Overview of Pediatrics teleECHO and the AACAP Objectives

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HEALTH UNIVERSITY OF UTAH

PROJECT ECHO
EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES

UPIQ
Utah Pediatric Partnership to Improve Healthcare Quality

Intermountain Primary Children's Hospital
The Child First and Always®

Disclosures of Potential Conflicts

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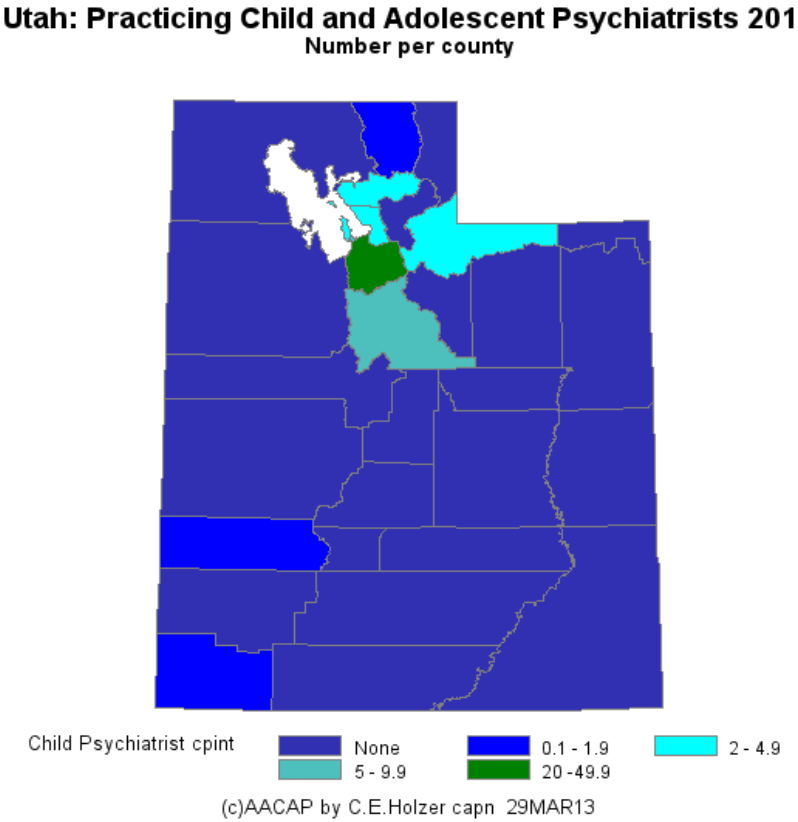
Basic Issues

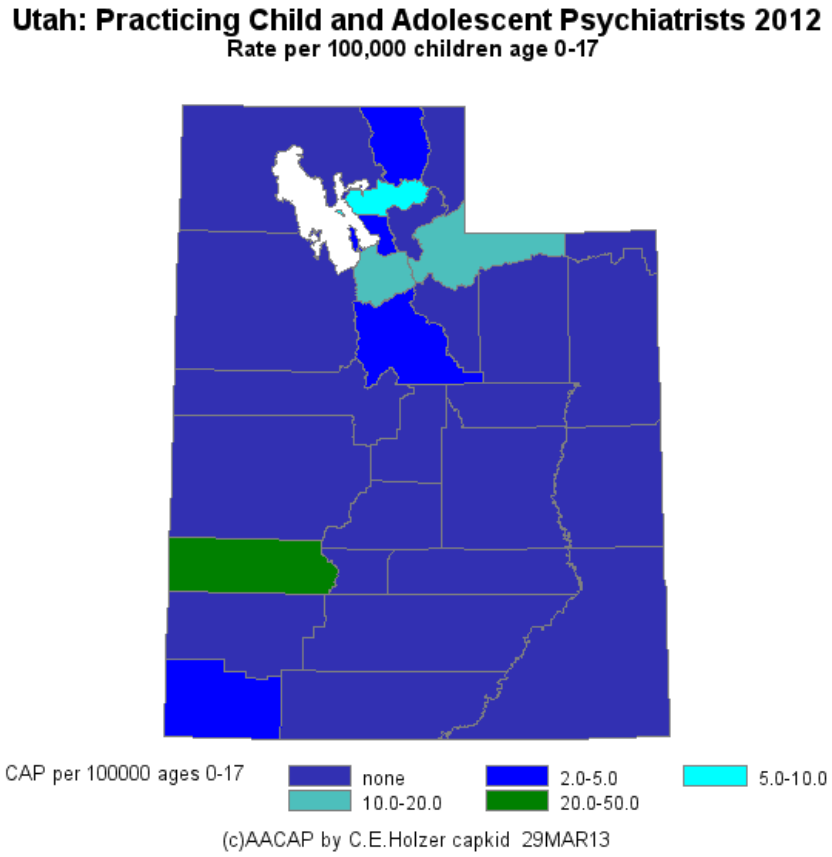
- 75% of children and adolescents with psychiatric disorder are seen in the pediatrician's office
- Shortages in child mental health professionals with distribution problems (urban versus rural)
- Increase the integration of child and adolescent psychiatric services into primary care practices
- Development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

Children's Mental Health Workforce Shortage



- 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)



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]

1. Merikangas K, He J, Brody D, Fisher P, Bourdon K, Koretz D. Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. Pediatrics. 2010;125(1):75-81.
2. Kazdin AE. Addressing the treatment gap: A key challenge for extending evidence-based psychosocial interventions. Behavior Research and Therapy. 2017;88:7-18.
3. National Comorbidity Survey Replication – Adolescent Supplement (2010)
4. de Voursney D, Huang L. Meeting the mental health needs of children and youth through integrated care: A systems and policy review. Psychological Services. 2016;13(1):77-91.
5. NIMH (2005)

Pediatrician Agreement on Responsibility
(Stein REK et al, Ambul Pediatr, 2008)

Child's Problem/Condition	Identification (Weighted %)	Treating/Managing (Weighted %)	Referring (Weighted %)
Attention-deficit/hyperactivity disorder	595 (91)	452 (70)	352 (54)
Child/adolescent depression	577 (88)	158 (25)	560 (86)
Behavior management problems	552 (85)	136 (21)	551 (85)
Learning disabilities	382 (59)	101 (16)	581 (89)
Anxiety disorders	536 (83)	180 (29)	509 (79)
Substance abuse	576 (88)	133 (21)	584 (90)
Eating disorders	597 (91)	204 (32)	551 (85)

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