Pediatric Behavioral Health: How to Improve Primary Care Coordination and Increase Access

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Introducing Population Health Advisor

PHA Offers Customized Support for Leaders in Care Transformation

1. Refine System Strategy and Train Staff
2. Evaluate Performance or Opportunities
3. Build New Programs or Scale Existing Operations

Popular PHA Projects:

- Population Health 101 and 201 Series
- Training Medical Assistants for the Advanced Medical Home
- Care Management Strategy Guide
- Developing a System-Wide Palliative Care Program and Strategy
- Care Management Survey Assessment
- Remote Patient Monitoring: Opportunity Analysis
- Cross-Continuum Senior Services Scorecard
- Post-Acute Market Overview and Opportunity Assessment
- Primer on Designing a Super-Utilizer Clinic
- Managing Care Transitions and Post-Discharge Follow Up
- Models for Integrating Behavioral Health and Primary Care
- Advancing Population Health Through Use of Call Centers
1. The Case for Integrated Care

2. Spectrum of Coordinated Models

3. Q&A
What is Integrated Behavioral Health?

At the Intersection of Mental and Physical Health

**Mental Health**
- Depression
- Mood disorders
- Learning disabilities
- Alcohol/drug abuse
- Pain management

**Physical Health**
- Anxiety
- Stress
- Grief management
- Other psychological issues
- Self-management for chronic diseases (e.g., diabetes, CHF, COPD)
- Medication adherence
- Smoking cessation
- Weight management

Central Principles of the Integrated Behavioral Health Model

- Embedded within Primary Care
- Team-Based, Care Management Focus
- Patient-Centered Self-Management Support
- Clinical Information Sharing Systems

Source: Population Health Advisor interviews and analysis.
### Anxiety, ADHD, Depression Most Common for Kids

#### Major Depressive Episode, by Age
2014 National Survey on Drug Use and Health

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 to 17</td>
<td>10.7%</td>
</tr>
<tr>
<td>18 to 25</td>
<td>20.1%</td>
</tr>
<tr>
<td>26 to 49</td>
<td>20.4%</td>
</tr>
<tr>
<td>50 or older</td>
<td>15.4%</td>
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</tbody>
</table>

#### Most Common BH Conditions
Prevalence by Age

**Pediatric**
1. Anxiety
2. ADHD
3. Depression

**Adult**
1. Depression
2. Anxiety
3. Substance use

Significant Gaps between Diagnosis and Follow Up

Majority of Patients Do Not Receive Appropriate Treatment

Provider Shortages
Nationally, there are only enough mental health practitioners to meet 51% of need, and many of these providers are concentrated in urban centers.

Reimbursement Limitations
Mental health services tend to have relatively low reimbursement rates and disparate coverage standards; many providers do not accept insurance.

Lack of Coordination
Mental health services are often uncoordinated among contacts for pediatric patients (e.g., schools, social services).

Perceived Stigma
Providers bypass opportunities for screening and early diagnoses in the primary care and school settings, due to insufficient training.

38.1%
Adolescents ages 12-17 years old with a major depressive episode that received any mental health treatment that year

Adherence Issues Exacerbated by Workforce Shortages

Too Few Providers...
Estimated Behavioral Health Staff Needed to Serve Adults and Adolescents in 2010

- Behavioral Health Provider Volume: 5,094
- Estimated Behavioral Health Provider Need: 11,688

6,594 shortage

...Offering Limited Coverage
Acceptance Rates of Private Insurance

- Psychiatrists: 55%
- Other specialists: 89%

34% difference


1) Includes psychologists, licensed clinical social workers, and other licensed medical health professions.
Behavioral Health is a Key Contributor to Chronic Disease Management

### Per Member Per Month Costs, by Payer and Behavioral Health Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Commercial</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>No behavioral health diagnosis</td>
<td>$397</td>
<td>$340</td>
<td>$528</td>
<td>$381</td>
</tr>
<tr>
<td>Behavioral health diagnosis</td>
<td>$1,085</td>
<td>$903</td>
<td>$1,409</td>
<td>$1,301</td>
</tr>
</tbody>
</table>

**Average increase in PMPM cost for patients with a behavioral health diagnosis: $688**

Clear Need for New Approach to Care Delivery

- **High Patient Demand**: 20% Prevalence of any mental illness among youth ages 12-17 years old.
- **Provider Shortages**: 6.6K Estimated national shortage of behavioral health providers in 2010.
- **Low Referral Adherence**: 45% Percent of adults with mental illness receiving mental health services.
- **Elevated Costs**: 2-3x Increase in health care costs among patients with BH dx.

Sources:
1. SAMHSA (December 2013).
Primary Care the Frontline for Behavioral Health

Yet, PCPs Lack Time, Training to Independently Manage Care

Primary care serves as a common treatment setting for behavioral health

- Children ages 4 to 17 who received non-psychopharmacologic treatment for emotional or behavioral difficulties by their pediatric or general medical practice
  - 25%

But the majority of primary care providers express discomfort in identifying, evaluating, and effectively managing behavioral problems

- General practitioners and family practitioners reporting low comfort and skill with diagnosis and evaluation of behavioral problems
  - 50%

- General practitioners and family practitioners reporting low comfort and skill with effectiveness in management of behavioral problems
  - 76%

Source: Simpson GA, Cohen RA, Pastor PN, Reuben CA. U.S. Children 4-17 Years of Age Who Received Treatment for Emotional or Behavioral Difficulties: Preliminary Data From the 2005 National Health Interview Survey. Atlanta, GA: National Center for Health Statistics, Centers for Disease Control and Prevention; 2006; Miller AR, et. al, “Family physicians involvement and self-reported comfort and skill in care of children with behavioral and emotional problems,” BMC, March 2005), 6(12); Population Health Advisor interviews and analysis.

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Integrated Programs Improve Access, Outcomes

Key Program Design Elements of IMPACT

1. **Standardized Patient Assessment**
   - Behavioral health specialist conducts the initial visit with patient, reviews educational materials, and discusses the patient’s treatment preferences

2. **Protocol-Based Treatment Plan**
   - The behavioral health specialist works with the patient and his/her regular primary care provider to establish a treatment plan informed by IMPACT’s treatment algorithm (primary care provider makes final treatment choices)

3. **Routine Care Team Meetings**
   - During weekly team meetings, the supervising psychiatrist, behavioral health specialist and primary care physician discuss new cases and cases requiring treatment plan adjustments

**IMPACT Clinical Outcomes at 12-Month Follow-up**

- **n=1,801**
  - 45% >50% reduction in depressive symptoms from baseline
  - 19% Complete remission of depression symptoms
  - 25% 8%

**Financial Outcomes of IMPACT**

- **$1.88** Average per member per month (PMPM) program cost
- **$6.50** Return on investment per dollar spent, IMPACT years 1-4

Range of Approaches to Deliver Behavioral Health

Behavioral Health Coordination Models Not Mutually Exclusive

Spectrum of Coordinated Behavioral Health Models

- **Coordination**
  - **Tele-mentoring**: Connects primary care providers to reliable behavioral health support through virtual consultation service.

- **Collaboration**
  - **Community Partnerships**: Enhanced collaboration with community organizations (e.g., dedicated shared practice space, mobile outreach).
  - **Remote Consultations**: Telepsychiatry in outpatient setting to address specialist shortages.

- **Integration**
  - **Rotating, Embedded Staffing**: Fully integrates behavioral health providers as core members of the primary care team.

Source: Population Health Advisor interviews and analysis.
Case in Brief: Colorado Psychiatric Access & Consultation for Kids (C-PACK)

• Program operated by Beacon Health Options with funding by Colorado Health Partnerships; serving 52 primary care practices within the Southern Colorado area representing a high-need, low-access patient population

• Program components include psychiatric “curbside consultation,” complex care referrals, training opportunities, and on-site “lunch and learn” sessions

• By December 2015, the Call Center had supported 1,489 calls representing 1,364 unique cases; at six months post-enrollment, participating providers demonstrated a 17 percent increase in their use of evidence-based screening tools for mental health conditions compared to baseline (98% vs. 81%)
Tiered Support Maps Need to Appropriate Resources

Expertise Offered as Direct Psychiatric Consults, Referrals, and Training

Care Connection
*For moderate to high acuity cases*
- Referrals to community mental health providers for patients with complex care needs
- Referrals are exclusively made to professionals who are taking new clients, accept the patient’s insurance, and are willing to work collaboratively with the patient’s primary care provider

Curbside Consults
*For high, moderate, or low acuity cases*
- Real-time telephonic consultations between a primary care provider and child psychiatrist (M-F; 8a-5p)
- Typical callback time within 15 minutes
- Topics include medication management, screening tools, diagnosis, and treatment planning
- The PCP operates as the treating physician and documents the consultation in his or her own record; no direct care is provided by the consulting psychiatrist

On-Site Training
*For ongoing education and skill development*
- Routine “Lunch and Learn” sessions with education and training specific to children’s behavioral health topics (e.g., psychopharmacology)
- Online resources including screening tools and state-specific services (e.g., Colorado Mental Health Crisis Hotline)

Source: Population Health Advisor interviews and analysis.
C-PACK Increases Patient Access, Screening Activity

Performance Evaluated at 6-Months with Surveys, Stakeholder Interviews

PROGRAM OBJECTIVES

1. Increased access to child psychiatric specialty consultation
2. Increased number of children screened for mental health conditions
3. Increased identification of children with undiagnosed mental health conditions
4. Increased access to evidence-based medication and psychotherapy treatments
5. Increased PCP confidence in their diagnostic and treatment skills
6. Increased access to specialty services in complex cases
7. Increased appropriate use of psychiatric medications in primary care
8. Increased provider satisfaction

EARLY IMPACT

C-PACK Call Volumes

December 2015

<table>
<thead>
<tr>
<th>Number of calls</th>
<th>Unique cases</th>
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<tr>
<td>1,489</td>
<td>1,364</td>
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Top Presenting Issues

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<tr>
<th>Condition</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Depression</td>
<td>23.6%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>23.3%</td>
</tr>
<tr>
<td>ADHD</td>
<td>18.5%</td>
</tr>
<tr>
<td>Disruptive Behavior/ODD</td>
<td>11.8%</td>
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EBP Screening Activity

Baseline 6-months

<table>
<thead>
<tr>
<th>Percentage</th>
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<tbody>
<tr>
<td>81%</td>
</tr>
<tr>
<td>98%</td>
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</tbody>
</table>

88% PCPs reporting increased comfort in addressing psychiatric/behavioral health issues in primary care settings

Source: Population Health Advisor interviews and analysis.
Maine Child Psychiatry Access Program (MeCPAP)

Case in Brief: Maine Child Psychiatry Access Program (MeCPAP)

- Pediatric psychiatric consult program working with over two dozen pediatric primary care providers across eight practices, and covering over 38,000 pediatric patients throughout western and mid-coast Maine.
- Initially supported with grant funding from the Maine Health Access Foundation; currently sustained by funding through philanthropic donations.
- Offers telephonic consultations with a child and adolescent psychiatrist to resolve questions around diagnosis, treatment planning, community resources, and educational tools and materials for participating primary care practices.
- Outcomes include improved primary care provider satisfaction, increased comfort with managing higher-acuity cases in the primary care setting, and time savings for patient caregivers (i.e., travel time, work hours).
Psychiatric Requests Fulfilled Within One Hour

Clinical Care Coordinator and Psychiatrist Collaboration at Every Step

Progression of Rapid Consultation Component of MeCPAP

Primary care office calls or sends secure email to clinical care coordinator (CCC)

CAP calls PCP for telephone consult within one hour of original request

CAP documents visit, provides documentation to CCC; CAP and CCC discuss next steps

CCC collects administrative and clinical information for service request

CCC and Child and Adolescent Psychiatrist (CAP) discuss service request; CCC offers ongoing support to primary care office

CCC tracks all data and follows through on next steps from outcome of call (e.g., referral for care)

Source: Population Health Advisor interviews and analysis.
Tele-Mentoring Extends Beyond Remote Consults

“Lunch and Learn” Meetings Boost Provider Engagement at Spoke Sites

MeCPAP Core Components

**CONSULTATION SERVICES**

- Telephone consultation with psychiatrist within 60 minutes of request
- In-person consultations for complex cases
- Referrals to community resources from clinical care coordinator

**EDUCATIONAL SUPPORT**

- Toolkit with screening instruments and educational materials
- Quarterly “Lunch & Learn” sessions offering targeted information on mental health diagnosis and treatment

Sample “Lunch and Learn” Topics

- “Basics for ADHD: Medications and Treatment”
- “Fundamentals of Antidepressant Medications”
- “Treatment of Anxiety in Primary Care”
- “Depression and Suicide: The Role of the PCP”
- “Encopresis & Enuresis”
- “Natural Therapies for Mental Health Issues and Sleep”
- “Substance Abuse”

Source: Population Health Advisor interviews and analysis.
MeCPAP Boosts PCP Comfort with Psychiatric Care

Difficult to Measure Short-Term Clinical Impact Among Pediatric Patients

PCP Access to Psychiatric Support

Survey response of “Agree” or “Strongly Agree” to the following statement (n=19):

“With the existing resources, I am usually able to meet the needs of children with psychiatric problems.”

<table>
<thead>
<tr>
<th>Baseline</th>
<th>5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-months</td>
<td>91%</td>
</tr>
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Key Lessons from MeCPAP

In staging pilot site selection, start with practices primed for success by first identifying a receptive, committed on-site program champions

Create single point of contact to streamline service requests and minimize PCP burden

Include experiential metrics in data tracking activity (e.g., reductions in absenteeism from school and/or work, travel time saved)

Feedback from Participating Primary Care Providers

“"The question I get answered helps me not just with that patient but with the next five.”

"I don't call that much, but I know you have my back.”

"You’re not going anywhere are you? I keep a sheet every day with mental health concerns/questions.”

Source: Maine Child Psychiatry Access Program; Population Health Advisor interviews and analysis.
Case in Brief: St. Charles Health System

- Four-hospital health system in Bend, Oregon
- Collaborated with several community-based organizations, provider groups, and health plans to create the Central Oregon Health Council, one of 16 care coordination organizations (CCOs) in the state
- In 2013, the CCO embedded 10 clinical psychologists within community-based primary care and pediatric practices to proactively identify behavioral health needs and assist in developing a treatment plan
- Early results show increased patient and provider satisfaction, decreased PCP visit volumes, and trends toward overall cost reduction
Build Strong Relationships Early to Spur Adoption
Establish Trust and Clarify Goals between PCPs and BH Consultants

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Providers</th>
<th>Patients</th>
<th>Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial PCP discomfort with psych consults</td>
<td>Primary care providers expressed uncertainty about the skill set of integrated psychologists and when to bring them in for consults</td>
<td>Difficulty starting conversations about mental health</td>
<td>Lack of consensus on partner site selection</td>
</tr>
<tr>
<td>Difficulty starting conversations about mental health</td>
<td>Patients occasionally reluctant to discuss mental health concerns due to perceived stigma</td>
<td>Differing strategies across internal stakeholders about how to partner with external practices outside the health system network</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Solutions</th>
<th>Providers</th>
<th>Patients</th>
<th>Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Create opportunities for meaningful PCP/BH interactions through shared training sessions or shadowing</td>
<td>• Train PCPs on effective communication tactics to discuss mental health during patient visits</td>
<td>• In pilot site selection, prioritize patient need, provider commitment, and program feasibility in addition to health system affiliation</td>
<td></td>
</tr>
<tr>
<td>• Educate providers on appropriate referrals and importance of warm handoffs</td>
<td>• Convey psychologist’s role to patients as part of the core medical team</td>
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</tr>
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Source: Population Health Advisor interviews and analysis.
Opaque Ownership of Process Steps Delays Care

St. Charles Procedural Packets Clarify Roles and Responsibilities

**Parents**

- Fill out forms and questionnaires relating to patient’s symptoms, clinical history, and social environment
- Sign “release of information” waiver to enable information sharing between child’s school and primary care provider

**Schools**

- Complete school assessment forms to supplement information on child’s behavioral health needs
- Compile relevant school-based documents from teachers (e.g., attendance records, discipline records, previous interventions)

**PCPs**

- Update parent/caregiver with clinical information relating to screening assessments, diagnoses, and treatment plan
- Coordinate with school representatives to identify additional resources available in the community

**Admin**

- Behavioral health program administrator coordinates across stakeholder groups to share completed packets and clarify next steps
- If process stalls, sends reminders to relevant stakeholder to re-engage and flag challenges

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*St. Charles Health System Parent and Teacher “ADHD Packets” available upon request*
Case in Brief: Michigan Child Collaborative Care (MC3)

• Multistakeholder initiative between the state, University of Michigan Health System, and regional community mental health providers to support provider consult and telepsychiatry services to pediatric populations with behavioral health needs.

• The program employs 17 full- and part-time boots-on-the-ground behavioral health specialists to identify, enroll, and engage primary care providers.

• The program currently offers consultation services to 385 enrolled providers (including school-based clinics) across 40 counties.

Combining Embedded and Virtual Care Delivery

A Three-Pronged Approach to Behavioral Health Integration

*Increasing Patient Acuity and Complexity*

**Embedded Behavioral Health Consultants (BHCs)**

BHCs are co-located to perform screenings, conduct independent patient visits and collaborate with the PCPs on care planning.

**On-Demand Psychiatric Consultations**

PCPs may request a consult with an on-call psychiatrist to give recommendations within 2-4 hours (M-F; 8-5).

**Virtual Patient Interactions**

For patients with repeat consults or complex needs, the BHC, on-call psychiatrist, and primary care provider make a joint decision to determine if a virtual telepsychiatry visit is appropriate.

Source: Population Health Advisor interviews and analysis.
Nurture Relationships with Team Members to Ensure Referral Volumes

MC3 Tactics to Improve PCP Buy-In and Engagement

- Streamline workflows to make referrals intuitive and easy
- Address any liability concerns around telehealth and psychiatric screening
- Create a single point of contact for each primary care practice
- Involve all members of the primary care team in behavioral health conversations
- Keep in touch, but be concise

Source: Population Health Advisor interviews and analysis.
Summary of Key Insights from Profiled Cases

Structure Services to Accommodate Various Levels of Patient Need

• Depending on patient need and provider engagement, primary care and behavioral health coordination can be enhanced with online resource libraries, telephonic consults, or embedded support

• Referrals should be easy, intuitive, and reliable, with clear expectations for when the behavioral health provider will respond

Use “Lunch and Learn” Sessions to Foster PCP Engagement

• Start early to use training sessions as a way to introduce behavioral health providers to the primary care teams and build trust and strong professional relationships

• Crowdsource topics from primary care teams to ensure the training content is relevant and impactful

Consider Multiple Stakeholder Groups in Program Design and Implementation

• Improving access to mental health services for pediatric patients requires coordination between parents or caregivers, schools, and medical teams

• Establish and reinforce clear lines of communication between the various stakeholder groups with standardized forms, processes, and timelines

Include Both Patient- and Provider-Oriented Performance Metrics

• There may be some time lag between the clinical and the financial outcomes of these programs, particularly if you are measuring downstream cost savings

• It is therefore important to track other qualitative metrics that demonstrate program impact (e.g., reduced patient absenteeism, provider satisfaction)

Source: Population Health Advisor interviews and analysis.
What are your QUESTIONS on pediatric behavioral health?
Please take a minute to provide your thoughts on today’s presentation.

Thank You!

Please note that the survey does not apply to webconferences viewed on demand.