Integrating Pediatric Behavioral Health into Primary Care

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Disclosure/Disclaimer

Dr. Betsy Fine, Dr. Patti Johnson and Dr. Lynette Pullmann have nothing to disclose

The views and opinions expressed during this presentation do not necessarily reflect those of the Madigan Healthcare System, the Dept. of the Army, or the Dept. of Defense.
Objectives

- Understand the rationale for integrated behavioral health (BH) care in pediatric primary care
- Explain how integrating BH in primary care is consistent with the concept of Patient Centered Medical Home (PCMH)
- Identify the curriculum needs for preparing primary care providers to integrate BH in the PCMH
- Recognize the particular relevancy of integrated BH care to the Military family
- Enumerate the challenges to implementation of integrated BH in the PCMH

PCMH, Integrated BH and the PCP

As the Military moves toward the PCMH model, the role of primary care in behavioral health care needs to evolve to meet the new challenge. There exists a critical gap between acknowledged rates of behavioral health problems in children and rates of recognition and evidence based treatment.

Primary care is uniquely suited to bridge the gap

Rationale

15-20%  - INCIDENCE BEHAVIORAL HEALTH DIAGNOSES
50%    - PEDS VISITS BEHAVIORAL or EDUCATION CONCERNS
75%    - CHILDREN W/ BEHAV. HEALTH DX SEEN BY PCM

Recognition

- Epidemiologic data suggest pediatric mental health disorders rates of 12-27%
- Primary care physician identification rates 4-17%, likely lower for mood-related symptoms
- Lowest identification rates for children from disadvantaged families

(Simonian, 2006)

Magnitude of Problem

- Only 20% of children receive care for their mental health problems
- 50% of adults in US with a mental health disorder displayed symptoms by age 14
- Families frequently do not recognize symptoms in psychosocial context

(Weitzman & Leventhal, 2006)

Why Integrate Behavioral Health Care Into PRIMARY CARE?

- Less stigma - patients prefer to be seen at PCMH rather than specialty clinic
- Better coordination - shorter wait times and better communication
- Reduce morbidity with early recognition and treatment
- Serve all patients - opportunity for prevention
- Integration of physical and emotional care
AAP Guidelines

- Skills to build resilience, promote healthy lifestyles
- Integrate brief psychosocial update into acute care visit
- Screen for mental health issues - select, use and interpret tools
- Conduct an assessment alone or collaboratively
- Overcome barriers to seeking mental health care

Barriers

- Time – average visit 13 min
- Training – insufficient training in behavioral health in most training programs
- Confidence – (Olson et. al, 2001)
  - 90% felt responsible for recognizing depression
  - 27% responsible for treating
  - 50% confident in recognizing depression
  - 10-14% confidence in ability to treat
- Stigma – not necessarily present as BH

Behavioral Health in PCMH

- **Integrated Comprehensive Care**: Screen for and recognize behavioral health as well as medical concerns
- **Establish BH capability**: Appropriately treat and/or refer patient with behavioral health problems
- **Full scope of practice**: Expand practice to include BH care
- **Bring care to patient**: Deliver behavioral health care in PCMH by PCM or integrated specialist

From Op Ord 11-20
Integration of Behavioral Health in PCMH

- **VA Study** - Better levels of detection (Kivin et al, 2010)
- **Netherlands** - Shorter referral delays, fewer appts, lower cost, higher patient satisfaction (Van Orden et al, 2009)
- **Canada** – (CCMHI) Hamilton FH-MHP:
  
  "increased access by co-locating mental health specialist and by supporting primary care providers as they enlarge their scope of practice to include evidence-based treatment of mental disorders." (Craven and Bland, 2006)

  Patient satisfaction high in receiving care in primary care office and lack of associated stigma (Kates, 2011)

Behavioral Health Training in Primary Care

- Behavioral health care needs are high, but recognition/treatment is not adequate
- Behavioral health care improves when integrated into Primary Care
- Training primary care providers in behavioral health is imperative for effective integration

CAF-BHO’s Pediatric Behavioral Health Training

- Comprehensive curriculum -12 hours (CME)
- Interactive seminar which emphasizes application of tools and behavioral skill rehearsal
- **Goal**: Give primary care providers skills and comfort in prevention, early recognition, evidence based treatments and appropriate referral of common pediatric behavioral health concerns
Training Components

- Didactics
- Video demonstrations
- Practice exercises
- Behavioral rehearsal to practice most critical skills (e.g. suicide assessments)
- Learn coding and other practice mgmt
- Opportunity to collaborate with BH specialist from installation

Curriculum Overview

- BH Screening in Primary Care: Rationale and review of screening tools
- BH Assessment: Including Strengths-Based Interviewing and Psychosocial Assessment/BH Diagnosis
- BH Disorders: Somatization Disorders, Anxiety, Depression, ADHD, and Oppositional Defiant Disorder
- Deployment: Prevention and recognition of deployment-related BH problems
- Preparing the Practice: Incorporating BH in Primary Care
- Referral Resources: How to develop Collaborative practice

Consensus Support for Screening

- USPTF 2009 recommends annual screen for depression in 12-18 year olds
  - Adequate evidence that screening questionnaires accurately identify depression in teens
- IOM evidence-based screening effective at preventing more severe mental illness
- SAHM and AAFP – support mental health check-ups as part of routine adolescent healthcare
Screening

• Teach and practice use of general screen – **Pediatric Symptom Checklist** for routine. Validated parent 4-18, youth 11-18.
• Disorder specific screens – non-proprietary, well validated:
  - Depression – **CES-DC**
  - Anxiety – **SCARED** parent/child
  - ADHD/ODD – **Vanderbilt** parent/teacher

Prevention

• “Several decades of research have shown that the promise and potential lifetime benefits of preventing mental, emotional, and behavioral (MEB) disorders are greatest by focusing on young people and that early interventions can be effective in delaying or preventing the onset of such disorders.”
  – National Research Council and Institute of Medicine, 2009. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.

• **Strength-based interviewing** and positive youth development
• Integration of **SSHADESS** questions in strength based approach
• **Circle of Courage** – framework for eliciting strengths: Mastery, Generosity, Independence and Belonging
### Disorder Specific

- Diagnostic interviewing and DSM criteria
- Evidence Based Treatments
- Critical areas: **Somatization Disorder** – formulating a treatment plan
  - Depression - suicide assessment
  - Anxiety - age specific manifestations
  - ADHD – medication management
  - Oppositional Defiant Disorder – appropriate prevention and treatment

### Impact of Deployment of Members of the Armed Forces on Their Dependent Children

- Army spouses whose Soldiers have deployed have increased depressive disorder, sleep disorders, anxiety and acute stress reaction disorders.
- Most significant predictor of child emotional distress.
- Increased more emotional issues in response to deployment.
- Over 1/3 of children experiencing deployment were seen as “high risk” for psychosocial issues.

### Preparing the Practice

- Entire staff involvement in how to integrate behavioral health in the PCMH
- Staff roles
- Coding workshop
- Care management - development of patient registry, monitoring and coordination role
Referral

- Meet with installation specific behavioral health resources
- Develop a “how to refer guide”
- Communication vehicle to optimize coordination
- Practice collaborative care with case discussions including use of integrated behavioral health personnel
- Facilitate referral from installation to installation

Summary

- Primary care is uniquely positioned to prevent, recognize, manage and or refer pediatric patients with social and behavioral concerns.
- Providing primary care with practical training in these areas is critical to implementation of integrated care.

Military Relevance

- Unique aspect of military health care system
- Culture of military families
- Deployment related behavioral health
Rationale for Integrating BH within Military Pediatric Primary Care

- BH issues decrease individual and family readiness, health, and morale
- Stigma and barriers to care prevent many in need of care from getting it
- Limited pediatric behavioral health care providers
- Need to take the BH care to where the families are: community, schools, primary care
- Physical health and behavioral health are inseparable in military health care

Healthy Families = Healthy Soldiers

Unique Needs of Military Families

- Military Lifestyle
  - Family Disruptions: Geographic Separations, Frequent Moves
  - Demands on Children: School Disruptions, Separation from Friends
  - Inherent Obstacles to Continuity of Care
  - Current Deployment Issues

BH Integration into Primary Care Can Help Minimize Negative Impact of these Issues

Effects of Deployment

- Preschool children, school-aged children, and adolescents of deployed parents are at an increased risk for behavioral and psychosocial problems, and decreased academic performance (Chandra et al, 2010; Charttrand et al, 2008; Engel et al, 2010; Flake et al, 2009; Lester et al, 2010, Richardson et al, 2010)
- There is a higher incidence of child maltreatment during deployment (Gibbs et al, 2007)
- Pediatric outpatient visits for behavioral and emotional problems increased 11% during deployment (Gorman et al, 2010)
Effects of Deployment (cont)

- Studies have found a dose effect (Lester et al, 2009; Mansfield et al, 2011)
- Studies show that the well-being of the caregiver influences child adjustment (Chandra et al, 2010)
- Negative effects may last for a period of time post-deployment (Engel et al, 2010)
- Social support may decrease the negative impact of deployment (Flake et al, 2008)

Effects of Deployment: Implications for Primary Care

- Screening for social-emotional-behavioral problems is critical
- Early intervention could decrease morbidity
- Need to be aware of family’s deployment history
- Need to be aware of parental functioning
- Recognize that effects can last post-deployment

Deployment Related Curricula

- Pediatric and Family BH risks associated with phases of the Army Force Generation cycle
- Common signs of deployment-related stress in children and adolescents
- Anticipatory guidance regarding deployment-related coping and resiliency
- Screening for adjustment issues
- Strategies for intervention
**Summary: Military Relevance**

- Primary care providers within the direct care system can utilize their knowledge regarding military culture and deployment effects to address BH issues
- Curricula trains Primary care providers in addressing these issues

**Challenges: Implementing Behavioral Health Care in the PCMH**

- **Time**
  - Average Visit = 13 min
  - Length of BH Training
- **Buy-In/Support**
  - Providers
  - Command
  - Staff
- **Referral Network**
  - Where do BH referrals go?

**Possible Solution:**

- **Time**
  - Prepare the practice
  - Streamline screening to referral
- **Buy-In**
  - Increase confidence through training and support
  - Integrated Behavioral Health in PC
  - Behavioral Health consultation
  - Find champion, lots of contact
    (verbal, written, handouts with rationale for training)
- **Referral Network**
  - Provide PCMs with up-to-date referral information
  - Opportunities to collaborate with BH
Challenges: Putting Behavioral Health Training Into Practice

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<thead>
<tr>
<th>Challenge</th>
<th>Possible Solution</th>
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<tbody>
<tr>
<td><strong>Provider Confidence</strong></td>
<td>• Regular “Behavioral Health Booster” sessions</td>
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<tr>
<td></td>
<td>• Consultation groups</td>
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<tr>
<td></td>
<td>• Regular contact with BH consultants and referral resources</td>
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<tr>
<td><strong>Too busy</strong></td>
<td>• System must be sustainable</td>
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<td>• Decrease provider time by using templates, staff to do screening etc.</td>
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<tr>
<td><strong>Not my job</strong></td>
<td>• Strong referral network for complex BH issues</td>
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<td>• Education</td>
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<td>• Can’t separate physical and mental health</td>
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Summary

• Integrating Behavioral Health into Primary Care is consistent with the Patient Centered Medical Home, and improves overall quality of patient care

• Training primary care providers in prevention, recognition, management, and referral of pediatric patients with social and emotional concerns is essential to fully integrating Behavioral Health into Primary Care

• The unique needs of the military family are best served by a model that integrates physical and emotional well-being and provides ready access to BH treatment
Bibliography


