DISCLOSURES

- I am a triple boarder
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  - Baptist Community Ministries
  - Louisiana Public Health Institute
  - SAMHSA/Louisiana Office of Public Health
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OBJECTIVES

- Be able to recognize challenges in traditional models of care
- Be able to describe national co-located models
- Be familiar with examples of child psychiatry access programs
- Be familiar with the potential for integration models in Louisiana
OVERVIEW

- Why mental health in the medical home?
- Evidence supporting integration nationally
- Louisiana models of integration
WHY MENTAL HEALTH IN PRIMARY CARE
TRADITIONAL MODEL OF CARE

Physical Health

- Mental Health Care
- Home and community safety promotion
- Developmental Specialty Care
- Educational issues
- Other Medical Specialty Care
Mind

“Physio-psychology”
(Body affects mind)

“Psycho-physiology”
(Mind affects body)

Body
**HEALTH MAINTENANCE PERIODICITY SCHEDULE**

- **Visits at**
  - Birth
  - 3-5 days
  - 1 month
  - 2 months
  - 4 months
  - 6 months
  - 9 months
  - 12 months
  - 15 months
  - 18 months

- **And**
  - 24 months
  - 30 months
  - 36 months
  - 48 months
  - 60 months

15 scheduled visits in 5 years!

Required for school entrance!!

Parents attend visits!
Well-Child Visits

- Multi-organ, multi-system assessment with prevention and health maintenance focus
- **CC:** Parental Concerns
- **History:** ER visits, hospitalizations, chronic illness update, immunizations up to date, development (social, motor, language), sleep history, feeding/eating history, family changes (divorce, new sibling, move), academic functioning/school transition, social/dating/sexual development, safety (guns in home, domestic violence, physical, sexual abuse, community violence), paternal well-being
- **Physical Exam:** Growth parameters, vital signs, HEENT, neck, CV, Resp, Abd, GU, Skin, Extremities, Neuro/cognitive
- **Anticipatory Guidance:** Safety proof home, Lead, nutrition & exercise, bullying, peer relationships and pressures, personal safety (strangers, know address, “good touch, bad touch”), helmets, smoke detectors, tooth brushing/dental hygiene, time-out, emotional regulation, sibling response, media exposure... substance abuse, sexual development,
- **Plan:** can include any of these spheres: meds, immunizations, blood work, IEP referral and/or developmental assessment, get guns out of home, obtain free mattress cover for atopic children, refer/advocate re: housing issues (bars on windows, smoke detectors), maternal depression referral, smoking cessation (parent or child), behavioral plan for typical behavioral challenges...

- ALL IN 8-11 MINUTES
“Health education must include anticipatory guidance and interpretive conference. Youth 2-20 must receive intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each visit.”
PEDIATRIC COMPETENCIES FOR MENTAL HEALTH (2009)

- Interpersonal and communication
  - Enhance communication with patients
  - Increase skills in cross-disciplinary communication

- Professionalism
  - Sensitivity to cultural differences
  - Confidentiality
  - Awareness of own limitations
PEDiatric Competencies for Mental Health (2009)

- **Systems Based Practice**
  - Insurance issues
  - Collaboration with mental health professionals

- **Patient Care**
  - Screening and basic assessment
  - Guidance on managing common behavioral problems and adjustment
  - Recognizing mental health emergencies
  - Develop treatment plans for ADHD, depression, anxiety, and substance abuse
MENTAL HEALTH IN PRIMARY CARE PRACTICE

- ~90% of US children have health insurance
- Primary care providers provide the vast majority of pediatric mental health services in the US
  - UP to 19% of visits have a MH component (Kelleher, 2000)
  - Mental health needs drive primary care utilization (Bernal, 2003)
  - 70-85% of psychototropic rx’s written by PCPs
80% of parents believe pediatric setting is appropriate for discussion of psychosocial issues.

Most parents want more information about behavioral issues. (Young et al., 1998)
<table>
<thead>
<tr>
<th>Pediatrician</th>
<th>CAP</th>
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<tbody>
<tr>
<td>Identify</td>
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<tr>
<td>ADHD</td>
<td>90%*</td>
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<tr>
<td>MDD, Anx</td>
<td>85%*</td>
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<td>DBDs</td>
<td>82%</td>
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<td>Subst. abuse</td>
<td>86%</td>
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<td>Eating D/O</td>
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</table>
80% of parents believe pediatric setting is appropriate for discussion of psychosocial issues
- Fewer than 50% of parents whose child had a psychosocial problem discussed with pediatrician (Horowitz, 1998)

When an MD reported counseling parent about child’s mood, anxiety, or behavior
- 75% of parents did not report that they received any counseling (Brown & Wissow, 2008)
IDENTIFICATION AND REFERRAL

- Using unstructured approaches, PCP’s identify
  - 50% of children with moderate symptoms
  - 80% of children with high level symptoms
  - Identification rates related to race/ethnicity
    - (Brown and Wissow, 2008)

- Within 6 mo of diagnosis and referral
  - < 50% have mental health appointment
  - < 1/3 have more than 1 MH appointment (Rushton 2002)
SYSTEMATIC DISINCENTIVES FOR PRIMARY CARE MH

- **Time**
  - 8 min on “medical only” appointments
  - 20 min on “behavioral only”

- **CPT billing codes**
  - 2.7 procedure code (1-10) for “medical only”
  - 1 procedure code for “behavioral only”

- **Billable income**
  - Per minute, billed 4-fold for “medical only” appointments vs “behavioral only”

- **In some insurance plans, PCPs cannot bill at all for MH diagnoses**

- **Training**
  - RRC requirements for mental health issues are minimal ER (exposure to psychiatric emergencies) and DBP (recognition and care coordination of psychosocial issues)

CULTURAL MILIEU
MENTAL HEALTH AND PEDIATRICS

- **Relationship with families**
  - Pediatrics: Extended relationship, infrequent contacts, automatic exposure to siblings
  - Mental Health: Shorter relationships, more frequent/intense contact

- **Patient population**
  - Pediatrics: Healthy, usually with typical development
  - Mental Health: Significant Psychopathology/Adjustment
• **Approach to concerns**
  - Pediatrics: Normalize
  - Mental health: Validate, dx, treat

• **Treatment outcomes**
  - Pediatrics: Most children get better
  - Mental health: Many disorders are chronic/recurring

• **Scope of care**
  - Pediatrics: Broad
  - Child Psychiatry: Clear boundaries
Communication
- Pediatrics: Often leave patient room to take a call
- Mental health: Rarely interrupt session

Communication among specialists
- Pediatrics: Specialists provide written consultation notes
- Mental Health: Confidentiality is supreme
WORKFORCE SHORTAGE (CAP)

- Currently ~7000 child psychiatrists in US
- Estimated # to meet need = 30,000 (COGME)
- At current recruitment rates, 8,300 C.A.P.s by 2020
- Demand for C.A.P. service in U.S. will increase by 100% from 1995 to 2020 (DHHS, 2000)

Distribution
- Massachusetts: 21.3 C.A.P.s/100,000 youth
- Alaska: 3.1 C.A.P.s/100,000 youth
- Louisiana 6.6 (#35)= 1 CAP/15,000 youth
- U.S. Average: 8.7 C.A.P.s/100,000 youth Thomas & Holzer, 2006
US PRACTICING CAP
PER 100,000 CHILDREN (2012)

http://www.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
LOUISIANA CHILD PSYCHIATRISTS
(PER 100,000 CHILDREN)
1 in 4 children with a psychiatric disorder receive any treatment \( (Jensen\ et\ al\ 2011) \)

5,250,000 children with untreated disorders in the U.S.
THE STATUS QUO WAS NOT WORKING!
INNOVATIONS IN PEDIATRIC MENTAL HEALTH CARE
MEDICAL HOME MODEL

- **Goal:** Coordinate medical care
  - Maintain comprehensive medical record
  - Interpret, discuss and evaluate specialty recommendations
  - Reduce discontinuities, duplications
  - Enhances preventative function of primary care

- **Unique medical care setting:** longstanding relationship between MD and family (prenatal-college)

- Exposure to multiple family members, not just “identified patient”
Medical Home as Hub for System of Care

- Mental Health Specialty Care
- Developmental Specialty Care
- Home and community safety promotion
- Other medical health specialty care
- Educational issues
FILLING THE GAP BETWEEN PRIMARY CARE AND SPECIALTY MH CARE

Medical Home

- Mental Health Specialty Care
- Developmental Specialty Care
- Home and community safety promotion
- Other medical health specialty care
- Educational issues
PEDIATRIC PROVIDER TRAINING MODELS

Communication training
- Motivational Interviewing skills
  - Does not increase time spent with patient in primary care
  - Is associated with decreased parental MH symptoms
  - Increases referral success

Content training
- REACH Institute psychopharmacology “fellowships” and supervision
APPROACHES TO INTEGRATED CARE

Office-centered coordination
- MH providers in the PCP office
- High MH:PCP ratio
- Co-location allows high level of informal collaboration

Hub-based coordination
- PCPs reach out to MH providers
- MH serve multiple practices
- Most interactions planned
OFFICE-BASED RATIONALE

- Expands capacity of the medical home
- Usually uses master’s level mental health providers
- Does not require behavioral shifts by PCPs
- Increases access to evidence based psychotherapies
Study of effectiveness of Incredible Years Series Parenting group administered in the primary care setting for toddlers with disruptive behavior disorders

150 parents randomized to IYS vs. WLC

Moderate baseline symptoms (ECBI ~60)

Immediately post treatment, at 6 months, and at 12 months

- ECBI scores: IYS < WL group
- Observed interactions
  - No difference negative parenting or child disruptive behaviors
  - Negative parent-child interactions: IYS < WL
DISRUPTIVE BEHAVIOR DISORDERS
DOCTOR OFFICE COLLABORATIVE CARE MODEL (KOLKO ET AL 2012)

- DOCC vs enhanced care as usual for children with behavioral problems
  - (PSC behavioral subscale positive)
- 2:1 randomization (n=78)
- Enhanced care as usual
  - Psychoeducation
  - 3 referrals tailored to geography and child factors
DISRUPTIVE BEHAVIOR DISORDERS
(2)

- **DOCC intervention**
  - Care manager (nurse, SW)
    - Face-face time with parent/child ≤ 12 hours over ≤ 6 months
    - Psychoeducation
    - School liaison/advocacy
    - Skills training in behavioral treatments (parent and child-focused)
    - care management coordination
    - Track progress/goal attainment weekly
  - CAP
  - Team leader
  - Consultation re complex diagnosis or medications
  - Train/supervise CM
Treatment completion
- 78% DOCC vs 0% EUC

Clinical outcomes (reduction in symptoms on VADRS)
- ADHD: DOCC > EUC
- Oppositional behavior: DOCC > EUC
- Conduct problems: DOCC = EUC
- Anxiety/depression: DOCC = EUC
13-21 year-old from 6 sites.

418 randomized:
- Quality improvement (QI) vs care as usual (CAU)
- on-site care manager (PhD, RN, Therapist)
- managers trained in CBT
- free evaluation
- Treatment plan not constrained

CAU
- training
- educational handouts
Depression*
- QI: 18 vs CAU: 21.4 (OR=2.9)

Medication rates: QI=CAU

Mental health care rates
- QI 32% vs CAU 17%

Suicidal ideation/attempts
- No difference
ACCESS AND CONSULTATION PROGRAMS

“Hub”-based (vs practice-based) approaches to collaborative care

Rationale

- Unmitigated work force shortage
- Impacts more than 1 practice
- Geographic distances/rural areas
- Enhancing PCP capacity rather than replacing
- Often medication-focused/related to drug utilization procedures
FORMS OF CONSULTATION

- Web-based resources
  - In-service trainings
  - Indirect consultation
    \((PCP \text{ discusses question with consultant})\)
  - Direct consultation
    \((PCP \text{ asks consultant to assess patient to answer specific question})\)
Child psychiatrist, social worker/psychologist, and a care coordinator= regional team
Available during working hours
75% indirect (not seeing patient) or resource questions
Associated with decreased access barriers, increased sense of competence, high satisfaction (Sarvet et al 2010)
MCPAP Funding System

- Initially funded directly by Medicaid
- Now supported by public and private third party payers
WASHINGTON PARTNERSHIP ACCESS LINE

- Developed as part of mandatory drug utilization reviews
- Offers voluntary child psychiatry consultation to PCPs
- Provides in-service training
- Provides phone consultation (indirect)
- (Now offer direct consultation in select geographic areas)
Consult requests: 2285 phone consults in 37 month period
- 58% questions about medications
- 89% of children had not seen a mental health provider in last year
- 30% repeat calls

Provisional diagnoses
- ADHD > Anxiety = DBD > Depression > ASD

High Provider Satisfaction (46% response rate): 4.6 (0-5)
- “PAL helps me to increase my own skills in the mental health care of my patients” (4.6)
- “PAL helped me to manage my patient’s care” (4.7)
Medication recommendations
- More increases than decreases

Psychosocial recommendations
- In nearly every case

Claims data
- Increased outpatient care for children in foster care
- No change in cost overall, despite some increase in prescriptions for ADHD and SSIR
MARYLAND PEER CONSULTATION

- Mandatory peer consultation for children on Medicaid
- Started with off-label use of AAA’s for children under 6
- Expanded up to off-label uses for children under 18
- MD is required to provide diagnosis, labs, height, weight as part of PA
- Associated with fewer preschool prescriptions

(Personal communication, G. Reeves MD 2014)
- Large geographical area
- Population spread out
- Substantial expertise in early childhood
- One of 8 states with program training residents in “triple board”
- Very limited work force
- Administrative integration of mental health into physical health MCO
- High rates of medication use (ADHD)
- High rates children in poverty
WHAT KIND OF INTEGRATION FOR LOUISIANA?

- Complex clinical situations call for evidence-based therapies
- Work force:patient ratio requires hub based
- High rates of medication use suggests need for psychopharmacologic consultation
- 5 MCOs
CONSULTATION MODEL

Why consultation?

- Insufficient numbers of trained IMH professionals around the state
- With guidance, PCPs and general mental health providers can implement basic behavioral strategies
- Good assessment can help families advocate for necessary services
- With partnership and support, providers in isolated areas can learn basic assessment skills, be familiar with recommended treatment approaches, and recognize their scope of practice
LOUISIANA PRIMARY CARE
CONSULTATION PROJECTS

- Gulf Coast Consultation in Child and Adolescent Psychiatry
  - Consultation to primary care 2008-2010
  - Oil-spill affected areas

- Mental and Behavioral Health Capacity Program
  - Onsite and telepsych support in primary care and schools
  - Oil-spill affected areas

- Project LAUNCH
  - Consultation to primary care, Early Steps, and child care
  - Lafayette, Acadia, Vermillion

- Tulane Early Childhood Collaborative
  - Consultation to primary care
  - Orleans, Jefferson, St Bernard, Plaquemines, St Tammany
LOUISIANA PROJECTS

- All focused on expanding capacity of front line child professionals and child-serving agencies
  - Primary care providers
  - School health and mental health providers
  - School/early educators
  - Early Steps professionals
- All collecting data
- Slightly different models and targets of consultation
- All using grant funding
CAVEAT: PRELIMINARY INFORMATION FROM PCPS
ACCESS TO MENTAL HEALTH PROVIDERS FOR CHILDREN

- Grossly inadequate: 56.3%
- Inadequate: 37.5%
- Nearly adequate: 6.3%
- Adequate: 0%

TECC unpublished data 2015
ACCESS MENTAL HEALTH SERVICES FOR YOUNG CHILDREN

- Grossly inadequate: 0
- Inadequate: 12.5
- Nearly adequate: 37.5
- Adequate: 50

- Grossly inadequate
- Inadequate
- Nearly adequate
- Adequate
ACCESS CASE MANAGEMENT AROUND MENTAL HEALTH NEEDS

- Grossly inadequate: 0
- Inadequate: 6.5
- Nearly adequate: 46
- Adequate: 46
PROJECT LAUNCH
MENTAL HEALTH CONSULTATION

- Going where the children are
- Primary care
  - Pediatrics, Family Practice, OB
- Child care
  - Center based
  - Home based
- Early Steps
  - High needs
CONSULTATION LAUNCH-STYLE

Hub-style components
- Web-based resources
  - Decision making guides
  - Parent handouts
- Consultation without seeing patient (assessment, management, resources)
  - Phone
  - Secure email
- Full evaluation appointments

Office-based components
- Lunch ‘n learn sessions
- Curbside consultation without seeing patient
- Brief consultation appointments
Provider Resources

**Screens for Early Childhood Mental Health Problems**

**Infants (0-18 months)**
- Baby Pediatric Symptom Checklist and Scoring Guide

**Child’s Family and Environment**
- Parental Depression
  - Patient Health Questionnaire-2 (PHQ-2)
  - Edinburgh Postnatal Depression Scale (EPDS)
- Clinical Information
- Environmental Safety
  - Safe Environment for Every Kid (SEEK)

**Toddlers/Preschoolers (18-60 months)**
- Early Childhood Screening Assessment (18-60 months)
  - ECSA Screen
  - ECSA Spanish
  - ECSA Scoring Guide
  - ECSA Manual
- Preschool Pediatric Symptoms Checklist
  - Preschool PSC
  - Spanish Version
  - PPSC Scoring Guide
Child Development By Age: Learn about your child's development from birth to 5 years old.

Topics that Affect All Families
- Childcare Safety Checklist
- Toilet Training Tips
- Developmental Principles Guiding Feeding Practices
- Social-Emotional Health Tips
- Screening Passport for Parents-Birth to 5
- Early Learning Handout
- Early Education
- Developmental Screening Fact Sheet

Early Childhood Problems for Parents
- Feeding Problems in Infants & Children
- Intellectual Disability
- Asperger Syndrome
- Sleep Challenges
- Shyness
- Separation Anxiety
- Preschool Defiance
- Preschool Aggression
- Colic
- Autism
- ADHD

Managing Difficult Behaviors
- Using Rewards
- Fighting Aggression
- Special Playtime
- Tantrums

Parent Support - Taking Care of Yourself
- Breathing for Parents
- Active Relaxation
- Learning to Relax

Parent Resources
- Child Development by Age
- Topics That Affect All Families
- Early Childhood Problems for Parents
- Managing Difficult Behaviors
- Parent Support-Taking Care of Yourself
EXAMPLES OF INDIRECT CONSULTATION

“I have a patient with ADHD and who seems really anxious and screened positive with the SCARED. What is the best treatment for him?

Just met a new adoptive mother of a 4 year old. Things are going well so far, but what kind of advice can we give her?

A mother at a 2 week postpartum visit screened positive for depression. She has a history of depression and wants to continue breastfeeding. What is the best SSRI? She did well with sertraline in the past.
“What do you do for a 6 year old who is hearing voices?”
“A mother of 40 month old twins seems overwhelmed. In the office, the children always cause damage and try to break things”
“Can you see an 5 year old girl with developmental delays and anxiety? I’m wondering about autism.”
‘A patient has adopted twin 4 year old girls from Romania. They are both deaf and we’re wondering about autism”
57 month old girl- impulsive, hyperactive, bites brother, uncontrollable, as an infant, would not let parents console her”
“42 month old running in the street at night. Referred by CSOC because of safety concerns. Has tried to burn house down.”
“33 month old boy with chromosomal anomaly, parents with developmental delays, and extreme aggression including throwing knives at people“
LUNCH N’ LEARNs

- ADHD
- Attachment in the primary care setting
- Motivating positive behaviors
- Parental mental health issues
- ACES and toxic stress
- Screens and measures for primary care
“This 9 month old baby came in for a well-child visit today. Mother said that the baby has lots of trouble sleeping... can you talk with her?”

“I asked this 7 year old to come in today. I’ve been treating for ADHD but he’s not getting better”

“This 4 year old stopped talking when he heard about shots and has run out of the room 3 times. Can you help us?”

This mother of a 6 year old is worried about his behavior at home but not at school. I am thinking about trauma-exposure because he hits his mother here in the office. How can I assess this? Is there a measure I can use to start clarifying this?”

“I’m really overwhelmed when I hear about abuse and violence. I don’t want to avoid it, but sometimes I do”
PRINCIPLES OF CONSULTATION

- Consultation is to the provider
- Validate strengths in existing approaches
- Tailor consult to the question

Promote
- Use of validated measures for screening
- Attention to symptoms and context
  - Symptom screens
  - Environmental screen for ACES
- Strengths-based approach
- Attention to parent-child relationships
- Common factors approach to mental health concerns
Offer

- Consistent recommendations that are generalizable
- Guidance about tracking symptoms/how to know when it moves beyond primary care level
- Recommendations for providers primarily, but also parents and schools when appropriate
- Behavioral interventions always
- Psychopharmacologic approaches when appropriate
- Detailed, step-by-step recommendations
- Support for PCP self-care and self-awareness
FACE-FACE CONSULTATION REPORTS

- Summary of the history and measures
  - IN ENGLISH

- Summary of the assessment/formulation
  - Biological factors (protective or risk)
  - Psychological patterns
  - Social factors
  - Strengths

- Recommendations
  - For primary care provider (detailed!)
  - For parent
  - For educational setting
  - Handouts from reputable sources
ANECTDOTAL OUTCOMES

- PCP thinking about trauma and context in every case of behavioral/emotional concerns
- Using measures before in-person consultation requests
- Use of handouts with consistent messaging
- Families connected to existing social supports
- Children accessing diagnoses that avail them of evidence-based treatments
FEEDBACK

“it helps to know there is someone to call”
“I have treated children I wouldn’t have felt comfortable treating”
“Knowing that you will see children in a short time helps”
“I can manage some of this once I know what is going on”
LESSONS LEARNED AND HIGHLIGHTED

- Relationships matter!
- PCPs are managing high level of acuity every day
- Wide range of comfort levels related to mental health in primary care
- Sometimes small consultation interventions make substantial difference
- Coordination among child-serving providers reduces family distress
Promote the program promotes the health and well-being of children from birth to age 8

- Improve coordination
- Build infrastructure
- Improve methods for providing services
MENTAL HEALTH CONSULTATION

- ...where the children are
- Primary care
  - Pediatrics, Family Practice, OB
- Child care
  - Center based
  - Home based
- Early Steps
FILLING THE GAP BETWEEN PRIMARY CARE AND SPECIALTY MH CARE

Medical Home

- Mental Health Specialty Care
- Developmental Specialty Care
- Child care/Educational issues
- Other medical health specialty care
- Home and community safety promotion
Every parent has what it takes to be a brain builder.
Community Mental Health Promotion

- Local and state-level advisory boards
- Increase interagency collaboration
- Identify strengths and areas for growth in mental health promotion
Children’s health includes physical, mental, and relationship components

Primary care providers are trusted child health professionals

Mental health providers can support medical homes in promoting well-being and providing first line interventions

Louisiana will benefit from hybrid access model

Project LAUNCH offers a model of comprehensive health and well-being promotion