Implementation: Behavioral Health Services and the Primary Care Setting

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Disclosure

- No relevant commercial interests

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Barriers

- Financial
- Time
- Knowledge base and confidence

AAP Clinical Practice Guideline

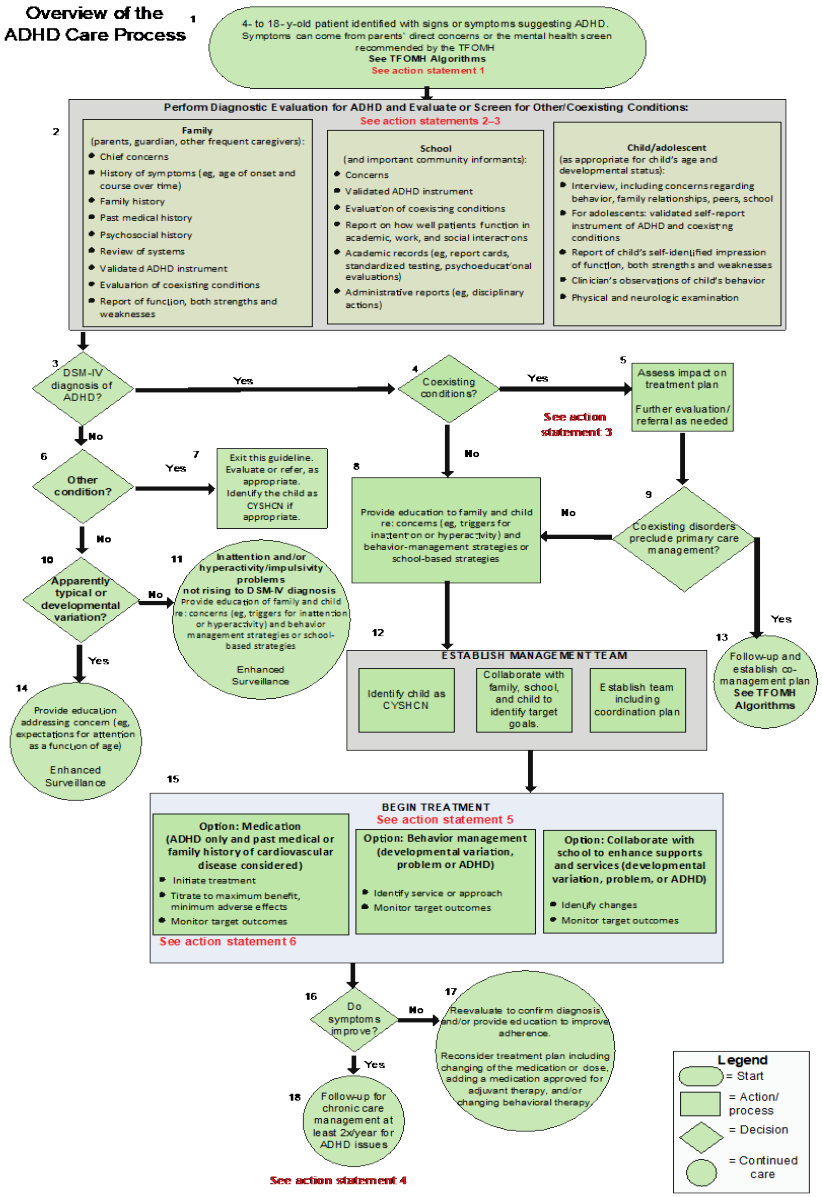
- Key Action Statements for the Evaluation, Diagnosis, Treatment and Monitoring of ADHD in Children and Adolescents
- Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms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

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

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.



SUPPLEMENTAL APPENDIX FIGURE 2

ADHD process-of-care algorithm. TFOMH indicates Task Force on Mental Health; CYSHCN, child/youth with special health care needs.[1]

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[a]	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[a]	5 mg	QD	20–60 min	10	40 mg	5-, 10-, 15-, 20-, 25-, and 30-mg capsules
Dextroamphetamine	Dexedrine[a]/ Dextrostat	2.5 mg	BID–TID	20–60 min	4–6	40 mg	5- and 10-mg (Dextrostat only) tablets
	Dexedrine Spansule[a]	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[a]	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[a]	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[a]	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	Intuniv	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.

[a] Available in a generic form.

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

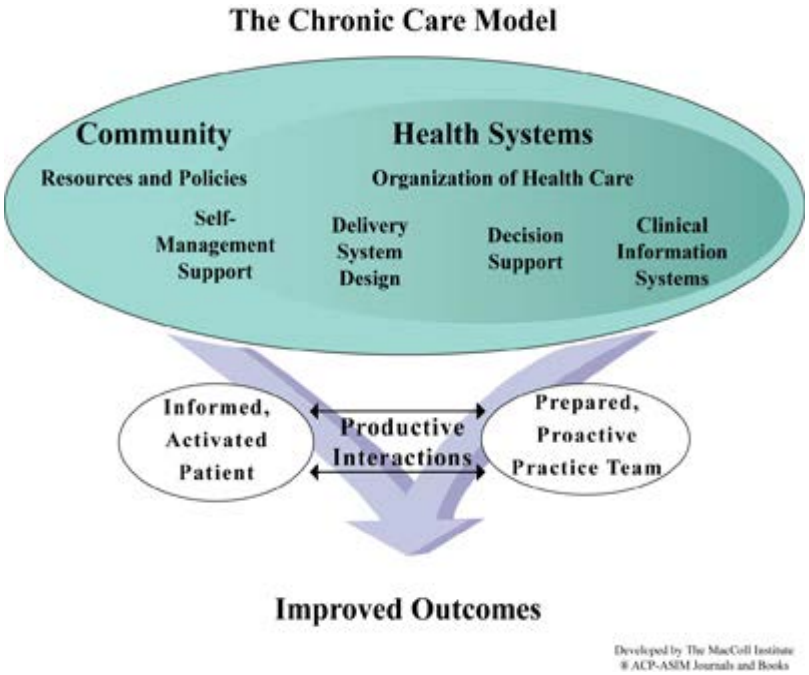
Overcoming Barriers

ProjectTEACH
TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

- 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

ProjectTEACH
TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

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



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

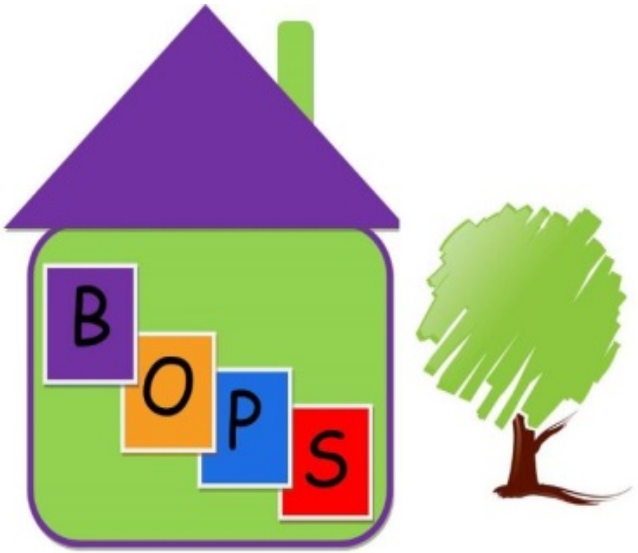
Diagnosis and Management

- 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 intervention.
- Strategies that were successful in improving patient outcomes were generally more complex interventions 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.

Gilbody S, Whitty P, Grimshaw J, Thomas R. Educational and Organizational Interventions to Improve the Management of Depression in Primary Care A Systematic Review. *JAMA.* 2003;289(23):3145–3151. doi:10.1001/jama.289.23.3145

Integrated Model

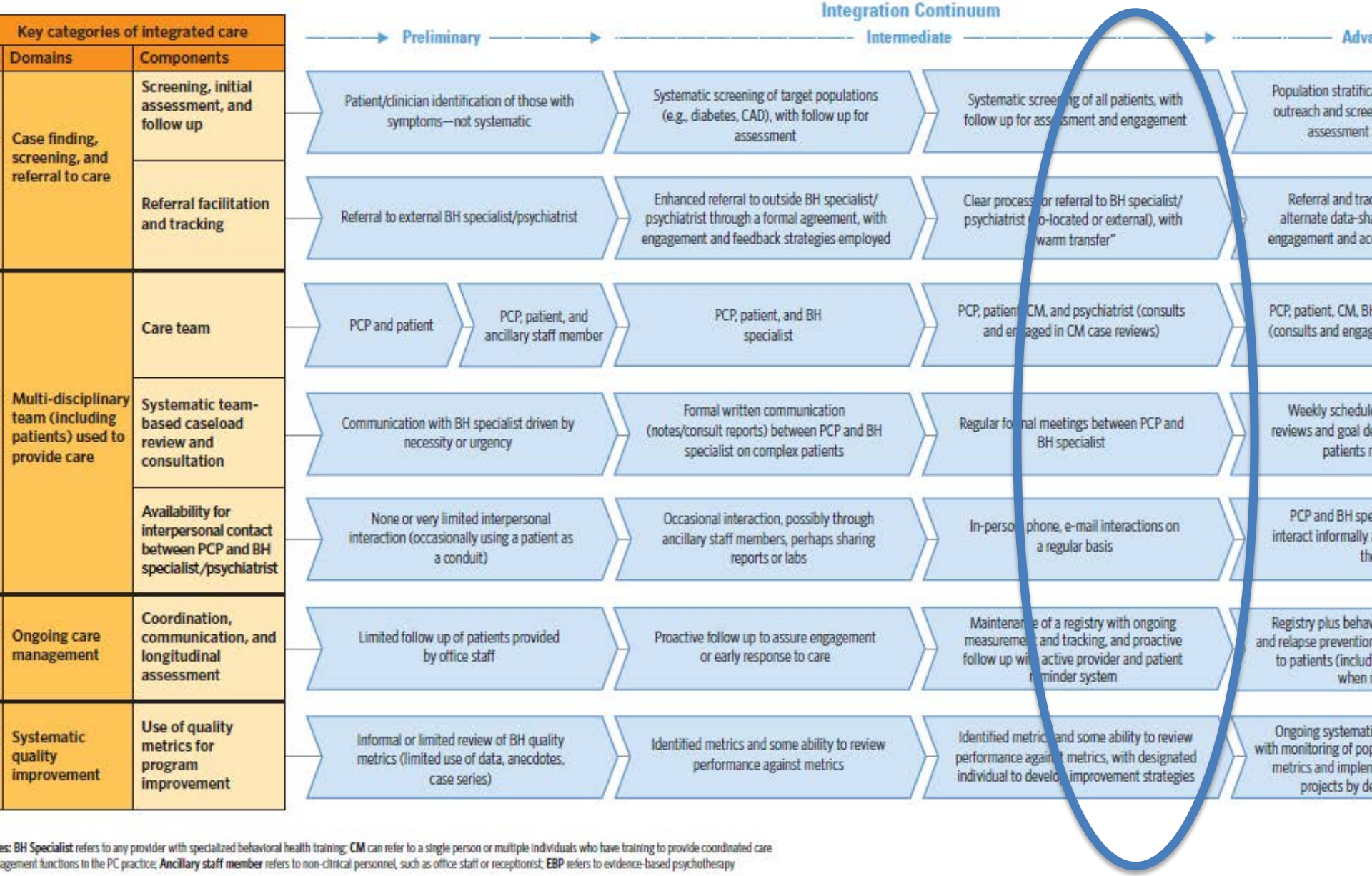
- Goal: to provide continued access for our patients to the behavioral health providers
- Education remains essential
  - Collaborative Office Rounds
  - Bi-directional feedback between mental health team and providers
- Empowering pediatricians to do more
  - Prescribing practices
  - Curbside consultations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

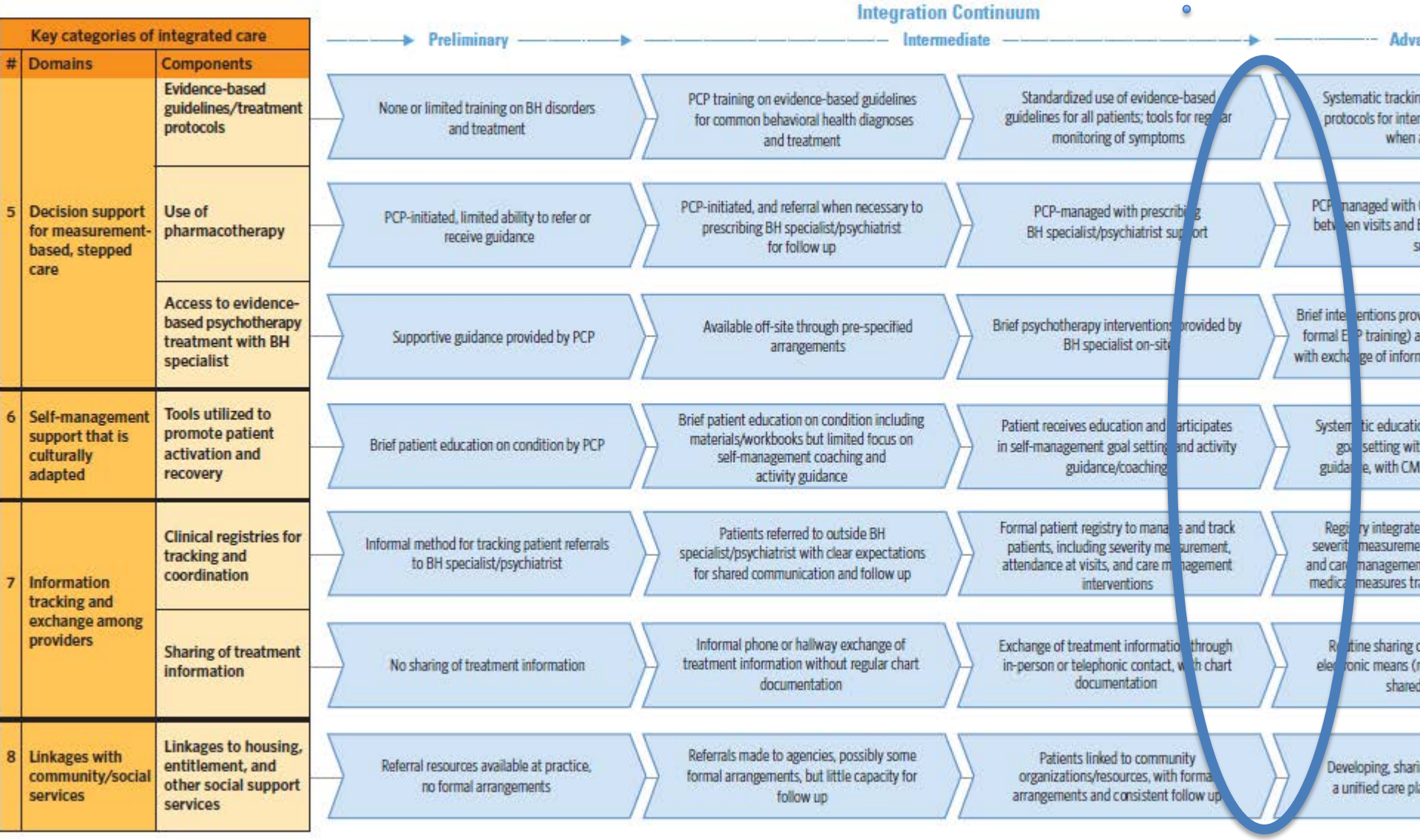
Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial
David J. Kolko, John Campo, Amy M. Kilbourne, Jonathan Hart, Dara Sakolsky, Stephen Wisniewski
Pediatrics Apr 2014, 133 (4) e981-e992; **DOI:** 10.1542/peds.2013-2516

ppendix A. An Evidence-Based Framework for Primary Care–Behavioral Health Integration



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



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Thank you from Team FCC