PEDIATRIC INTEGRATED CARE

Louisiana Behavioral Health Summit

June 30, 2015

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DISCLOSURES

- I am a triple boarder
- Funding from
  - Baptist Community Ministries
  - Louisiana Public Health Institute
  - SAMHSA/Louisiana Office of Public Health

ACKNOWLEDGEMENTS

- Tulane Early Childhood Collaborative
  - Monica Stevens PhD
  - Bryan Goldman MS
- Tulane and Brown triple board residents
- The patients and families we serve!
- Project LAUNCH
  - Megan Kersch LSCW
  - Melissa Hardy LCSW
  - Jody West LCSW
  - Betsy Wilks LSCW
  - Sarintha Strickland PhD
  - Tina Stefanski MD
  - Sebreanna Domingue MS
  - Karen Webb MA
  - Amy Zapata MPH
  - Leslie Brougham Freeman PhD LPP

OBJECTIVES

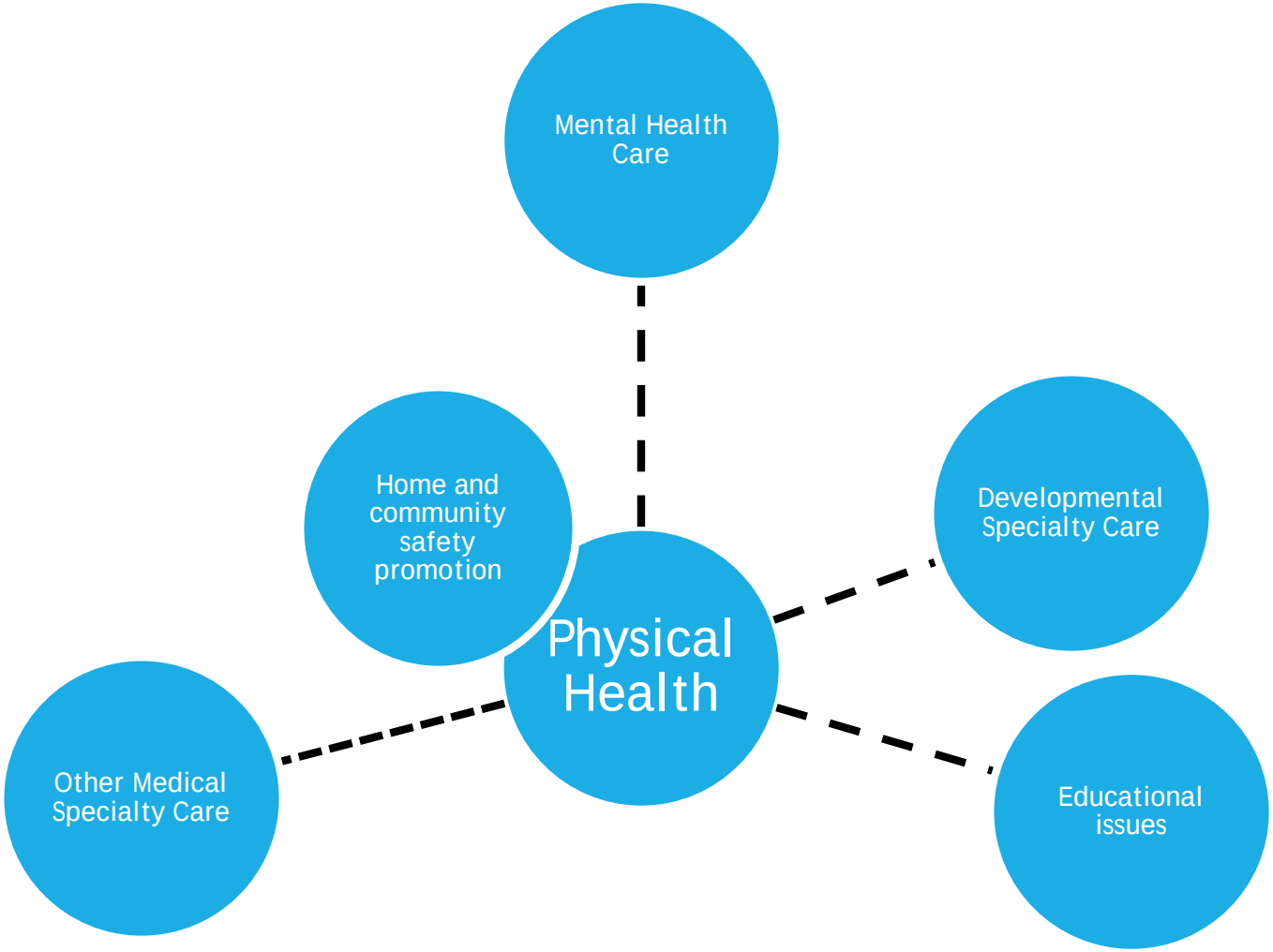
- Be able to recognize challenges in traditional models of care
- Be able to describe national co-located models
- Be familiar with examples of child psychiatry access programs
- Be familiar with the potential for integration models in Louisiana

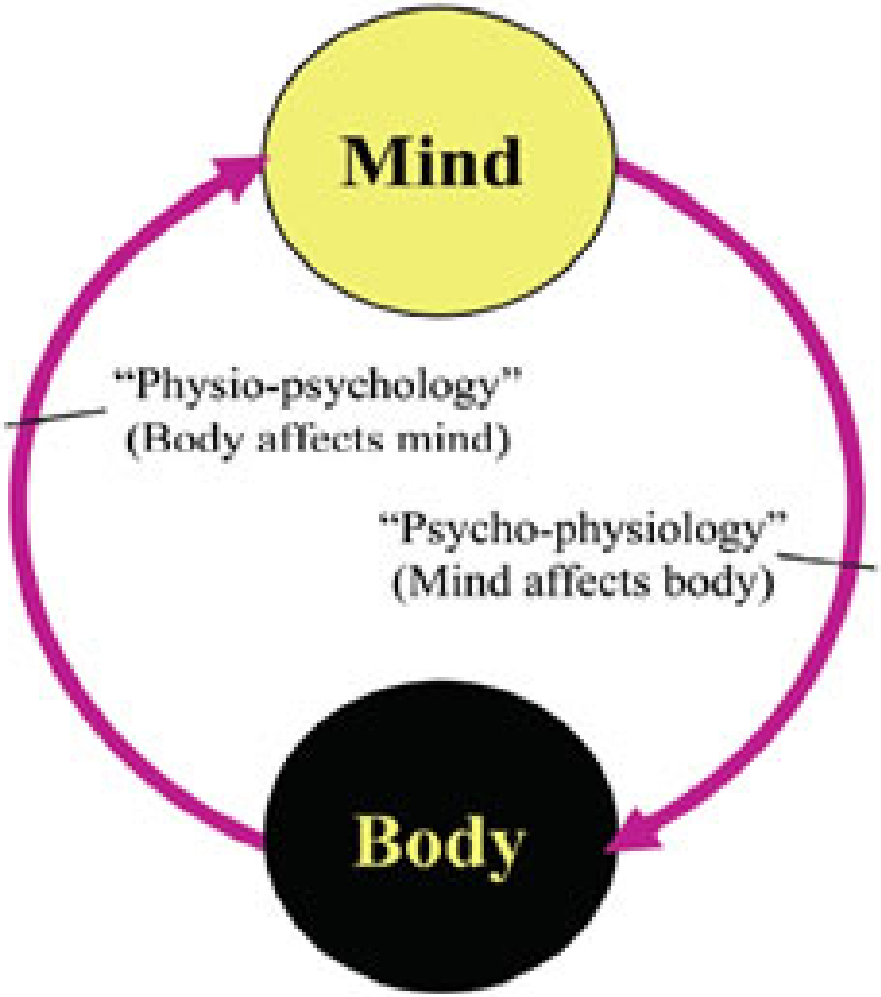
OVERVIEW

- Why mental health in the medical home?
- Evidence supporting integration nationally
- Louisiana models of integration

WHY MENTAL HEALTH IN PRIMARY CARE

TRADITIONAL MODEL OF CARE




Mind
"Physio-psychology"
(Body affects mind)
"Psycho-physiology"
(Mind affects body)
Body

HEALTH MAINTENANCE PERIODICITY SCHEDULE

- Visits at
  - Birth
  - 3-5 days
  - 1 month
  - 2 months
  - 4 months
  - 6 months
  - 9 months
  - 12 months
  - 15 months
  - 18 months
- And
  - 24 months
  - 30 months
  - 36 months
  - 48 months
  - 60 months

15 scheduled visits in 5 years!

Required for school entrance!!

Parents attend visits!

WELL-CHILD VISITS

- **Multi-organ, multi-system assessment with prevention and health maintenance focus**
- **CC**: **Parental Concerns**
- **History**: ER visits, hospitalizations, chronic illness update, immunizations up to date, development (social, motor, language), sleep history, feeding/eating history, family changes (divorce, new sibling, move), academic functioning/school transition, social/dating/sexual development, safety (guns in home, domestic violence, physical, sexual abuse, community violence), paternal well-being
- **Physical Exam**: Growth parameters, vital signs, HEENT, neck, CV, Resp, Abd, GU, Skin, Extremities, Neuro/cognitive
- **Anticipatory Guidance**: Safety proof home, Lead, nutrition & exercise, bullying, peer relationships and pressures, personal safety (strangers, know address, "good touch, bad touch"), helmets, smoke detectors, tooth brushing/dental hygiene, time-out, emotional regulation, sibling response, media exposure… substance abuse, sexual development,
- **Plan-** can include any of these spheres: meds, immunizations, blood work, IEP referral and/or developmental assessment, get guns out of home, obtain free mattress cover for atopic children, refer/ advocate re:housing issues (bars on windows, smoke detectors), maternal depression referral, smoking cessation (parent or child), behavioral plan for typical behavioral challenges…
- ALL IN 8-11 MINUTES

LOUISIANA FINE PRINT

- "Health education must include anticipatory guidance and interpretive conference. Youth 2-20 must receive intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each visit."

KIDMED Periodicity Schedule

QUIRED KIDMED MEDICAL, VISION, AND HEARING SCREENING COMPONENTS BY AGE OF RECIPIENT[1]

	2 MO	4 MO	6 MO	9 MO	12 MO	15 MO	18 MO	2 YR	3 YR	4 YR	5 YR	6 YR	8 YR	10 YR	12 YR	14 YR	16 YR	18 YR	20 YR
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X											
									X	X	X	X	X	X	X	X	X	X	X
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	X	X	X		X	X				—	X	—				X	—		
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			X	X	X	X	X	X	X	X	X								
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	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO
	S	S	S	S	S	S	S	S	S	SO	SO	SO	SO	SO	SO	SO	SO	SO	SO

ective by history O = Objective by Medicaid – approved standard testing method
be administered during this time frame

be done at the initial medical screening on all children under age six.
st occur prior to hospital discharge.
unclothed or undraped and include all body systems.
dule must be followed per AAP recommendations.
creening must be repeated.
and 12 months or earlier if medically indicated, one year to four years, five years to 12 years, and between 13 and 20 years.
en one and four years, (as soon as toilet trained), five to 12 years, and between 13 and 20 years.
nt for lead must be done at every medical screening.
to CDC guidelines. The frequency of screening using the blood lead test depends on the result of the verbal risk assessment.

Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 through 20, must receive more intensive health education which addresses psychological issues, emotional issues, substance usage, and reproductive health issues at each screening visit.

PEDIATRIC COMPETENCIES FOR MENTAL HEALTH (2009)

- Interpersonal and communication
  - Enhance communication with patients
  - Increase skills in cross-disciplinary communication
- Professionalism
  - Sensitivity to cultural differences
  - Confidentiality
  - Awareness of own limitations

PEDIATRIC COMPETENCIES FOR MENTAL HEALTH (2009)

- Systems Based Practice
  - Insurance issues
  - Collaboration with mental health professionals
- Patient Care
  - Screening and basic assessment
  - Guidance on managing common behavioral problems and adjustment
  - Recognizing mental health emergencies
  - Develop treatment plans for ADHD, depression, anxiety, and substance abuse

MENTAL HEALTH IN PRIMARY CARE PRACTICE

- ~90% of US children have health insurance
- Primary care providers provide the vast majority of pediatric mental health services in the US
  - UP to 19% of visits have a MH component (Kelleher, 2000)
  - Mental health needs drive primary care utilization (Bernal, 2003)
  - 70-85% of psychotropic rx's written by PCPs

PARENT PREFERENCE

- 80% of parents believe pediatric setting is appropriate for discussion of psychosocial issues
- Most parents want more information about behavioral issues *(Young et al., 1998)*

WHAT ROLE SHOULD PEDIATRICIANS HAVE FOR MH PROBLEMS?

HENEGHAN ET AL. (2008) JDBP

	Pediatrician		CAP	
	Identify		Identify	
ADHD	90%*		73%*	
MDD, Anx	85%*		65-68%	
DBDs	82%		78%	
Subst. abuse	86%		81%	
Eating D/O	89%		87%	

WHAT ROLE SHOULD PEDIATRICIANS HAVE FOR MH PROBLEMS?

HENEGHAN ET AL. (2008) JDBP

	Pediatrician		CAP	
	Identify (%)	Treat (%)	Identify (%)	Treat (%)
ADHD	90*	86*	73*	57*
MDD, Anx	85*	13-16	65-68*	7-9
DBDs	82	17	78	13
Subst. abuse	86	11	81	7
Eating D/O	89	15	87	10

COMMUNICATION IN PRIMARY CARE

- 80% of parents believe pediatric setting is appropriate for discussion of psychosocial issues
  - Fewer than 50% of parents whose child had a psychosocial problem discussed with pediatrician *(Horowitz, 1998)*
- When an MD reported counseling parent about child's mood, anxiety, or behavior
  - 75% of parents did not report that they received any counseling (Brown & Wissow, 2008)

IDENTIFICATION AND REFERRAL

- Using unstructured approaches, PCP's identify
  - 50% of children with moderate symptoms
  - 80% of children with high level symptoms
  - Identification rates related to race/ethnicity
  - *(Brown and Wissow, 2008)*
- Within 6 mo of diagnosis and referral
  - < 50% have mental health appointment
  - < 1/3 have more than 1 MH appointment *(Rushton 2002)*

SYSTEMATIC DISINCENTIVES FOR PRIMARY CARE MH

- Time
  - 8 min on “medical only” appointments
  - 20 min on “behavioral only”
- CPT billing codes
  - 2.7 procedure code (1-10) for “medical only”
  - 1 procedure code for “behavioral only”
- Billable income
  - Per minute, billed 4-fold for “medical only” appointments vs “behavioral only”
- In some insurance plans, PCPs cannot bill at all for MH diagnoses
- Training
  - RRC requirements for mental health issues are minimal ER (exposure to psychiatric emergencies) and DBP (recognition and care coordination of psychosocial issues)

Meadows 2011, Clin Pediatrics, ACGME 2007 Pediatrics Program Requirements

CULTURAL MILIEU
MENTAL HEALTH AND PEDIATRICS

- Relationship with families
  - Pediatrics: Extended relationship, infrequent contacts, automatic exposure to siblings
  - Mental Health : Shorter relationships, more frequent/intense contact
- Patient population
  - Pediatrics: Healthy, usually with typical development
  - Mental Health: Significant Psychopathology/Adjustment

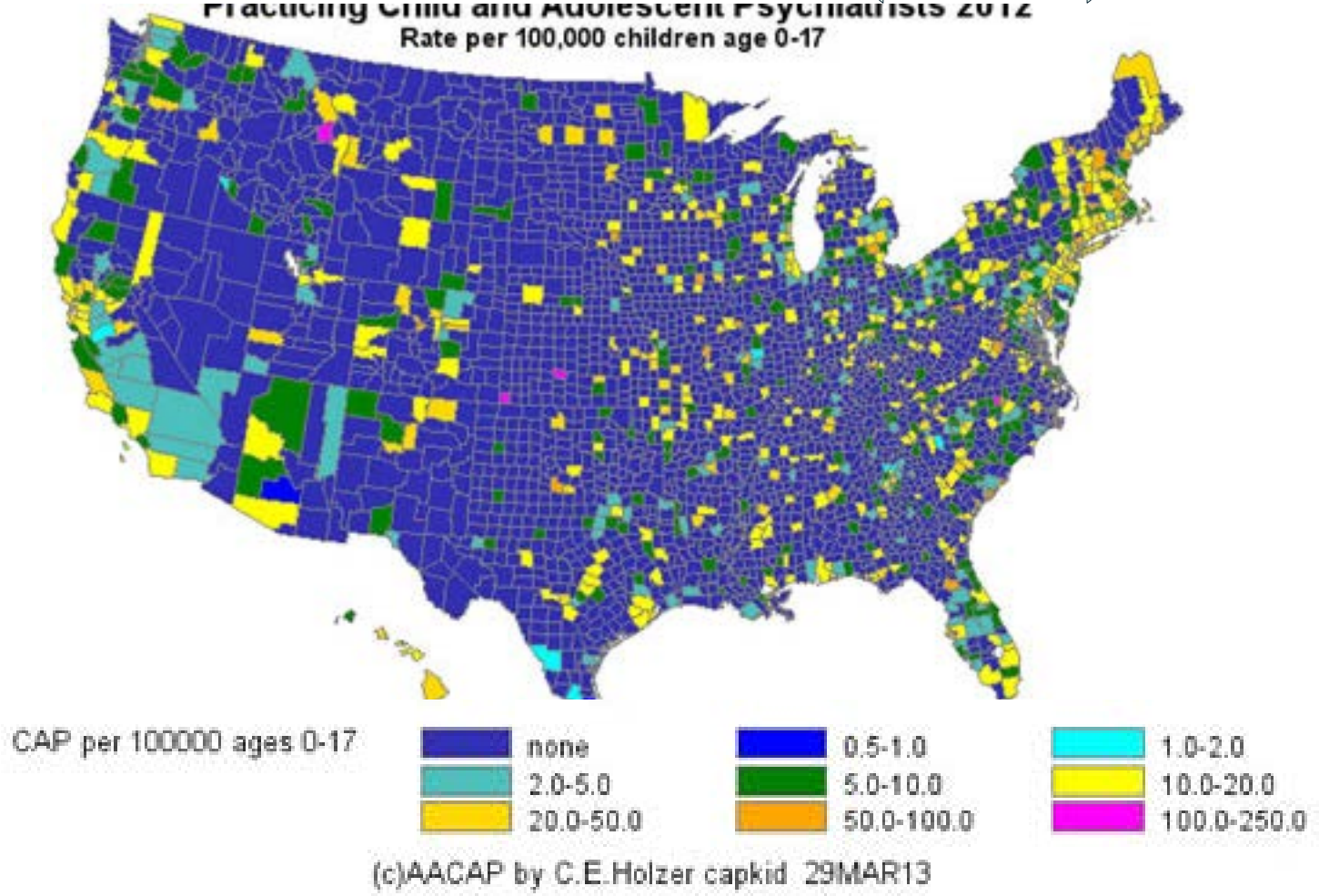
- Approach to concerns
  - Pediatrics: Normalize
  - Mental health : Validate, dx, treat
- Treatment outcomes
  - Pediatrics: Most children get better
  - Mental health: Many disorders are chronic/recurring
- Scope of care
  - Pediatrics: Broad
  - Child Psychiatry: Clear boundaries

- Communication
  - Pediatrics: Often leave patient room to take a call
  - Mental health: Rarely interrupt session
- Communication among specialists
  - Pediatrics: Specialists provide written consultation notes
  - Mental Health: Confidentiality is supreme

WORKFORCE SHORTAGE (CAP)

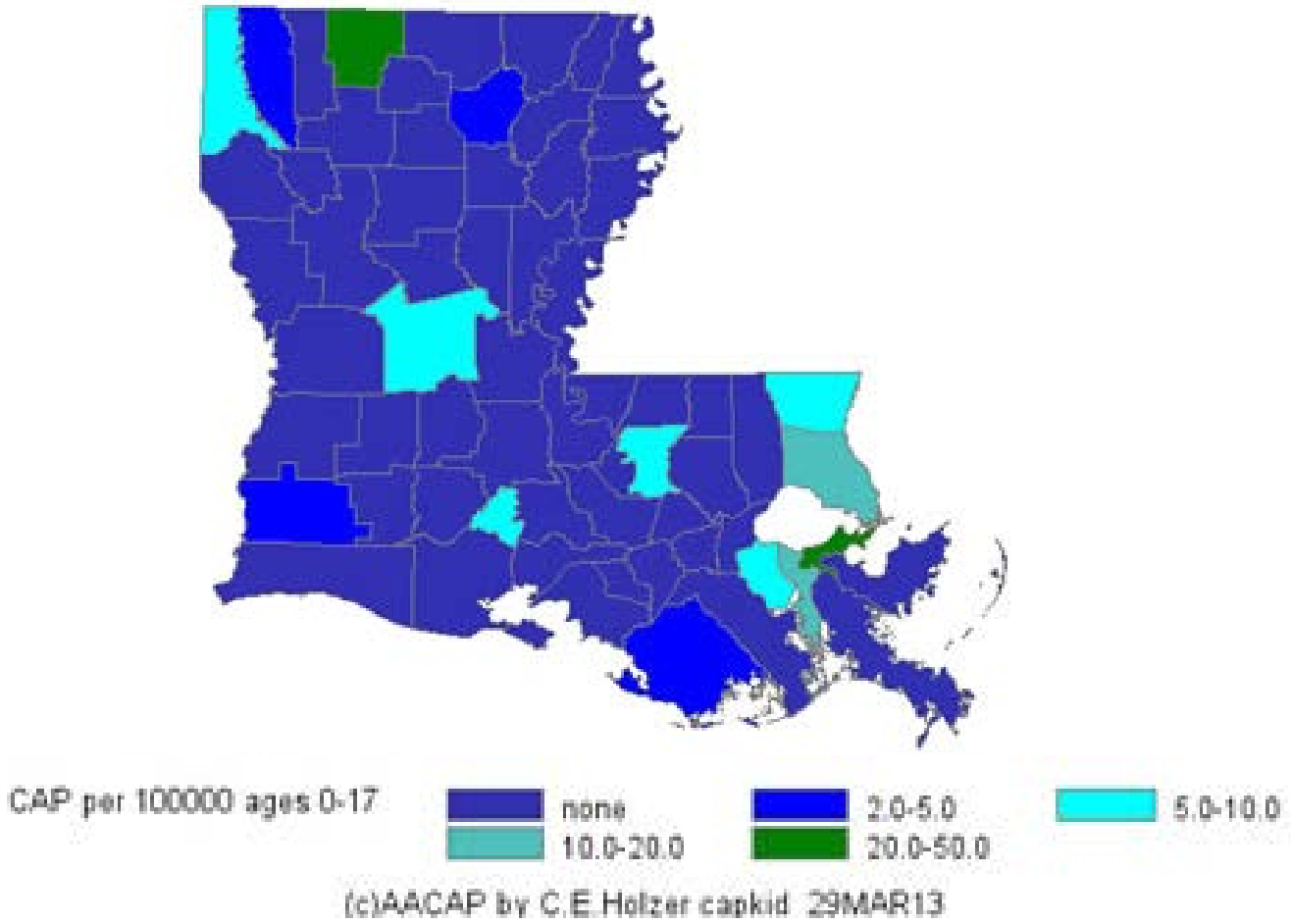
- Currently ~7000 child psychiatrists in US
- Estimated # to meet need = 30,000 (COGME)
- At current recruitment rates, 8,300 C.A.P.s by 2020
- Demand for C.A.P. service in U.S. will increase by 100% from 1995 to 2020 *(DHHS,2000)*
- Distribution
  - Massachusetts: 21.3 C.A.P.s/100,000 youth
  - Alaska: 3.1 C.A.P.s/100,000 youth
  - Louisiana 6.6 (#35)= 1 CAP/15,000 youth
  - U.S. Average: 8.7 C.A.P.s/100,000 youth *Thomas & Holzer, 2006*

US PRACTICING CAP PER 100,000 CHILDREN (2012)



http://www.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

LOUISIANA CHILD PSYCHIATRISTS (PER 100,000 CHILDREN)



MENTAL HEALTH ACCESS

- 1 in 4 children with a psychiatric disorder receive any treatment *(Jensen et al 2011)*
  - *5,250,000 children with untreated disorders in the U.S.*

THE STATUS QUO WAS NOT WORKING!

INNOVATIONS IN PEDIATRIC MENTAL HEALTH CARE

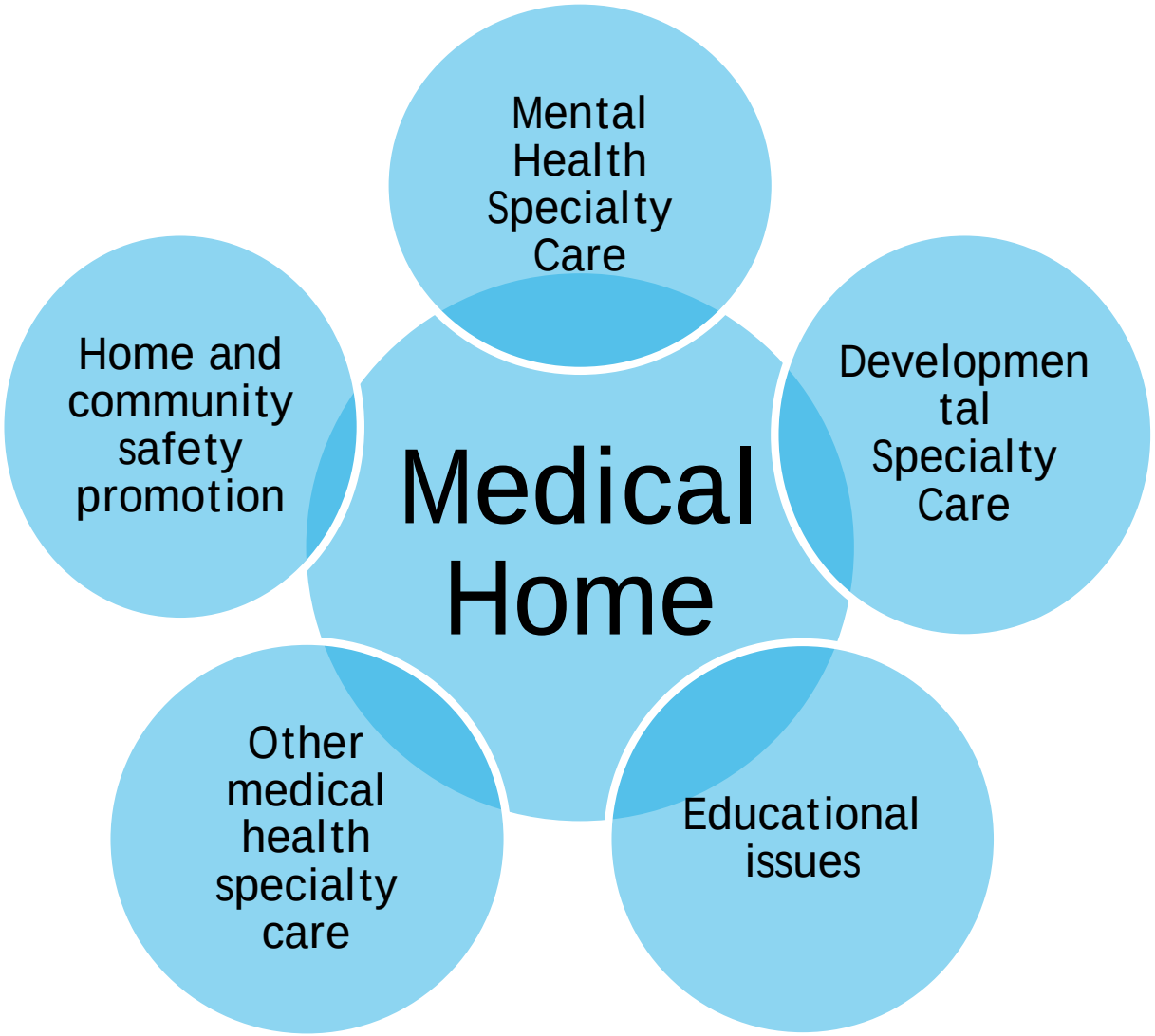
MEDICAL HOME MODEL

- Goal: Coordinate medical care
  - Maintain comprehensive medical record
  - Interpret, discuss and evaluate specialty recommendations
  - Reduce discontinuities, duplications
  - Enhances preventative function of primary care
- Unique medical care setting: longstanding relationship between MD and family (prenatal-college)
- Exposure to multiple family members, not just "identified patient"

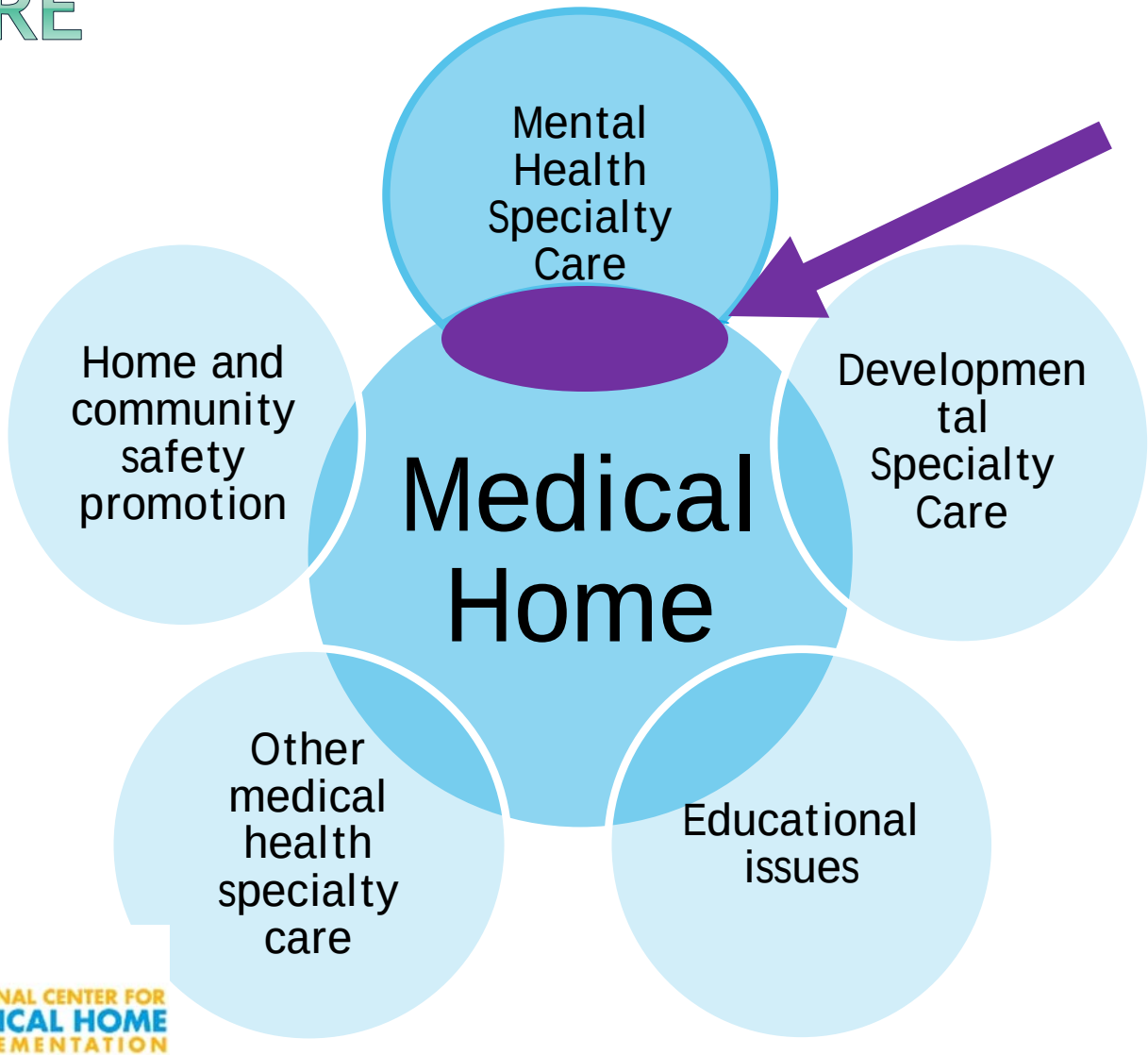
NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

A cooperative agreement between the Maternal and Child Health Bureau/HRSA and the American Academy of Pediatrics

MEDICAL HOME AS HUB FOR SYSTEM OF CARE



FILLING THE GAP BETWEEN PRIMARY CARE AND SPECIALTY MH CARE



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PEDIATRIC PROVIDER TRAINING MODELS

- Communication training
  - Motivational Interviewing skills
    - Does not increase time spent with patient in primary care
    - Is associated with decreased parental MH symptoms
    - Increases referral success
    - *Erikson (2005) Archives Ped Adol Med; Wissow 2009*
- Content training
  - REACH Institute psychopharmacology "fellowships" and supervision

APPROACHES TO INTEGRATED CARE

- Office-centered coordination
  - MH providers in the PCP office
  - High MH:PCP ratio
  - Co-location allows high level of informal collaboration
- Hub-based coordination
  - PCPs reach out to MH providers
  - MH serve multiple practices
  - Most interactions planned

OFFICE-BASED RATIONALE

- Expands capacity of the medical home
- Usually uses master's level mental health providers
- Does not require behavioral shifts by PCPs
- Increases access to evidence based psychotherapies

PARENT MANAGEMENT TRAINING IN PRIMARY CARE (PERRIN ET AL 2014)

- Study of effectiveness of Incredible Years Series Parenting group administered in the primary care setting for toddlers with disruptive behavior disorders
- 150 parents randomized to IYS vs. WLC
- Moderate baseline symptoms (ECBI ~60)
- Immediately post treatment, at 6 months, and at 12 months
  - ECBI scores: IYS < WL group
  - Observed interactions
    - No difference negative parenting or child disruptive behaviors
    - Negative parent-child interactions: IYS< WL

DISRUPTIVE BEHAVIOR DISORDERS DOCTOR OFFICE COLLABORATIVE CARE MODEL (KOLKO ET AL 2012)

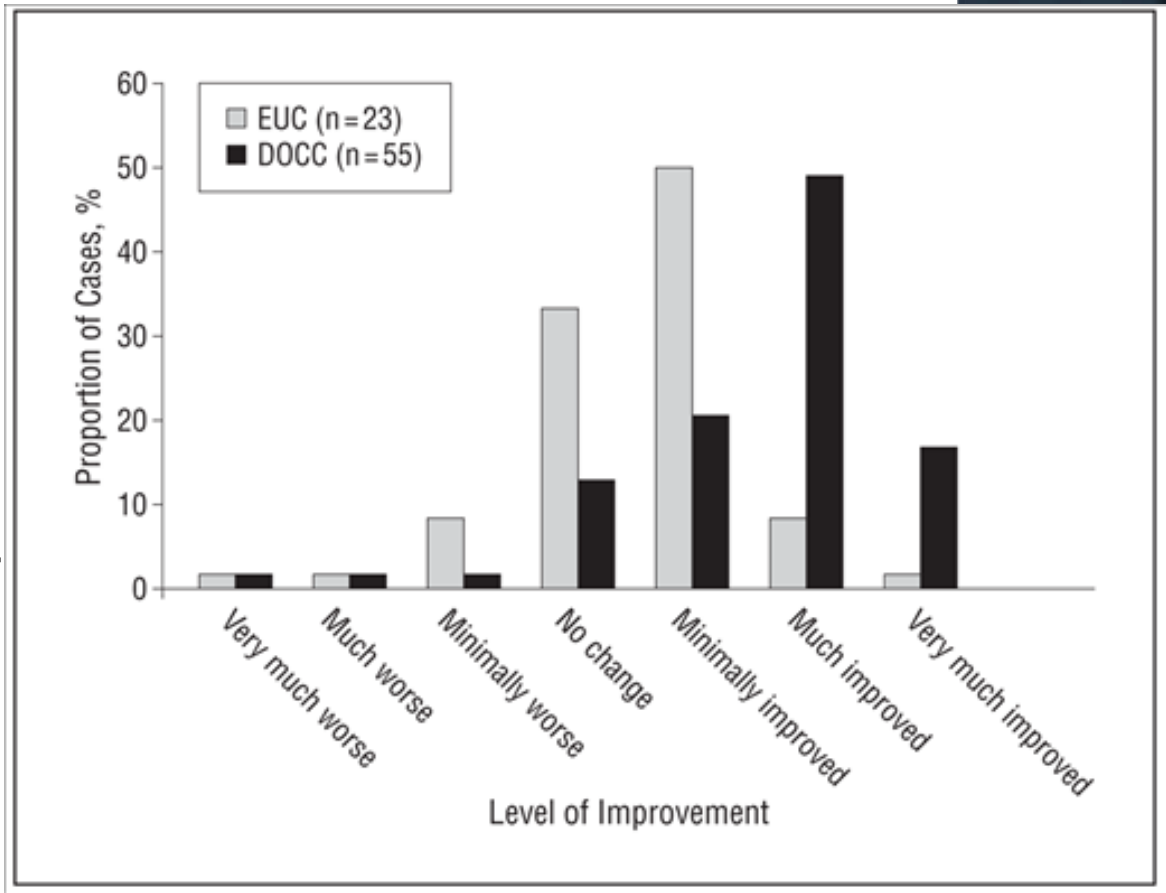
- DOCC vs enhanced care as usual for children with behavioral problems
  - (PSC behavioral subscale positive)
- 2:1 randomization (n=78)
- Enhanced care as usual
  - Psychoeducation
  - 3 referrals tailored to geography and child factors

DISRUPTIVE BEHAVIOR DISORDERS (2)

- DOCC intervention
  - Care manager (nurse, SW)
    - Face-face time with parent/child ≤ 12 hours over ≤ 6 months
    - Psychoeducation
    - School liaison/advocacy
    - Skills training in behavioral treatments (parent and child-focused)
    - care management coordination
    - Track progress/goal attainment weekly
  - CAP
    - Team leader
    - Consultation re complex diagnosis or medications
    - Train/supervise CM

DISRUPTIVE BEHAVIOR DISORDERS (3)

- Treatment completion
  - 78% DOCC vs 0% EUC
- Clinical outcomes (reduction in symptoms on VADRS)
  - ADHD: DOCC > EUC
  - Oppositional behavior DOCC > EUC
  - Conduct problems: DOCC= EUC
  - Anxiety/depression: DOCC = EUC



ADOLESCENT DEPRESSION
ASARNOW ET AL. (2005)

- 13-21 year-old from 6 sites.
- 418 randomized:
  - Quality improvement (QI) vs care as usual (CAU)211 to
- QI
  - on-site care manager (PhD, RN, Therapist)
  - managers trained in CBT
  - free evaluation
  - Treatment plan not constrained
- CAU
  - training
  - educational handouts

ADOLESCENT DEPRESSION (2)

- Depression*
  - QI: 18 vs CAU: 21.4 (OR=2.9)
- Medication rates: QI=CAU
- Mental health care rates
  - QI 32% vs CAU 17%
- Suicidal ideation/attempts
  - No difference

ACCESS AND CONSULTATION PROGRAMS

- "Hub"-based (vs practice-based) approaches to collaborative care
- Rationale
  - Unmitigated work force shortage
  - Impacts more than 1 practice
  - Geographic distances/rural areas
  - Enhancing PCP capacity rather than replacing
  - Often medication-focused/related to drug utilization procedures

FORMS OF CONSULTATION

- Web-based resources
  - In-service trainings
    - Indirect consultation

      (PCP discusses question with consultant)
    - Direct consultation

      (PCP asks consultant to assess patient to answer specific question)

MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT (MCPAP)

- Child psychiatrist, social worker/psychologist, and a care coordinator= regional team
- Available during working hours
- 75% indirect (not seeing patient) or resource questions
- Associated with decreased access barriers, increased sense of competence, high satisfaction (*Sarvet et al 2010)*

MCPAP FUNDING SYSTEM

- Initially funded directly by Medicaid
- Now supported by public and private third party payers

WASHINGTON PARTNERSHIP ACCESS LINE

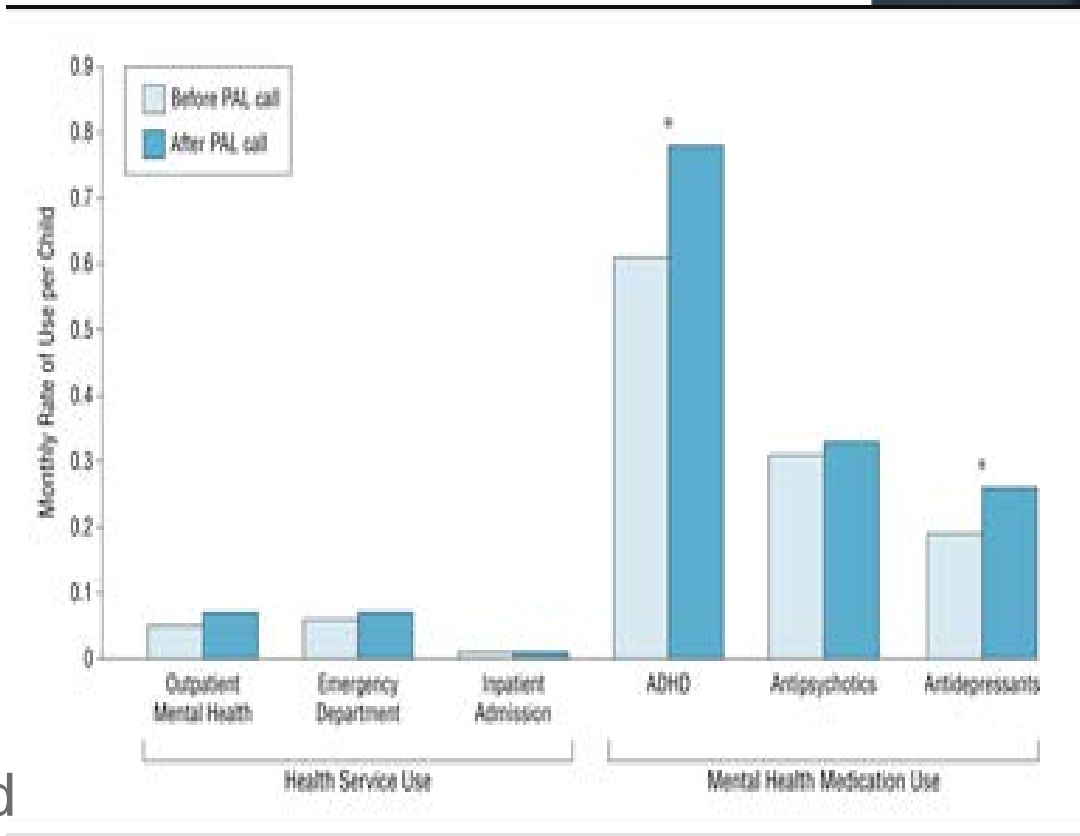
- Developed as part of mandatory drug utilization reviews
- Offers voluntary child psychiatry consultation to PCPs
- Provides in-service training
- Provides phone consultation (indirect)
- (Now offer direct consultation in select geographic areas)

PAL (2) (Hilt et al 2013)

- Consult requests: 2285 phone consults in 37 month period
  - 58% questions about medications
  - 89% of children had not seen a mental health provider in last year
  - 30% repeat calls
- Provisional diagnoses
  - ADHD> Anxiety = DBD > Depression > ASD
- High Provider Satisfaction (46% response rate): 4.6 (0-5)
  - “PAL helps me to increase my own skills in the mental health care of my patients” (4.6)
  - “PAL helped me to manage my patient’s care” (4.7)

PAL HEALTH SERVICE USE (MEDICAID)

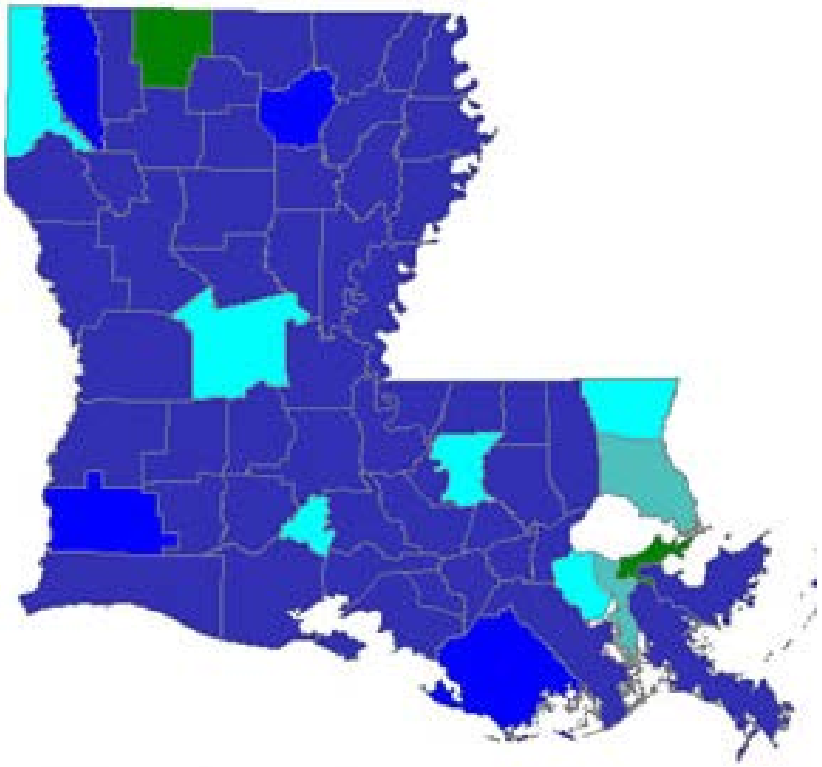
- Medication recommendations
  - More increases than decreases
- Psychosocial recommendations
  - In nearly every case
- Claims data
  - Increased outpatient care for children in foster care
  - No change in cost overall, despite some increase in prescriptions for ADHD and SSIR



MARYLAND PEER CONSULTATION

- Mandatory peer consultation for children on Medicaid
- Started with off-label use of AAA's for children under 6
- Expanded up to off-label uses for children under 18
- MD is required to provide diagnosis, labs, height, weight as part of PA
- Associated with fewer preschool prescriptions
- (Personal communication, G. Reeves MD 2014)

LOUISIANA



- Large geographical area
- Population spread out
- Substantial expertise in early childhood
- One of 8 states with program training residents in “triple board”
- Very limited work force
- Administrative integration of mental health into physical health MCO
- High rates of medication use (ADHD)
- High rates children in poverty

WHAT KIND OF INTEGRATION FOR LOUISIANA?

- Complex clinical situations call for evidence-based therapies

- Work force:patient ratio requires hub based
- High rates of medication use suggests need for psychopharmacologic consultation
- 5 MCOs

Practiced based	Hub-based

CONSULTATION MODEL

- Why consultation?
  - Insufficient numbers of trained IMH professionals around the state
  - With guidance, PCPs and general mental health providers can implement basic behavioral strategies
  - Good assessment can help families advocate for necessary services
  - With partnership and support , providers in isolated areas can learn basic assessment skills, be familiar with recommended treatment approaches, and recognize their scope of practice

LOUISIANA PRIMARY CARE CONSULTATION PROJECTS

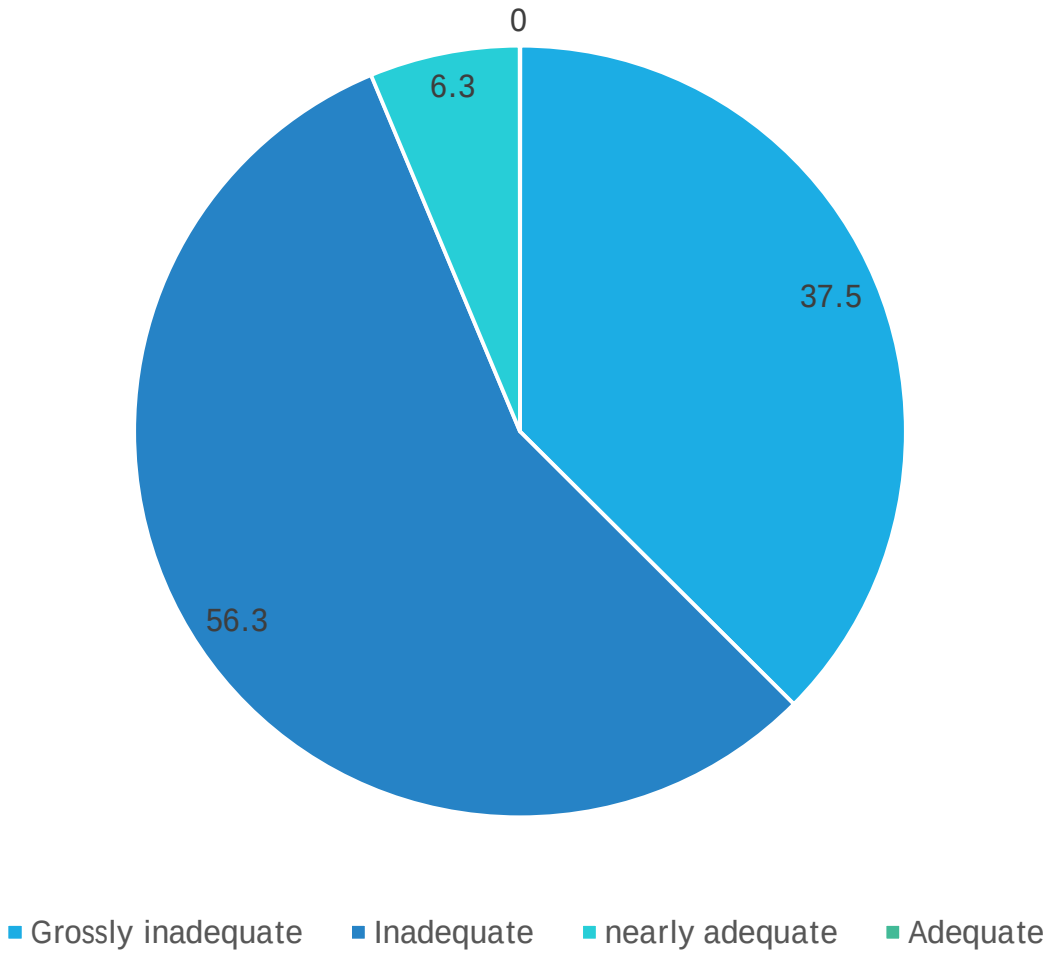
- Gulf Coast Consultation in Child and Adolescent Psychiatry
  - Consultation to primary care 2008-2010
  - Oil-spill affected areas
- Mental and Behavioral Health Capacity Program
  - Onsite and telepsych support in primary care and schools
  - Oil-spill affected areas
- Project LAUNCH
  - Consultation to primary care, Early Steps, and child care
  - Lafayette, Acadia, Vermillion
- Tulane Early Childhood Collaborative
  - Consultation to primary care
  - Orleans, Jefferson, St Bernard, Plaquemines, St Tammany

LOUISIANA PROJECTS

- All focused on expanding capacity of front line child professionals and child-serving agencies
  - Primary care providers
  - School health and mental health providers
  - School/early educators
  - Early Steps professionals
- All collecting data
- Slightly different models and targets of consultation
- All using grant funding

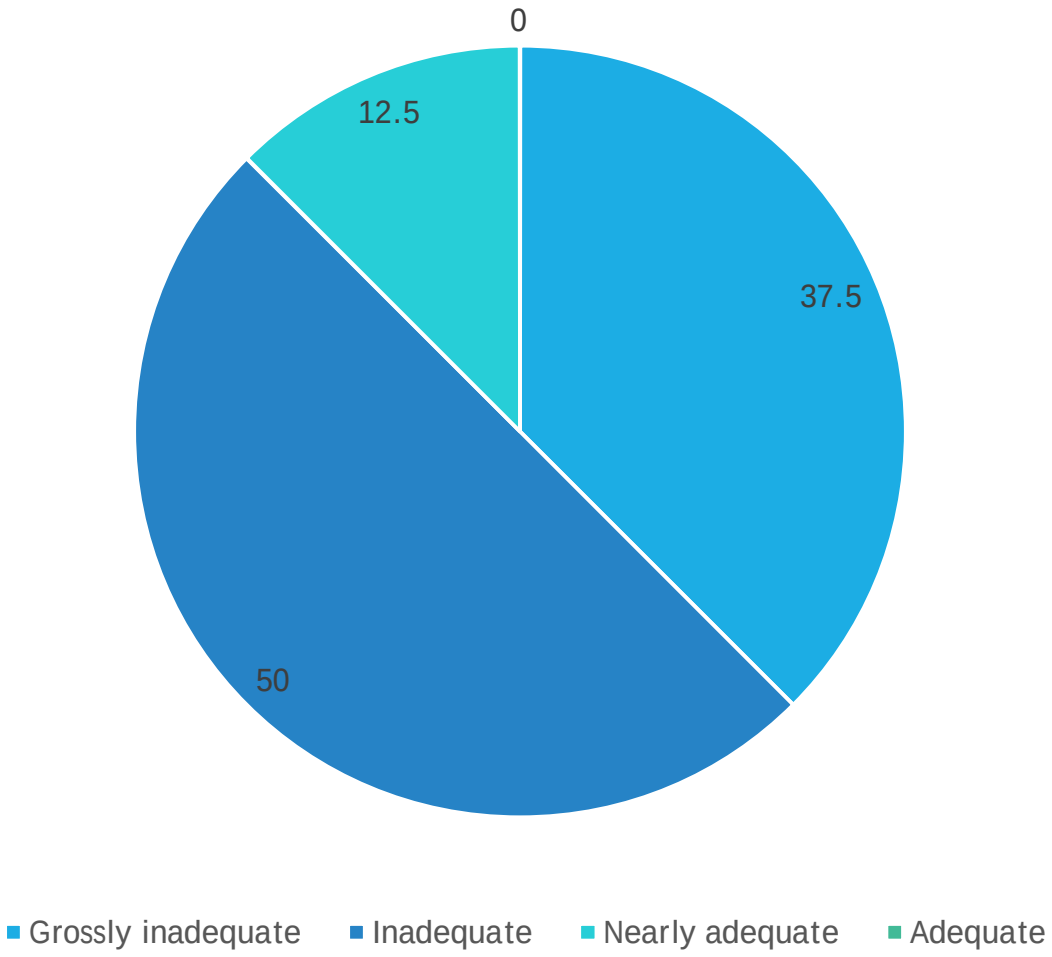
CAVEAT: PRELIMINARY INFORMATION FROM PCPS

ACCESS TO MENTAL HEALTH PROVIDERS FOR CHILDREN

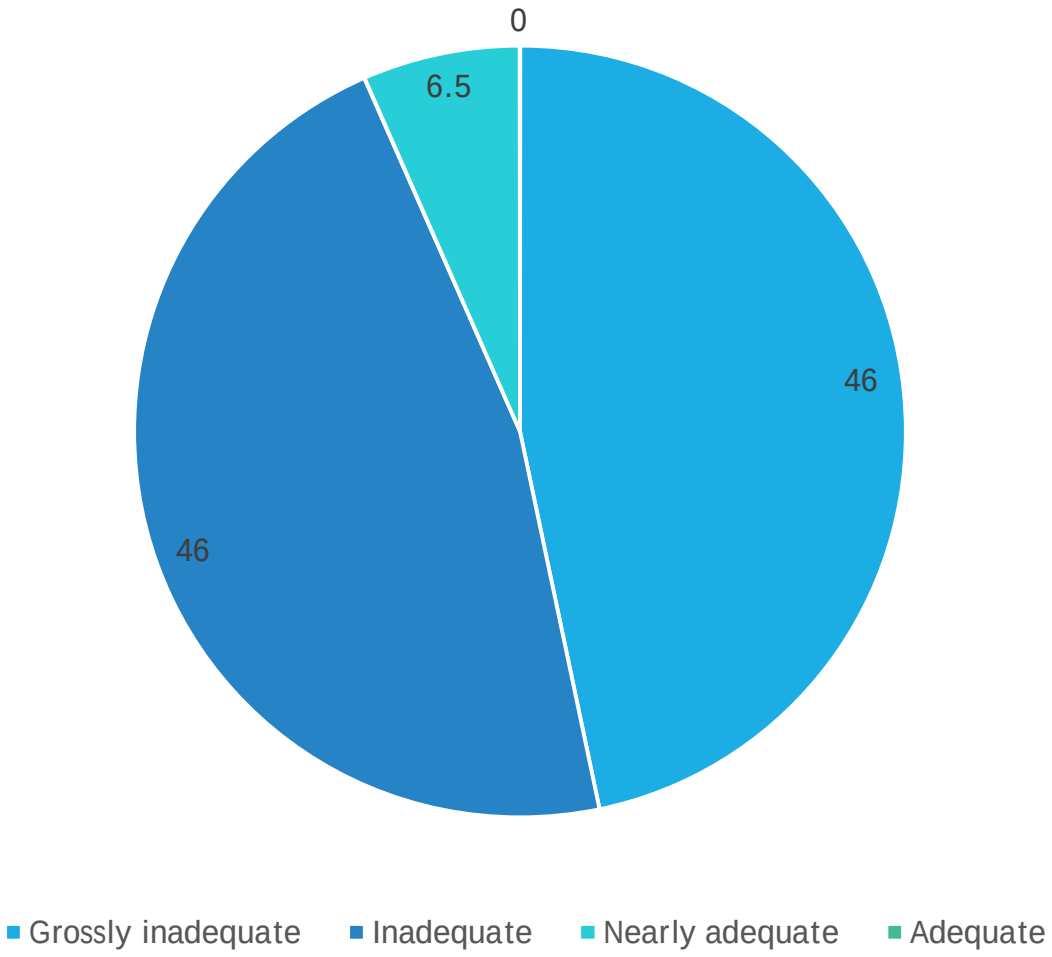


TECC unpublished data 2015

ACCESS MENTAL HEALTH SERVICES FOR YOUNG CHILDREN



ACCESS CASE MANAGEMENT AROUND MENTAL HEALTH NEEDS



PROJECT LAUNCH MENTAL HEALTH CONSULTATION

- Going where the children are
- Primary care
  - Pediatrics, Family Practice, OB
- Child care
  - Center based
  - Home based
- Early Steps
  - High needs

CONSULTATION LAUNCH-STYLE

- Hub-style components
  - Web-based resources
    - Decision making guides
    - Parent handouts
  - Consultation without seeing patient (assessment, management, resources)
    - Phone
    - Secure email
  - Full evaluation appointments
- Office-based components
  - Lunch ‘n learn sessions
  - Curbside consultation without seeing patient
  - Brief consultation appointments

WEB-SITE RESOURCES: TULANE.EDU\SOM\TECC

Provider Resources

Screens for Early Childhood Mental Health Problems

Infants (0-18 months)

- Baby Pediatric Symptom Checklist and Scoring Guide

Child's Family and Environment

- Parental Depression
  - Patient Health Questionnaire-2 (PHQ-2)
  - Edinburgh Postnatal Depression Scale (EPDS)
- Clinical Information
  - Maternal Depression Screening, Olson (2006) Pediatrics
- Environmental Safety
  - Safe Environment for Every Kid (SEEK)

Toddlers/Preschoolers (18-60 months)

- Early Childhood Screening Assessment (18-60 months)
  - ECSA Screen
  - ECSA Spanish
  - ECSA Scoring Guide
  - ECSA Manual
- Preschool Pediatric Symptoms Checklist
  - Preschool PSC
  - Spanish Version
  - PPSC Scoring Guide

TECC Forms

Early Childhood Science & Policy

Parent Resources

Child Development by Age

Topics That Affect All Families

Early Childhood Problems for Parents

Managing Difficult Behaviors

Parent Support-Taking Care of Yourself

TULANE.EDU\SOM\TECC

Child Development By Age - Learn about your child's development from birth to 5 years old.

Topics that Affect All Families

- Childcare Safety Checklist
- Toilet Training Tips
- Developmental Principles Guiding Feeding Practices
- Social-Emotional Health Tips
- Screening Passport for Parents-Birth to 5
- Early Learning Handout
- Early Education
- Developmental Screening Fact Sheet

Early Childhood Problems for Parents

- Feeding Problems in Infants & Children
- Intellectual Disability
- Asperger Syndrome
- Sleep Challenges
- Shyness
- Separation Anxiety
- Preschool Defiance
- Preschool Aggression
- Colic
- Autism
- ADHD

Managing Difficult Behaviors

- Using Rewards
- Fighting Aggression
- Special Playtime
- Tantrums

Parent Support - Taking Care of Yourself

- Breathing for Parents
- Active Relaxation
- Learning to Relax

Parent Resources

- Child Development by Age
- Topics That Affect All Families
- Early Childhood Problems for Parents
- Managing Difficult Behaviors
- Parent Support-Taking Care of Yourself

EXAMPLES OF INDIRECT CONSULTATION

- "I have a patient with ADHD and who seems really anxious and screened positive with the SCARED. What is the best treatment for him?
- Just met a new adoptive mother of a 4 year old. Things are going well so far, but wat kind of advice can we give her?
- A mother at a 2 week postpartum visit screened positive for depression. She has a history of depression and wants to continue breastfeeding. What is the best SSRI? She did well with sertraline in the past.

MORE EXTENSIVE EVALUATIONS

- *"What do you do for a 6 year old who is hearing voices?"*
- *"A mother of 40 month old twins seems overwhelmed. In the office, the children always cause damage and try to break things"*
- *" Can you see an 5 year old girl with developmental delays and anxiety? I'm wondering about autism."*
- *'A patient has adopted twin 4 year old girls from Romania. They are both deaf and we're wondering about autism"*
- *57 month old girl- impulsive, hyperactive, bites brother, uncontrollable, as an infant, would not let parents console her"*
- *"42 month old running in the street at night. Referred by CSOC because of safety concerns. Has tried to burn house down."*
- *"33 month old boy with chromosomal anomaly, parents with developmental delays, and extreme aggression including throwing knives at people"*

LUNCH N' LEARNS

- ADHD
- Attachment in the primary care setting
- Motivating positive behaviors
- Parental mental health issues
- ACES and toxic stress
- Screens and measures for primary care

CURBSIDE CONSULTS

- “This 9 month old baby came in for a well-child visit today. Mother said that the baby has lots of trouble sleeping… can you talk with her?”
- “I asked this 7 year old to come in today. I’ve been treating for ADHD but he’s not getting better”
- “This 4 year old stopped talking when he heard about shots and has run out of the room 3 times. Can you help us?”
- This mother of a 6 year old is worried about his behavior at home but not at school. I am thinking about trauma-exposure because he hits his mother here in the office. How can I assess this? Is there a measure I can use to start clarifying this?”
- “I’m really overwhelmed when I hear about abuse and violence. I don’t want to avoid it, but sometimes I do”

PRINCIPLES OF CONSULTATION

- Consultation is to the provider
- Validate strengths in existing approaches
- Tailor consult to the question
- Promote
  - Use of validated measures for screening
  - Attention to symptoms and context
    - Symptom screens
    - Environmental screen for ACES
  - Strengths-based approach
  - Attention to parent-child relationships
  - Common factors approach to mental health concerns

PRINCIPLES OF CONSULTATION (2)

- Offer
  - Consistent recommendations that are generalizable
  - Guidance about tracking symptoms/how to know when it moves beyond primary care level
  - Recommendations for providers primarily, but also parents and schools when appropriate
  - Behavioral interventions always
  - Psychopharmacologic approaches when appropriate
  - Detailed, step-by-step recommendations
  - Support for PCP self-care and self-awareness

FACE-FACE CONSULTATION REPORTS

- Summary of the history and measures
  - IN ENGLISH
- Summary of the assessment/formulation
  - Biological factors (protective or risk)
  - Psychological patterns
  - Social factors
  - Strengths
- Recommendations
  - For primary care provider (detailed!)
  - For parent
  - For educational setting
  - Handouts from reputable sources

ANECDOTAL OUTCOMES

- PCP thinking about trauma and context in every case of behavioral/emotional concerns
- Using measures before in-person consultation requests
- Use of handouts with consistent messaging
- Families connected to existing social supports
- Children accessing diagnoses that avail them of evidence-based treatments

FEEDBACK

- “it helps to know there is someone to call”
- “I have treated children I wouldn’t have felt comfortable treating”
- “Knowing that you will see children in a short time helps”
- “I can manage some of this once I know what is going on”

GCAP Follow up 2013

LESSONS LEARNED AND HIGHLIGHTED

- Relationships matter!
- PCPs are managing high level of acuity every day
- Wide range of comfort levels related to mental health in primary care
- Sometimes small consultation interventions make substantial difference
- Coordination among child-serving providers reduces family distress

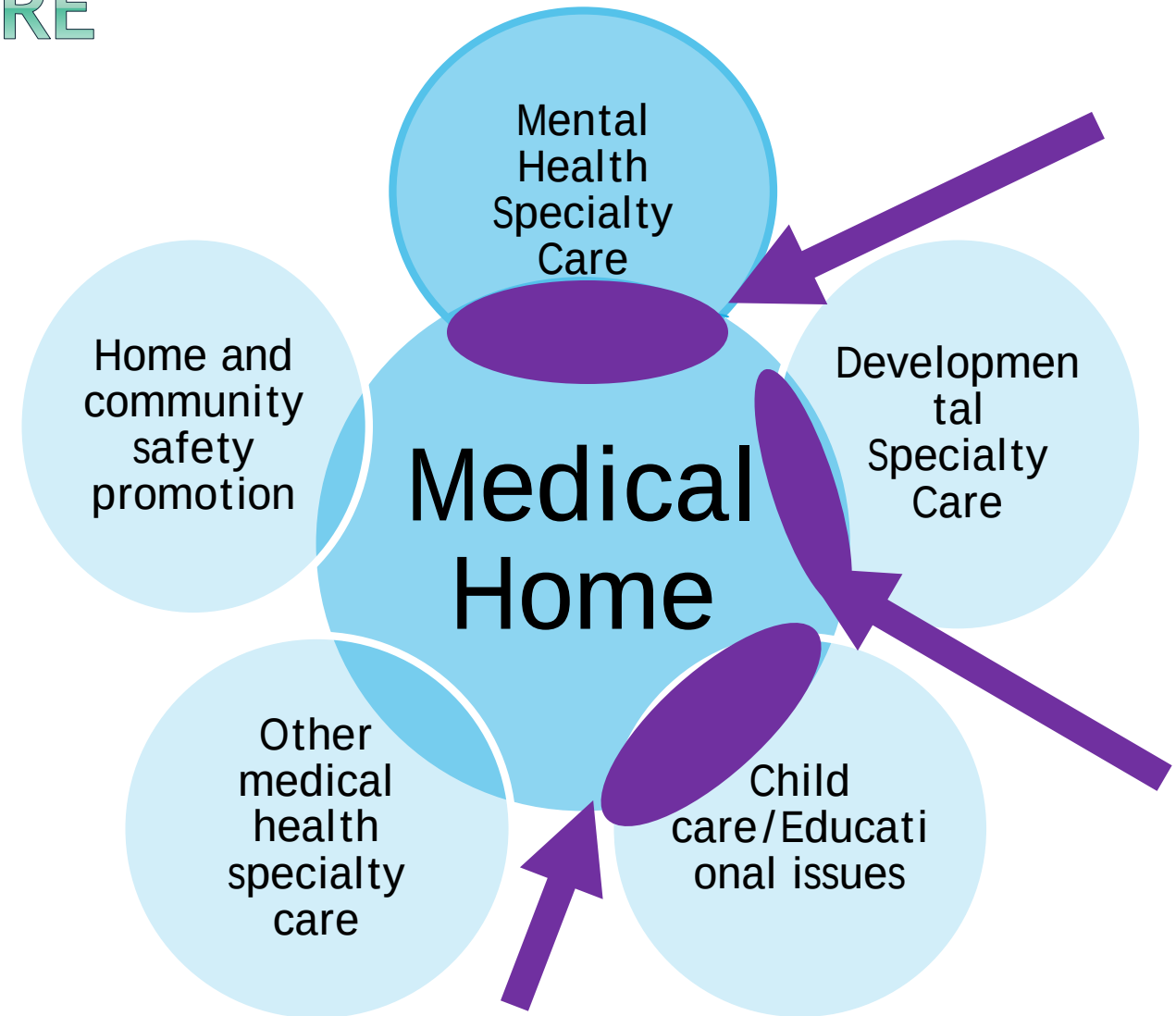
PROJECT LAUNCH

- Promote the program promotes the health and well-being of children from birth to age 8
  - Improve coordination
  - Build infrastructure
  - Improve methods for providing services

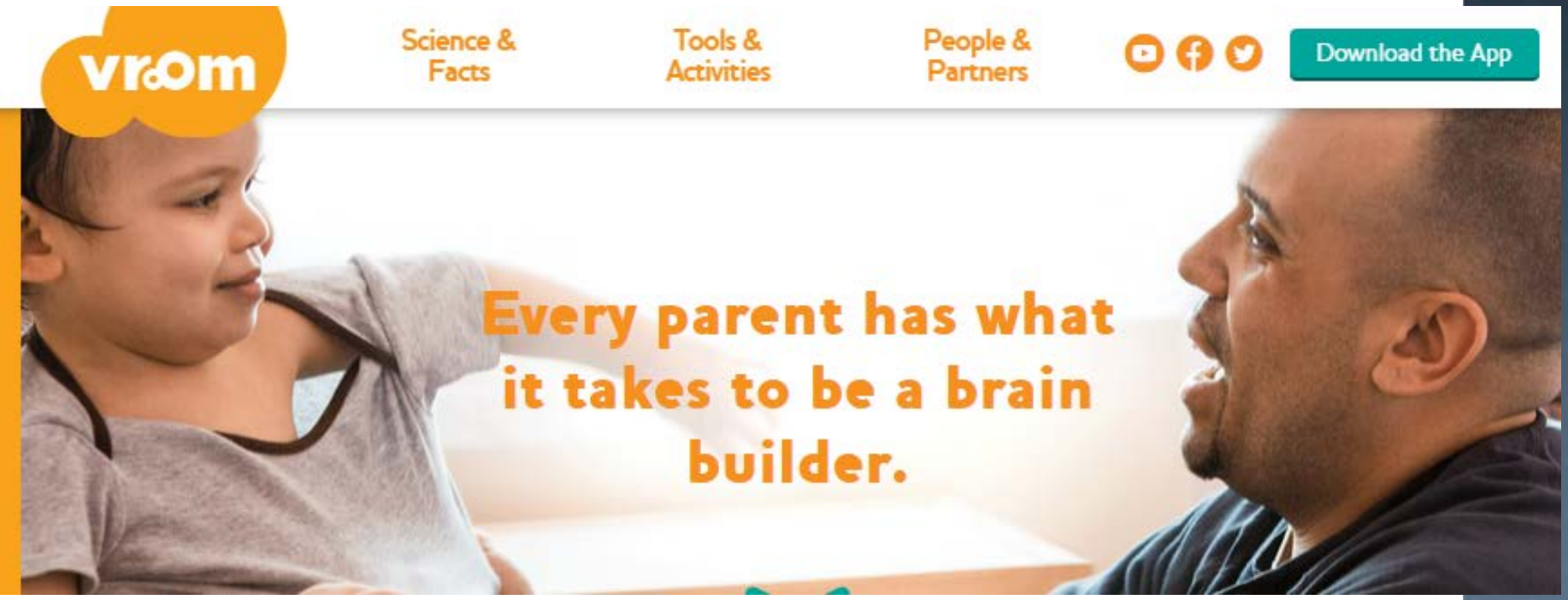
MENTAL HEALTH CONSULTATION

- …where the children are
- Primary care
  - Pediatrics, Family Practice, OB
- Child care
  - Center based
  - Home based
- Early Steps

FILLING THE GAP BETWEEN PRIMARY CARE AND SPECIALTY MH CARE



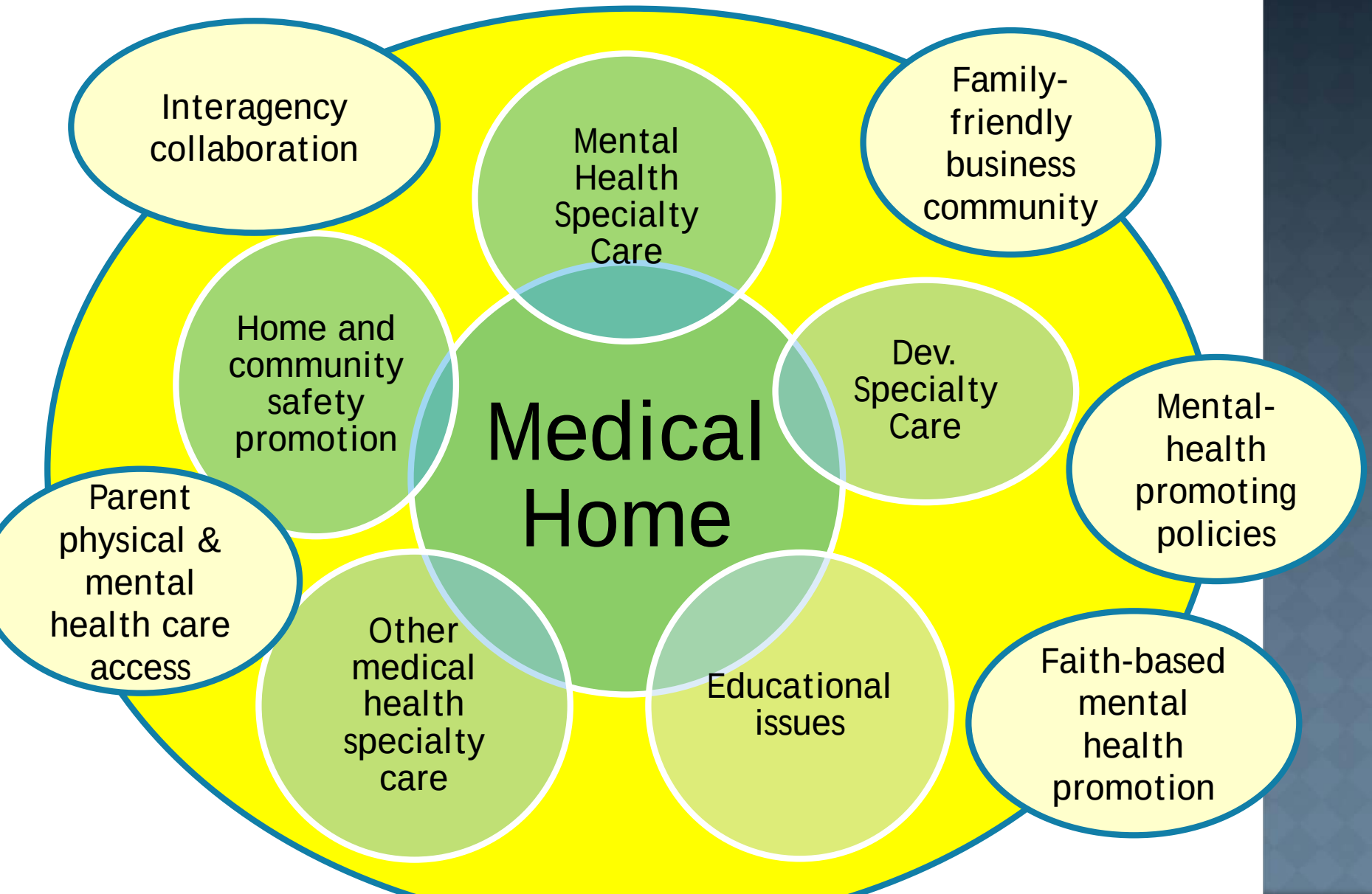
COMMUNITY MESSAGING



COMMUNITY MENTAL HEALTH PROMOTION

- Local and state-level advisory boards
- Increase interagency collaboration
- Identify strengths and areas for growth in mental health promotion

CHILD-HEALTHY COMMUNITY



SUMMARY

- Children's health includes physical, mental, and relationship components
- Primary care providers are trusted child health professionals
- Mental health providers can support medical homes in promoting well-being and providing first line interventions
- Louisiana will benefit from hybrid access model
- Project LAUNCH offers a model of comprehensive health and well-being promotion