

Disclosures

- None

Outline

- Introduction
- Collaborative Care Models
- Behavioral Health Integration Program (BHIP)
@ Montefiore
- Case Example
- Role Plays
- Takeaways

Presenters

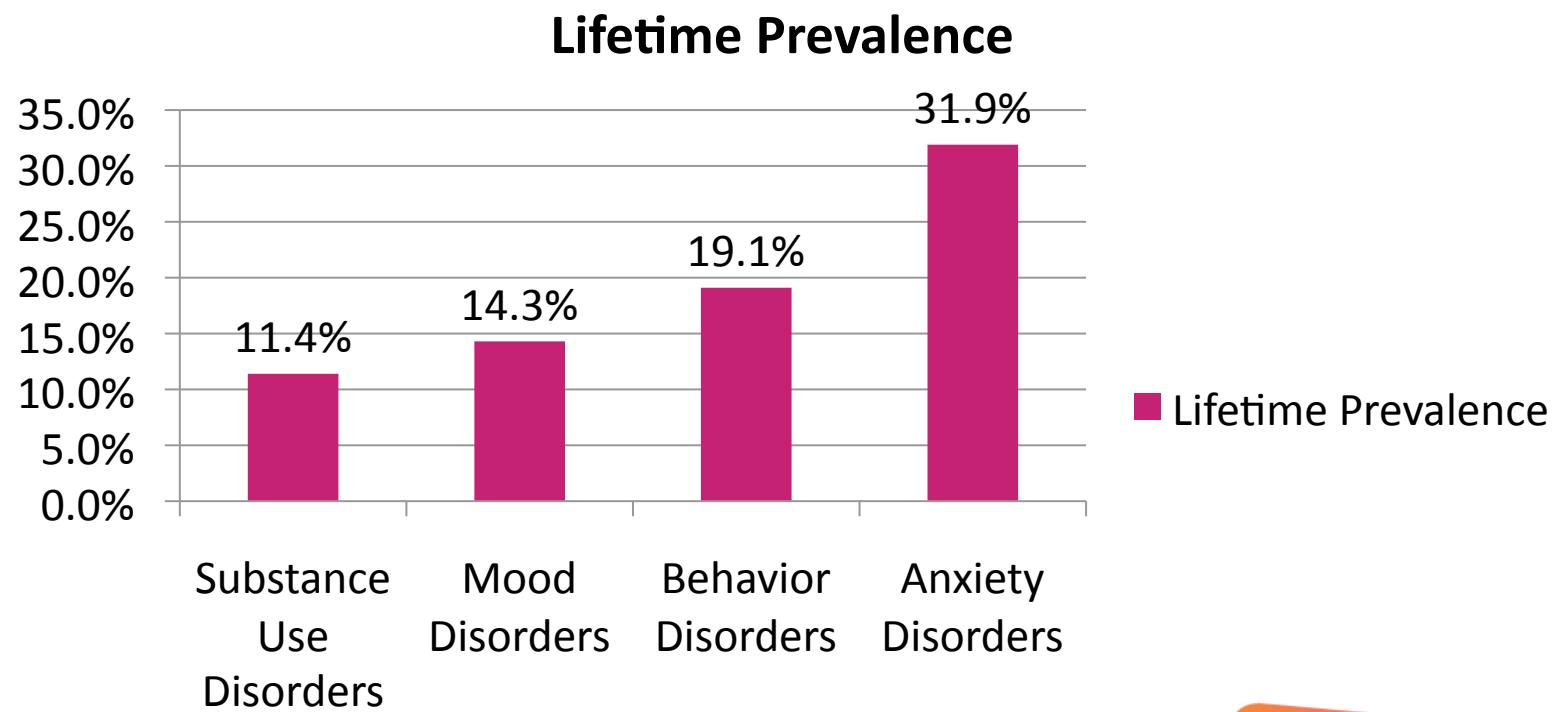
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Prevalence Of Mental Health Disorders Among U.S. Children (Merikangas, *Pediatrics* 2010)

- Approximately 1 out of every 5 youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime
- 14% of children with one disorder met criteria for ≥ 2 disorders.
- Poverty correlated with higher rates of all mental disorders
- Boys > Girls

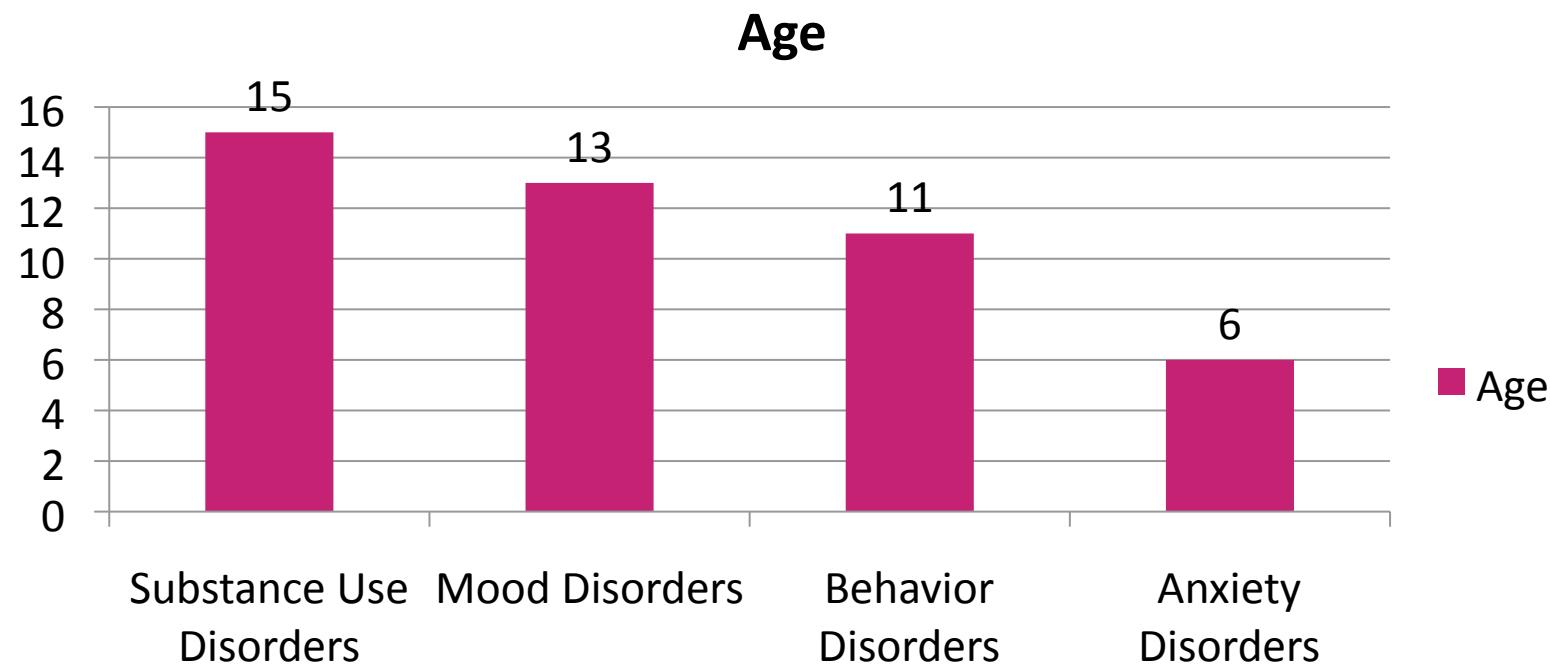
Lifetime Prevalence of Mental Disorders among Adolescents

(Merikangas et al, 2010)



Median age of onset for various disorders

(Merikangas et al, 2010)



Impact of Comorbidity

- Primary care patients with one chronic medical condition are twice as likely to have a psychiatric illness
- Primary care patients with 4 or more chronic medical conditions have 5 times higher rates of psychiatric illness.
- Children with mental disorders are at higher risk of having a co-morbid physical disorder

Pediatric Referrals to Outpatient Mental Health: Barriers

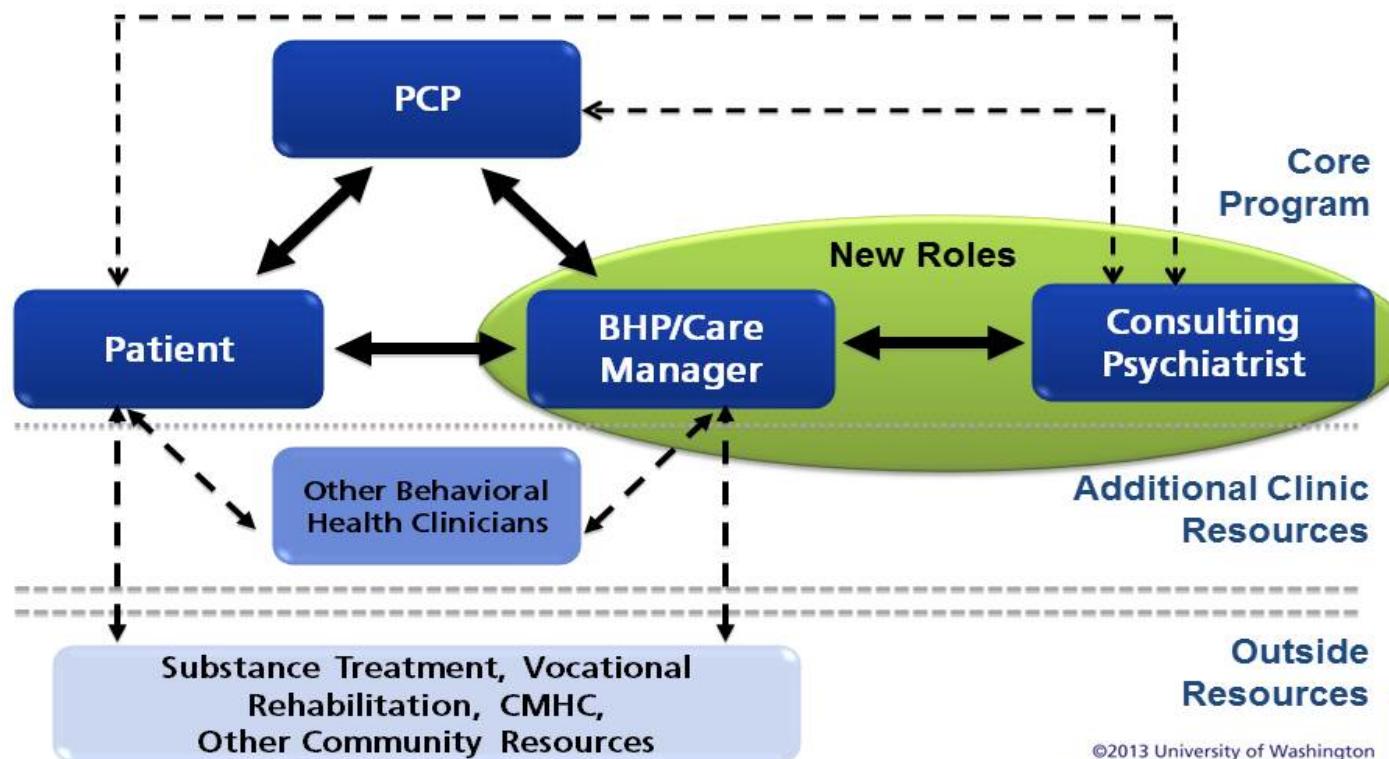
- One third of adolescents with mental illness received needed services (*Merikangas et al, 2011*)
- Paucity of resources
- Inaccessibility of resources
- Referral barriers: 60%-80% of children referred to behavioral health providers by pediatric practitioners DO NOT KEEP the first referral appointment.
 - “Cold Handoff”
 - Stigma

Consultation/Liaison vs. Integrated Care Models

- Consultation Care Model
- Collaborative Care Model
 - Co-Location vs. Integration



Collaborative Care Team Structure



Integrated Collaborative Care Models

- Extensive data for adults indicating that Collaborative Care Models (CCM) improve outcomes and reduce costs related to both mental and physical health problems

Synergy Program (Chung H, et al. *General Hospital Psychiatry*, 2013)

Participants: 61 adult patients with chronic illness (diabetes, coronary artery disease and/or congestive heart failure) and depression

Results: Decreased HbA1C (0.5%), Framingham Risk Score (34%), and PHQ9 Scores (35%)

Cost Savings By Category

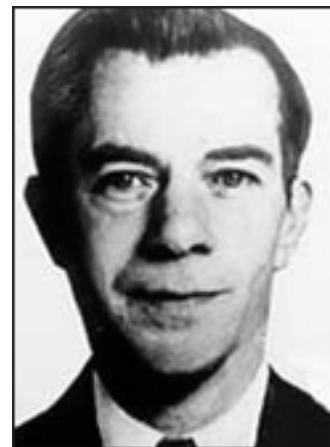
IMPACT Study

Cost Category	Overall Mean	Cost, \$		
		Randomized Group		Difference
		Intervention	Usual Care	
Outpatient				
IMPACT intervention	—	522 (495 to 550)	0 (0 to 0)	522 (495 to 550)
Mental health	661	558 (362 to 753)	767 (561 to 974)	-209 (-494 to 75)
Pharmacy	7284	6942 (6062 to 7822)	7636 (6287 to 8984)	-694 (-2304 to 916)
Other	14 306	14 160 (12 899 to 15 421)	14 456 (12 909 to 16 002)	-296 (-2291 to 1700)
Total[†]	22 516	22 182 (20 368 to 23 996)	22 859 (20 470 to 25 247)	-677 (-3676 to 2323)
Inpatient				
Medical	8452	7179 (5450 to 8908)	9757 (6455 to 13 059)	-2578 (-6305 to 1149)
Mental health and substance abuse	114	61 (-8 to 129)	169 (-2 to 340)	-108 (-292 to 76)
Total Healthcare During 4 y				
Overall Total	31 082	29 422 (26 479 to 32 365)	32 785 (27 648 to 37 921)	-3363 (-9282 to 2557)

IMPACT indicates Improving Mood: Promoting Access to Collaborative Treatment.
*Data are given as mean (95% confidence interval) unless otherwise indicated.
[†]Total outpatient costs include IMPACT intervention costs which only apply in the intervention group.

Unutzer J, et al. The American Journal of Managed Care 2008.

Why did Willie Sutton Rob Banks?



“because that’s where the money is”

Why Integrate into Primary Care?



“because that’s where the patients
are...”

Behavioral Health Integration Program (BHIP) at Montefiore Medical Center

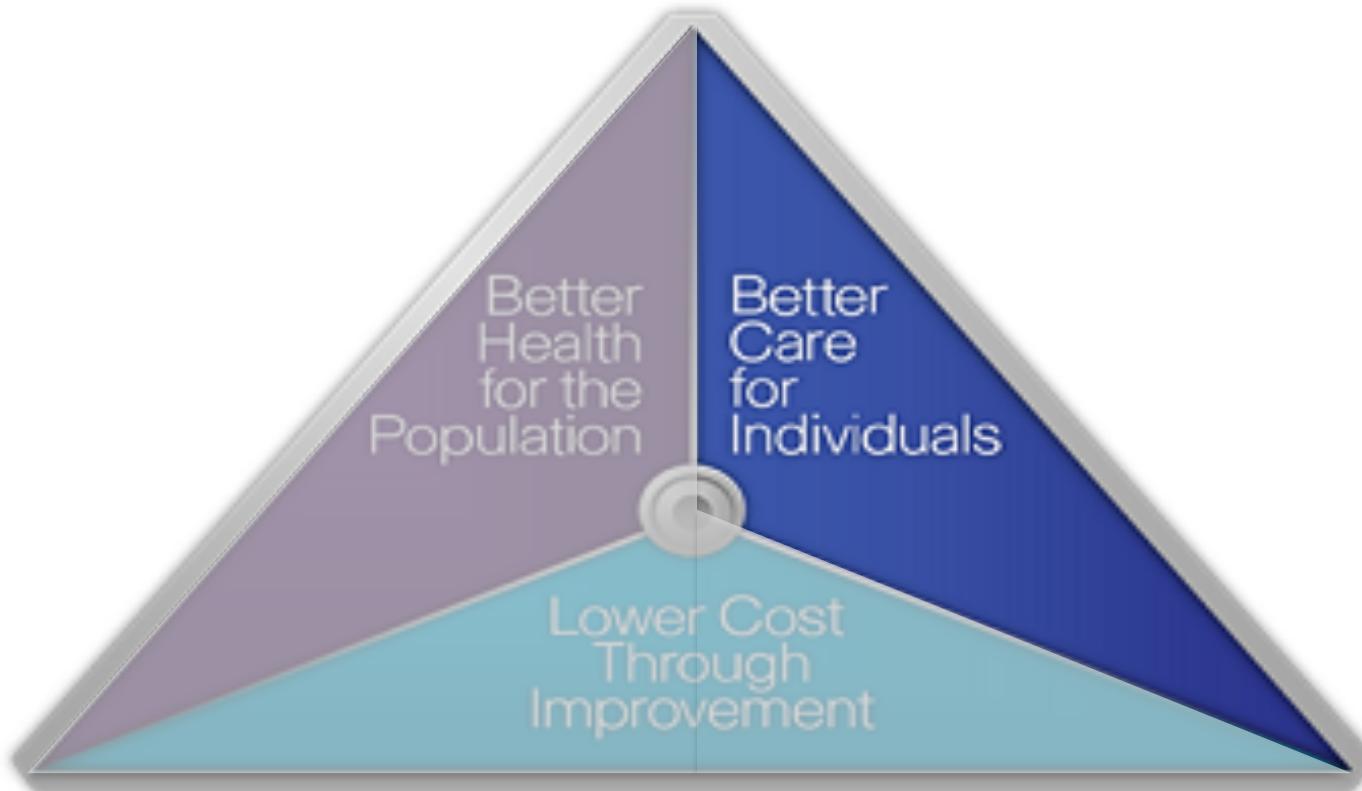
What does BHIP do?

- Integrate psychiatrists, psychologists and social workers within primary care across the lifespan (pediatric and adult practices)
- Aims to treat “mild to moderate” mental health illnesses using evidence-informed treatments; severe cases are referred out to local community mental health clinics
- Training pediatric and psychiatric residents and child and adolescent fellows
- Collaborative Office Rounds
- Evidence informed brief interventions

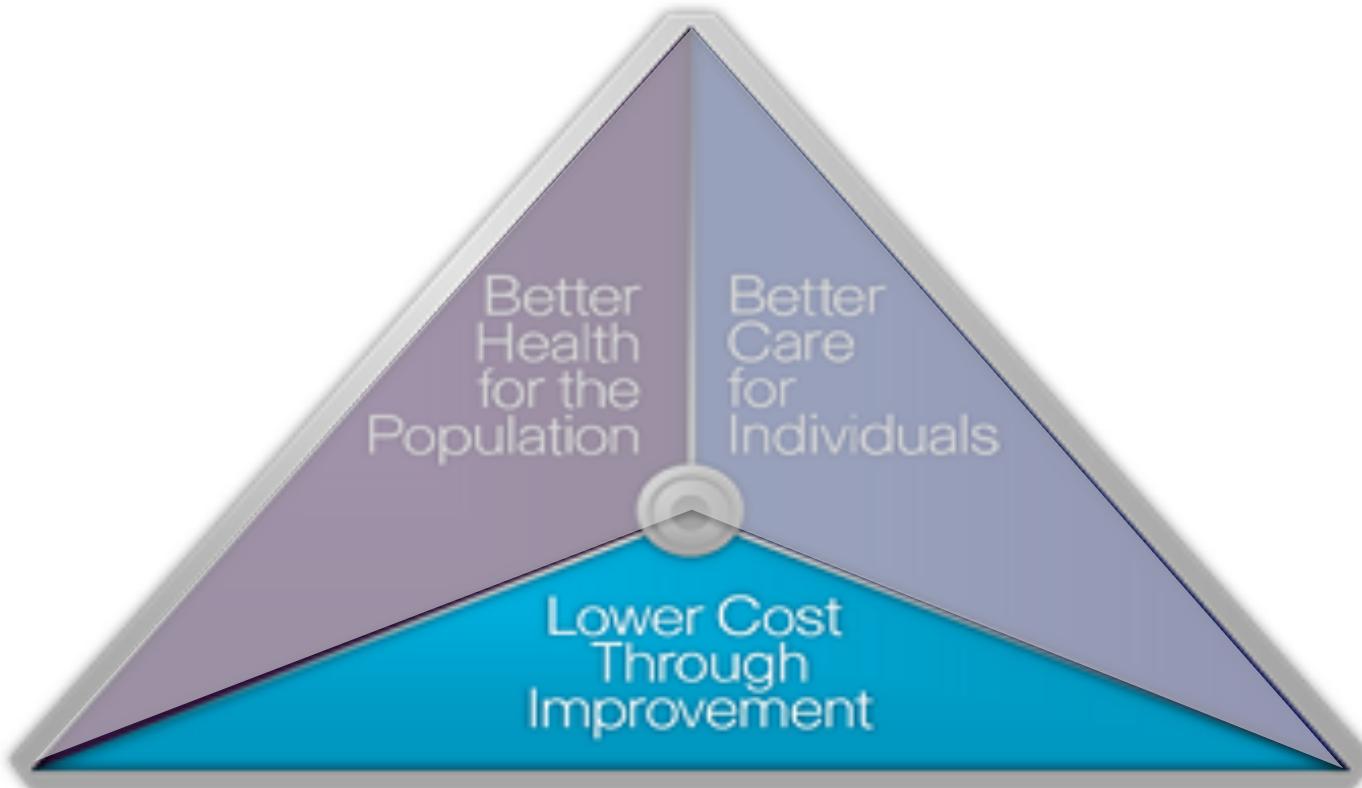
BHIP Goals: The “Triple Aim”



BHIP Goals: The “Triple Aim”



BHIP Goals: The “Triple Aim”



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Pediatric BHIP: Sept 2014 – Nov 2014

- Data were collected on all pediatric patients, ages 5 years and older, referred to the BHIP team across eight primary care outpatient clinics
- Total well-child visits across 8 primary care BHIP Clinics = 4,457
- Total referrals made to BHIP = 833 (18.6%)
- Referred patients completing at least one BHIP session by December 31, 2014 = 460 (55%) which exceeds national rates of follow-up to mental health services



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Justin

14 year old male

Referral

- 14 y.o. male, referred **10/8/2014** by PCP for poor academic performance; r/o anxiety
 - PPHx of ADHD, h/o Concerta trial 1.5 years ago, well tolerated with partial response
 - Non-adherent with f/u appts, frequently out of meds
 - Non-adherent with referrals to community providers
 - Vanderbilt and SCARED negative

Evaluation

- Scheduled and seen on **10/21/2014** by BHIP for initial evaluation
 - Pt. continued to endorse inattention (forgetful, lack of focus, ‘spaces out’), impulsivity (calling out, ‘flicking’ classmates ears, impatience), and also a new onset anxiety, worrying about:
 - Peer’s well being
 - Being rejected by girls
 - What others think of him (particularly regarding sexuality)

Evaluation

- Denied panic attacks, anxiety surrounding performance or social interactions, OCD symptoms, specific phobias
- Denied depressive sxs, manic sxs, psychotic sxs, SI, HI
- Denied conflict at school. Reported good grades, having good friends, and denied current bullying (was bullied in middle school about perceived sexuality, now in new school)
- No EtOH, drugs, tobacco
- Denied significant trauma
- Family Hx of ADHD (father)
- H/O epilepsy (seizure free ‘for years’)

Evaluation (Mom's Report)

- Mom expressed concern over pt.'s declining grades at school, noting he has been receiving D's and F's recently
- Mom stated pt. also demonstrates inattention and impulsivity in the home
- Mom endorsed partial improvement when pt. was compliant with Concerta
- Mom also expressed concern that pt had been acting increasingly “private,” spending more time alone, on the computer, and in his room.

MSE

- *Appearance*: Appropriately dressed, well groomed, appeared his age
- *Attitude*: Cooperative and **playful during interview**
- *Psychomotor*: **increased**
- *Speech*: regular rate, rhythm, volume
- *Mood*: good
- *Affect*: appropriate, mood congruent
- *Thought Process*: coherent but digressive
- *Thought Content*: no delusions, no SI or HI
- *Perception*: no AVH
- *Cognition*: A&O x 4. **poor attention.**
- *Insight*: age appropriate
- *Judgment*: age appropriate

Assessment

- 14 year old M with ADHD, h/o partial improvement on Concerta 27mg, now off medication with return of sxs.
- ADHD viewed as the primary driver of presenting symptoms (impulsivity, inattention) that contribute to academic difficulties.
- Anxiety as reported seemed appropriate for developmental stage and DID NOT interfere with functioning
 - Sexuality
 - ‘Fitting in’
 - Relationships
 - Future

Plan

- Increase Concerta to 36mg qAM
- Continue to monitor anxiety; teach and practice relaxation strategies
- Reassurance provided to mom regarding normal adolescent behaviors
- Psycho-education on ADHD, Adjustment Disorders, and importance of adherence

Justin: Integrated Care Approach

- After thorough evaluation, collaborate with PCP via EMR, email, and/or ‘pop-in’:
 - Psycho-education regarding assessment measures used in this case (Vanderbilt, SCARED)
 - Review of ADHD and Anxiety Disorders commonly seen in adolescents
 - Overview of stimulant use
 - Treatment plan

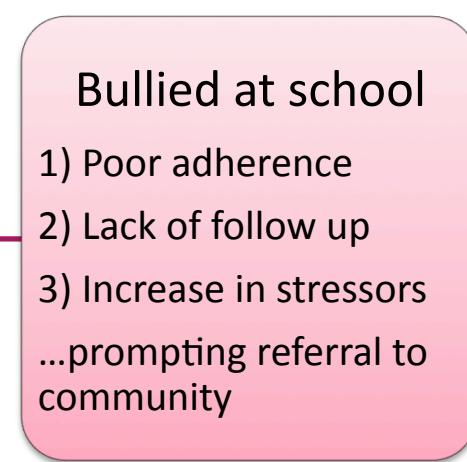
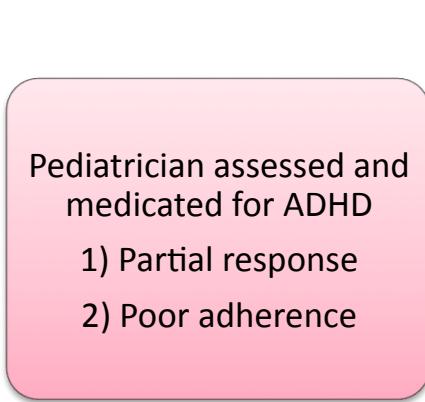
Justin: Integrated Care Approach

- Follow up/Stabilization
 - Active monitoring and motivational interviewing to improve adherence (parent and child)
- “Refer back” to PCP for ongoing management
 - Real time support
 - Brief in person assessments prn
 - Telephone/curbside consults

Childhood

Entering Adolescence

Next Steps



Traditional Model

Referral to community clinic:

- 1) 3 month waiting list for psychiatric services
- 2) Pt. continues to be non-adherent
- 3) Decompensates



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Training in Core Competencies in an Integrated Primary Care Pediatric Setting

“Please evaluate for ADHD”



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What We Can Do...

- Teach residents to collaborate with and empower primary care providers to diagnose and manage less complex mental health diagnoses
- Teach residents to strengthen their “integrative care backbone” when teaching up the training hierarchy
- Allow for flexibility within the model to build rapport

“Please evaluate for aggression”



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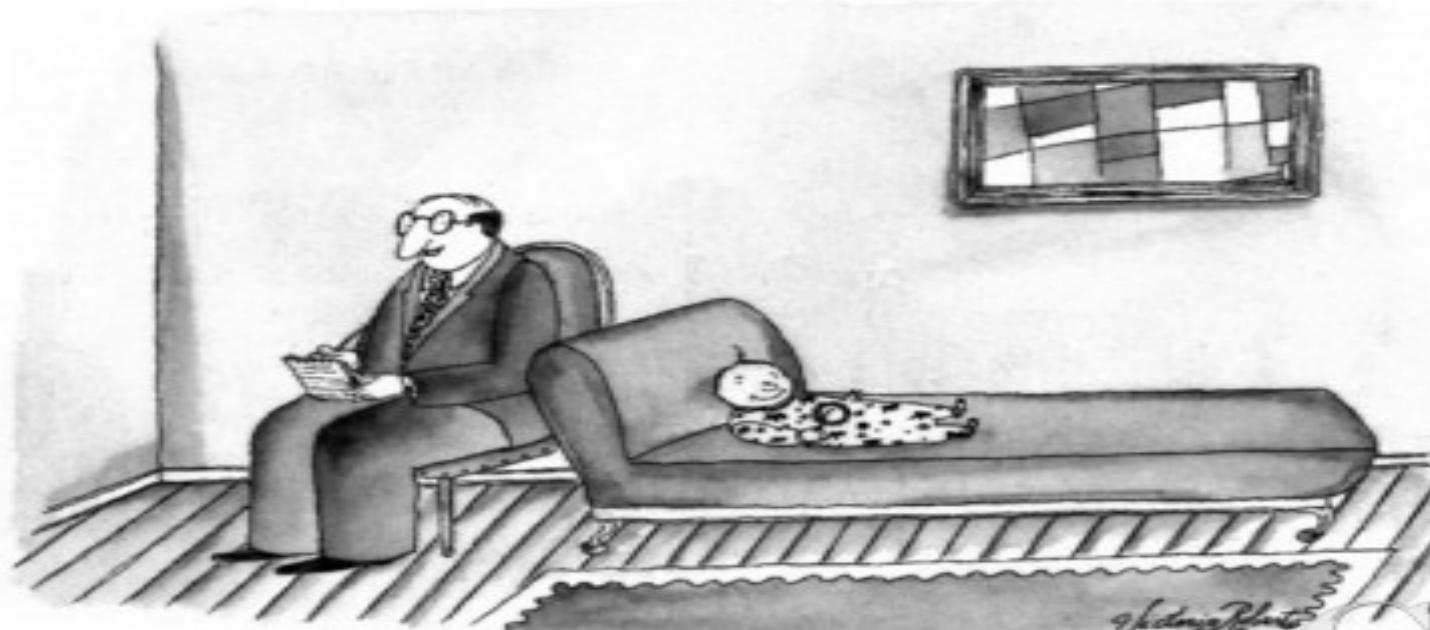
Complexities of What We Cannot Do...

- In the BHIP model, we cannot treat the severe and persistently mentally ill population
- We can teach residents why it is sometimes best NOT to help patients despite having the capability to do so
- We can teach residents to effectively communicate this limit to providers using their “integrative care backbone,” and emphasize how we CAN empower providers to help severe and persistently mentally ill patients

Conclusion

- With increases in behavioral health integration programs, adult and pediatric, we need to better prepare our trainees to work in such settings
 - 1) “Backbone”
 - 2) Short term care
 - 3) Team approach
- Core Competencies for trainees in pediatric integrated care (see hand out)

Thank you.



"I wish I'd started therapy at your age."

GN
COLLECTION

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References

- 1) Cowley D, Dunaway K, Forstein M, et al. Teaching Psychiatry Residents to Work at the Interface of Mental Health and Primary Care. *Academic Psychiatry* 2014; 38: 398-404.
- 2) Eicher SJ, Gerstle M, Feldstein SW. Brief Interventions and Motivational Interviewing with Children, Adolescents, and Their Parents in Pediatric Health Care Settings. *Arch Pediatr Adolesc Med* 2005; 159: 1173-1180.
- 3) Gayes L, Steele R. A Meta-Analysis of Motivational Interviewing Interventions for Pediatric Health Behavior Change. *Journal of Consulting and Clinical Psychology* 2014; 82(3): 521-535.
- 4) Kolko DJ, Campo J, Kilbourne AM, et al. Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial. *Pediatrics* 2014; 133: 981-992.
- 5) Kolko DJ, Perrin E. The Integration of Behavioral Interventions in Children's Health Care: Services, Science, and Suggestions. *Journal of Clinical Child and Adolescent Psychology* 2014; 43(2): 216-228.
- 6) Merikangas KR, He J, Brody D, et al. Prevalence and Treatment of Mental Disorders Among US Children in the 2001-2004 NHANES. *Pediatrics* 2010; 75-81.
- 7) O'Donnell A, Williams M, Kilbourne A. Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care. *J Gen Int Med* 2013; 28(12): 1667-1672.
- 8) Pollard RQ, Betts W, Carroll J, et. al. Integrating Primary Care and Behavioral Health with Four Special Populations: Children with Special Needs, People With Serious Mental Illness, Refugees, and Deaf People. *American Psychologist* 2014; 69(4): 377-387.
- 9) Richardson LP, Ludman E, McCauley E, et al. Collaborative Care for Adolescents with Depression in Primary Care: A Randomized Clinical Trial. *JAMA* 2014; 312(8): 809-816
- 10) Sindelar HA, Abrantes AM, Hart C, et.al. Motivational Interviewing in Pediatric Practice. *Curr Probl Pediatr Adolesc Care* 2004; 34: 322-339.
- 11) Thomasgard M, Collins V. Collaborative Office Rounds Between Pediatricians and Child Psychiatrists. *Clinical Pediatrics* 1998; 37: 327-330.