ProjectTEACH

TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

Pediatric Behavioral Health Integration

Project TEACH: A Model of a Virtual Team

Rachel A. Zuckerbrot, M.D., F.A.A.P.

Associate Professor of Clinical Psychiatry

Site Director for Project TEACH

Columbia University Irving Medical Center/New York State Psychiatric Institute

October 3, 2018

Columbia University Department of Psychiatry
Vagelos College of Physicians and Surgeons

Division of Child & Adolescent Psychiatry

NEW YORK STATE OF OPPORTUNITY. New York State Psychiatric Institute

Disclosure

- No relevant commercial interests

AGENDA

- Do children need behavioral health integration too?
- What challenges are unique to pediatric care?
- What advantages are unique to pediatric care?
- Is it the role of the Pediatric PCP to address behavioral health?
- What is current standard of care in pediatric practice?
- Are there evidence based models of BHI in Pediatric 1^{o} Care?
- What are statewide-consultation child psychiatry programs?
- How can NYS's Project TEACH help PCPs form a Virtual BHI Team?
- Can a virtual team be evaluated with chronic care metrics?
- What obstacles are unique to the virtual team model?

AGENDA

Do children need behavioral health integration too?

JAMA July 2012

MEDICAL NEWS & PERSPECTIVES

Chronic Mental Health Issues in Children Now Loom Larger Than Physical Problems

Anita Slomski

IT'S HARD TO BE A KID TODAY. FOR THE first time in the half century that the US government has continuously collected data, the top 5 disabilities affecting US children are mental health problems rather than physical problems.

In 2008-2009, 7.7% of US children younger than 18 years had a disability that limited usual activity, which is a 4-fold increase in the prevalence of childhood activity limitations since 1960, according to data from the National Health Interview Survey from the US Department of Health and Human Services. Among these children, a speech problem; learning disability; attention-deficit/

UCLA Center for Healthier Children, Families, and Communities and professor of pediatrics, health sciences, and policy studies, a disproportionate amount of the increase in mental, developmental, and behavioral problems over the past decade appears to be in children from higher-income families.

PREVALENCE VS DIAGNOSIS CREEP

One explanation for why mental, behavioral, and developmental problems have soared is that parents are pushing their children to develop the advanced cognitive, social, and emotional skills they'll need to compete in our knowledge-based economy.

"The conveyor belt [to adulthood] that

quent risks for neurodevelopmental disorders or exposure to new or more environmental toxins during pregnancy and early childhood. A growing body of research has found that developmental disorders such as ADHD have complex etiologies with multiple genetic and environmental risk factors (Willcutt EG et al. *J Dev Behav Pediatr*. 2010; 31[7]:533-544). And physicians may be diagnosing more of these problems as a result of better diagnostic tools, lower diagnostic thresholds that recognize greater numbers of children as having cognitive problems, greater access to screening for low-income children, and even a trend of savvy parents demanding a diagnosis of ADHD [illegible]

Children's Mental Health

More than 14 million children and adolescents in the United States, or 1 in 5, have a diagnosable mental health disorder that requires intervention or monitoring and interferes with daily functioning.

US Department of Health and Human Services (USDHHS). Mental Health: A Report of the Surgeon General. Washington, DC: US Government Printing Office; 2000. Available online at www.surgeongeneral.gov/library/mentalhealth/home.html

Ages of Onset Risk

- Autism Spectrum Disorders – 0-3 years or later for mild
- **ADHD - 4-7 or later for mild, but differential is broader**
- Anxiety – 6-12 years
- **Depression – 13-16 years**
- Bipolar and psychosis - > 16 years
- **Panic Disorder 16-25 years**
- Disruptive behavior – <u>almost anytime</u>

Slide courtesy of John Walkup, M.D.

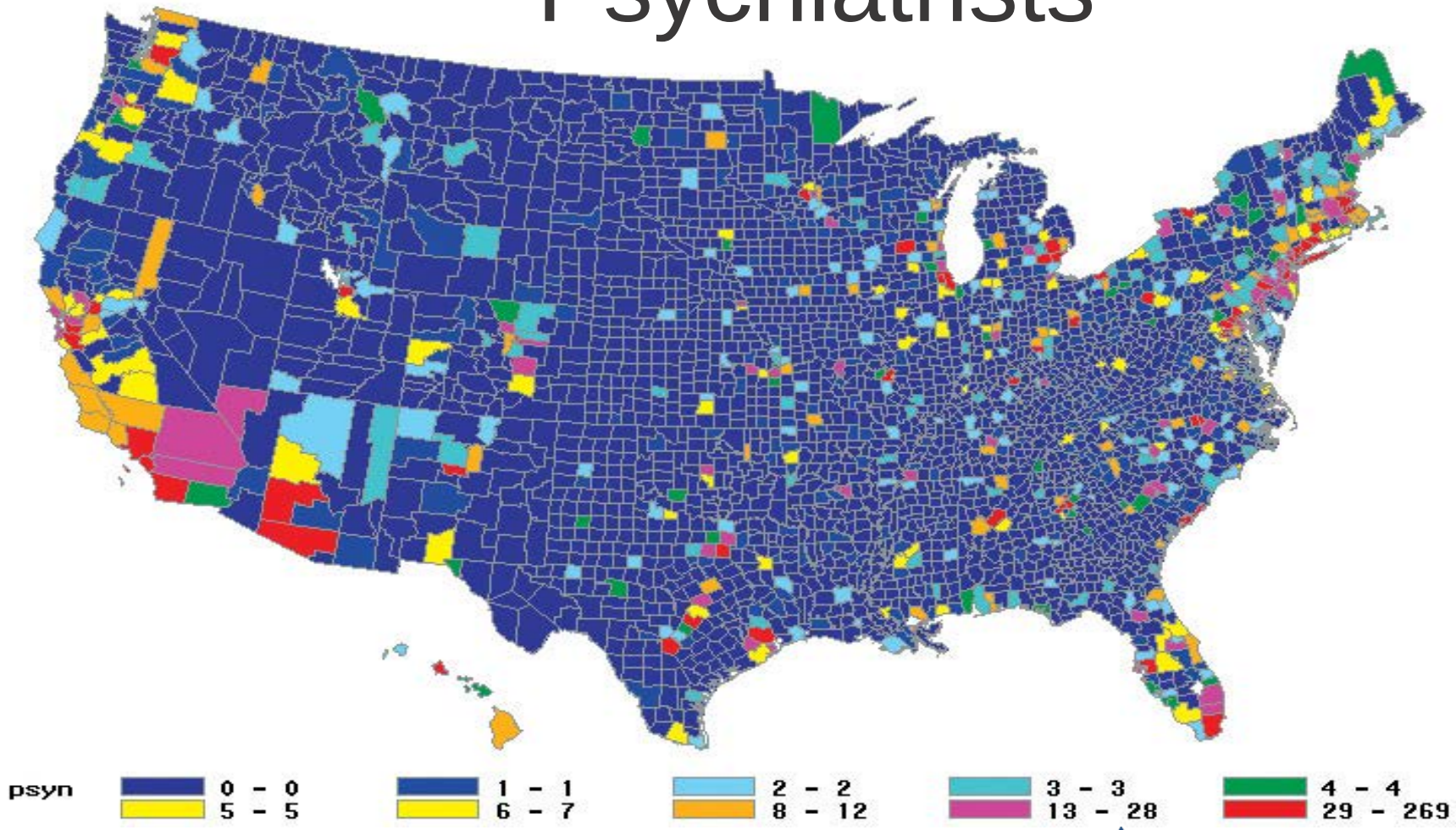
Prevalence of child mental health problems in context of General Pediatrics

Disorder	Prevalence
Cerebral palsy	0.20%
Cystic fibrosis	0.03%
Epilepsy	0.30%
Diabetes 1 and 2	0.20%
Any DSM disorder	20.00%
Severe psychiatric disorder	9.00%

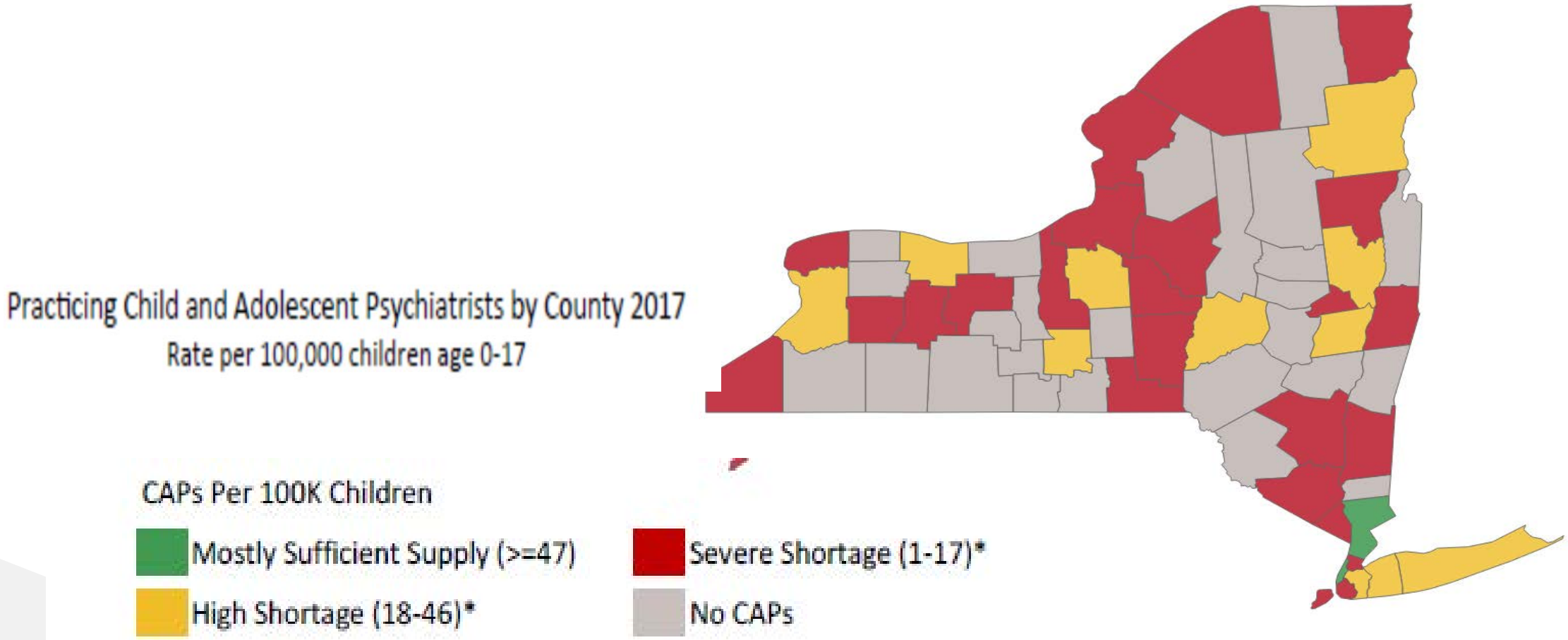
AGENDA

What challenges are unique to pediatric care?

Distribution of the 8,000 U.S. Child Psychiatrists



New York State CAP Workforce



AACAP, March 2018

Unique challenges around Pediatric Medication that interfere with BHI

- Evidence-based Caution re medicating kids
  - Implement evidence based psychosocial interventions first
    - Difficulties with primary care accessing those interventions
    - Fear that medication will be used instead if BHI is implemented
- Fear and Stigma re medicating kids
  - Stigma against using medication even when evidence-based
    - Preventing BHI prevents medicating kids and that is good in the public perception

AGENDA

What advantages are unique to pediatric care?

Pediatric PCPs have always been there to support the family

- Pediatricians have long been an important first resource for parents who are worried about their children's behavioral problems, and today *psychosocial problems are the most common chronic condition for pediatric visits, eclipsing asthma and heart disease.*

--American Academy of Pediatrics Mental Health Task Force (2004-2009)

The Medical Home

- **A medical home is not a building, house, or hospital, but rather an approach to providing *comprehensive* primary care.**

The Primary Care Advantage

- Trusting relationship
- Continuity
- Familial and community context
- Access

- AAP Mental Health Task Force

AGENDA

Is it the role of the Pediatric PCP to address behavioral health?

Mental Health Competencies for Pediatric Primary Care, AAP 2009

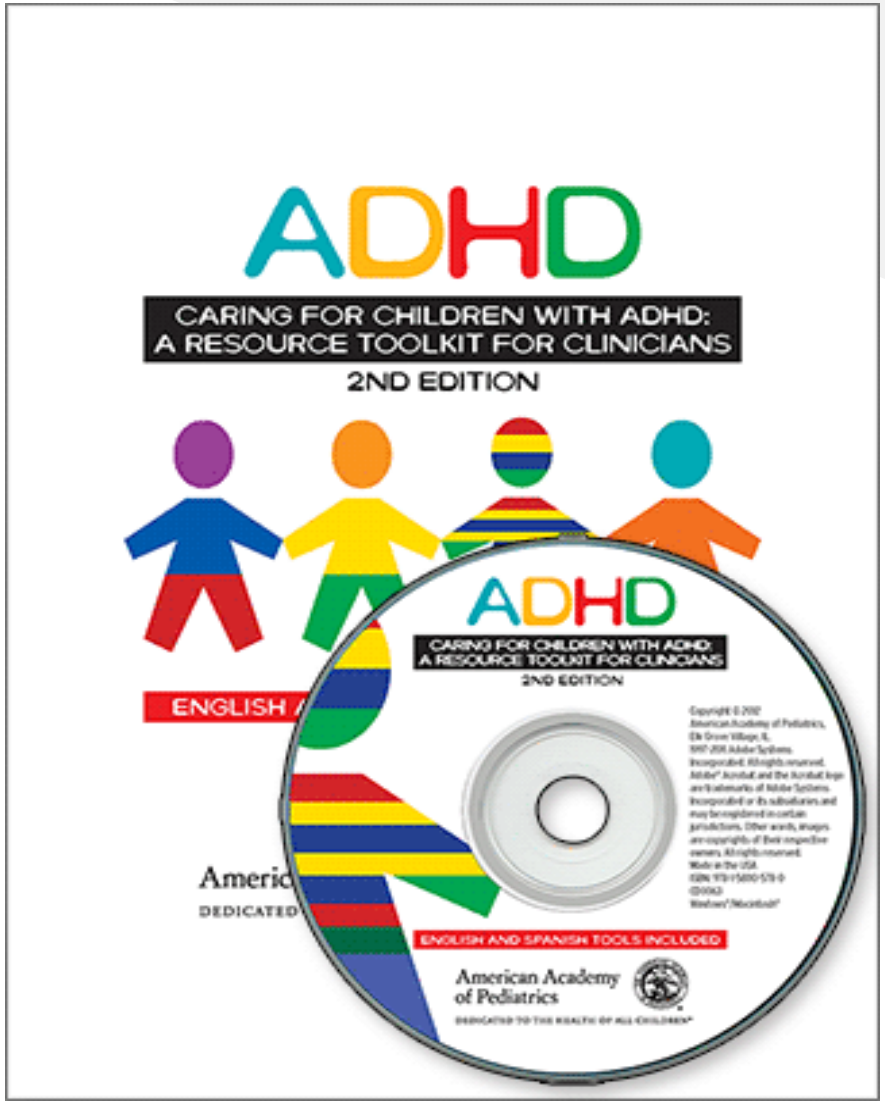
- 2009 Policy Statement
- *Pediatrics* Volume 124, Number 1,Pages 410-421
- *COMPETENCIES:*
  - *Systems-Based Practice*
  - *Patient Care*
  - *Medical Knowledge*
  - *Practice-Based Learning and Improvement*
  - *Interpersonal and Communication Skills*
  - *Professionalism*

AGENDA

What is current standard of care in pediatric practice?

ADHD Guidelines

- ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
- Pediatrics, 2011
- Update to the AAP's 2001 Guideline

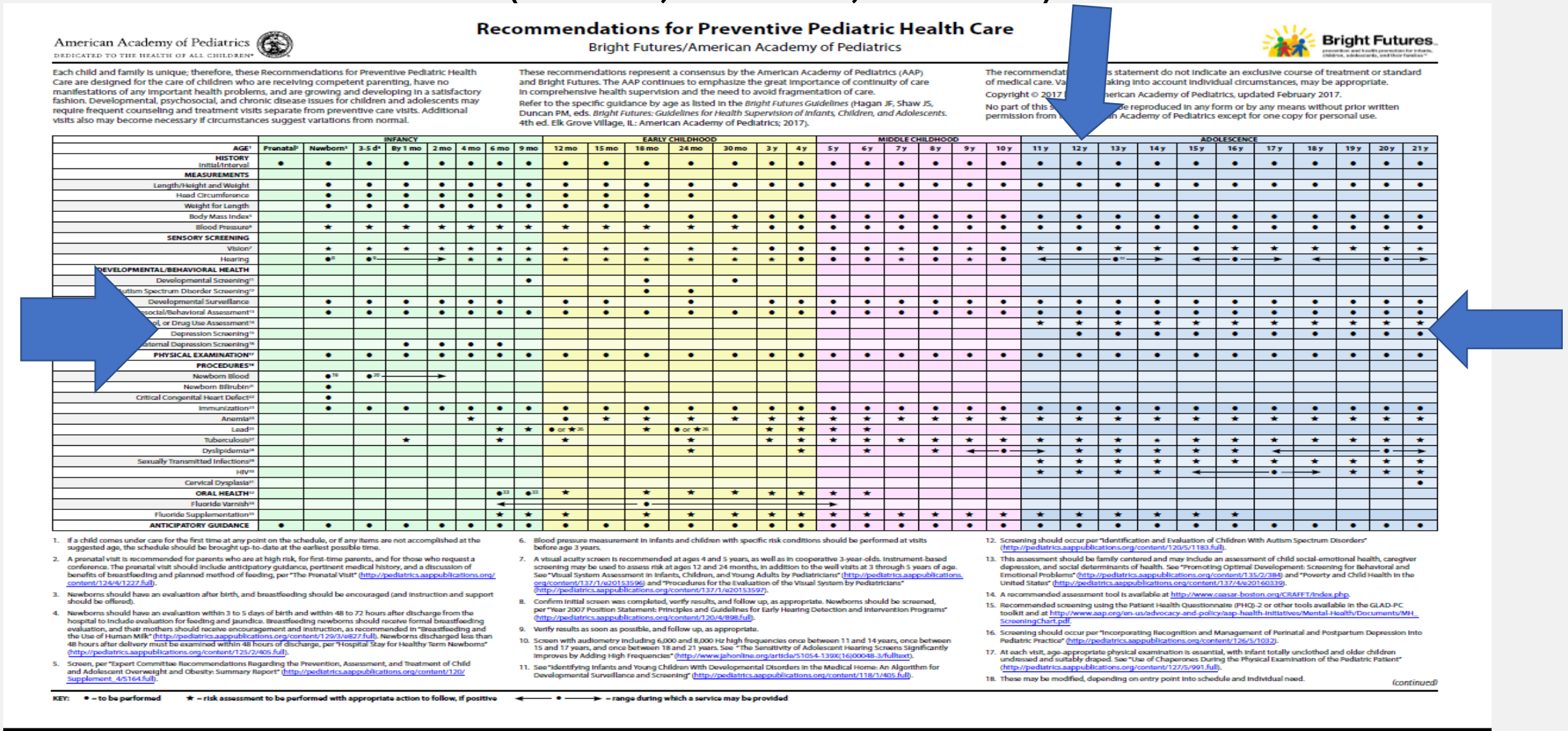


Universal Teen Depression Screening

- The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

(2016 update to the 2009 recommendation)

Advocates for Universal Screening (AAP, 2016, 2014)



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendat… statement do not indicate an exclusive course of treatment or standard of medical care. Va… aking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	←	→	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	●	●[10]	→	←	●	→	←	●	→	←	● →
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]								●			●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	→																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	★	←		●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★			●	→	★	★	★
Cervical Dysplasia[31]																																●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★															
Fluoride Varnish[34]							←			●					→																	
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.casaa-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● – to be performed ★ – risk assessment to be performed with appropriate action to follow, if positive ← ● → – range during which a service may be provided

Depression Guidelines

- Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Practice Preparation, Identification, Assessment, and Initial management
  - Zuckerbrot RA et al
- Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and ongoing management.
  - Cheung AH et al

- Pediatrics, 2018
- Update to the 2007 Guideline

Guidelines for Adolescent Depression in Primary Care

AGENDA

Are there evidence based models of BHI in Pediatric 1^{o} Care?

Pediatric Behavioral Health Integration

- Adolescent Depression:
  - Collaborative Care for Adolescents with Depression in Primary Care: A randomized clinical trial –Richardson et al., 2014
  - The Costs and Cost-effectiveness of Collaborative Care for Adolescents with Depression in Primary Care Settings, A Randomized Clinical Trial -Wright et al., 2016
  - Effectiveness of a Quality Improvement Intervention for Adolescent Depression in Primary Care Clinics: A Randomized Controlled Trial –Asarnow et al., 2005.
- ADHD, Anxiety, and Behavior Problems:
  - Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial -Kolko et al, 2014

AGENDA

What are statewide-consultation child psychiatry programs?

www.nncpap.org

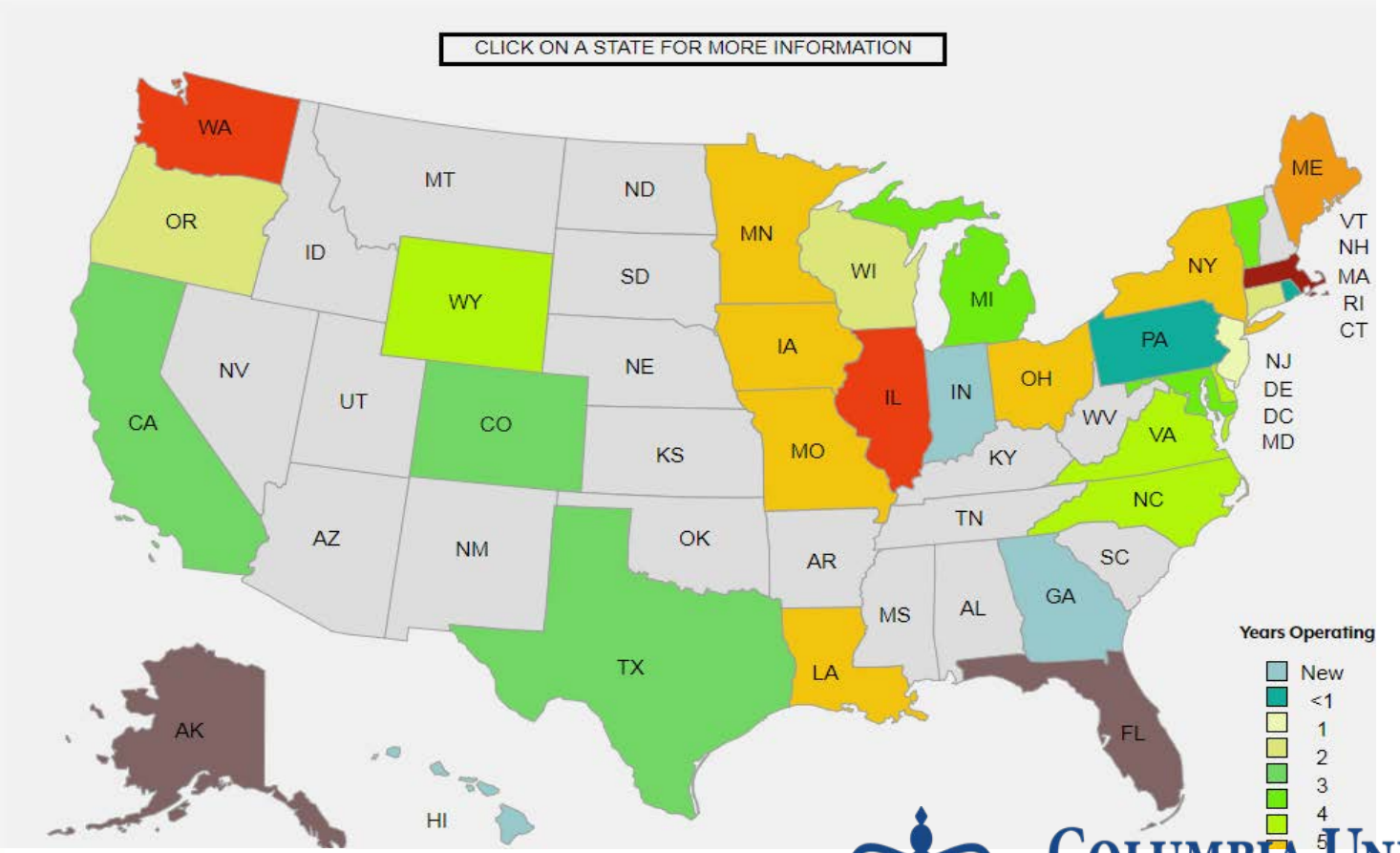
NNCPAP

National Network of Child Psychiatry Access Programs

Welcome

The National Network of Child Psychiatry Access Programs supports existing and emerging child psychiatry consultation programs and works to further national progress toward effective integration of mental health with primary care.

The Network


CLICK ON A STATE FOR MORE INFORMATION
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MS
MI
IN
KY
TN
AL
OH
WV
GA
FL
SC
NC
VA
PA
NY
ME
VT
NH
MA
RI
CT
NJ
DE
DC
MD
AK
HI
Years Operating
New
<1
1
2
3
4
5

AGENDA

How can NYS's Project TEACH help PCPs form a Virtual BHI Team?

ProjectTEACH

TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

Project TEACH

NEW YORK STATE | Office of Mental Health

ProjectTEACH

TRAINING AND EDUCATION FOR THE ADVANCEMENT OF CHILDREN'S HEALTH

A Project Funded by

NEW YORK STATE OF OPPORTUNITY.™ | Office of Mental Health

Supporting Agencies & Organizations

New York State Academy of Family Physicians

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
New York Chapter 1

NEW YORK STATE | Department of Health

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
New York Chapter 2

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
NYS AAP - Chapter 3

NYS Conference of Local Mental Hygiene Directors, Inc.

NEW YORK STATE | Office of Mental Health

NEW YORK STATE OF OPPORTUNITY. | New York State Psychiatric Institute

COLUMBIA UNIVERSITY IRVING MEDICAL CENTER

Statewide Coordination Center

Operated by the Massachusetts General Hospital Psychiatry Academy

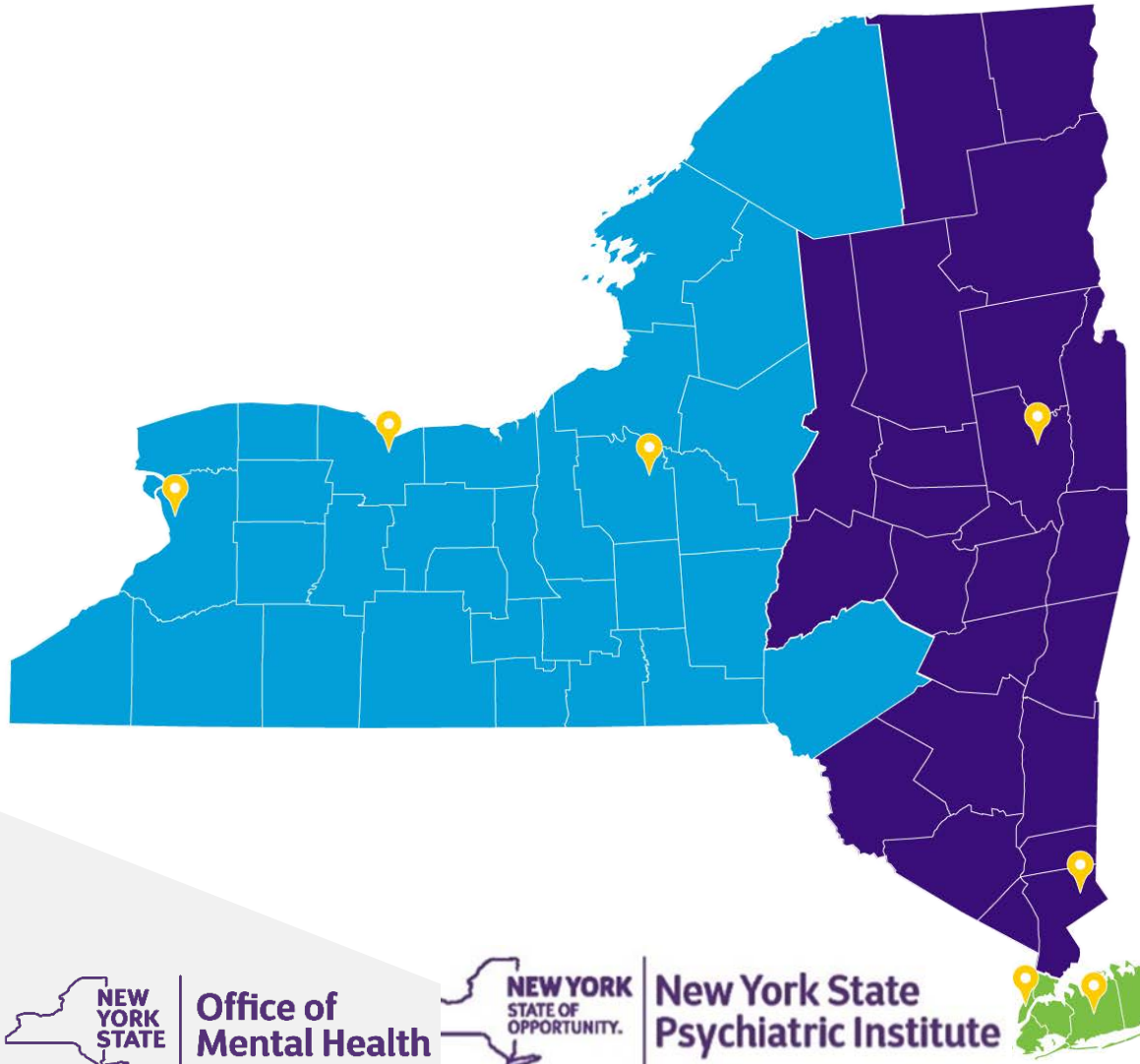
- Internationally renowned for education
- 65,000+ members in 125+ countries
- Live conferences, online courses, books, & more
- Provides clinical services, telehealth, & interim leadership to hospitals & health systems

LEARN MORE → www.mghcme.org

MISSION

To strengthen and support the ability of New York's pediatric primary care providers (PCPs) to deliver care to children and families who experience mild-to-moderate mental health concerns.

Regional Map



Region 1 - (855) 227-7272

- University at Buffalo Jacobs School of Medicine and Biomedical Sciences
- University of Rochester School of Medicine and Dentistry
- SUNY Upstate Medical University

Region 2 - (844) 892-5070

- Four Winds- Saratoga
- Four Winds- Westchester

Region 3 - (855) 227-7272

- Columbia University Medical Center/New York State Psychiatric Institute
- Hofstra Northwell School of Medicine

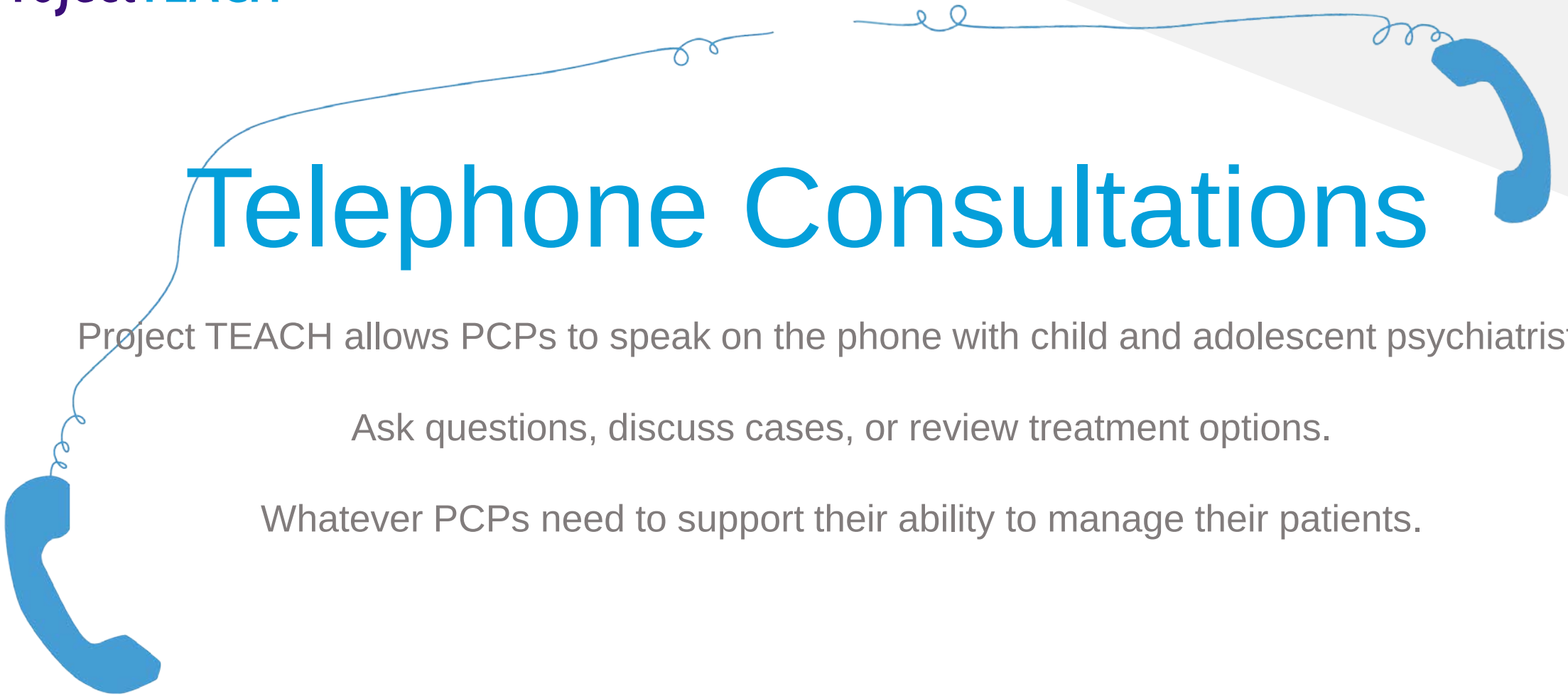
The Way it Works

Project TEACH provides consultation, education, training, and referrals and linkages to other key services for pediatricians, family physicians, psychiatrists, nurse practitioners, and other prescribers.



Training

Project TEACH offers training in several different formats for pediatric primary care providers (PCPs). These programs support the PCPs ability to assess, treat and manage mild-to-moderate mental health concerns in their practice.



Telephone Consultations

Project TEACH allows PCPs to speak on the phone with child and adolescent psychiatrists.

Ask questions, discuss cases, or review treatment options.

Whatever PCPs need to support their ability to manage their patients.

Top 5 Clinical Issues for Consultation Calls

1. Anxiety or Fear
2. Inattention or Hyperactivity
3. Sad or Depressed
4. Aggression
5. Oppositional, defiant

Face-to-Face Consultations

PCPs can also request face-to-face consultations with child and adolescent psychiatrists for the children and families in their practice.

If the office would like to offer consultations via videoconference, Project TEACH regional provider teams can work with the practice to make this service available.

It is our expectation that face-to-face consultations will occur within two weeks of requests. All face-to-face consultations are followed by written reports to the referring PCPs.

Referrals and Linkages

Linkage and referral services help pediatric primary care providers and families access community mental health and support services. This includes clinic treatment, care management, or family support. Project TEACH can refer PCPs to appropriate and accessible services that children and families in their practices need.

AGENDA

Can a virtual team be evaluated with chronic care metrics?

Evaluation

Psychiatr Serv. 2015 Apr 1;66(4):430-3.

Detection and treatment of mental health issues by pediatric PCPs in New York State: an evaluation of Project TEACH.

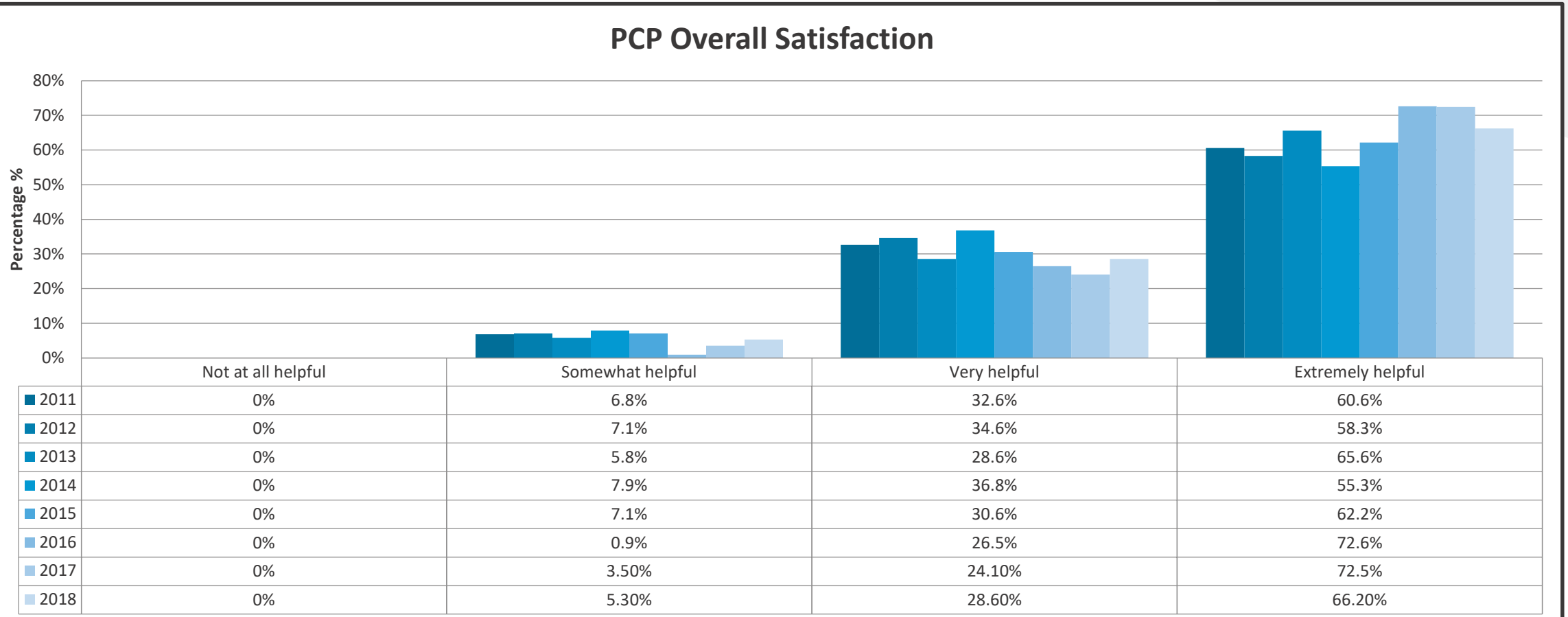
Kerker BD[1], Chor KH, Hoagwood KE, Radigan M, Perkins MB, Setias J, Wang R, Olin SS, Horwitz SM

Gen Hosp Psychiatry. 2014 Nov-Dec;36(6):555-62.

Encouraging and sustaining integration of child mental health into primary care: interviews with primary care providers participating in Project TEACH (CAPES and CAP PC) in NY.

Gadomski AM[1], Wissow LS[2], Palinkas L[3], Hoagwood KE[4], Daly JM[5], Kaye DL[6].

Two Week Survey



	Not at all helpful	Somewhat helpful	Very helpful	Extremely helpful
2011	0%	6.8%	32.6%	60.6%
2012	0%	7.1%	34.6%	58.3%
2013	0%	5.8%	28.6%	65.6%
2014	0%	7.9%	36.8%	55.3%
2015	0%	7.1%	30.6%	62.2%
2016	0%	0.9%	26.5%	72.6%
2017	0%	3.50%	24.10%	72.5%
2018	0%	5.30%	28.60%	66.20%

YEAR	2011	2012	2013	2014	2015	2016	2017	2018
Total number of surveys sent out	266	528	650	615	706	769	715	572
Number of surveys Received	135	252	247	226	245	201	170	183
Response Rates	50.7	47.7	38	36.7	34.7	26	23.7	31.9

AGENDA

What obstacles are unique to the virtual team model?

Next Steps: Can we reimburse the PCPs for the time they spend with Project TEACH?

- Pediatricians are not paid for their time calling a phone line if the patient is not there.
- Pediatricians are not paid for their time going to educational programs even if they are free.

The Role of the Primary Care Champ in Project TEACH

- *Joint Teaching*
- *PCP directed office detailing*
- *PCPs as the real experts as MH in Primary Care is not the same as MH*
- *Pediatric PCPs are the real heroes*