Integrating Pediatric Primary Care and Behavioral Health Care

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Objectives

Participants will be able to...

1. Describe history and components associated with integration of primary care and behavioral health services;

2. Describe promising practices of state health agencies and local health departments to integrate primary care and behavioral health services;

3. List outcomes of the integration of public health, primary care, and mental health services; and

Definitions

- Integration
- Co-location
- Reverse co-location
- Collaboration
- Mental health
- Behavioral health
- Primary care providers (PCPs)
- Medical home
Epidemiology of pediatric mental health disorders, problems, & concerns

- 9.5-14.2% of children birth to 5 have S-E problems interfering with functioning
- 16% (++) of children and adolescents in the U.S. have impaired MH functioning and do not meet criteria for a disorder
- 13% of school-aged, 10% of preschool children with normal functioning have parents with “concerns”
- 50% of adults in U.S. with MH disorders had symptoms by the age of 14 years
- 21% of children and adolescents in the U.S. meet diagnostic criteria for MH disorder with impaired functioning
MH problems in children with chronic illness: hidden morbidity

- Children with chronic illness 2X more likely to have psychosocial dysfunction
- Parental depression increases the likelihood that child with chronic illness will have psychosocial dysfunction
- Children with MH problems (and their parents) are higher users of healthcare services in general (eg, ED use)
Service gaps

- >20% of children/youth have mental disorder
  - 20%-25% receive treatment
  - 40%-50% terminate services prematurely
  Factors: lack of access, transportation, finances, stigma
- Minority children disproportionately lack access
- Minority children less likely to receive e-b treatment
- Chronically under-funded public mental health (MH) system focuses on individuals with severe impairment
- Little support for prevention or services to children with emerging or mild/moderate conditions
Workforce issues

- Insufficient #s of child MH specialists, especially, child psychiatrists and providers of services to young children
- Administrative barriers in insurance plans limit access to existing providers
- Many forces leading families to seek help for MH problems in primary care and schools
History

- Medical home, “new morbidities” (1960’s)
- Healthy People 2010>>>>> mental health as a public health issue (2000)
- President’s New Freedom Commission on Mental Health (2003)
AAP response:
the Mental Health Task Force
2004-2010

Charge: assist pediatric primary care clinicians in enhancing their mental health practice.
Advantages/potential roles of primary care setting in BH

- Longitudinal, trusting relationship
- Prevention
- Early identification / screening
- Early intervention / engagement
- Diagnostic assessment
- Specific treatment
- Referral / collaborative care (with BH professionals)
- Monitoring progress in care
- Care coordination (as for other CYSHCN)
Barriers to integrating BH care into primary care settings: clinician perspective

- Ambivalence / variability / boundary issues
- Discomfort
- Time constraints
- Poor payment
- Unfamiliarity with existing MH / SA resources
- Variable access to BH specialty resources / pressures to prescribe
- Limited information exchange with BH specialists
Children and families’ perspective

- Stigma
- Frequency/impact of adverse childhood experiences (ACE)
- Barriers to help-seeking / access (especially for minority families)
- Low health literacy
- Lack of parenting resources
- Parent MH/SA needs
- Role of faith-based organizations
Challenges in systems / financing

- Need for new training models (primary care and BH)
- Limited MH / SA referral sources
- Poor communication between primary care and BH systems: “silo” mentality
- Disconnect between primary care & agencies involved in BH care (schools, juvenile justice, social services)
- Omission of primary care from BH care coordination systems
Challenges (continued)

- MH system reform: targeting of public services to the severely ill, frequent changes
- Procedural requirements of public and private MH programs (impact on relationships)
- Non-parity of MH benefits in insurance plans
- Adolescent-specific issues: denial, confidentiality...
- Lack of payment to any providers for treating undiagnosed (& undiagnosable) MH problems
- Lack of payment to PCPs for treating MH disorders
TFMH activities / publications

- Chapter Action Kit / funding of 5 chapter projects
- “Peds 21” symposium: common factors
- Paper on administrative and financial barriers (Peds, April, 2009) + advocacy successes
- MH competencies policy statement (Peds, July, 2009) + numerous educational programs
- Supplement (Peds, June, 2010), including algorithms
- Toolkit (June, 2010)
Promising practices: new models of care

- Population perspective / public health principles used in activating communities
- Integration of BH into preventive visits and acute care
- Routine psychosocial screening (child and parent) -- increases the rate of detection and BH treatment and improves BH outcomes
- New applications of technology
- Application of “common factors” and “common elements” approaches to undifferentiated problems
- Brief BH visits
New models of care (continued)

- Application of chronic care model to primary care
- New roles of staff within primary care
- Collaborative arrangements with community-based BH / developmental specialists
- Co-location of BH specialist(s) in primary care
- Integration of a BH specialist(s) in primary care
- Child psychiatry consultation by telephone, telemedicine, face-to-face
- “Reverse co-location” (primary care in BH practice)
Provide anticipatory guidance for age per Bright Futures, Connected Kids, or KySS Concerns (symptoms, functional impairment, risk behaviors, perceived problems)?

No

A10a

Emergency?

Yes

A8a

Facilitate referral for specialty services or emergency facility; re-enter algorithm at appropriate point (or A1a).

No

A9a

A6a

Further diagnostic assessment needed?

No

A10a

Yes

A11a

Provide initial intervention; facilitate referral of family member for specialty services, if indicated.

A5a

Concerns (symptoms, functional impairment, risk behaviors, perceived problems)?

Yes

A8a

A12a

Collect and review data from collateral sources

A7a

Return to routine health supervision

A13a

Proceed to Algorithm B
Common symptom clusters

- Inattention and impulsivity
- Depression
- Anxiety
- Disruptive behavior and aggression
- Substance use
- Learning difficulties
- Symptoms of social-emotional problems in children birth to 5
Promising practices: 
NC’s State Employee Health Plan

1992 - NC introduced into the SHP full coverage parity of MH and non-MH conditions:

- Single insurance deductible
- Full freedom of choice of MH providers
- Only moderate management of generous benefits through a contract with Value Behavioral Health
NC’s State Employee Health Plan: 1998 results

- MH payments as a percentage of total health payments decreased from 6.4% to 3.1%.
- MH hospital days decreased by 70%.
- Actual PMPM cost for MH benefits (including administrative overhead) went from $5.43 in fiscal year 1990 to $4.11 in fiscal year 1998.
- Actual utilization patterns remained constant and modest: 6% to 7% of enrollees sought outpatient services per year; half went for only 3 to 4 sessions, three-fourths completed treatment within 11 to 13 sessions; utilization >26 visits remained constant and low (0.40%–0.75%).
Promising practices: NC Medicaid

- Community Care of North Carolina (1998...)
- NC Medicaid / mental health changes (2000-2003)
  - 26 unmanaged visits / PCP authorization
  - 6 visits without diagnosis
  - New categories of providers / service sites / incident to
- Growth of integrated primary care-mental health models (2003-present)
Integrated models compared with usual care, from case reports

- Greater likelihood of consultation and referral
- Improved HEDIS indicators for depression
- Lower utilization of MH specialty services, lower overall costs per patient, lower ED use, lower hospital admissions
- Cost-neutrality, lower psychiatric in-patient admissions and length of stay, lower medical in-patient length of stay
- Greater convenience to families, comfort of families, immediacy of services, access to psychiatry consultation; increased satisfaction, comfort, perceived quality of care by medical providers; improved “buy-in” of families; improved continuity of services for children and families
Roles for the public health community....
Provide the population perspective

- Publicize MH trends
- Identify and address risk factors for childhood mental illness
- Identify and enhance protective factors
Expand partnerships

- Consumers (e.g., NAMI, Federation of Families)
- Professional associations of MH providers
- Academic pediatricians and psychiatrists
- Area Health Education Center
- Primary care clinicians (peds, fam med, NP, PA)
- Early Intervention system
- State department of ed / local school systems
- Juvenile Justice / DSS
- Medicaid / SCHIP agencies
- Insurers
Increase collaboration and coordination across “silos”

Examples:
- Community protocols (e.g., psychiatric emergencies, ADHD)
- MH resource guide
- Mixers
- System of Care
- Pediatric managed care “councils”
- Mental health / school health committee
- Forms / exchange of information / clarification of consent and HIPAA regs
- Team supporting integration models
Family-centered community-based system of services for children and youth

Champion the cause of prevention

Examples:
- Bright Futures
- Nurse-family Partnership (Olds model)
- Evidence-based parenting programs
- Environmental health (lead, mercury...)
- Healthy lifestyles (nutrition, physical activity, stress management, sleep...)
Improve early identification

Examples:

- MH screening at all ages
- Warning signs (child and family)
- Training of school / public health personnel
- Child care training / consultation
- Transition from EI program
- Referral assistance
Incorporate MH services / perspective into public health programs

- Disaster preparedness
- Child care consultation
- School Health (!!!)
- Maternity care coordination
- High risk obstetric clinics
- Child service coordination
Educate public

Examples:

- Parent education (anticipatory guidance, building resilience, early signs of distress)
- Public campaign addressing stigma, promoting primary care as resource
Advocate for resources and system changes

Examples:

- Fully implement insurance parity & healthcare reforms
- Subsidize child psychiatrists (e.g., consultation network)
- Incorporate MH care coordination into ECCS (Early Childhood Comprehensive Services) early childhood health plan
- Forge links between programs for at-risk families and PCPs
- Support funding of public MH system
- Participate in child and family advisory committees
- Support school-based MH programs
- Support peer-to-peer services
Foster policies favorable to MH integration

Examples:
- Bright Futures implementation
- Incentives for co-location / integration
- PCP involvement in System of Care, reform
- Communication, screening standards
- Payment for all facets of mental health care
Medicaid policies that foster MH integration

- Generally enhanced reimbursement for MH/SA services
- Payment for visits not resulting in a diagnostic code (i.e., screening, testing, multi-visit assessment)
- Unmanaged visits (e.g., up to 26)
- “Incident to” rule changes (supervision requirements, site restrictions, limitations on certain disciplines), creating economic incentive for co-location
Medicaid policies (continued)

- Direct enrollment of BH providers
- Payment for new categories of BH professionals and peer specialists
- Addressing systems issues in state BH system (patient access, referrals, collaborative practice)
- Enhancements in locations of service (e.g., school-based services, health departments)
Medicaid policies (continued)

- Enhancement in care coordination system / linkage to other care coordination systems
- Enhanced payment for physicians with advanced credentials (e.g., developmental-behavioral peds)
- Payment for non-face-to-face services, including consultation and team meetings
- Communication between MH specialist and primary care clinician as an expectation / standard
Monitor impact of changes

- Participating MH providers
- Claims data / Medicaid & SCHIP
- Youth Risk Behavior Survey
- Persons receiving MH services by race / ethnicity
- Abuse / neglect rates; out-of-home placements
- Educational outcomes (drop-out, suspension, graduation rate)
- Juvenile crime rate
- Injuries
- Consumer / provider opinion
References for outcomes


AAP publications


AAP Website:
www.aap.org/mentalhealth

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