

## **SAMHSA-HRSA**

CENTER for INTEGRATED HEALTH SOLUTIONS

Pediatric Integrated Care:
Opportunities for Screening,
Prevention and Intervention

Julie M. Austen, PhD Behavioral Health Consultant and Clinical Trainer





# **Setting the Stage: Today's Moderators**



Andrew Philip
Deputy Director



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# Slides for today's webinar will be available on the CIHS website:

https://www.integration.samhsa.gov/pbhcilearning-community/webinars

## To participate

Use the chat box to communicate with other attendees



#### **Disclaimer:**

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#### **Presenter**



Julie M. Austen, PhD
Behavioral Health Consultant and Clinical Trainer

## **Overview of Today's Webinar**

- Background
- Models of Care
- In Focus: ADHD Care Teams
- Getting Started
- Conclusion & Questions

## Why Integrate?

40 – 60% of all pediatric medical visits have a behavioral component

Limited behavioral health access available for rural/non urban areas

Pediatricians report feeling unable to manage behavioral needs

Pediatricians also report that they don't have enough time

#### **Outcomes**

- Improvement in provider satisfaction in quality and access to services
- High patient and family satisfaction
- Improvement in early recognition and treatment of issues, such as mental health
- Promising outcomes for improvement of parenting skills, obesity, sleep, and other issues.

## **Models of Integrated Care**

Consultation

- Behavioral health specialists deliver "point-of-care" service, often in the exam room
- Brief, problem-focused interventions; 4 6 visits are typical
- Consults with medical provider on potential treatment plan including possible referral to higher level of care

Care Coordination

- Usually care managers or nurses.
- Focuses on communication and building relationships across systems of support
- Often population –focused (e.g., children with asthma, obesity)

Co-Location

- Behavioral health specialists in same building
- Usually implements a "referral" system
- Interventions at tier III level, may include family, often ongoing

## Children 0 – 5 Years

	Consultation	Care-Coordination	Co-Location
Health/Development Needs	Typical Developmental Screenings - Help with toilet training - Help with weaning - Help with diet/ nutrition	Locating services	In-house Speech Language Pathologist/ Outpatient Therapeutic Practitioner
Mental Health	<ul><li>- ACES (Adverse</li><li>Childhood</li><li>Experiences Study)</li><li>- Attachment/bonding</li></ul>	Parenting groups Referrals to mental health or intensive in home parenting help Substance Use	<ul><li>Substance Use</li><li>Treatment</li><li>Family therapy</li></ul>
Complex/Co- Occurring	<ul><li>Parenting skills for differences in development</li><li>Family Support</li></ul>		

## Children 6 – 12 Years

	Consultation	<b>Care-Coordination</b>	Co-Location
Health/Development Needs	<ul><li>- Enuresis/encopresis</li><li>- Needle phobia</li><li>- Healthy Eating/Picky</li><li>Eating</li><li>- Autism Screening</li></ul>	Referrals for Sleep Studies Child Development Programs	
Mental Health	<ul> <li>- ADHD</li> <li>- Emotional regulation skills</li> <li>- Social Skills</li> <li>- Sleep issues</li> <li>- Brief Grief and Trauma</li> <li>- Behavioral issues</li> </ul>	Parenting groups - Referrals to mental health or intensive in home parenting help - Collaboration with schools and other community stakeholders	<ul> <li>Substance Use Treatment</li> <li>Family therapy</li> <li>Individual therapy</li> <li>Parent- child interaction therapy</li> </ul>
Complex/Co-Occurring	<ul> <li>Parenting skills for children with chronic illness</li> <li>Health Empowerment</li> <li>Assessing level of needs</li> </ul>	<ul><li>Coordination with youth services</li><li>Coordination with schools</li></ul>	<ul><li>Family therapy,</li><li>In-home intensive therapy</li></ul>

## Adolescents 12 – 18

	Consultation	Care-Coordination	Co-Location
Health/Development Needs	<ul><li>Consent and medical decision-making</li><li>Sexual health</li><li>Needle phobia</li><li>Healthy Eating</li><li>Autism Screening</li></ul>	- Referrals to obesity programs, nutritionist, sleep studies, family planning	- Brief therapy for chronic illness, support for pregnancy.
Mental Health	<ul> <li>- ADHD (still!)</li> <li>- Emotional regulation skills</li> <li>- Social Skills</li> <li>- Sleep issues</li> <li>- Brief Grief and Trauma</li> <li>- Behavioral issues</li> <li>- Substance use</li> <li>- Depression &amp; Anxiety</li> </ul>	<ul> <li>Parenting groups</li> <li>Referrals to mental health or intensive in home parenting help</li> <li>Collaboration with schools and other community stakeholders</li> </ul>	<ul><li>Substance Use     Treatment</li><li>Family therapy</li><li>Individual therapy</li><li>Parent- child interaction therapy</li></ul>
Complex/Co-Occurring	<ul> <li>Parenting skills for children with chronic illness</li> <li>Health Empowerment</li> <li>Assessing level of needs</li> </ul>	Coordination with schools, juvenile justice - Help with launching, college	Individual therapy, family therapy, systems-level interventions

## In Focus:

Pathway for ADHD Evaluation and Treatment

## ADHD Evaluation & Treatment

# Pre-visit Planning

- a.ROI for school
- b. Gives family Vanderbilts for teachers and parents
- c.lf child is >13, gives Pediatric Symptom Checklist self-report
- d.Same day visit to introduce BHC or flags BH for consult at next visit

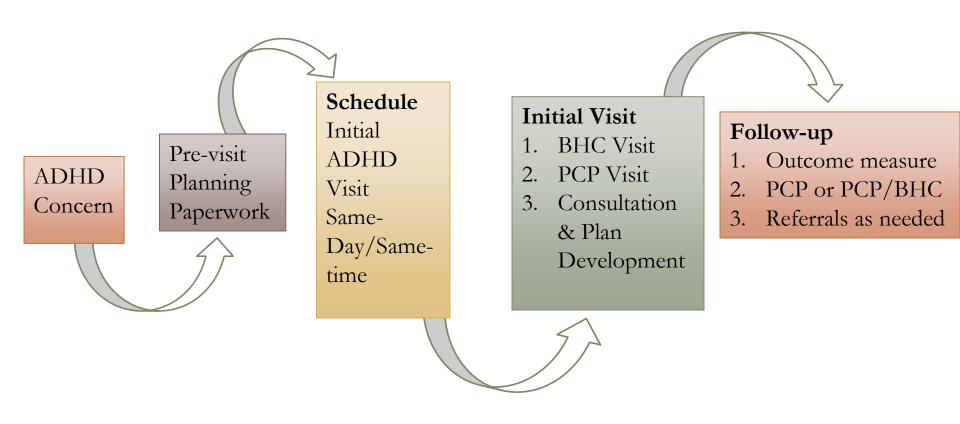
## Initial Visit

- a.Review information provided by school through ROI
- b.Screen for differential diagnoses
- c.Provide anticipatory guidance to families
- d. Provide brief intervention to families
- i.Parent training for children of all ages
- ii.Consult with medical provider regarding Dx

## Followups

- a. Follow-up Vanderbilts at 3 month intervals.
- b.Potential ADHD -5 assessment
- c.Continued brief intervention
- d.Follow-up with school as needed
- e.Wrap around services to outpatient mental health as needed

## **Pathway**



## Getting Started in Your Clinic: Two Ways

#### **Needs assessment**

#### **Population-based**

How many children are there in the community, what are disease prevalence rates, how many behavioral health providers does your community have?

#### Clinic based

What is the clinic's prevalence rate for chronic health conditions, like ADHD, Asthma, Obesity, depression?

### **Universal Screening**

- Align with current universal screening process
- Pick an age range or issue and start there
- Choose from the many free or inexpensive broad measures like Pediatric Checklist

### **Clinical Pearls**

 Consider starting with process improvement.

Collect data and compare it to best practices

- Consider starting with universal screening
   Use universal screening data to gain
   buy in and support
- Match your training to needs
   Find the right kid-trained people to get started or begin with good professional development



#### Resources

#### **Johns Hopkins PICC Toolkit:**

http://web.jhu.edu/pedmentalhealth/PICC%20TOOLKIT%201.pdf

#### **SAMHSA:**

https://www.integration.samhsa.gov/integrated-care-models/children-and-youth

#### **Project Launch:**

https://healthysafechildren.org/topics/integration-behavioral-health-primary-care-settings

## **Questions?**

Contact: Julie M. Austen, PhD

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**Piedmont Health Services** 

#### **CIHS Tools and Resources**

Free consultation on any integration-related topic!



Visit <u>www.integration.samhsa.gov</u> or e-mail <u>integration@thenationalcouncil.org</u>