PEDIATRIC PRIMARY CARE and BEHAVIORAL HEALTH INTEGRATION
AN OASIS IN THE FUTURE

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WHAT WE WILL DISCUSS

Why?
What?
How?
When?
WHY SHOULD THE BEHAVIORAL HEALTH TREATMENT OF CHILDREN AND ADOLESCENTS BE MIXED WITH THEIR MEDICAL TREATMENT?
Epidemiology of Pediatric Mental Health Conditions

- 9.5 - 14.2% of children birth to 5 have S-E problems interfering with functioning
- 21% of children and adolescents in the U.S. meet diagnostic criteria for MH disorder with impaired functioning
- 16% of children and adolescents in the U.S. have impaired MH functioning and do not meet criteria for a disorder
- 13% of school-aged and 10% of preschool children with normal functioning have parents with “concerns”
- 50% of adults in U.S. with MH disorders had symptoms by the age of 14 years
MH Conditions in Children with Chronic Illness: Hidden Morbidity

- Children with chronic illness 2X more likely to have psychosocial dysfunction

- Children with MH problems (and their parents) are higher users of healthcare services in general (eg, ED use)
Impact on Families

- Families are completely unprepared to have MI hit - the topic alone is loaded – stigma, blame and shame.
- The path from onset to acceptance of MI in a child can be long and difficult.
- The diagnosis impacts the whole family.
- There are predictable stages of emotional reaction for families.
Impact on Families

Accessing MH services:

- Silos lead families to seek services from multiple systems, often unsuccessfully;
- Workforce shortage and wait lists lead to lag time in getting a child services and support; and
- A full array of effective services are rarely available and are often targeted at the child and not at the whole family.
Impact on Primary Care

“By 2020-2030, it is estimated that up to 40% of patient visits to pediatricians will involve long-term chronic disease management of physical and psychological/behavioral conditions.”

“In 2020 pediatricians have a wider array of skills including more in-depth knowledge of, and comfort treating, behavioral, developmental, and mental health concerns. Medical education includes mental health interventions, which are now an established aspect of pediatric care.”

-AAP Task Force on the Vision of Pediatrics 2020
GENERAL RECOGNITION THAT A PROBLEM EXISTS

“There is a dearth of child psychiatrists ... Furthermore, many barriers remain that prevent children, teenagers, and their parents from seeking help from the small number of specially trained professionals...This places a burden on pediatricians, family physicians, and other gatekeepers to identify children for referral and treatment decisions.”

(Mental Health: A report of the U.S. Surgeon General, 1999)
SCOPE OF THE PROBLEM

• Only about 20% of children and adolescents with psychiatric disorder in the U.S. receive any kind of mental health services.

• Only small fraction of those getting service get evaluation and/or treatment by C.A.P.
PROJECTION OF DEMAND

• U.S. Population under age 18 will increase by 40% in 50 years
  • 70 million in 2000
  • >100 million in 2050

• Demand for C.A.P. service in U.S. will increase by 100% from 1995 to 2020

• Demand for general psychiatrists will increase by 19%

(DHHS, 2000)
What is in the Eyes of the Beholder?

The State of Well-Child Care: A Snapshot

Parents reporting important unmet needs by pediatric clinicians: 94%

Pediatricians who agree they have sufficient time to perform developmental assessments: 46%

Parents reporting they were not asked about learning, development, or behavior concerns: 40%

U.S. children up-to-date with vaccinations at end of first year of life: 26.9%

Pediatricians who agree they have sufficient time to address family psychosocial problems: 16.3%

Advantage/Potential Roles of Primary Care Clinicians in MH & SA Care

- Longitudinal, trusting relationship
  - Prevention
  - Early identification / screening
  - Early intervention / engagement
    - Diagnostic assessment
    - Specific treatment
  - Referral / collaborative care (with MH / SA professionals)
    - Monitoring progress in care
    - Care coordination
PRIMARY CARE BARRIERS to INTEGRATED CARE

• Ambivalence / variability
  • Discomfort
  • Time constraints
  • Poor payment
• Variable access to MH specialty resources
  • Administrative barriers to MH services
  • Limited information exchange with MH specialists
• Children and families’ reluctance to seek MH specialty care
THE AMERICAN HEALTHCARE SYSTEM IS A SILO SYSTEM WHERE ACCESS AND COMBINED CARE IS DIFFICULT FOR ALL CONSUMERS TO OBTAIN, RESULTING IN A LIMITATION TO COMPREHENSIVE DELIVERY OF CARE.
EMR SOFTWARE SYSTEMS ARE NOT STANDARDIZED!
THE PUBLIC SECTOR REIMBURSEMENT (MEDICARE, MEDICAID) STRUCTURE REMAINS UNSETTLED.
ARIZONA PUBLIC SECTOR FUNDING (MEDICARE, MEDICAID) IS FURTHER COMPLICATED BY STATE LAW SEPARATING THE MEDICAL and BEHAVIORAL HEALTH FACILITY LICENSING, THUS IMPEDING THE ABILITY TO COORDINATE CARE IN ONE FACILITY.
WHY SHOULD WE MIX SERVICES, YOU ASK? Families, health care providers and program leaders who have experience with integrated care have reported the following benefits for families:

- Improved adherence to treatment
- Greater convenience and satisfaction for families
- Increased likelihood that families follow through with referral for mental health services and supports
- Decreased wait times between mental health referrals and initial appointments
- Decreased use of unneeded medical and emergency services
- Increased attention to the treatment preferences of families
WHY SHOULD WE MIX SERVICES, YOU ASK?

• Improved access to care

• Reduced stigma

• Avoidance of treatment errors and duplicative tests and lab work that are costly
  
  • Reduced treatment errors by using an integrated medical chart

• Increased consultation referral and collaboration because of regular contact between mental health and primary care providers

• Encouraged the development of individualized care plans and established clear lines of responsibility for follow up
WHAT DOES AN INTEGRATED CHILD AND ADOLESCENT CLINIC LOOK LIKE?
THE GOALS:

**C:** Reduce the cost of behavioral health and medical care.

**A:** Improve access to behavioral health and medical care.

**QE:** Improve the quality and effectiveness of behavioral health and medical care.
WHAT A CHANGE!

This will incur a massive rethinking and restructuring of each Health Professional's traditional role in the Integrated Health Care System.

Think of the impact upon all medical systems, the administrators, the multitude of insurance companies, the authorization of services, the billing of services and these are only a few.
MODELS of INTEGRATED CARE
THE BASIC MODELS

1. Chevrolet: The Medical Clinic site

2. Ford: The Behavioral Health Clinic site

3. Cadillac: The Fully Integrated site

4. Rolls Royce: The Community Integrated site
Early Attempts at Integration

- Collaborative practice first introduced by Schroeder (1975, 2004)

- That practice involved:
  - Teaching of Health Professionals, Community Advocacy and Public Health Issues


- Each group needs to determine which of these multiple roles Pediatric and BH Professionals need to fill, the organizational structure and what type of professional is needed.
THE TEAM APPROACH
BEHAVIORAL HEALTH PROFESSIONAL INTO PEDIATRIC CLINIC, THE CHEVROLET

• BHP integrated into primary care

• 70% unscheduled time

• 30% of time traditional screens patients in exam rooms before/after/during doctor visit.

The BHP does not have to be a Child Psychiatrist or Psychologist.

• Patients who need further counseling are scheduled to return for a "psy-med" visit with Physician/BHP
The PMP is integrated into the behavioral health clinic with 75% of their time with scheduled Consumers.

25% of the PMP's time is spent being directly available to the BHP for verbal or Consumer face to face consultation.

The PMP is not always a physician.
In each of these models, **THE CHEVROLET and THE FORD**, the Initial Intake is completed by the Intake Staff of the originating clinic.

Consumers in need of medical or behavioral health assistance are identified by screening tools or the professional's opinion.
The Complete Integrated Clinic, **THE CADILLAC**.

- A multi-professional clinic, usually under one roof, where treatment for children, adolescents and families is delivered in a COMPLETE TEAM approach.

- The sub-specialist physician's role is a consultation position, where s/he is available to assist other professionals in the delivery of medical and/or behavioral health services.

- The sub-specialist physician does fulfill a role in seeing and managing the consumer with a complex medical and/or behavioral health problem.

- The majority of the care is provided by non-physician health care providers and the team is led by a Care Coordinator, usually an RN or Medical Social Worker.
CENTRAL THEMES of the FINE TUNED CADILLAC

• Begins with an Intake Evaluation that identifies Behavioral and Medical problems.

• Team Treatment

• Total Treatment is coordinated by the Team Leader, the Care Manager.

• The BHP position is designed to be available to the Pediatric PCP for QUICK curbside consults and for brief intervention therapies with the child and family.

• The Case Manager (CM) is central, maintaining contact and assistance to the child and family.
CENTRAL THEMES of the FINE TUNED CADILLAC

• The Specialty Care Providers (specialist or subspecialist) are available to all other team members.

• Team meetings are scheduled on a regular basis or as needed by the Care Coordinator.
THE COMPLETELY INTEGRATED CLINIC
THE FORD and CHEVROLET

INTAKE

CENTRAL INTAKE

MEDICAL CARE

BEHAVIORAL HEALTH CARE

INTAKE

PED PROVIDER

BEH HEALTH PRO

CASE MANAGER

CARE COORDINATOR

PED SPECIALIST

CHILD PSCHIATRIST
ADVANTAGES of THE CADILLAC

• One stop shopping

• More rapid access to care

• More thorough Intake Evaluation

• More time spent with consumer and family; More consumer education being done; More support available for families

• Severely ill consumers can be followed more closely

• Multiple levels of contact for the consumer

• May be able to avoid frequent ER visits or hospitalizations

• Improved consumer satisfaction
The Big Rolls Royce Team
Family-Centered Community-based System of Services for Children and Youth. **The Rolls Royce**

WHERE DO WE GO FROM HERE?