Improving Behavioral Health Services in Pediatric Primary Care: Collaboration and Integration

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Outline

- Place our program in context
- The Process of Designing the Program
  - Empowered Leadership Team
  - Clear Mission statement
- The Program
  - Clearly Defined Roles
- Implementation
- Outcomes
- Ongoing improvement
- Future steps
Our Program in Context
That was then this is now...
Behavioral Health & Mortality

- **0-1 years:**
  - Developmental and genetic conditions that were present at birth
  - Sudden infant death syndrome (SIDS)
  - All conditions associated with prematurity and low birth weight
- **1-4 years:**
  - Accidents
  - Developmental and genetic conditions that were present at birth
  - Cancer
- **5-14 years:**
  - Accidents
  - Cancer
  - Homicide
- **15-24 years:**
  - Accidents
  - Homicide
  - Suicide
The Scope of the Problem

- 14-20% of children and adolescents have behavioral health problems.
- Up to 75% of children and adolescent with behavioral health problems are seen in the primary care setting.
- Half of pediatric visits involve behavioral, psychosocial, or educational concerns.
- 2% of kids with behavioral health concerns are seen by mental health specialists.
Barriers for Pediatricians

- Preparation: Behavioral Health Training/Education limited
- Structure of Visits:
  - Brief visits result in fear of “opening pandora’s box”
  - Not designed to support chronic care management
- Complexity of referring: Reimbursement carveout
- Lack of feedback after referral due to different cultures
  - HIPPA, privacy, documentation, approach, training
Changes in SSRI Utilization

- Therapy appointments down
- SSRIs – down s/p Black Box Warning
Timing is everything
The Process: Designing the Program

THE STAKEHOLDERS
SOME HISTORY
THE FIRST STEPS
THE MISSION STATEMENT
Child & Family Counseling Center

- Small therapy department within Children’s Hospital of Pittsburgh
- Long history of working closely with pediatricians – both specialty and general pediatricians
- No history of working with psychiatrists
Former Efforts that Couldn’t Go To Scale

- Researchers
  - ADHD integration projects
  - Attempts to treat DBD in primary care

- Clinical
  - WPIC providers – therapist placed in one clinic
  - CHP providers
    - Child & Family Counseling Center
    - Isolated programs within departments

- Shadyside hospital providers – family practice clinic
The vital role of the pediatrician

- Pediatricians – primary stakeholders were looking for system redesign
  - Buy in/support from administration – at CHP and WPIC
  - Early adopters with vision
The First Steps of This Project

• Form an Empowered Leadership Group
  ○ All clinical and administrative stakeholders at the table
  ○ Power to change systems
  ○ Clinician and practice-level buy-in to drive change
The First Steps of This Project

- Agree on **Mission Statement** and **Primary Goals of Service**
  - Provide case management, therapy, both?
  - Provide “warm” handoff for all cases
  - Be available for all case that have fallen thru cracks
  - Replace current system?
  - Augment current system?
  - What role would pediatricians have?
  - What role would psychiatrists have – phone consultation, treatment, curbsides, supervision...
The Children’s Community Pediatrics (CCP) Behavioral Health program is a collaborative effort between pediatricians, licensed clinical social workers, psychologists and psychiatrists to provide timely access to high-quality, empirically supported behavioral health assessments, behavioral interventions, and psychiatric interventions to children and families in an integrated model of care provided within the pediatric primary care office.
What does integrate mean?
The Program
Pediatricians
- Screen for behavioral health problems/risk
  - informally in well-child checks,
  - (eventually developed to formally with PHQ-9A/EPDS)
- Refer to therapist

Therapist Evaluates & provides
- Short Term Treatment and/or
- Refers to higher level of care
- Collaborates with psychiatrist

Psychiatrist evaluates & either
- Refers to higher level of care or
- Provides short-term treatment with team
Pediatrician identifies behavioral health needs

**Routine Care in the Office**

**Mild symptoms/impairment**
- ADHD managed by meds within practice
- Mild adjustment issues
- Mild anxiety or depression
- Parenting/child development education
- Family support

Managed by the Pediatrician

**Moderate to severe Symptoms/Impairment**
- ADHD/Need for family treatment
- ADHD/Comorbid anxiety mood sx
- Anxiety/phobia/OCD
- Chronic illness
- Depression/mood sx
- Defiance/opposition
- Disordered eating
- Encopresis/enuresis
- Grief/Loss
- Parent management training

Referral to Behavioral Health Therapist for assessment and possible treatment

If no symptoms resolution or specialized care required (bipolar disorder, psychosis, etc.)

Referral to child psychiatrist

Therapists/psychologist collaborate with psychiatrist and pediatrician

**Immediate/Safety Issues**
- Suicidality
- Homicidality
- Severe substance abuse
- Violence
- CYF report
- Safety concerns

Pediatrician refers to Emergency Dept. or appropriate community agency

**Psychiatric Facility/ED**

**Non-behavioral concerns are not referred to behavioral provider:**
- Custody Issues
- CYF/child welfare issues
- Learning/school evals
- Financial/housing, etc.

Pediatrician refers to appropriate community agency

G.Crum/A.Schlesinger 5-13-08
Care Pathways for Referrals

- **Mild behavioral health symptoms & impairment**
  - Routine management by pediatric primary care provider

- **Moderate to severe behavioral health symptoms & impairment**
  - Management by Collaborative Behavioral Health Team

- **Psychiatric Emergency/ Safety Intensive Services Needed/ Behavioral health not primary service needed**
  - Community Referrals/ Emergency Department
## Referral to Collaborative Team:

<table>
<thead>
<tr>
<th>Indications</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD / Family treatment</td>
<td>Autism Spectrum Disorders</td>
</tr>
<tr>
<td>ADHD / Comorbid anxiety/mood symptoms</td>
<td>Developmental Delay / MR</td>
</tr>
<tr>
<td>Anxiety / phobia / OCD</td>
<td>Severe psychiatric illness</td>
</tr>
<tr>
<td>Adjustment to Chronic Illness</td>
<td>(severe mood disorder, severe ED, etc)</td>
</tr>
<tr>
<td>Depression / mood disorder symptoms</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Defiance / Oppositional behavior</td>
<td>Complex psychiatric illness requiring higher level of care, intensive services</td>
</tr>
<tr>
<td>Disordered eating behavior</td>
<td></td>
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<tr>
<td>Encopresis / enuresis</td>
<td></td>
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<tr>
<td>Grief / loss</td>
<td></td>
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<tr>
<td>Parent management training</td>
<td></td>
</tr>
</tbody>
</table>
ED: Immediate Safety Concerns

- Suicidality
- Homicidality
- Severe substance abuse
- Violence
- CYF report
- Safety concerns
Non-behavioral concerns: Not referred to therapist

- Non-behavioral concerns are not referred to behavioral provider:
- Custody Issues
- CYF/child welfare issues
- Learning/school evals
- Financial/housing, etc.
Implementation

CHALLENGES
BREAKING DOWN BARRIERS
INTRODUCING THE PROGRAM
INTRODUCING A PRACTICE
ONGOING EDUCATION
Challenges

- Stigma
- Pediatric Education Re: behavioral health
- Concerns about medicolegal
- Time for appointments
- Cultural differences – confidentiality
- Billing
- Credentialing
Breaking Down Barriers

- Communication – Integrated Record
- The patient is a member of the pediatric practice – checks in just like primary care patient and can schedule just like they were scheduling with their primary care physician
- Avoiding hand-offs – This is not your patient or my patient it is our patient
Introducing the Program to CCP

- Therapists and psychiatrist attended CME dinners
- Lead therapist and psychiatrist briefly introduced the model and gave updates (to reintroduce the model)
- Therapists and psychiatrists attended sessions to “get to know” the CCP docs
Introducing a Practice

- Practice meets with clinical leaders to discuss model
  - Administrative champion - often the office manager, but can be lead nurse
  - Clinician Champion
    - Must buy-in to the concept of moving towards integrated services
    - Should have leadership role within the practice – but does not need to be the lead MD for the practice
    - Open communication is vital
  - Lead social worker
  - Psychiatric Medical Director
- Follow-up meetings with administrative and clinical teams to work out specifics
Communicating with Stakeholders

- Pediatrician
- Office Managers
- Nurses
- Operations Staff
- Scheduling Staff
- Triage Staff
- Therapist/Psychologist
- Families
- Front desk
- Child and Adolescent Psychiatrist
Shared resources

- Behavioral Health Billing Specialists
- Credentialing with insurance
- Supervision
- Education – of therapists and pediatricians
- Integrated Chart
“Protocolized treatment”

- Protocols
  - When to refer to service (as seen previously)
  - When to refer to psychiatry
  - Who should be referred out
  - How to use medication
SSRI Clinical Treatment Protocol

**Initiation:**
Patient started on SSRI*
- ≥ 3 appointments with therapist in 6 weeks
- ≥ 3 appointments with psychiatrist in first 6 weeks

**Stabilization**
- medication adjusted over next 8 weeks.
- ≥ 1 appointment/mo with CAP
- ≥ 2 appointments/mo with therapist

**Maintenance**
- 9-12 months
- Target appointments every 6-8 weeks with therapist and/or MD.

**Discontinuation**
- decrease medication (citalopram or fluoxetine) by 10 mg every week.***
- parent and patient should watch for resurgence of sxss beginning 1 month after medication discontinued

*If significant decline and/or no significant response referral to higher and/or more intensive level of care.
** maintenance recommended for 2 years or greater if multiple episodes, also should be extended if family/child/youth desires
***can slow down decrease if parent/patient concerned about resurgence of physical and/or emotions symptoms and/or develops physical and/or emotional symptoms within 1 week of titrating to a new dose.
SSRIs Initiation

- Pts should have frequent follow-up with CAP and/or therapist

- CCP Staff may facilitate scheduling a brief follow up appointment with the therapist or the CAP within 2-3 weeks of initiation of SSRI
SSRI Stabilization

- Patients should continue to have regularly scheduled appointments with CAP and therapist.

- CCP Staff may facilitate scheduling a brief follow up appointment with the therapist or the CAP within 2-3 weeks of initiation of SSRI.
SSRI Maintenance

- Target of appointments every 6-8 weeks with therapist (or MD/PCP).

- If patient needs a refill, and has not seen for 6-8 weeks, CCP Staff should facilitate scheduling a follow-up appointment with therapist or MD/PCP.

- Request for refill initiated if pt stable
SSRI Maintenance

- SSRI prescriptions
- Calls regarding refills, med side effects, and/or questions routed to CAP for refill and/or approval (update pharmacy info)

- CAP will approve and complete EPIC eRx refill (if able).
SSRI Discontinuation

- If parent would like to see CAP to plan discontinuation, therapist will facilitate scheduling appointment.
- If patient has increased sxs during discontinuation, appointment with CAP will be facilitated by therapist.
- Plan outlined in Epic notes
- Status of problem is reviewable in “annotated Problem list”
“Internalizing Disorders in Primary Care”

- **Four Part Evening Educational Series over 5 months**
  - Identification of Internalizing Disorders
  - Medicolegal Issues in Treatment
  - Nonpharmacologic Interventions for Internalizing Disorders
  - Pharmacologic Interventions for Internalizing Disorders
- **Well attended by pediatricians**
The Outcomes
Integrated Behavioral Health Pediatrics

- Ten licensed master’s and doctoral level multi-disciplinary therapists
- Providers embedded in 13 practices and
- Providing integrated care with more than 150 pediatricians and their patients and families.
- 5 Psychiatrists located regionally
- The service provides behavioral health integrated access to more than 150,000 children in Western Pennsylvania and their families.
- Four regional (N,S,E,W) access hubs provide service to children affiliated with 18 additional primary care practices
Ease of Access: 2011 Data

- Greater than 12,000 Visits
- Show rates in 2011: over 90%
  - National norms range from 50-70%

- Early Access:
  - Median age of youth in service 13 years old (compared to 15 years old in traditional behavioral health service)
  - Two peaks in referrals 15-16 years old and 10-11 years old
    - Traditional behavioral health slowly rises with peak in late teens
Distribution of Primary Care Patients seen in Segregated Service by Referral Source

- Direct Primary Care Referral (n=8,362)
- Integrated BH Referral (n=846)

Age of Children

Percentage of Children at that age

- 1% for ages 1 and 3
- 5% for age 5
- 8% for ages 9 and 11
- 11% for age 15
- 9% for age 17
- 8% for age 19

The graph shows the distribution of children across different ages, with the percentage of children at each age ranging from 0% to 12%. The direct primary care referral is represented by a solid line, while the integrated BH referral is indicated by a dashed line.
Distribution of All Patients seen: Primary Care Providers & Integrated System

All Primary Care Patients (n=186,131)

All Integrated BH Patients (n=4,367)

Percentage of Children at that age

Age of Children

0% 1% 3% 5% 7% 9% 11% 13% 15% 17% 19% 21%

6% 6% 8% 9% 4% 6% 4% 3% 3% 1%
## Age by Referral

### All PCP Patients vs Integrated BH Patients

<table>
<thead>
<tr>
<th></th>
<th>Direct Primary Care Referral</th>
<th>Integrated BH Referral</th>
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<tbody>
<tr>
<td>Median Age</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Std Deviation</td>
<td>4.2</td>
<td>4</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>All Primary Care Patients</th>
<th>Integrated BH Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Std Deviation</td>
<td>5.8</td>
<td>4.3</td>
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Increasing Use of Empirically Supported Interventions

- Self report: Over 75% of attendees at internalizing disorders educational series said that the training would change their practice.
- Follow-up data: A 50% increase in the use of evidence-based interventions by pediatricians in the six months following the intervention.
Improving Utilization of Medical Care

- There is a significant decrease in the use of pediatric primary care services in the year after a child & family engages with our service.
- There is not a decrease in utilization of well-child services.
Increasing Services Pediatricians Provide

- Pediatricians Screening for adolescent depression with PHQ-9A
- Pediatricians Screening for maternal depression with Edinburgh Postnatal Depression Screen
Accomplishments

- Referrals to specialty mental health services have decreased by 1.2% in 2011 representing a net savings of $2,128,359
- 2012 Hospital Association of Pennsylvania Award Winner for Patient Care and Innovation
- 2012 Bronze Award for Teamwork Excellence in Health Care awarded by Fine Foundation/Jewish Healthcare Foundation
Future Directions

- Utilizing Brief tool to assess outcomes
  - Parent Report: Parent Symptom Checklist
  - Child/Youth Report: PHQ – 9A, SCARED 5
- Expanding model to other services –
  - Integration in the Hospital (R Ortiz)
  - Integration with Speech, Occupational Therapy and Physical Therapy
Thank you!

G CRUM
K GUATTERI
J DEE
D WOLFSON
M LUBETSKY
D HENRY
F GHINASSI
M JACKSON
ALL CCP PRACTICES: INCLUDING PEDIATRICIANS, OFFICE STAFF, AND PRACTICE CHAMPIONS
ALL CFCC THERAPISTS & PSYCHIATRISTS