Collaborative Mental Health Care in Pediatric Primary Care

AACAP Committee on Collaboration with Medical Professionals
AACAP Committee on Training and Education

Target audience:
Child & Adolescent Psychiatry (CAP) fellows

Participants in this course will learn:

- Examples of collaborative care models
- Core components of collaborative mental health care partnerships
- Steps to consider in implementing an effective collaborative mental health care partnership
- Importance of collaboration during CAP training

“It is critical to the mental health care of our nation’s children and adolescents that we, as child and adolescent psychiatrists, remain at the forefront of development and implementation of collaborative mental health care partnerships in the pediatric setting.”

Institute of Medicine, Crossing the Quality Chasm. The New Health System for the 21st Century. Washington, DC: National Academy Press; 2001

Why is this important?

- 13% of youth aged 8-15 live with a mental illness that causes significant impairment, and the percentage jumps to 21% by age 18
- Half of all mental illness begins by age 14 and three-quarters by age 24. Early intervention has been shown to improve outcomes.
- Despite effective treatment, there are average delays of 8-10 years between age of symptom onset and intervention.
- Only 20% of children with mental illness receive treatment.
- Approximately half of all pediatric office visits involve behavioral, psychosocial, and/or educational concerns. Primay care is an ideal place for identification of childhood mental illness.
- Child and adolescent psychiatrists do not provide the majority of mental health care.

Primary Care is On Board!

- American Academy of Pediatrics:
  - Formed the Task Force on Mental Health
  - Stated that primary care clinicians (PCCs) can and should be able to provide mental health services to children and adolescents in the primary care setting

Who is best suited for collaborative work?

Child and Adolescent Psychiatrists who:

- Enjoy seeing new patients
- Possess good communication skills
- Can tolerate less direct control
- Are efficient, particularly in formulating concise recommendations
- Enjoy teaching
- Have a strong interest in prevention and systems of care

What is being asked of us?

1. Diagnostic questions
2. Management questions
3. Disposition questions
4. Crisis and safety questions

Primary care physicians have identified the following as barriers to appropriate mental health care:

- Lack of mental health training
- Insufficient time
- Lack of knowledge about community mental health resources
- Poor referral feedback from their community mental health clinicians
- Inadequate reimbursement

Despite barriers, primary care recognizes mental health responsibilities of the “medical home”:

- Prevention
- Screening
- Assessment
- Treatment
- Coordination of services

These responsibilities vary according to the severity and complexity of mental health problems for individual patients

Levels of complexity:

- Basic preventative services and screening
- Early intervention and routine care provision
- Specialty consultation, treatment and care coordination
- Complex clinical problem / Intensive mental health services

As the complexity of mental health problems being addressed in the medical home rises, the need for collaborative approaches increases

Types of Collaborative Models:

1. **Consultation**: PCCs will consult with CAPs via telepsychiatry or telephone
    a) Informal "curbside" consults
    b) Formal collaboration program
    c) Formal consults
2. **Co-location**: mental health specialists work in the PCC's practice to improve access to care and enhance care coordination
3. **Collaborative/Integrative**: treatment partnerships between PCCs and CAPs in which co-management occurs

Consultation model

Informal "curbside" consult:

- CAPs do not personally evaluate the patient
- No direct patient-doctor relationship
- CAPs inform PCCs about best practice appropriate to the clinical scenario, avoiding prescriptive language
- Records should document the patient scenario related by the PCC as well as the resulting suggestions offered by the CAP
- In the unlikely event of a later question about appropriateness of advice, the record should support that the CAP offered what any reasonable clinician would advise
- Patient specific identifiers are not required

Consultation model

Formal collaboration program:

- Patient is discussed more in detail but CAP still does not see patient
- Patient identifiers are utilized
- PCC is responsible for medical judgments and treatment
- Document as a true consultation; it is considered a legitimate professional service that can be billed in some health plans

Consultation model

Formal consult:

- CAPs evaluate the patient directly and render recommendations (effective communication is essential!)
- Informed consent should be obtained
- Written release from guardian should be obtained for CAPs and PCCs to communicate
- **Documentation includes a complete psychiatric evaluation of the patient with diagnostic formulation and treatment recommendations**

Co-location model

- Mental health specialists work in the PCC practice to improve access to care, streamline billing, and enhance care coordination
- Close proximity generally allows for more communication
- Location alone does not necessarily mean there will be collaboration—PCC and CAP will need a mutually agreed upon means of communication

Collaborative/Integrative Model

- A true “health home”
- Mental health specialists and PCCs co-manage the patient
- Mental health specialists and PCCs have a shared medical record
- Scheduled case discussions

What should be provided in any of these models?

1. Timely access to services
2. Direct psychiatric services
3. Care coordination/case management
4. PCC education

Timely access to services: A Communication Protocol

- When is the CAP available (days and hours)?
- Determine type of availability (telephone, fax, email, shared EMR, telemedicine)
- What the consultation will and will not include
- How and where the PCC and CAP will document in the patient record
- Procedures for routine, urgent, and emergency requests
- What will the process be if PCCs have questions in the future about interim medication changes?

Direct psychiatric services: The traditional model

Should include:

- Diagnostic impressions
- Specific and pragmatic treatment recommendations
- Need for further referral or treatment that cannot be provided by PCC

Prompt, succinct communication shortly afterwards including:

- Urgent recommendations and brief summary by the next business day
- Written evaluation summary within 2 weeks

What does care coordination include?

1. CAP providing advice to the PCC, such as information that allows for PCCs to advocate for and obtain necessary psychiatric services for their patients
2. PCC providing feedback to the CAP, such as new side effects or new information around which the child's plan of care may need to be altered
3. CAPs and PCCs should advocate to include a care manager in their collaborative relationship to facilitate utilization of available community mental health resources
4. Collaborative care teams should consider regularly scheduled case reviews to monitor treatment progress, outcomes, and need for change in level of care

PCC Education

CAPs have the opportunity to educate PCCs regarding mental health issues, which PCC can then share with patients and their families

- Case-based teaching that occurs in consultations
- CAPs can provide brief lectures in primary care practices about best practices, treatment, and community resources
- CAPs can implement/facilitate/participate in collaborative office rounds, case conferences, and CME training events
- Routine mental health screening practices such as available rating scales (e.g.. CRAFFT, PHQ-9, C-SSRS)
- Provide AACAP “Facts for Families” and other resources for families

Malpractice liability and privacy concerns should not prevent this work:

- maintaining medical records is a MUST for all consultations
- medical records should be securely maintained per HIPAA guidelines
- Curbside advice is not a high malpractice risk if the CAP ***documents the question that was asked as well as the response***
    - i.e. if child is suicidal and CAP says the child should go to an ED, the CAP should simply make a record of this interaction
- CAPs should have their malpractice insurer review this concept to ensure coverage

Program Evaluation:

- Specialized funding and/or resources will not continue to be available if we do not show that this type of collaboration works!
- In order to expand small pilot programs into larger, statewide programs, outcome data is critical in justifying their expansion

What can be measured?

- Improved patient and family satisfaction
- Improved clinician satisfaction
- Improved quality of mental health care in the primary care setting
- Improved clinical outcomes; reduced utilization of emergency rooms and inpatient hospitalizations
- Improved dissemination of evidence-based treatment

Performance may be measured by:

- Number of total encounters
- Rates of psychiatric diagnosis and treatment (use of billing codes)
- Number of mental health clinician consult requests
- Response time for consultations
- Wait time for consultation

CAP training offers a unique opportunity for establishing collaborative care relationships[1]:

- Close proximity to multiple specialties
- Continuity clinics are resources to model future collaboration once in practice
- Communication with primary care residents through consultation services offers a good opportunity to practice collaborative care principles

Goals of training-based collaborative care programs:

- Establish collaborative care opportunities early in training
- Teach collaborative care principles in a structured environment before moving out into a “real world” practice

A resident based collaborative care program should embody the goals of collaborative care:

- Triage of patients to appropriate level of care
- Timely access to services
- Direct psychiatric services
- Prompt and concise impressions and recommendations
- Care coordination/case management
- PCC education

Common Residency-based Models:

1. Case conferences – Interdisciplinary case presentations highlighting mental health management in primary care patients.

2. Co-location/Integrative models – Utilizing continuity clinics to integrate CAP trainees into the primary care setting in training.

3. Existing consultation/liaison services – Modeling collaborative principles in existing consultation service to other specialties.

Collaborative opportunities in specialty pediatrics clinics

- high association of mental illness with chronic illness
- critical role for CAP input around coping, adjustment to illness, and family factors
- many children with chronic illnesses see their specialists more often then their PCC– specialty clinic may be their “health home”
- unique medical complications that require collaboration with the specialist to determine medication choice

Specialty Clinics- Benefit for Fellows

- Learning about the special needs of children with chronic illnesses
- Complex medical/psychiatric clinical decision-making
- Common challenges around adherence to treatment that are relevant to work with children with chronic mental illnesses

Specialty Clinics- Benefit for Clinics

- High prevalence of emotional distress and psychiatric illness
- Help with addressing medical adherence
- Help with addressing family distress
- Ongoing education about use of psychiatric medications

Benefits for Pediatric Residents: Collaborating with a pediatric resident clinic provides many benefits for the residents as well

- CAP fellows can lead didactic sessions for pediatric residents
- Building confidence in prescribing practices, especially if they will practice in an area with a shortage of child psychiatrists
- Improving clinical triage skills-- when to manage, when to refer

Thank you

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