ADVANCING INTEGRATED HEALTHCARE

Integrated Behavioral Health in Pediatrics

Care Transformation Collaborative of RI

APRIL 25, 2019

LIZ CANTOR, PHD

PEDIATRIC IBH PRACTICE FACILITATOR

Agenda

- Pediatric IBH and Adult IBH are different
- Why Pediatric IBH?
  - Prevalence rates of BH conditions in pediatric population
  - Overview of the model and its benefits
  - Patient example
- Introduce screening options under this contract
    - School age children
    - Adolescents
    - New mothers

Pediatric Primary Care ≠ Adult Primary Care

Because, e.g.:

- Prevalence of medical and BH conditions is different in kids vs. adults
  - most common chronic condition in children is ASTHMA (8%);
  - about 25% of children have significant SLEEP problems;
  - only .24% of children under 20 have DIABETES vs. 9% of adults
- Parents play a central role in the healthcare of their children, from decision-making to transportation to financial responsibility
- Confidentiality with children and esp adolescents is a specific challenge
- Pediatricians are more accustomed to thinking about prevention and early detection, compared to adult primary care physicians

ADVANCING INTEGRATED HEALTHCARE

Why Pediatric IBH?

1. Increase access to care
   - Only 20% of kids with MH disorder receive specialty care (nationally)
2. Response to the shortage of child psychiatrists– we have no choice
3. Improve physician comfort with mental health
   - While pediatricians increasingly are involved in mental health visits, 2/3 report they are not prepared/lack of training[1]
4. Improve provider satisfaction[2]

Why Pediatric IBH? (cont.)

5. Cost & efficiency
   - Kids are generally physically healthy; mental health disorders cost the system more than medical disorders in children
   - With BHC in practice, medical provider has more time to spend on patients' medical concerns (one study showed PCP could add 1 pt/session)

6. It works! (e.g. recent meta-analysis showed "*The probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care.")*[3]

Prevalence of BH disorders in children

- Per the CDC, about 20% of children are diagnosed with a mental health disorder
  - Only 20% of those diagnosed receive care from a MH provider
  - BUT 90% of all children receive regular medical care from a primary care provider

- Per NIMH, 50% of all lifetime cases of mental illness begin by age 14
  - Average time between symptom onset and intervention is 8-10 years
  - Suicide is the 3rd leading cause of death in teens, most of whom had an underlying mental illness

Depression, Anxiety, Behavior Disorders, by Age

12%
10
8
6
4
2
0

3-5 6-11 12-17
Years
Depression

3-5 6-11 12-17
Years
Anxiety

3-5 6-11 12-17
Years
Behavior Disorders

ADVANCING INTEGRATED HEALTHCARE

Prevalence of Substance Use in (RI) Adolescents

- ANY substance use is considered a problem/risk, not just a full disorder
- The earlier teens start using substances, the greater their chances of continuing to use substances
- Per KIDS COUNT, in RI, in 2017 (reported in 2019):
  - 23% reported current ETOH consumption
  - 23% marijuana
  - 20% e-cigs
  - 11% binge drinking
  - 6% cigs
  - 5% OTC drugs
  - 4% Rx drugs

ADVANCING INTEGRATED HEALTHCARE

Prevalence of Postpartum Depression in new mothers

- Per the CDC, about 10-15% of new mothers nationally experience PPD symptoms; in RI (2012-2015), 11-14% reported sxs
- Per NIMH, risk factors for PPD include:
  - Sxs of depression in the past
  - Family hx of depression
  - A stressful life event during pregnancy or shortly after giving birth (e.g. job loss)
  - Medical complications for baby or for mom
  - Mixed feelings about the pregnancy
  - Social isolation
  - Substance use problems

What is Pediatric IBH?

It's an *approach to care* whose most central characteristic is coordinated team-based care that is individualized to the patient; you are making a commitment, like with PCMH, to develop a care plan for each individual child based on his/her needs.

You are more effectively identifying problems/opportunities and connecting patients to treatment/resources to prevent conditions from getting worse.

What is Pediatric IBH?

- Central components:
  - **Universal Screening** (systematically identifying problems)
  - **Triage** and **referral** (systematically determining level of care and connecting patients to the care they need)
  - **Brief treatment** (systematically treating only those problems that have been shown to benefit from this model of intervention – mild to moderate)
    - Brief in session length – 30 minutes
    - Brief in treatment length – 1 to 6 sessions
  - **Education** of staff and patients

ADVANCING INTEGRATED HEALTHCARE

A patient example

- **Universal Screening**
  - 7 y.o. Billy in January for Annual Physical; mom completes PSC; results are significant for Attention Problems Subscale; mother notes transition to 1st grade has been very hard for him, not improving, he's starting to hate himself and isolate because he feels like a failure; note in EHR indicates this has been an area to watch for a couple years; you rule out a sleep disorder, food allergies, or other medical conditions; explain possibility of an ADHD Dx and possibility of a medication trial, but you recommend she meet with the BHC first for further assessment, and she agrees.
- **Triage** and **referral**
  - Through a 5 minute **"warm hand-off"** mother and Billy meet the BHC before they leave, and mother makes an appointment to return later that week
- **Brief treatment**
  - Mother meets with BHC for brief assessment; clinician rules out other MH explanations (e.g. anxiety, learning disorder); provides ADHD education; plan to meet for 3-4 sessions for parent training to help manage the behavior at home, help her advocate at school; after several weeks, mother reports improvement at home, but ongoing struggles at school; BHC documents in EHR so you can see progress; mother returns to see you, you start a med trial…

Recommended Screeners

- School-Age (5-11)
  - Pediatric Symptom Checklist (general social-emotional functioning)
- Adolescence (12-17)
  - PHQ-A or PHQ-9M (Depression, adolescent version)
  - GAD-7 (Anxiety)
  - CRAFFT (Alcohol and Substance Use)
- New Mothers
  - Edinburgh Postpartum Depression Scale (EPDS)

- *Copies are in your orientation binder*

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
pcmh kids patient-centered medical home
ADVANCING INTEGRATED HEALTHCARE

Resources: Screeners and Instructions

NOTE: THESE ARE ALL AVAILABLE THROUGH CHADIS

PSC (Pediatric Symptom Checklist)

- Overview, forms, translations https://www.massgeneral.org/psychiatry/

PHQ-A (modified PHQ-9, or PHQ-9M)
http://www.uacap.org/uploads/3/2/5/0/3250432/phq-a.pdf

GAD-7 https://www.phqscreeners.com/

CRAFFT https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

EDPS https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

ADVANCING INTEGRATED HEALTHCARE

References

1. Horwitz, S., Storfer-Isser, A., Kerker, B., et al. (2015). Barriers to the identification and management of psychosocial problems: changes from 2004 to 2013. *Acad Pediatr*. 2015;15(6):613-620.
2. Hine, J., Grennan, A., Menousek, K., Robertson, et al. (2017). Physician Satisfaction With Integrated Behavioral Health in Pediatric Primary Care: Consistency Across Rural and Urban Settings. *Journal of Primary Care & Community Health*, Vol. 8(2) 89 –93.
3. Arsanow, J., Rozenman, M., Wiblin, J., Zeltzer, L. (2015). Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. *JAMA Pediatrics*; 169(10): 929-937.