Overview of Pediatrics teleECHO and the AACAP Objectives

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## Disclosures of Potential Conflicts

<table>
<thead>
<tr>
<th>Source</th>
<th>Research Funding</th>
<th>Advisor/Consultant</th>
<th>Employee</th>
<th>Speakers’ Bureau</th>
<th>Books, Intellectual Property</th>
<th>In-kind Services (example: travel)</th>
<th>Stock or Equity</th>
<th>Honorarium or expenses for this presentation or meeting</th>
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**No conflicts of interest or disclosures**
Basic Issues

- 75% of children and adolescents with psychiatric disorder are seen in the pediatrician’s office
- Shortages in child mental health professionals with distribution problems (urban versus rural)
- Increase the integration of child and adolescent psychiatric services into primary care practices
- Development of partnerships between child and adolescent psychiatry and primary care
Children’s Mental Health Workforce Shortage

Utah: Practicing Child and Adolescent Psychiatrists 2012
Number per county

- AACAP is continuing to work to address the shortage of CAPs including, but not limited to, potential reforms of the National Health Service Corps in 2015. This is a major priority.
Children’s Mental Health Workforce Shortage (Continued)

Utah: Practicing Child and Adolescent Psychiatrists 2012
Rate per 100,000 children age 0-17

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Components of an Integrated System

• Early detection of behavioral problems
• System of triage and referral to appropriate mental health services
• Access to child and adolescent psychiatric consultation
  – On demand and indirect
  – Scheduled consultations with the patient and family
• Care coordination among the health care team, parents, family, and agencies
• Access to child psychiatric specialty treatment
• Monitor outcomes
Epidemiology

- 20-25% of children in the U.S. suffer from mental disorder, but only 50% of these children receive treatment\(^1,2\)
- More prevalent than any other childhood physical illness with early onset and a need for ongoing care
- 50% of all psychiatric disorders begin before age 14, 75% before age 24.\(^3\)
- Annual treatment costs are estimated to be nearly $12 Billion\(^4\)
- The delay between onset of symptoms and treatment is between 8 and 10 years for children\(^5\)


5. NIMH (2005)
### Pediatrician Agreement on Responsibility
(Stein REK et al, Ambul Pediatr, 2008)

<table>
<thead>
<tr>
<th>Child’s Problem/Condition</th>
<th>Identification (Weighted %)</th>
<th>Treating/Managing (Weighted %)</th>
<th>Referring (Weighted %)</th>
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<tbody>
<tr>
<td>Attention-deficit/hyperactivity disorder</td>
<td>595 (91)</td>
<td>452 (70)</td>
<td>352 (54)</td>
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<tr>
<td>Child/adolescent depression</td>
<td>577 (88)</td>
<td>158 (25)</td>
<td>560 (86)</td>
</tr>
<tr>
<td>Behavior management problems</td>
<td>552 (85)</td>
<td>136 (21)</td>
<td>551 (85)</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>382 (59)</td>
<td>101 (16)</td>
<td>581 (89)</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>536 (83)</td>
<td>180 (29)</td>
<td>509 (79)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>576 (88)</td>
<td>133 (21)</td>
<td>584 (90)</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>597 (91)</td>
<td>204 (32)</td>
<td>551 (85)</td>
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</table>
Response from the American Academy of Pediatrics

- Task Force on Mental Health
  - Pediatricians should provide mental health services to children and adolescents in primary care settings

- Bright Futures
  - Outlines an approach to the developmental and mental health needs of pediatric patients

- Development of mental health competencies
  - Interpret psychological and neuropsychological testing
  - Identify psychiatric disorders in family members
Barriers for the Pediatrician

• Lack of mental health training in recognizing, diagnosing, and treatment mental health disorders in residency
• Insufficient time
• Lack of knowledge about community mental health resources
• Insufficient referral feedback from community mental health agencies
Treatment by the Primary Care Physician

- Need for advice, feedback and input from child and adolescent psychiatrists
- Co-management or transfer of care
  - Advanced psychotropic medication treatment
  - Complex cases that require active collaboration
Referrals to Child and Adolescent Psychiatry

- Lack of availability
- Inadequate insurance coverage
- Long distance to the nearest psychiatrist
- Refilling prescriptions initiated by the psychiatrist with no written or verbal communication
  - Better communication from other surgical and medical specialists
  - Confidentiality is a perceived barrier to psychiatric communication
Role of the Child and Adolescent Psychiatrist

- Development of comprehensive biological, psychological, and social treatment plans that are evidence based
- Support screening, assessment, treatment and referrals by the PCP
- Foster communication with other child systems including schools, child welfare, and the juvenile justice system
  - Provision of care in schools
- Access to intensive specialty services
  - Potential centers of care
Basic Principles in Primary Care

• Family focused care
  – Patients and families are partners with providers
  – Services should be culturally appropriate
  – Contacts supported by the reimbursement system

• Professional collaboration between child and adolescent psychiatrists and primary care clinicians
  – Direct Service collaboration
  – Reimbursement for consultative discussion and review
  – Reimbursement for joint time with the child and family for the psychiatrist and the PCP
• Account for complex mental health cases in the development of care plans
  – Support patients and families in the development of coordinated care plans across child serving agencies
  – Location of services and the involvement of primary care practices

• Coordinate care
  – Assist caregivers to navigate the mental health system
  – Support communication between specialty mental health services and the PCP (EMR)
Education for Primary Care Practitioners

• History of successful and supportive cross training between PCP’s and MH professionals

• Didactic trainings can improve knowledge and confidence in providing pediatric MH care
  – One time training opportunities combined with telephone-based consultation

• Group learning collaboratives

• Limited evidence on improved clinical outcomes
Goals of Training

• Identify common “practice elements” of evidence based treatment
  – Exposure for anxiety related problems
  – Positive rewards and increased structure for ADHD and disruptive behavioral problems

• Rely less on diagnosis-specific treatment
  – Leverage the relationships among providers, children, and families
Preventative Services and Screening

- Example: 12 year old child for routine well child care

- Role of the Primary Care Provider
  - Screen for mental health, substance abuse, developmental and family psychosocial problems
  - Promote parent and youth self management skills
  - Anticipatory guidance on developmental and behavioral concerns
  - Consultation and referral to mental health professionals
Early Intervention and Routine Care Provision

• Example: 12 year old with symptoms consistent with ADHD

• Role of the primary care provider
  – Provide a focused mental health assessment that utilizes a clinical interview, relevant rating scales, and additional resources
  – Screen for co-morbid concerns (learning disabilities, depression, anxiety)
  – Provide self-management advice (communication with school)
  – Provide behavioral recommendations and pharmacotherapy
  – Establish brief consultations with child and adolescent psychiatrist
  – Refer for specialty clinical assessment when there are diagnostic or treatment issues
  – Plan to monitor the patient’s progress
Administrative Issues

• Patient centered and family driven care  
  – Evaluation and treatment of parents

• Outcomes and quality improvement initiatives  
  – Status tracking  
  – Population based information
Quality Improvement

• Structure measures
  – Staffing plan, training processes, use of information technology, and the overall scope of services

• Process measures
  – Rates of screening, diagnosis and referral
  – Use of evidence based practices
  – The time required to access mental health services
  – Use of care coordination
• **Outcome measures**
  
  – Service Utilization by the patient (outpatient, inpatient, and ED visits)
  – Patient health (substance abuse disorder, school performance, family stability, involvement with criminal justice)
  – Cost to the clinic, payer, and consumers
  – Selection of symptom rating scales
  – Improved functional outcomes for patients