Family-Centered Pediatric Integrated Care

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The Children’s Health Initiative
## Disclosures of Potential Conflicts

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What’s the Story? Barriers to Child Mental Health Care

- On average, out of every 100 children, up to 20 meet criteria for mental illness, but only four will receive mental health evaluation\(^1\)

- Even when evaluation is accessed, engagement with treatment may be limited, resulting in premature termination of services and significant under-treatment\(^2\)
Enhanced Systems of Care (E-SOC): Supporting Families and Improving Child Outcomes

• In 2012, the Children’s Health Initiative at Cambridge Health Alliance began piloting a Collaborative Practice Model in community-based primary care settings.

• 2013-2015, the Collaborative Practice Model received BCBSMA Foundation support to locate Family Support Specialists and consulting Child Psychiatrists in a pediatric continuity clinic and measure outcomes.

• 2016-2020, SAMHSA funded a replication study (“E-SOC”) in four sites, and Clinical Care Managers were added to the model.
The “E-SOC” Collaborative Practice Model

- Pediatrician Screens for Child Mental Health/Substance Use Needs
- Mental Health/Substance Use Disorder or Social Risks Identified
- Family Support Specialist
- Clinical Care Manager
- Child Psychiatrist
- Primary Care Pediatrician

CPM Child and Family Team Evaluation

- Real-time CPM team response to PCP concerns
- FSS assesses family needs & strengths
- CP identifies psychiatric needs
- CCM evaluates child and family functioning & identifies resources

TREATMENT PLANNING

#LEADINGCHANGE
E-SOC Process

- E-SOC evaluations are multi-disciplinary, involving CCM clinician and FSS interviews (youth and parent seen individually and/or together, as appropriate to age and circumstances of the child) and formal child psychiatry consultation
- Interview findings exchanged among the E-SOC team; then observations, diagnosis and treatment ideas discussed in real-time with the referring primary care clinician
- Combined recommendations discussed with youth and family; shared treatment plan and next steps are in place prior to end of session
E-SOC Team Facilitates Next Steps with and for the Family

- Low Risk: Routine Care by PCP with consultation as necessary and option to bring case back to CPM Child & Family Team
- Moderate Risk: Shared Practice With PCP; active monitoring and close coordination with CPM Team
- High Risk: Management by CPM’s Child & Family Team; in partnership with PCP and community supports

- Based on child needs assessed in multi-disciplinary evaluation
- Needs can change, level of risk is re-assessed when indicated
Preliminary Findings

• Access (N=228) - Statistically significant difference in predicted probabilities of treatment access for each group: 91.5% for CPM youth versus 75.4% for youth receiving usual care (p<.001)

• Engagement (N = 186) - Odds of engagement for the CPM group were more than seven times higher than those for the control group (aOR=7.54, 95% CI=2.01-28.31)
Facilitators

• New state Medicaid ACO contract contributes to active organizational interest in monitoring health status and expense outcomes
• Development of E-SOC CPM implementation protocols makes replication more reliable for study
• Research contributing to emerging evidence-base for peer-to-peer parent support and team based, integrated care
Barriers

• Hiring multi-lingual clinical staff
• Tailoring the process to site-based variations in infrastructure and organization
• Finding clinic space for “curbside” C-L and direct E-SOC services in primary care
• Systemic child mental health workforce capacity limitations; hard to find treatment for children whose needs we identify
Key Outputs

• Longitudinal measures of clinical functioning, care experience, service use and expense for children in the CPM (reference data collected from TAU control group)

• Exploration of opportunities for increased efficiency and cost-effectiveness via “going to scale”

• Development of formal, interdisciplinary training programs for integrated care delivery
Outcomes
• Earlier Initiation of Care
• Increased Treatment Adherence
• Reduced Total Medical Expense
• Change in Practice

CPM Logic Model for System Change*

Population Health Status

Interventions
• Focused
• Family-driven
• Integrated
• Persistent – with check-ins, if needed

Real-time response to Peds Team

Family Support Interview; simultaneous with child evaluation

Child Psych/CCM/FSS review findings with PCP

Shared Ownership for follow-up

Outcomes
• Earlier Initiation of Care
• Increased Treatment Adherence
• Reduced Total Medical Expense
• Change in Practice

Based on Principles of Continuous Quality Improvement
Policy Implications

• Pilot data suggest the Collaborative Practice Model, with its predictably available, onsite specialty consultation, including the integral role of the FSS, has the potential to improve mental health care access and engagement rates in populations at-risk for disparities.

• Reduced time to treatment could lessen the morbidity burden of childhood trauma or emerging mental illness; if so, better care would more than “pay for itself”
Hearing the Whole Story: Peer-to-Peer Parent Support in Primary Care

Karen Martinez
Supervisor, Family Support Specialists
Enhanced Systems of Care, Children’s Health Initiative
Cambridge Health Alliance
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Background: Lived Experience

- I am a parent of a child with mental health needs
- I know what it is like to be worried, frightened and confused about how to find help for my child
- Having “lived experience” is key to providing effective family support
- But Family Support Specialists (FSSs) also need training; to tell their story with “purpose and intention”
- And working as a FSS in a primary care clinic requires even more training
What is a Family Support Specialist?

• By sharing their stories to build trust, the FSS connects with and supports parent/caregivers referred by primary care to have “voice and choice”
• Creates a safe environment in which families can speak honestly about their needs & frustrations
• Listens for the “rest of the story”; things a family might be less likely to say to clinicians
• Helps family construct an informed, family-driven care plan with individualized resources
• Provides candid feedback in a supportive way
• Actively coaches and follows up
Moving Families Towards Change

Do For

Do With…

Cheer On!
“Doing For”

- Families in crisis may arrive exhausted and overwhelmed, or they may not know “how to navigate”

- With so much attention going to one child, parents may neglect their own needs or those of their other children

- Connecting around basic needs, or first steps in navigating access to care, lets the FSS be a resource while also modeling self-care behavior
“Doing With”

• Peer-to-peer support in prioritizing needs and reflecting on choices

• Guiding and coaching parents in how to do the action steps that might be needed (such as getting testing at school, or seeking therapy)

• Join parents in looking up resources or thinking through whom they might want on their child’s care planning team
“Cheer Them On!”

• A FSS guides and educates the family through a process that encourages skill building and resilience

• A child’s needs may or may not have changed, but information can give parents new tools to manage those needs

• Be there to celebrate the successes of empowerment!
Family Support in Integrated Care

• A FSS brings a family perspective to clinical teams providing integrated care to children and families in primary care

• The FSS can help "translate" between the professional culture and the family's culture, fostering a strengths-based process

• A key team member, the FSS builds trust and facilitates critical information sharing to/from family to support treatment recommendations
Vignette #1
Vignette #2
Vignette #3
Lessons Learned: Ask-Share-Celebrate!!!

• Ask parents about their accomplishments, as you work with them
• Invite them to share what they feel they still need help with, and offer to look for relevant supports
• Share your observations, such as the gains you see, or progress happening with the child or family
• Also, share good news with your integrated team; success strengthens teams and helps lessons stick
• Celebrate the power of families helping families!
By: Jordan
To: Karen
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Putting the Story Together: Clinical Care Manager Role on Pediatric Integrated Team

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Background: Clinical Social Worker

Definition of Pediatric Integration can vary widely: Two examples

- Personal experience as a member of a primary care team, prevention model
  - Co-facilitated well-child visits with pediatricians, unique immersion into culture of pediatrics
  - Problem #1: Not designed for ad hoc responsiveness to mental health needs
  - Problem #2: Not linked to larger child-serving system of care

- Also have experience as a co-located child therapist, brief intervention model
  - Problem #1: Complex, traumatized children and families poorly matched with brief intervention model
  - Problem #2: Not enough time, expertise, or coordination to “unload the groceries”
  - Problem #3: PCPs, families, and therapists are left feeling overwhelmed and unsupported, while poor outcomes continue
Collaborative Practice Model: Unique Role

- **E-SOC, shared practice model**
  - Referral from primary care is the door into E-SOC
  - Social worker is the key communicator among and across primary care and mental health members of the child and family team
  - Work side by side with FSS, has access to child psychiatry consultation and community linkages to schools, child welfare and court systems
What is a Clinical Care Manager?

- Expert child and adolescent mental health clinician
- Fluent with both medical care delivery settings and systems of care for children
- Team leader, triages and assigns E-SOC resources
- Accessible onsite for “warm-handoffs” or curbside consults
- Key contact for PCPs; collaborates with primary care clinicians to prioritize new referrals and coordinate care
- Participates in shared “real time” child mental health assessment with child psychiatrist and FSS
- Facilitates treatment planning/referrals/follow-up; helps PCP “hold” the case till disposition found
Vignette #3
References


9. A family guide: Integrating mental health and pediatric primary care. NAMI, the National Alliance on Mental Illness. Family Guide_Integrating Mental Health and Pediatric Primary Care_SAMHSA.pdf 2011