Implementation: Behavioral Health Services and the Primary Care Setting

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THE PEDIATRIC HOSPITAL FOR:



Disclosure

No relevant commercial interests





Barriers

- Financial
- Time
- Knowledge base and confidence















AAP Clinical Practice Guideline

- Key Action Statements for the Evaluation, Diagnosis, Treatment and Monitoring of ADHD in Children and Adolescents
- Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity

American Academy of Pediatrics, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011;128(5):1007–1022

Children's

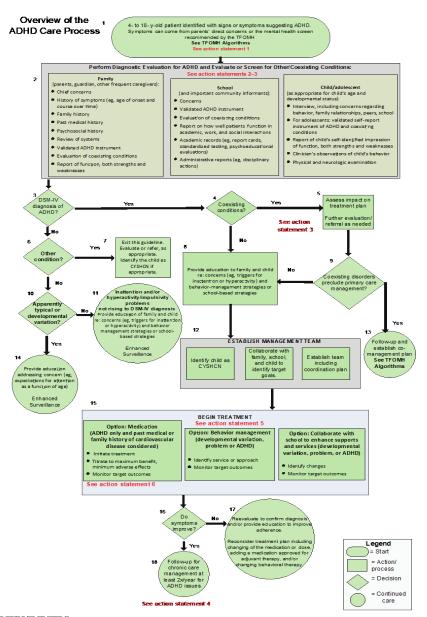
Hospital

at Montefiore



Key Action Statements 2.

- In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD
- including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders),
- developmental (eg, learning and language disorders or other neurodevelopmental disorders)
- physical (eg, tics, sleep apnea) conditions



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Supplemental Appendix

SUPPLEMENTAL TABLE 3 FDA-Approved Medications: Dosing and Pharmacokinetics

| Medication | Brand | Initial Titration Dose | Frequency | Time to Initial Effect | Duration, h | Maximum Dose | Available Doses |
|-------------------------------|---------------------------|--|---------------|---------------------------|------------------|---------------------------------|--|
| Mixed amphetamine salts | Adderall* | 2.5–5.0 mg | QD-BID | 20-60 min | 6 | 40 mg | 5.0-, 7.5-, 10.0-, 12.5-, 15.0-, 20.0-, and 30.0-mg tablets |
| | Adderall XR* | 5 mg | QD | 20-60 min | 10 | 40 mg | 5-, 10-, 15-, 20-, 25-, and 30-mg capsules |
| Dextroamphetamine | Dexedrine*/ Dextrostat | 2.5 mg | BID-TID | 20–60 min | 4-6 | 40 mg | 5- and 10-mg (Dextrostat only) tablets |
| | Dexedrine Spansule* | 5 mg | QD-BID | ≥60 min | ≥6 | 40 mg | 5-, 10-, and 15-mg capsules |
| Lisdexamfetamine | Vyvanse | 20 mg | QD | 60 min | 10-12 | 70 mg | 20-, 30-, 40-, 50-, 60-, and 70- mg capsules |
| Methylphenidate | Concerta | 18 mg | QD | 20–60 min | 12 | 54 mg (<13 y); 72 mg (≥13 y) | 18-, 27-, 36-, and 54-mg capsules |
| | Methyl ER | 10 mg | QD | 20-60 min | 8 | 60 mg | 10- and 20-mg tablets |
| | Methylin | 5 mg | BID-TID | 20-60 min | 3-5 | 60 mg | 5-, 10-, and 20-mg tablets and liquid and chewable forms |
| | Daytrana | 10 mg ^b | Apply for 9 h | 60 min | 11-12 | 30 mg | 10-, 15-, 20-, and 30-mg patches |
| | Ritalin* | 5 mg | BID-TID | 20-60 min | 3-5 | 60 mg | 5-, 10-, and 20-mg tablets |
| | Ritalin LA | 20 mg | QD | 20-60 min | 6-8 | 60 mg | 20-, 30-, and 40-mg capsules |
| | Ritalin SR* | 20 mg | QD-BID | 1-3 h | 2-6 | 60 mg | 20-mg capsules |
| | Metadate CD | 20 mg | QD | 20-60 min | 6–8 | 60 mg | 10-, 20-, 30-, 40-, 50-, and 60- mg capsules |
| Dexmethylphenidate | Focalin* | 2.5 mg | BID | 20-60 min | 3-5 | 20 mg | 2.5-, 5.0-, and 10.0-mg tablets |
| | Focalin XR | 5 mg | QD | 20-60 min | 8-12 | 30 mg | 5-, 10-, 15-, and 20-mg capsules |
| Atomoxetine | Strattera | 0.5 mg/kg per d, then increase to 1.2 mg/kg per d; 40 mg/d for adults and children at >154 lb, up to 100 mg/d | QD-BID | 1–2 wk | At least 10-12 h | 1.4 mg/kg | 10-, 18-, 25-, 40-, 60-, 80-, and 100-mg capsules |
| Extended-release guanfacine | Intuniy | 1 mg/d | QD | 1-2 wk | At least 10-12 h | 4 mg/d | 1-, 2-, 3-, and 4-mg tablets |
| Extended-release clonidine | Kapvay | 0.1 mg/d | QD-BID | 1-2 wk | At least 10-12 h | 0.4 mg/d | 0.1- and 0.2-mg tablets |

QD indicates daily; BID, twice daily; TID, three times daily.

[·] Available in a generic form.

^b Dosages for the dermal patch are not equivalent to those of the oral preparations.

Overcoming Barriers





- Emphasized systematic ways to assess children with mental health concerns including differential diagnoses
- Education about the science behind the treatment options
- Interactive, case-based, practice using algorithms for initiating treatment and managing the condition
- Provided materials that could be used in practice



 Virtual Team: real-time access to a mental health provider for advice and guidance on assessment, management and accessing care in the community

The Chronic Care Model Community **Health Systems** Resources and Policies Organization of Health Care Self-Delivery Clinical Decision Management Information System Support Support Design Systems Prepared. Informed. Productive Proactive Activated Interactions Practice Team Patient

Improved Outcomes

Developed by The MacColl Institute # ACP-ASIM Journals and Books

Implementation

Buy-In

- Staff: Front-line and Providers
- Parents

Screening Tools

- Universal use of the Pediatric Symptom Checklist 17
- Diagnosis Specific Tools: SCARED, Vanderbilt, PHQ9M

Diagnosis and Management

- Phone Consultation with Project TEACH providers
- Psycho-educational materials for Providers and Parents
- Consultation with Social Work and Outreach for Community Resources

Implementation: Elements to Remember

- Importance of proving to your institution that behavioral health care can be delivered without derailing throughput
- Clear documentation of all interventions to meet the requirements of DSRIP and NCQA-PCMH
 - Standardizing forms in the electronic medical records
 - Creating a registry
- Team Building by presenting success stories at practice meetings

Success and Spread



Meta-analysis of Depression Assessment and Management

- Twenty-one studies showed positive results for the <u>intervention</u>.
- Strategies that were successful in improving patient outcomes were generally more complex <u>interventions</u> that included:
 - Elements of clinician education and more integration between primary and secondary care.
 - Interventions of medication counselling delivered over the telephone by practice nurses or trained counsellors were also successful.

Integrated Model

- Goal: to provide continued access for our patients to the behavioral health providers
- Education remains essential
 - Collaborative Office Rounds
 - Bi-directional feedback between mental health team and providers
- Empowering pediatricians to do more
 - Prescribing practices
 - Curbside consultations
 - Coaching

Collaborative Care Model

- Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial
- David J. Kolko, John Campo, Amy M.
 Kilbourne, Jonathan Hart, Dara Sakolsky, Stephen
 Wisniewski
- Unlike our pilot study, this study included PCP training in an expanded ADHD care management protocol, practice-based randomization to optimize PCP participation, technology to collect and share patient progress, and greater communication among CMs, PCPs, and families.

pendix A. An Evidence-Based Framework for Primary Care—Behavioral Health Integration

| WAS ASSESSED TO THE STORY | | 2 | Integration Continuum | | | |
|--|---|--|---|--|--|--|
| Key categories of | | | Intermediate | Adv | | |
| Domains | Components | | | 1 | | |
| Case finding, screening, and referral to care | Screening, initial assessment, and follow up | Patient/clinician identification of those with symptoms—not systematic | Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment and engagement | Population stratific outreach and scree assessment | | |
| | Referral facilitation and tracking | Referral to external BH specialist/psychiatrist | Enhanced referral to outside BH specialist/ psychiatrist through a formal agreement, with engagement and feedback strategies employed Clear process or referral to BH specialist/ psychiatrist o-located or external), with warm transfer" | Referral and tra alternate data-sh engagement and ac | | |
| | Care team | PCP and patient PCP, patient, and ancillary staff member | PCP, patient, and BH specialist PCP, patient CM, and psychiatrist (consults and en laged in CM case reviews) | PCP, patient, CM, B (consults and engage | | |
| Multi-disciplinary team (including patients) used to provide care | Systematic team- based caseload review and consultation | Communication with BH specialist driven by necessity or urgency | Formal written communication (notes/consult reports) between PCP and BH specialist on complex patients Regular for nal meetings between PCP and BH specialist | Weekly schedul reviews and goal d patients | | |
| | Availability for interpersonal contact between PCP and BH specialist/psychiatrist | None or very limited interpersonal interaction (occasionally using a patient as a conduit) | Occasional interaction, possibly through ancillary staff members, perhaps sharing reports or labs | PCP and BH spo interact informally th | | |
| Ongoing care management | Coordination, communication, and longitudinal assessment | Limited follow up of patients provided by office staff | Proactive follow up to assure engagement or early response to care Maintenan e of a registry with ongoing measurement and tracking, and proactive follow up will active provider and patient minder system | Registry plus beha and relapse preventio to patients (includ when | | |
| Systematic quality improvement | Use of quality metrics for program improvement | Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series) | Identified metrics and some ability to review performance against metrics and some ability to review performance against metrics, with designated individual to develo improvement strategies | Ongoing systemat with monitoring of po metrics and impler projects by d | | |

es: BH Specialist refers to any provider with specialized behavioral health training; CM can refer to a single person or multiple individuals who have training to provide coordinated care agement functions in the PC practice; Ancillary staff member refers to non-clinical personnel, such as office staff or receptionist; EBP refers to evidence-based psychotherapy

Appendix A cont'd. An Evidence-Based Framework for Primary Care—Behavioral Health Integration

| | Van estamala est | Entropy to describe | | Integration Continuum | |
|--|--|---|---|--|---|
| # | # Domains Components | | | Intermediate | Advi |
| # | Domains | Components Evidence-based guidelines/treatment protocols | None or limited training on BH disorders and treatment | PCP training on evidence-based guidelines for common behavioral health diagnoses and treatment Standardized use of evidence-based guidelines for all patients; tools for region monitoring of symptoms | Systematic trackin protocols for inter when |
| 5 Decision support for measurement- based, stepped care | Use of pharmacotherapy | PCP-initiated, limited ability to refer or receive guidance | PCP-initiated, and referral when necessary to prescribing BH specialist/psychiatrist prescribing BH specialist/psychiatrist support for follow up | PCF nanaged with bety en visits and i | |
| -3 | | Access to evidence- based psychotherapy treatment with BH specialist | Supportive guidance provided by PCP | Available off-site through pre-specified Brief psychotherapy interventions provided BH specialist on-site | Brief intellentions prov formal E training) a with exchange of inform |
| 6 | Self-management support that is culturally adapted | Tools utilized to promote patient activation and recovery | Brief patient education on condition by PCP | Brief patient education on condition including materials/workbooks but limited focus on self-management coaching and activity guidance Patient receives education and articipate in self-management goal setting and activity guidance | |
| 7 | 7 Information tracking and exchange among providers | Clinical registries for tracking and coordination | Informal method for tracking patient referrals to BH specialist/psychiatrist | Patients referred to outside BH specialist/psychiatrist with clear expectations for shared communication and follow up Formal patient registry to mana and transpectations patients, including severity me surement attendance at visits, and care management interventions | t, \severit measureme |
| | | Sharing of treatment information | No sharing of treatment information | Informal phone or hallway exchange of treatment information throug treatment information without regular chart documentation Exchange of treatment information throug in-person or telephonic contact, with characteristic | |
| 8 | Linkages with community/social services | Linkages to housing, entitlement, and other social support services | Referral resources available at practice, no formal arrangements | Referrals made to agencies, possibly some formal arrangements, but little capacity for follow up Patients linked to community organizations/resources, with forma arrangements and consistent follow up | Developing, shari a unified care pl |

Notes: BH Specialist refers to any provider with specialized behavioral health training: CM can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; Ancillary staff member refers to non-clinical personnel, such as office staff or receptionist; EBP refers to evidence-based psychotherapy

Thank you from Team FCC

