INTEGRATING MENTAL HEALTH IN PEDIATRIC PRIMARY CARE:
THE COLLABORATIVE CARE INITIATIVE AND THE PEDIATRIC WELLNESS CENTER

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OUR MISSION

Working with the community to advocate for, develop and implement services and systems of care to improve the health and wellbeing of all children and youth in Northeast Florida, especially those with special health care needs.
EXAMPLES OF PROGRAMS AND SERVICES

• Medical Home
• Criminal Justice Reinvestment Grant
• Project AWARE
• Jacksonville Cleft and Craniofacial Program
• Nurse Care Coordination for Medically Complex Children
• America’s Promise
• Rights Respecting Schools
• Child Friendly Cities
Jacksonville System of Care Initiative

In collaboration with the City of Jacksonville, community partners, youth and families, The Partnership developed the Jacksonville System of Care of Initiative with funding from the Federal Substance Abuse and Mental Health Service (SAMHSA).
Populations of Focus – Implementation 2010-2016(17)

- Juvenile Justice
- Child Welfare
- Homeless
- Early Learners
SYSTEM OF CARE

CORE COMPONENTS: PROGRAMS AND SERVICES

- Federation of Families
- YouthMOVE
- CLC
- High-Fidelity Wraparound
- Nurse Care Coordination
- Collaborative Care
- Training
- Evidence-based practices
- Evaluation and Research
- Pediatric Wellness Center
ENGINEERING A SYSTEM OF CARE

BEHAVIORAL HEALTH SCREENING

OBJECTIVE
Utilize a public health framework to screen and assess all children and youth for behavioral health issues and refer appropriately for treatment.

18,610 children have been screened for social and emotional issues.

10,068 children have been referred to on-going treatment.

OBJECTIVE
Expand the community’s capacity to serve children and youth identified with serious emotional disturbances.

OBJECTIVE
Since 2010, First Care Coordination has been provided to an average of
600 Foster Care Youth Annually.

PHYSICAL AND BEHAVIORAL HEALTH INTEGRATION

OBJECTIVE
Integrate physical and behavioral health through the development of the pediatric/psychiatric Collaborative Care model.

Since 2012, more than 100 community pediatrics have been trained to identify and manage children with complex medical health conditions.

12,000 children referred to the screening of more than 100.

THE JACKSONVILLE SYSTEM OF CARE INITIATIVE

has met the grant objectives initially established and provided improved access to care for services that are family-driven, youth-guided, and culturally and linguistically competent.

Our metrics are measured in the concrete, sustainable outcomes highlighted here. SAMHSA’s recent commitment of an additional $4 million grant to our community will allow JSOCC to continue to connect kids to this network of care, keeping Jacksonville’s children on track for a healthy childhood and adulthood.

PROFESSIONAL TRAINING

OBJECTIVE
Increase the community’s capacity to provide a broad array of accessible, effective, and fiscally accountable services, treatments, and supports for children and families.

OBJECTIVE
199 children's mental health individuals have been trained and certified to provide evidence-based trauma informed, empathetic, and infant mental health.

OBJECTIVE
FAMILY-DRIVEN AND YOUTH-GUIDED EMPOWERMENT

Implement authentic participation of families and youth in the development, evaluation, and sustainability of local services and supports and in overall system transformation activities.

486 community stakeholders have been trained in Youth America Health Prof As.

UNFINISHED BUSINESS

The Federation of Families of Northeast Family through Mental Health America serving more than 250 families annually.

LEGISLATIVE REFORM

OBJECTIVE
Serve as a catalyst for treatment-based, sustainable systems change through policy reform and infrastructure development.

Provided leadership development and opportunities on community councils, networks and boards for 200 touris.

Linking Community Children with Mental Health Resources: 2010-2016 Jacksonville System of Care Initiative
SYSTEM OF CARE

Hall-Halliburton Project for Collaborative Care

An endowment awarded to The Partnership to sustain an initiative to improve the delivery of mental health care and provide pediatricians with specialized training to identify and manage depression and suicide risk in youth.
Collaborative Care Initiative: A Partnership between Pediatrics and Psychiatry

What is the Collaborative Care Initiative?

The mission of the Collaborative Care Initiative (CCI) is to improve identification and treatment of child and adolescent mental health problems through a collaborative model of mental health between pediatricians, pediatric psychologists, and child and adolescent psychiatrists.

Since 2012, the CCI has established a network of primary care providers and child and adolescent mental health providers to improve access to child mental health care. The CCI offers advanced child mental health clinical training and outpatient psychiatric consultation to pediatric providers. The CCI is generously funded by a $1.26 million endowment from the JDSU through The Partnership, the Baptist Foundation, and the Hall-Halliburton Foundation.

http://partnershipforchildhealth.org/collaborative-care/
AN OVERVIEW

- Why collaborate with Primary Care?
- How the Collaborative Care Initiative works
- How-to-Implement Collaborative Care
WHY COLLABORATE WITH PRIMARY CARE?

AACAP Workforce Maps by State
http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx
HOW COLLABORATIVE CARE WORKS

1 – Build a team

2 – Clinical Training

3 – Outpatient consultation

4 – Patients receive mental health in primary care
STEP 1 - BUILD A TEAM

- Recruit CAPs
  - Liaison work, education
  - Strong communication skills
  - Open to consultation vs. ongoing care
  - Flexible
    - *Train fellows and residents!*
IMPROVES ACCESS TO MENTAL HEALTH CARE

CAP

PCP

PCP

PCP

Children and adolescents

Children and adolescents

Children and adolescents
STEP 1 - BUILD A TEAM

Recruit PCPs

- Large practices with Champions
- Propose and “Sell” the model

<table>
<thead>
<tr>
<th>Status Quo</th>
<th>Collaborative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of access</td>
<td>Improved, expedited access</td>
</tr>
<tr>
<td>Limited PCP comfort, training</td>
<td>Free Clinical training</td>
</tr>
<tr>
<td>Poor communication between PCP and psychiatry</td>
<td>Partnership between PCP and psychiatry</td>
</tr>
</tbody>
</table>
Network of 227 PCPs from 40 practices
STEP 2 – CLINICAL TRAINING FOR PCPS

**Pediatric Mental Health in Primary Care Workshops:**

- Fear and Trembling: Identification and treatment of Pediatric Anxiety Disorders in Primary Care
- Screening, Assessment, and Treatment of Adolescent Depression for Primary Care Providers
- Primary Care Screening For Early Childhood Problems and Caregiver Depression
STEP 2 – CLINICAL TRAINING FOR PCPS

Screening, Assessment, and Treatment of Adolescent Depression for Primary Care Providers

• How to screen for adolescent depression
• A 3-Step approach to diagnosing depression
• How to assess for suicidal thoughts/intent/plan/attempts
• When/Where to refer patients
• How to choose antidepressant medication

2+1/2 hour training
Part A: Case-Based seminar
Part B: Clinical practice with 1:1 interviews using standardized patients
Part C: Debriefing
CC: 17 yo patient with declining grades and elevated score on depression screen.

You have 10 minutes to:
Obtain a **history** pertinent to this patient’s problem focusing on the assessment of **suicide risk** and **depression**.
## PHQ9 Depression Screen

<table>
<thead>
<tr>
<th>Question</th>
<th>(0) Not At All</th>
<th>(1) Several Days</th>
<th>(2) More Than Half the Days</th>
<th>(3) Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling down, depressed, irritable, or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Little interest or pleasure in doing things?</td>
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<td></td>
<td></td>
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<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much?</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Poor appetite, weight loss, or overeating?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Feeling tired, or having little energy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things like school work, reading, or watching TV?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed?</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANTIDEPRESSANT DOSING GUIDELINES

<table>
<thead>
<tr>
<th>DEPRESSION MEDICATION: DOSING RECOMMENDATIONS (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting dose</strong></td>
</tr>
<tr>
<td>FLUOXETINE (Prozac&lt;sup&gt;®&lt;/sup&gt;)</td>
</tr>
<tr>
<td>SERTRALINE (Zoloft&lt;sup&gt;®&lt;/sup&gt;)</td>
</tr>
<tr>
<td>CITALOPRAM (Celexa&lt;sup&gt;®&lt;/sup&gt;)</td>
</tr>
<tr>
<td>ESCITALOPRAM (Lexapro&lt;sup&gt;®&lt;/sup&gt;)</td>
</tr>
</tbody>
</table>

© Collaborative Care Initiative: A Partnership between Pediatrics and Psychiatry

- Medication is one part of the treatment for depression. It is important to take your medication every day.
- As your body adjusts to the new medication, you may feel too sleepy, have trouble sleeping, or have an upset stomach. These side effects should go away in a few days. Very few (1-2%) people who take this medication may feel worse (more irritable, agitated).
- Most people feel much better after a few weeks on medication, and see a big difference after 4-6 weeks. If you have any concerns, call our office and we will talk about what to do.

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# LOCAL RESOURCES

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Accepts Medicaid</th>
<th>Psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duval County</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>AP Psychiatric/Counseling Services</strong></td>
<td>Emerson Ave</td>
<td>904-399-0324</td>
</tr>
<tr>
<td><strong>Baptist Behavioral Health</strong></td>
<td>University, Prudential Dr, Jax Beach and Regency</td>
<td>904-376-3800</td>
</tr>
<tr>
<td><strong>Carl Burak, MD</strong></td>
<td>Jacksonville Beach</td>
<td>904-246-6702</td>
</tr>
<tr>
<td><strong>Child Guidance Center</strong></td>
<td>Southside, Westside, Northside, Arlington</td>
<td>904-448-4700</td>
</tr>
<tr>
<td><strong>Psychiatric &amp; Behavioral Management (Ages 12+)</strong></td>
<td>Southside</td>
<td>904-296-2999</td>
</tr>
<tr>
<td><strong>Daniel Kids Foundation, Inc.</strong></td>
<td>Southside</td>
<td>904-296-1055</td>
</tr>
<tr>
<td><strong>Family Foundations</strong></td>
<td>Downtown</td>
<td>904-396-4846</td>
</tr>
<tr>
<td><strong>Hope Haven</strong></td>
<td>Spring Park</td>
<td>904-346-5100</td>
</tr>
<tr>
<td><strong>Jewish Family and Community Services</strong></td>
<td>Southside</td>
<td>904-448-1933</td>
</tr>
<tr>
<td><strong>Marsh Landing Behavioral Health</strong></td>
<td>Jax Beach</td>
<td>904-543-0161</td>
</tr>
<tr>
<td><strong>Mental Health Resource Center (MHRC-North)</strong></td>
<td>West 20th St</td>
<td>904-695-9145</td>
</tr>
<tr>
<td><strong>Mental Health Resource Center (MHRC-South)</strong></td>
<td>Beach Blvd</td>
<td>904-642-9100</td>
</tr>
<tr>
<td><strong>Nemours Children’s Specialty Care</strong></td>
<td>San Marco</td>
<td>904-697-3600</td>
</tr>
<tr>
<td><strong>Nikhil Nihalani, MD</strong></td>
<td>University Blvd</td>
<td>904-410-4027</td>
</tr>
<tr>
<td><strong>Northwest Behavioral Health Services</strong></td>
<td>Northside</td>
<td>904-781-0600</td>
</tr>
<tr>
<td><strong>Kamalesh Pai, MD</strong></td>
<td>Southside</td>
<td>904-998-9442</td>
</tr>
<tr>
<td><strong>Rebecca Farinas, MD</strong></td>
<td>Southside</td>
<td>904-997-7776</td>
</tr>
<tr>
<td><strong>Sivanta Paul, MD</strong></td>
<td>Southside</td>
<td>904-279-1666</td>
</tr>
<tr>
<td><strong>University of Florida Psychiatry Center</strong></td>
<td>Dupont Station</td>
<td>904-383-1038</td>
</tr>
</tbody>
</table>
Who is appropriate for the Collaborative Care Consult Clinic?

- Depression with mild-moderate severity with/out anxiety
- Anxiety that has failed a trial of therapy
- ADHD that has failed 2 trial medications

**Please refer the following for LONG TERM CARE**
- Aggression
- Trauma/abuse
- Substance use
- Bipolar
- Current Suicidal Intent
- Past suicide attempt
- Past Psych Hospitalization
- Psychosis

**Refer to UF Health or Daniel for CCI**
3-STEP ASSESSMENT: DEPRESSION

1) Symptoms, Severity, Stressors

2) Differential Diagnosis, Comorbidity

3) Suicide Risk Assessment

STEP 3 – OUTPATIENT CONSULTATION

Primary Care Provider → Refer for consult → Child and Adolescent Psychiatrist

Return to PCP care

Intake and follow up: April 28
DATA
PRE VS POST TRAINING PRACTICES: BILLING FOR SCREENING

Figure 1. Adolescent Depression Screening at Well Visits: Before vs After PCP Training

Fallucco EM et al., manuscript in preparation
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Baseline</th>
<th>2–8 Months After Training</th>
<th>18–24 Months After Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of PCP screening</td>
<td>49%</td>
<td>68%*</td>
<td>74%*</td>
</tr>
<tr>
<td>Odds ratio (95% confidence interval)</td>
<td>—</td>
<td>2.78 (2.10–3.68)</td>
<td>3.18 (2.16–4.67)</td>
</tr>
</tbody>
</table>

PCP indicates primary care provider.

*P < .0001.
POST-TRAINING PEDIATRICIAN CONFIDENCE ASSESSING ADOLESCENTS WITH SUICIDAL THOUGHTS

5 = very high confidence
4 = high
3 = neutral
2 = low
1 = very low

Fallucco EM et al. Pediatrics. 2010
PRE VS. POST TRAINING PCP CONFIDENCE


5 = very high
4= high
3= neutral
2=low
1= very low

PCP Pre- and Post-SP Intervention Confidence

- Interpreting depression screening tools
  - Pre-training: 2.58
  - Post-training: 3.4

- Diagnosing depression
  - Pre-training: 2.91
  - Post-training: 3.44

- Initiating an SSRI for depression
  - Pre-training: 2.53
  - Post-training: 3.06

- Assessment of suicide risk
  - Pre-training: 2.67
  - Post-training: 3.33

* p < 0.05; ** p < 0.001
SCREENING LEADS TO IMPROVED IDENTIFICATION AND TREATMENT

DID PCP TRAINING WORK?

“The training was superb. The interactive lecture kept me involved in the material. All the clinicians in the room could see how we could apply it in practice and then we got to practice what we had learned with standardized patients. I truly appreciate their feedback and feel more comfortable applying what I have learned with my patients. Two thumbs up.”

LW: Orlando, FL

“Our entire practice found that the depression training was very helpful. We now all use the depression screening tool at well-visits – it is short and easy for patients to fill out. It helps us target in who needs to be referred.”

WS: Jacksonville, Florida
PEDIATRIC WELLNESS CENTER

- A comprehensive pediatric care center
- Collaboration between UF, Baptist Health and the Partnership for Child Health
- Integration of behavioral and primary healthcare services
WHY A PEDIATRIC WELLNESS CENTER?

- 1 in 5 children suffer from some type of mental illness; only 20% receive treatment
- Half of lifetime mental illnesses begin by age 14
- 13% of youth ages 8-15 and 21% of youth 13-18 live with severe mental illness
- Families 85% more likely to follow up if referred by PCP

- In 2013-14, 796 youth were Baker Acted more than 1000 times
- According to CSU- about 70% no show rate for follow up
- Jacksonville has a psychiatric shortage
- Lack of CSU discharge planning resources
2013-2014 BAKER ACT DATA

Baker Acts by Number of Admissions (796 unduplicated youth, 1058 total admissions)
GOAL: REDUCE BAKER ACTS

1) Refer discharged CSU patients to the PWC;
   • Home visit - consents/safety plan/behavioral health assessments/insurance/PCP

2) Assess and respond to their immediate health and mental health needs;
   • Office visit – triage medication/assessments/physical complaints/follow up appts

3) Refer to the level of mental health services required;

4) Provide comprehensive care coordination to optimize outcomes;

5) Engage the child’s community pediatrician in the care of the child or establish a medical-behavioral health home for the child in the Center.
THE MEDICAL HOME IS A MODEL OF CARE IMPLEMENTED BY MEDICAL PRACTICES.

State programs—such as Title V—can provide technical assistance and support to medical practices implementing the medical home model. Title V programs can explore their state needs assessment data to prioritize which medical home components need to be addressed in order to make progress on National Performance Measure 11.

ACCESSIBLE
Care is physically and geographically accessible, practice hours are accessible, and the clinic accepts all insurance types.

COMPASSIONATE CARE
Well-being of the child and family is explicitly expressed and demonstrated.

COMPREHENSIVE CARE
All health care needs of the child/youth are met, including well-care, sick-care, and behavioral health needs.

CONTINUOUS CARE
Children and families develop relationships and are cared for by the same care team from infancy through young adulthood.

COORDINATED CARE
Care is coordinated among multiple providers and community services, including adult providers to assist with transition from pediatric to adult care.

CULTURALLY COMPETENT CARE
Child and family culture, beliefs, rituals, and traditions are valued, respected, and incorporated into care.

FAMILY-CENTERED CARE
Care is centered on the goals, needs, and preferences of the child and their principal caregivers.

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION
CLINICAL PRACTICES CAN BUILD RELATIONSHIPS AND PARTNERSHIPS WITH...

- Families and family organizations (such as Family-to-Family Health Information Centers)
- Clinicians and clinician organizations (such as American Academy of Pediatrics chapters)
- Community-based organizations (such as, but not limited to, schools, faith-based organizations, WIC, SNAP, early education/child development centers)
- State departments of public health and/or other state agencies and programs

STRATEGIES TO BUILDING RELATIONSHIPS AND PARTNERSHIPS...

- Lunch-and-learns
- Formal written cross agency agreements
- Documentation across multiple agencies
- Multidisciplinary and cross agency medical home work groups

THE MEDICAL HOME MODEL SUPPORTS PRACTICE FUNCTIONS AND PHILOSOPHIES THAT PROMOTE HIGH QUALITY CARE THROUGH TRUSTING RELATIONSHIPS AMONG FAMILIES, PATIENTS, CLINICIANS, AND THE COMMUNITY.

NATIONAL CENTER FOR MEDICAL HOME IMPLEMENTATION

A cooperative agreement between the Maternal and Child Health Bureau/HRSA and the American Academy of Pediatrics
Expansion Grant Flow Chart

CSU Discharges

Pediatric Wellness Clinic (NCC/Physician/Behavioral Health Coordinator)

Community Mental Health Providers Wraparound Program

Referrals from community
PWC Partners

• UF
• Wolfson’s Children’s Center for Behavioral Health
• Wolfson Children’s Hospital
• AGAPE
• Mental Health Resource Center
• Riverpoint

• Daniel
• SEDNET
• Children’s Home Society
• Child Guidance
• Federation of Families/YouthMOVE
INTEGRATION OF MENTAL AND BEHAVIORAL HEALTH: LESSONS LEARNED

• Physician Champion: enhanced training, lead pediatrician accessible to other providers
  • Expanding the treatment capabilities of the pediatrician
  • Assessing the readiness of the practice
• Inventory of community resources: medical, mental/behavioral, social.
• Coordination, collaboration, closing the loop
• Screening: If we don’t ask, we won’t know. How much is too much? Parents, child, both?
  • PHQ-9, PSC-17, SCARED, UCLA-PTSD, TSCC, ACE-Q, ASQ, MCHAT
• Patient and family voice.
• Spectrum of mental health, behavioral health and adverse childhood experiences.
• Substantial need.
INTEGRATION OF MENTAL AND BEHAVIORAL HEALTH: ONGOING CHALLENGES

- There have been many!
- Insurance / Billing
- Transportation
- Time
- Access to psychiatry
- How much is too much for the pediatrician?
- Spectrum of adverse childhood experiences and mental health
- Collaboration between multiple organizations
- Sharing of Information
- Clinical capacity of our community
NEXT STEPS
CONTINUOUS QUALITY IMPROVEMENT

- Towards a Trauma Informed approach.
- Medical-Behavioral Health Home anchoring a trauma-informed system of care.
- Consolidating programs and resources: Baker act, foster care, juvenile justice.
- Improving screening tools.
- Outcomes?
- Decrease Baker Acts, decrease emergency room utilization, decrease recidivism, school engagement, etc..
- Access to psychiatry: Telepsychiatry?
Muchas Gracias