A woman with long dark hair, wearing a white shirt, is smiling and looking down at a baby. She is holding a small white toy ring. The baby is sitting in a wooden toy car, wearing a light blue sweater and has a red pacifier in its mouth. The background is a soft-focus indoor setting.

Building Access, Building Trust: Lessons from Arizona on Scaling Perinatal and Pediatric Mental Health

Presented by:

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Date:

May 2025

Learning Objectives

1. Examine Arizona's Access Lines as a case study in overcoming funding and sustainability challenges.
2. Show how partnerships with state leaders, systems, and communities expand access and drive policy change.

Disclosures

I have no financial disclosures

Arizona Children and Youth Mental Illness



#49

Arizona ranks #49 for youth mental health.

#2

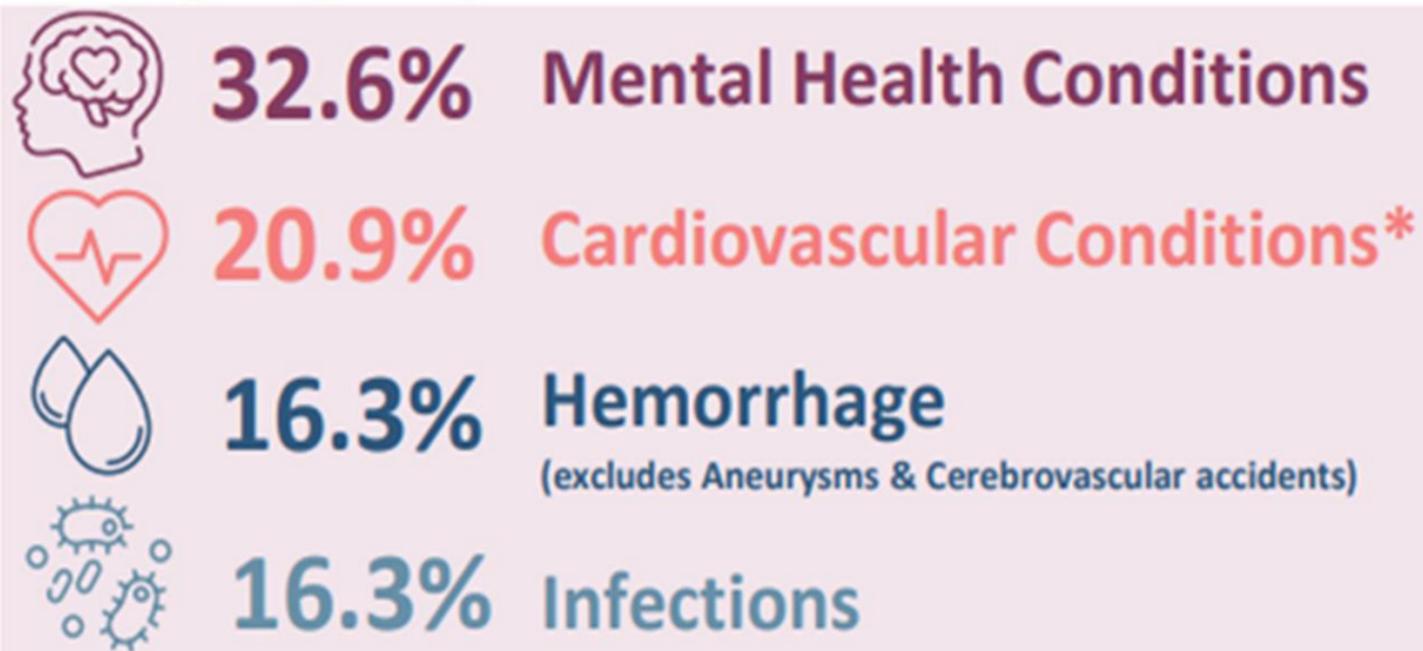
Suicide is the second leading cause of death among individuals aged 15-24

91%

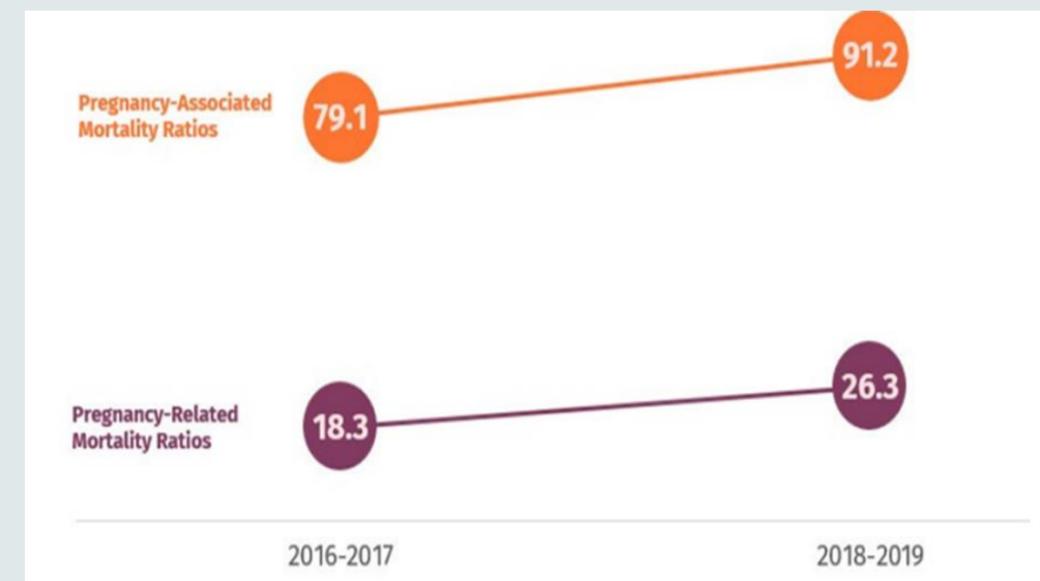
91% of communities do not have enough behavioral health providers according to federal guidelines.

Maternal Mental Health – AZ

The most common primary underlying cause of death among Pregnancy-Related cases was mental health



**Includes Amniotic Fluid Embolism, Cardiomyopathy, Embolism- Thrombotic (Non-Cerebral), Hypertensive Disorders of Pregnancy, and Other Cardiovascular Conditions*



90%

of Pregnancy-Associated deaths were considered **PREVENTABLE**

Arizona's Current Mental Health Workforce: Severe Shortage

Key Workforce Gaps

Arizona meets only ~10% of its psychiatric workforce need — a 144 psychiatrist FTE gap statewide.

Psychiatrist-to-population ratio: 1 per 10,739 residents, worse than the U.S. average of 1 per ~8,347.

All Arizona counties have mental health workforce shortages designated as HPSAs (Health Professional Shortage Areas).

Access & Distribution Challenges

233 mental health shortage areas reported, with ~34% in rural/frontier regions.

Nearly **3 million Arizonans** live where there are insufficient mental health professionals

Severe provider maldistribution: most providers cluster in urban centers, leaving rural & tribal areas underserved.

These are not new problems — they are predictable outcomes of workforce design.

Pediatric Behavioral Health in AZ

Arizona Pediatric Population



Total pediatric population: 1,668,827 children (2023)

Access barriers:

- 55% of Arizona adolescents report difficulty accessing behavioral health care
- 53% of Arizona counties have **no Child and Adolescent Psychiatrists (CAPs)**

Severe provider shortage:

- Arizona has **only 11 CAPs per 100,000 children** — qualifying as a *behavioral health desert*

High-need areas:

- Rural and tribal communities disproportionately affected

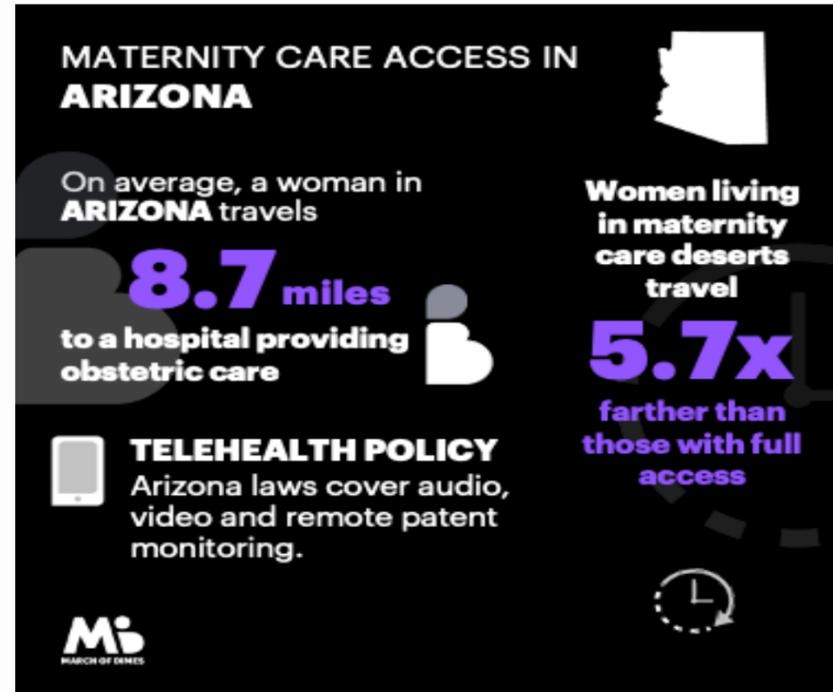
Maternal Mental Health Workforce in Arizona

MATERNITY CARE ACCESS IN ARIZONA

On average, a woman in ARIZONA travels **8.7 miles** to a hospital providing obstetric care

Women living in maternity care deserts travel 5.7x farther than those with full access

TELEHEALTH POLICY
Arizona laws cover audio, video and remote patient monitoring.



HEALTH

Gaps in mental health training, rural access to care compound Arizona's maternal mortality crisis

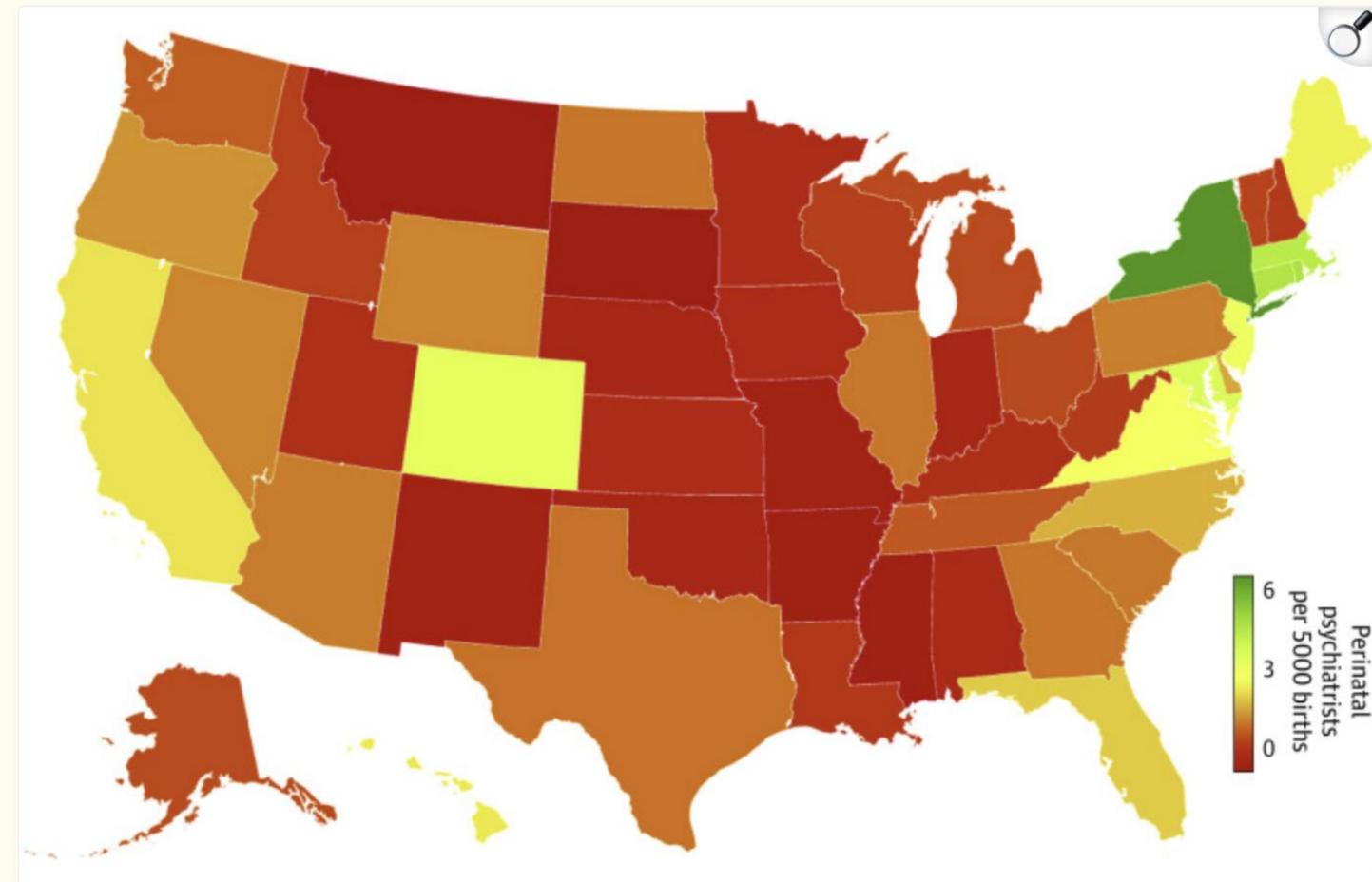


by Natasha Yee and Carmela Guaglianone December 19, 2024



[Open in a new tab](#)

Figure. Heatmap of Perinatal Psychiatrist Density in the US.



Data are based on the number of psychiatrists on the Psychology Today website indicating "pregnancy, prenatal, postpartum" as an issue they treat.

Maternal and Pediatric Mental Health Are Braided — Not Separate

Maternal Mental Health

Up to **20%** of pregnancies/postpartum periods affected by PMADs

60% of women with depression are never diagnosed

Up to 80% with PMADs do not receive treatment

Pediatric & Child Outcomes

Children of mothers with poor mental health are **more likely to develop mental health disorders**

Maternal mental health decline is associated with:

Increased anxiety, mood, and behavioral diagnoses in children

Higher risk during **adolescence**, when suicide risk peaks

Suicide is the **2nd leading cause of death** for ages **15–24**

When maternal mental health goes untreated, pediatric mental health systems absorb the cost — years later.

Before APAL: Why This Had to Exist

University of Arizona, College of Medicine.
Perinatal Psychiatry Elective Track





Build frontline provider
capacity to provide mental
health care to increase
access to care

Improving perinatal depression care: the Massachusetts Child Psychiatry Access Project for Moms

Nancy Byatt ¹, Kathleen Biebel ², Tiffany A Moore Simas ², Barry Sarvet ³, Marcy Ravech ⁴, Jeroan Allison ², John Straus ⁴

Massachusetts Child Psychiatry Access Program for Moms: Utilization and Quality Assessment

Nancy Byatt ¹, John Straus, Arielle Stopa, Kathleen Biebel, Leena Mittal, Tiffany A Moore Simas

> Arch Womens Ment Health. 2023 Jun;26(3):401-410. doi: 10.1007/s00737-023-01324-1.

E Archives of women's mental health

Improving front-line clinician capacity to address depression and bipolar disorder among perinatal individuals: a longitudinal analysis of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms

Grace A Masters ¹, Yiyang Yuan ², Nien Chen Li ³, John Straus ⁴, Tiffany A Moore Simas ^{2 5}, Nancy Byatt ^{2 5}

New Research: As Demand for Child and Adolescent Psychiatry Rose, Promise in “Pediatric Mental Health Care Access Programs” Emerged

November 29, 2021

APAL: The Beginning



APAL – The model



Phone Consultation

APAL provides guidance to medical professionals through free, live phone consultations with perinatal psychiatrists, followed by an email with written treatment recommendations.

APAL also offers free, one-time direct patient evaluations to provide increased support for complex cases.

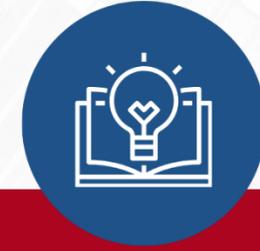


Resource Network

APAL provides resources for professionals including screening and treatment guidelines.

For moms and families, APAL has a resource library including local, state and general resources.

The APAL team connects families with county, state, and national resources for perinatal patients.



Education

APAL creates educational material and provides education on maternal behavioral health topics to increase the capacity of healthcare providers to care for struggling moms.

APAL provides free continuing medical education (CME) credits through their monthly grand rounds series and individualized trainings tailored to providers.

APAL Funding History (2023–2025)

Jan 2023: APAL received initial funding from Arizona Health Care Cost Containment System (AHCCCS) to establish the Arizona Perinatal Psychiatry Access Line. Ending Sept 2024

January 2022 – June 2023: Funding supported infrastructure development, staffing, policies, and statewide launch preparation.

June 2023: Perinatal Line launched with half time coverage.

October 2023: Perinatal Line went to full time operations.

February 2024: AHCCCS awarded ARPA funding to launch the Arizona Pediatric Psychiatry Access Line.

May 2024: Pediatric Line launched with part-time coverage.

July 2024: Grants applied through Mercy Care, AZ Blue finalized in Sept 2024

Sept 2024: Original Perinatal AHCCCS grant expired and was renewed with 6 weeks to go

January 2025: Pediatric Line expanded to full-time statewide access.

March 2025: ARPA Funding terminated

May 2025 : 8 weeks later ARPA funding restored ending Sept 2025

August 2025: 800k through AHCCCS for both lines. Funding through CRH(UA), BCBS, AZ Blue, Mercy Care

Challenge: Funding instability

Year at a time funding since beginning

Reliance on ARPA Derived Mental health block grants

Sudden stop work order

No state general fund appropriation

Staffing at risk

Response:

Secured **\$108K emergency support** for Perinatal Line

Secured **\$80K emergency support** for Pediatric Line

Restructured two existing grants to preserve staffing

Submitted proposals to philanthropic partners

Extended sustainability through **September 2026**

Sustainability
depends on nimble
restructuring,
diversified funding,
and clear value
demonstration

Leadership That Made Survival Possible

- Departmental leadership support
- Institutional trust during uncertainty
- Protected time to execute during crisis



College of Medicine
Tucson

Data as a sustainability engine

Track call volume, response times, outcomes

Cost saving analyses

Economic impact one pagers for legislators

Provider testimonials + rural impact stories

Data + narrative = policy traction

Strategic Partnerships

AHCCCS, ADHS, Center of Rural Health

Legislative champions across both parties

Statewide hospital systems (Banner, HonorHealth, Valleywise)

Medical societies: AzAAP, ArMA, Maricopa, Pima

Multi channel Legitimacy -> stronger advocacy

Community Partnerships

- PSI- AZ
- Chamber of Mothers
- Tribal and IHS
- 4th Trimester
- Arizona birth workers of color
- FQHCs
- Women's Health Innovations

Expand reach beyond traditional
healthcare systems

Provider to Provider Trust building

Rapid response consults
Always available, no wrong door
Longitudinal relationships
Maintaining relationships with OBs, midwives,
pediatricians
High-touch navigation for complex cases

Trust fuels adoption more than marketing.

Trust is infrastructure. It just doesn't show up in budgets.

Expanding access through education

Statewide Learning Management System (LMS)

Prescriber + non-prescriber tracks

CME + certificate tracking

52 trainings in 2025

15 conferences

Grand Rounds featuring national experts

Tailored trainings for rural/tribal sites

Workforce training is a force multiplier

Access builds trust

Trust builds systems.

Systems build healthier mothers, children and communities

How is it going?

Access & Reach

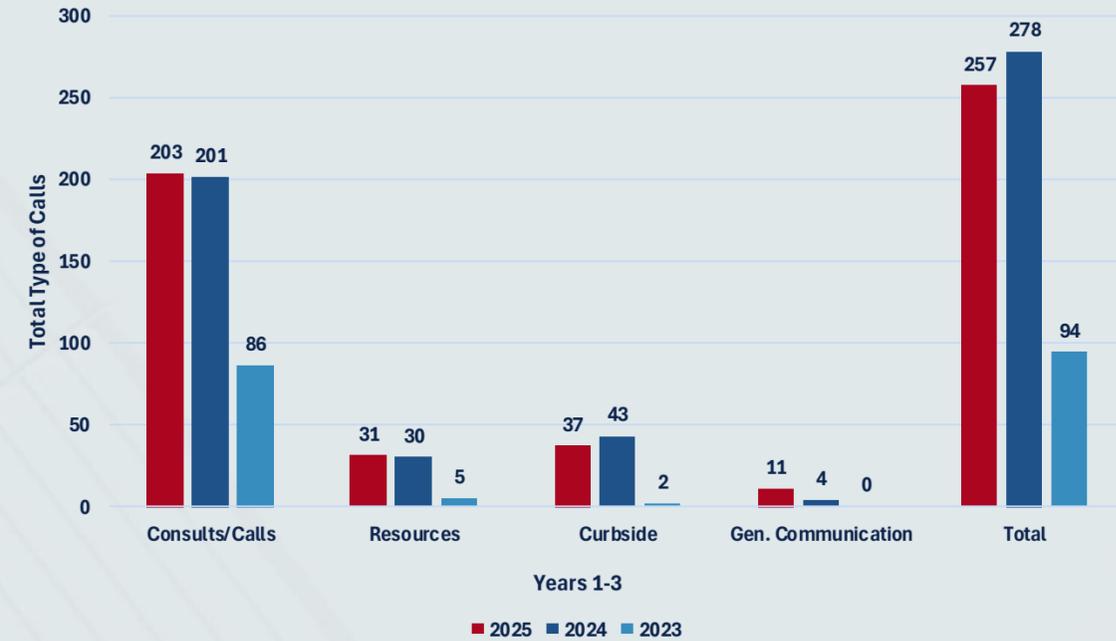
PERINATAL LINE:

- Perinatal line has completed **490 consultations and 82 curbsides.**
- **66 resource calls** have been received.
- **13 out of 15 Arizona counties** have been reached through consultations and curbsides with **11 of those counties** being rural/tribal.
- **Provider types** served:
 - OBs – 159
 - Midwives – 24
 - Pediatricians – 6
 - Psychiatrists – 348

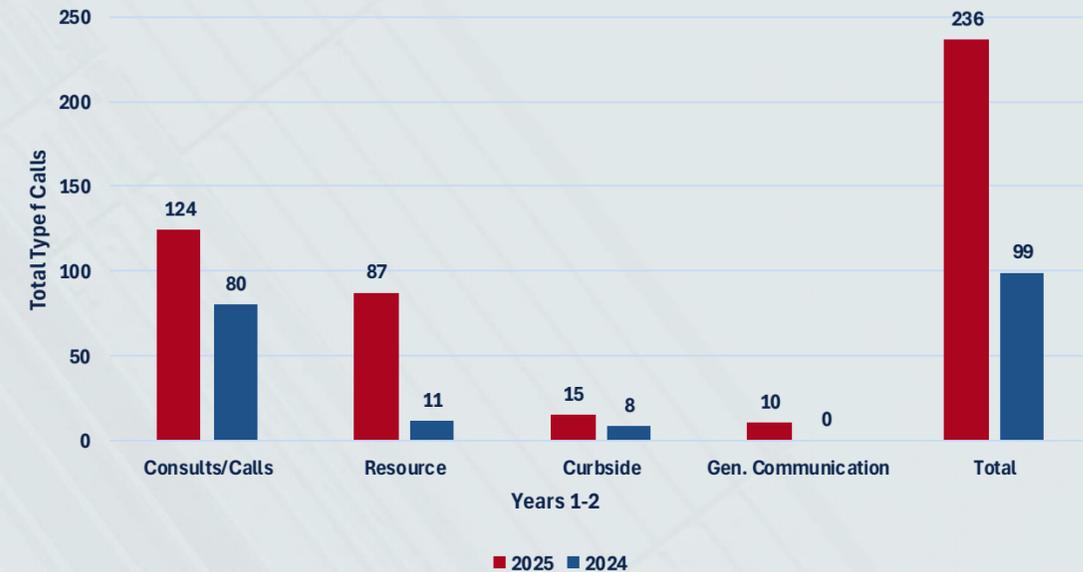
PEDIATRIC LINE:

- Pediatric line has completed **204 consultation and 23 curbsides**
- **98 resource calls** have been received.
- **12 out of 15 counties** have been reached through consultations and curbsides with **10 of those counties** are rural/tribal
- **Provider types** served:
 - Pediatricians – 214
 - Family Medicine – 6
 - Psychiatrists – 14
 - Therapists/Psychologists - 5

Perinatal Contact Type

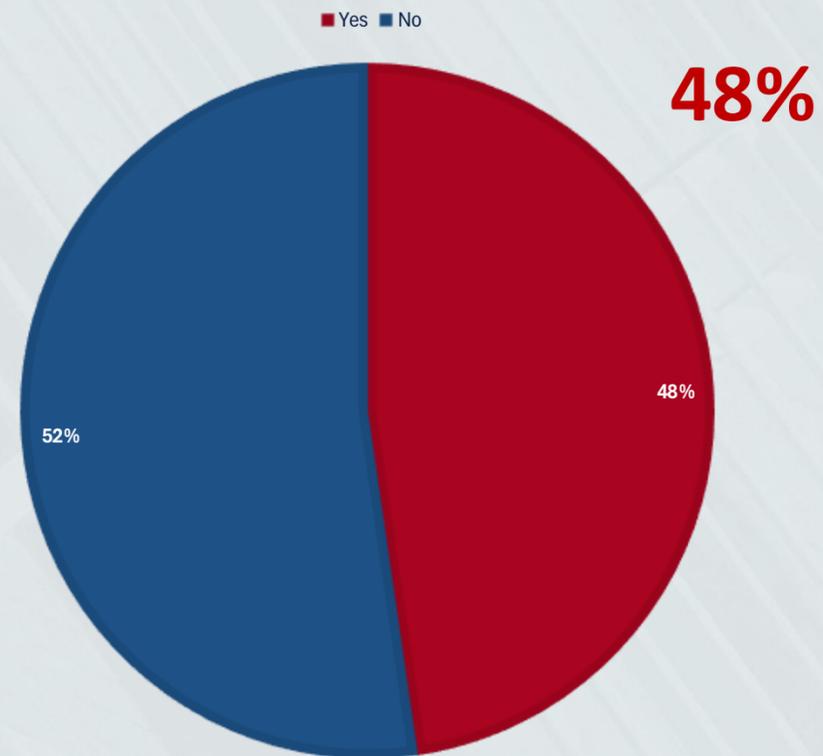


Pediatric Contact Type

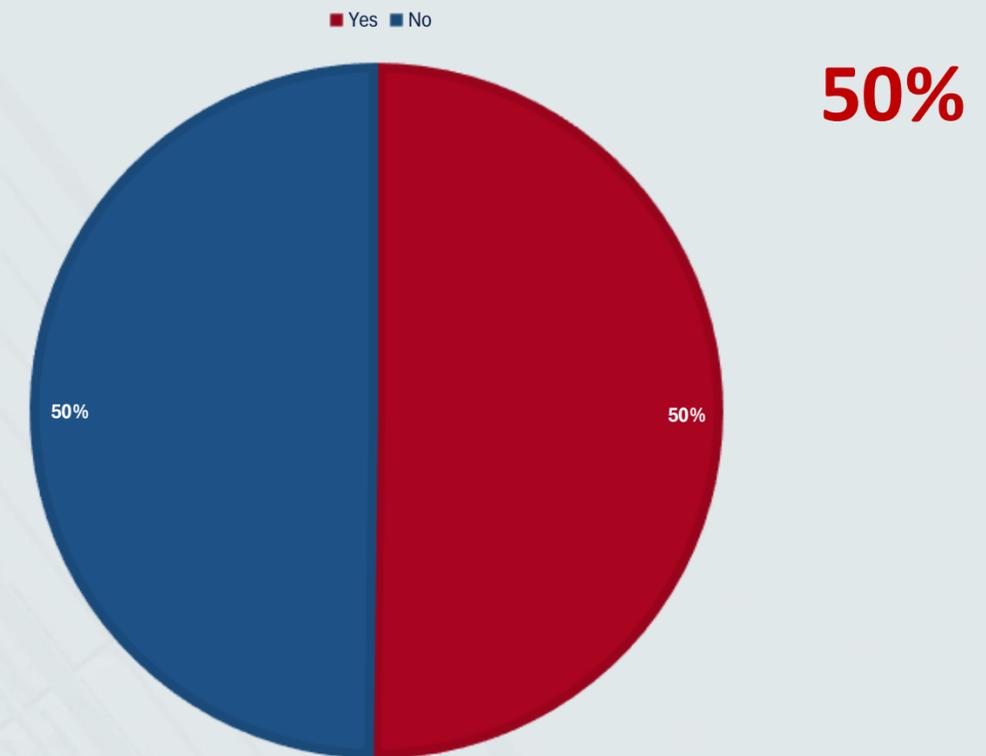


Access & Reach

PERINATAL REPEAT CALLERS



PEDIATRIC REPEAT CALLERS



Callback = repeat use by the same provider, often for a different patient

Education & Capacity Building

Pediatrics:

- 40 trainings provided to medical personnel virtually or in-person

Perinatal:

- 131 trainings provided to medical personnel virtually or in-person
- 33 CME events

Learning Management System:

- In collaboration with Arizona Hospital and Healthcare System
- Launched officially November 2025
- 137 enrollments for the Non-Prescribing Providers track
- 12 enrollments for the Prescribers track

Survival is not Stability

Paths to Long-Term Sustainability

Program Support

State investment
Medicaid administrative funding
Public–private partnerships
Rural Health Transformation Program
Grants (time limited)

Provider Billing

Payment for clinician consult time
Builds on **existing patient–provider relationships**

- Why not bill directly ?

Value-Based Financing

Insurer participation by covered lives (needs legislation, voluntary participation not likely or sustainable)
Less costly than specialty expansion
Aligns with workforce reality

Program sustainability : **Why not bill insurance?**

1. Creates professional – patient relationship which destroys medicolegal protection of “curbside consult”
2. Not cost effective - \$30 - \$40 will not cover cost of setting up billing account
3. Patient gets bill from stranger with potential copay and/or deductible.
4. Would generate token amount towards cost of program.

Should insurers pay?

1. Most common service (phone consultation) benefits a specific patient and should be insurance reimbursable encounter
2. Value based, not FFS, fits program model and direction of health insurance payment structures
3. Primary Care management less expensive than specialty care
4. Insurers sensitive to child/perinatal psychiatry shortage, waiting lists
5. Patients from all insurers helped by program
6. Good investment! Little money!

Once insurer payment system set up - It is sustainable.

Survival is not Stability

- RHTP Rural Health Transformation
- HB 2593

Scaling beyond Arizona

Tri-state collaboration (AZ–NM–UT) and Peds (CO, NM, UT, AZ)
Unified digital backbone (National vision)
Shared resource navigation + LMS
National alignment with HRSA/PMHCA

Scaling requires both infrastructure and relational capital.

Next steps for APAL

Perinatal

- Grant funded till Sept 2026
- Offer One-time Direct patient Evaluations
- Work towards follow-up funding

Pediatric

- Grant funded till Sept 2026
- Increase hours to full time coverage –started Jan 2026
- Hire Child Psychologist (posting soon)
- Offer One-time Direct patient evaluations
- Work towards follow-up funding

What we've Learned

Build early, build nimble.

Diversify funding before crisis hits.

Use data relentlessly.

Policy follows proof of concept, not the other way around.

Community partnerships elevate trust and visibility.

Relationships are the real infrastructure.



Visit our Website

To request an APAL training, download the toolkits, and access other resources, scan the QR code to visit our website.

Thank you

Dr. Saira Kalia

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