing clinic staff in Mental Health First Aid so they would be more attuned to behavioral health needs. We saw

improvements in service utilization overall, but the average number of visits per patient remained relatively low, and utilization remained lower than anticipated. All of which raised concerns that screening processes were not identifying all of the patients who needed services.

Our plan in year 3 was to implement intensive process improvement work, including coaching in process mapping and concordance reviews to ensure documentation matched the services provided. That plan was submitted in March 2020; by the end of the month it would feel hopelessly out of date.

As in many communities, our clinic partners did what they could early in the pandemic to minimize COVID exposures among patients and staff. They scheduled fewer in-person visits and managed as many services as possible via telehealth. Routine screening for behavioral health concerns fell by the wayside as clinics pivoted their operations to telehealth and pandemic response activities, and there was little spare energy for process improvement work unrelated to Covid-19 testing, treatment, and eventually vaccination services. As the pandemic has dragged on, staffing turnover among the behavioral health providers acting as clinic champions disrupted improvement potential even more. As of 2022 pediatric well visit volume has begun to rebound, but there was not enough time within the grant period to resurrect screening process improvement efforts. We plan to use the CWC experience to support advocacy for larger quality assurance investments in the CFK program, similar to the routine measures monitoring and quarterly review built into the Montgomery Cares program, which serves an adult population with similar income and insurability requirements.

Related to process improvement challenges—and supporting the need for a broader quality assurance strategy—were problems gathering regular screening, service, and outcome data for all patients from all providers. Each clinic had their own electronic health records with their own structured field capacity and documentation protocols. Simply mapping how information was

entered and determining whether or not it represented extractable data took more than one grant year. Providers generate a wealth of information in notes but may generate comparatively few structured data points. Future grantees should plan to map the project-specific information/data process as part of their program and proposal development, since our experience indicates that even extensive experience extracting and analyzing quality data will not be sufficient if clinic partners do not have needed data collection processes in place.

This appears to be a particular challenge for behavioral health, where many prevention/early detection tools like screenings are not reimbursable. Clinics tend not to capture data on these services, and are unlikely to invest in structured EHR fields or documentation time when there is no associated reimbursement. Future projects may opt to fund the development of structured fields or other tools to support data collection by clinical partners.

Creating viable mechanisms for participant program advising was also a major challenge. Because the official advisory board for CFK, the Montgomery Cares Advisory Board, has long struggled to staff its patient representative slots, we opted to test strategies for incorporating regular client feedback into CWC. Based on advice during our 2018 TA visit, we offered refreshments and participation stipends as compensation for the time dedicated. We also held parent and teen sessions at the same place and time to minimize travel and time burdens. During the pandemic, we also experimented with virtual meetings that eliminated transportation altogether. Participation in group meetings—whether held in person or virtually—was inconsistent and often very low. For our final participant input activities, CFK staff scheduled calls with individuals rather than groups, and participation was quite high: 8 adolescents and 7 adults. This model loses the ability for participants to build on each other's comments, but it may work better as a way to include more participant voices.

Despite these challenges, the Caring for the Whole Child project achieved important results that we believe will be long-lasting.

Results Sustained

Our primary outcome was establishing a sustainable system for Care for Kids participants to access affordable behavioral health services. We achieved that outcome by the end of Year 2, when Montgomery County included $69,500 in funding for CFK behavioral health services in its base budget. These funds cover counseling/psychotherapy for patients and their families as well as psychiatry visits and substance abuse treatment for patients who need these services. Following the grant period we are in discussion with the County and other funders about mechanisms to eliminate the $15 co-pay, which proved to be cost-prohibitive for some very low-income families given the frequency of behavioral health visits. In year 5, Montgomery County Public Schools contracted with a community-based organization to provide behavioral health counseling in a group of schools not already served by school-based behavioral health services. Those services are reimbursed by public and private insurance programs. With behavioral health service funding from the County already in place to serve CFK participants, PCC was able to contract with this organization as well to reimburse them for services provided to CFK participants—effectively ensuring that CFK participants in these schools have another integrated service option.

This systems change work built upon an existing structure to provide health services for children who do not qualify for other assistance programs, making its replication sensitive to the political will in specific communities to fund such services. However, in communities experiencing a rise in newcomer youth and children fleeing violence—particularly when many, if not most, of them have faced incredible trauma *en route*—providers and community organizations may be able to make a persuasive case for the return on investment in behavioral health. Patterns of pandemic

impact—which is often more severe among racial/ethnic minority and immigrant communities—may also spur more enthusiasm for such investments.

That systems change allowed us to serve 428 children and adolescents[2] with 1,463 behavioral health visits over the life of the grant. Nearly 40% of these children and adolescents were Hispanic/Latino, though ethnicity was unrecorded for nearly 60% of CFK participants served in behavioral health (see Appendix 2 for the distribution of patients by race and ethnicity per evaluation year). Prior to HRSA funding, there was no established mechanism to serve these patients. Available data suggest that 30%of patients reported feeling better after therapy. CFK has already provided 83 behavioral health visits between March and May 2022 independent of HRSA funding.

The project also established an ongoing framework for cooperation among pediatric behavioral health providers offering these services. Partner clinics received stipends for their participation in data collection and a quarterly learning collaborative during the life of the grant. At our final meeting in March of 2022, participants opted to continue meeting even without this funding support. They have now committed to participating in ongoing quarterly meetings, to share challenges and ideas for improvement as well as connections to other services.

Publications/Products

- Behavioral Health Services with Latino Adolescents: A Focus Group Research Report Executive Summary. (2018) Rivera Group, Inc. for Primary Care Coalition.
- Caring for the Whole Child: Year One Evaluation. (2018) Primary Care Coalition.
- Emotional Health for Your Child/Salud emocional para su hijo(a). (2018) Primary Care Coalition.

[2] Note: This figure is the sum of the unduplicated participants in each evaluation year. There may be some overcounting if participants received behavioral health services in more than one evaluation year.

- Care for Kids Annual Report July 1, 2017-June 30, 2018. (2018) Primary Care Coalition.
- Care for Kids Annual Report July 1, 2018-June 30, 2019. (2019) Primary Care Coalition.
- Care for Kids Annual Report July 1, 2019-June 30, 2020. (2021) Primary Care Coalition.
- Care for Kids Annual Report July 1, 2020-June 30, 2021. (2021) Primary Care Coalition.

Dissemination/Utilization of Results

Program results have been shared primarily with local networks and with fellow Healthy Tomorrows grantees. In particular, we have shared annual service figures and program updates with the Montgomery County Department of Health and Human Services as part of required reporting and to maintain support for service coverage and with the Montgomery Cares Advisory Board. We anticipate sharing the experience as part of a Learning Journey in the coming year, designed to explore how different communities support newly-arrived children and families with complex needs.

Future Plans/Sustainability

Our project achieved its sustainability objective in year 1 with the approval of county funding to reimburse providers for behavioral health services. We also succeeded in generating some interest among private foundations in supporting these services as well.

What the Healthy Tomorrows grant experience has made clear is that quality improvement remains an ongoing need, particularly given pandemic shifts to provider workflows and the services available to patients. We will use data generated by our project evaluation to advocate for public investment in a formal quality assurance program for CFK, commensurate with existing investment in quality assurance for adult healthcare access services.

In the interim, learning collaborative members have committed to maintaining their participation beyond the life of the grant, offering a forum for continued collaboration around service

improvement. HRSA funding has spurred sustained investment in meeting children's behavioral health needs, playing a foundational role in the availability of behavioral health services for children, many of whom have a history of trauma exposure. These services cannot erase the harm children have experienced, but they can help assure the brightest possible future for some of our newest neighbors.

Appendix 1: Complete List of Project Goals and Objectives

Table 2 Project Goals and Objectives - Original and Revised

Original Goals and Objectives	Revised Goals and Objectives (2018)	Revised Goals and Objectives (2020)
Goal 1: Adolescents enrolled in Care for Kids will receive regular screening for behavioral health conditions and have access to integrated behavioral health services in the primary care setting.	**Goal 1:** Identify CFK participants with depression and other common behavioral health problems during medical visits at all CFK sites.	**Goal 1:** Identify CFK participants with depression and other common behavioral health problems during medical visits at all CFK sites.
Objective 1A: During project year 1, 70% of CFK adolescents seen in primary care partner clinics will be screened for depression and trauma exposure using validated tools. During project years 2-5, screening rates will increase by at least 5% per year.	**Objective 1A:** Increase **annual** depression screening of CFK adolescents from 61% in Year 1 to at least 81% by Year 5.	**Objective 1A:** Increase behavioral health screening of CFK adolescents from 61% in Year 1 to at least 90% by Year 5.
Objective 1B: During project year 1, at least 110 CFK adolescents with positive screening results will receive services from behavioral health clinicians. During project year 2, at least 330 CFK adolescents will receive behavioral health services (with use of HRSA and project matching funds).	**Objective 1B:** Improve identification of CFK participants' behavioral health needs through Mental Health First Aid training for CFK clinic staff in Year 2 and annual parent education outreach.	**Objective 1B:** Improve identification of CFK participants' behavioral health needs through annual parent or participant education outreach.
Objective 1C: Pediatricians, pediatric primary care providers, and behavioral health providers from project sites and PCC will form a Learning Collaborative to share experiences, information and tools for serving CFK adolescents and to identify needs for	**Goal 2:** Develop a network of integrated and community behavioral health services that can meet the full scope of behavioral health needs for the entire CFK population.	**Goal 2:** Involve clinical and community stakeholders in CWC process improvement and service expansion efforts.

training and/or other programmatic tools in order to fully integrate clinical behavioral health services into their models of pediatric care.		
Goal 2: The Montgomery County community, including policy makers, will gain greater understanding about the behavioral health needs of uninsured and immigrant children based on data and communication from this project and develop an ongoing commitment to provide needed services.	**Objective 2A** Among CFK participants referred for behavioral health concerns, increase the number receiving behavioral health services at CWC sites by at least 10% annually.	**Objective 2A:** Form a learning collaborative among pediatric primary care and behavioral health providers to share information and identify training needs to connect CFK patients with appropriate behavioral health services.
Objective 2A: In the first half of year 1, a Community Advisory Board comprised of project and community stakeholders, including at least two CFK parents, will begin meeting to provide advice and oversight to the project.	**Objective 2B** Assess the effectiveness of the CWC treatment network in meeting CFK participants' behavioral health needs.	**Objective 2B:** Utilize input of experts, parents, and participants to increase quality and utilization of services.
Objective 2B: By December 2017, a communications and advocacy plan will address the behavioral health needs and services available for CFK children based on data collected in partner clinics and analyzed using project metrics. During year 2, funding from public and private funders will be sufficient to meet Healthy Tomorrows matching requirements. By year 5, secure funding will be in place to support ongoing behavioral health services for CFK children.	**Goal 3:** Involve clinical and community stakeholders in CWC process improvement and service expansion efforts.	**Goal 3:** Build community support for sustainable behavioral health services provided through CFK.
	Objective 3A: Form a learning collaborative among pediatric primary care and behavioral health providers to share information and identify training needs to connect CFK	**Objective 3:** Beginning in Year 1, CWC will pursue non-HRSA funding for the project. By year 5, secure funding will be in place to

	participants with appropriate behavioral health services.	support ongoing behavioral health services for CFK children.
	Objective 3B: Utilize input of parents and participants to increase quality and utilization of services.	
	Goal 4: Build community support for sustainable behavioral health services provided through CFK.	
	Objective 4: Beginning in Year 1, CWC will pursue non-HRSA funding for the project. By year 5, secure funding will be in place to support ongoing behavioral health services for CFK children.	

Appendix 2: Project Data

Table 3 CWC Partner/Provider Trainings and Results

Topic	Grant Year	Evaluation Results
Family Reunification	1 (September 2017)	Average respondent scores of 3.8 and higher out of 5
Mental Health First Aid	2 (January 2019)	64% of respondents felt "better prepared" for their professional duties after the course
Grief in the Newly-Arrived Immigrant Community	4 (May 2020)	100% of respondents felt training was "good" or better
Compassion Fatigue Training	4 (Fall 2020 – Winter 2021)	92% of respondents agreed or strongly agreed that they "have strategies to manage and reduce the impact of compassion fatigue, vicarious trauma, moral injury, burnout and acute stress disorder" after the training and 73% had "integrated trauma-informed strategies into [their[professional life to build resilience and manage the impact of trauma and grief." Note: results are not specific to grant partners, as training was a community-wide resource
Trauma and Resilience	5 (January 2022)	More than 90% of respondents agreed or strongly agreed to all evaluation questions

Table 4 Behavioral Health Screening Indicators

Evaluation Year	% of Medical Visits with Depression Screening	% Change from Prior Year	% of Active Patients with Depression Screening	% Change from Prior Year
1	40%	-	61%	-
2	41%	2.5%	58%	-4.9%
3	39%	-4.9%	56%	-3.5%
4	42%	7.7%	58%	3.6%
5	46%	9.5%	57%	-1.7%

Table 5 Indicators of Behavioral Health Needs and Services Received

Evaluation Year	% of Screenings Positive for Depression	% of Patients with Positive Screenings Receiving Follow-Up within 90 days	% of CFK Patients Served in Behavioral Health	% of Behavioral Health Patients with follow-up PHQ-9 score ≤9 or decreased by ≥50% from baseline
1	8%	33%	7%	Not enough data
2	13%	62%	8%	44%
3	14%	65%	11%	27%
4	15%	36%	11%	17%
5	30%	48%	9%	34%

Table 6 CWC Participants by Age, Race, and Ethnicity

	Year # 1 - 4/1/2017 to 3/31/2018	Year # 2 - 4/1/2018 to 3/31/2019	Year # 3 - 4/1/2019 to 3/31/2020	Year # 4 - 4/1/2020 to 3/31/2021	Year # 5 - 4/1/2021 to 3/31/2022
Unduplicated Children	86	86	116	75	65
Age					
1-11 years old	21	26	36	20	16
12-19 years old	65	60	80	55	49
Total	86	86	116	75	65
Race					
Blank	4	21	46	32	28
Asian	0	0	0	0	0
Black	3	1	1	1	1
Native American	0	0	0	0	0
White	20	17	21	8	13
Other	59	47	48	34	23
Total	86	86	116	75	65
Ethnicity					
Hispanic	17	34	46	40	31
Non Hispanic	0	0	2	2	2
Blank	69	52	68	33	32
Total	86	86	116	75	65