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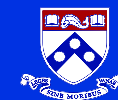

Working with Health Care and Mental Health Care Systems

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Research Workshop on Prevention Science Methodology and Implementation

October 30, 2007

The Children's Hospital of Philadelphia

Pediatric Primary Care

- 16-27% of PC patients have MH problems (Horowitz 1992; Briggs-Gowan 2000; Kelleher 2000)
- 24% of office visits address MH problems (Cooper 2005)
- 2.5 fold increase in office visits for MH problems (Kelleher 2000; Zito 1999)
- Externalizing disorders more frequent than internalizing disorders 12% vs. 7% (Briggs-Gowan 2000; Wasserman 1999)

Detection of MH Problems in PC

- PCPs identify 4-17% of children with MH problems (Weitzman 2006)
- Better detection for certain high prevalence disorders, e.g. ADHD, than for others, e.g. Mood/anxiety (Weitzman 2006)
- 55% of parents of children with MH problems do not discuss concerns with PCP (Briggs-Gowan 2000)
- Lack of use of standardized screening instruments by PCPs (Weitzman 2006; Wasserman 1999)
- Predictors of MH problems in PC (Briggs-Gowan 2000):
  - -Marital stress
  - -Parental depression/anxiety
  - -Stressful life events
  - -Child abuse

General PC Screening Instruments

Instrument	Respondent	Age Range (yrs)	No. Items (min)	Scoring/Purpose
Pediatric Symptom Checklist	Parent	4-16	35 (5-10) 17 (3-5)	Cut-point for psychosocial dysfunction
Parent Evaluation of Developmental Status	Parent	0-8	10 (2)	Identify risk level (low, medium, high)
Child Behavior Checklist	Parent Teacher Youth	1.5-5 6-18	99 (20) 118 (20)	Scores for competence, syndromes, problems
Ages and Stages Questionnaire: Social-Emotional	Parent	0.5-5	30 (10-15)	Cut-point for MH referral

Barriers to detection of MH Problems

- Limited behavioral health training
- Lack of knowledge about screening instruments
- Time and reimbursement
- Lack of disclosure by parents
- Reluctance to label
- Few community MH resources

(Briggs-Gowan 2000; Owens 2002; Weitzman 2006)

Primary Care Management of MH Problems

- Counseling is most common intervention for newly identified MH problems but least well studied (Kelleher 2006)
- Standardized psychotherapy by PCPs has not been studied, but there exists interest in on-site MH provision of psychotherapy (Kelleher 2006)
- Psychotropic medication prescriptions have grown in PC and occur in half of visits for MH problems, most notably for stimulants (Hoagwood 2000; Gardner 2000)
- Referrals to MH for consultation, shared management or transfer of care (Forrest 1999)

MH Referrals

- 14-18% of patients referred following identification (Horowitz 1992; Rushton 2002; Cooper 2005; Hacker 2006)
- Referrals more likely for younger patients, new or more severe MH problems, those with internalizing conditions, minorities, and those with family dysfunction (Rushton 2002; Kelleher 2006)
- PCP rarely (12%) had direct contact with referred MH provider (Rushton 2002)
- 61% of referred patients follow-up with MH provider (Rushton 2002)
- 31% of referred patients saw MH provider >1 visit (Gardner 2000; Rushton 2002)

Barriers to PC-MH Collaboration

- Lack of consensus on accountability
- Frequent changes in providers were disruptive to long-term collaboration
- Uncertainty in diagnosis, insufficient training, few resources, lack of time
- Distrust and blame
- Lack of administrative support
- Behavioral health carve-outs & fragmented care

(Guevara 2005; Leslie 2004)

Managed behavioral healthcare

- Cost containment and MH access problems have led to managed care approaches: integrated, partial carve-outs, full carve-outs (Grazier 1999)
- Little incentive for preventive care and detection of mental health needs (Grazier 1999)
- Effects of managed care on quality and outcomes appears mixed (Grazier 1999)
- Carve-outs may exacerbate fragmentation in systems of care (Grazier 1999)

Fragmented mental health system

- The mental health system for children has been described as fragmented, difficult for families to navigate, and a major obstacle to high quality care
- There is little evidence of effective communication and coordination of care across systems
- Reasons for fragmentation are unclear

(Report of the Surgeon General's Conference, 2000; New Freedom Commission Report, 2003)

Innovations in PC-MH Collaboration

- Use of MH providers as consultants to support PCP management (e.g. Massachusetts)
- Co-location of MH providers in PC
- Clinic-based care managers to facilitate PC-MH collaboration

Systems-based preventive approach

- Integrate PC, MH, schools, daycare, and social services to facilitate communication, coordination of care, and referral
- Allow for multiple entry points for screening and referral
- Facilitate referral pathway among participating agencies
- Encourage data sharing among systems to monitor progress and identify potential problems

Suggestions for system improvement

- Bolster MH training for PCPs and other entry point providers to enhance recognition and facilitate treatment
- Encourage use of standardized screening tools
- Align reimbursement incentives to favor prevention, detection, and care coordination
- Integrate systems for communication, coordination of care, and referral
- Make more widely available community-based prevention and education programs to enhance existing community resources

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