Collaborative Medical and Mental Health Care in a Pediatric Medical Home: A necessity for medically underserved children
Workshop Goal

To discuss strategies for improving the early identification and management of mental health problems in medically underserved children as part of an Enhanced Pediatric Medical Home.
Objectives

To present and discuss:

- Existing evidence for the effectiveness of collaborative work between primary care medical clinicians and mental health providers;

- Discuss different models of collaboration and strategies for their selection; and

- Models currently being used by health care teams supported by Children's Health Fund.
Background

- History
- Solution to a public health problem
- Mission
Congregate Shelter
NYC 1987
CHF’s first mobile medical clinic, circa 1987.
Prototypical CHF mobile medical clinic.
National Network

- San Francisco Peninsula, CA
- Los Angeles, CA
- Idaho
- Montrose, CO
- Arkansas
- Chicago, IL
- Philadelphia, PA
- CHF National Office, NY
- New York City Programs
- Long Island, NY
- New Jersey
- Washington D.C.
- West Virginia
- Memphis, TN
- Mississippi
- Mississippi Gulf Coast
- South Florida
- Orlando, FL
- New Orleans, LA
- Baton Rouge, LA

Legend:
- Red dot: Children's Health Fund National Office
- Blue dot: Children's Health Fund Programs
- Triangle: Affiliates—Special Initiatives
A Mobile Clinic as a Pediatric Medical Home

An innovative solution to a public health problem
Keys for success

• Committed Medical Director & interdisciplinary healthcare team

• Clear mission/focus

• Identification and partnerships with effective Community Based Organizations (CBO)

• Institutional support
Identifying Need: Target Populations

- Uninsured & under-insured
- Health Professional Shortage Areas (HPSA)
- Preventable Emergency Department (ED) visits/hospitalizations
- Transportation barriers
- Special populations
Medically underserved: A special needs population

• Risk factors*
  – Economic
  – Geographic
  – Psychosocial

Sustainability

• Home institutional relationship
• Community Partners
• Local sources of financial support
  – Hospitals
  – Foundations
  – Other philanthropic support
• Grants
  – Local
  – Regional/state
  – Federal
CHF Mission

• The CHF is committed to providing health care to the nation’s most medically underserved children and their families –
  – Through the development and support of innovative primary care medical programs;
Medical Home: Key Components

- Accessible;
- Continuous;
- Comprehensive;
- Family-centered;
- Coordinated;
- Compassionate;
- And Culturally effective
The Pediatric Medical Home

- Comprehensive primary care
- Prevention-focused
- Acute & chronic care management
- Health education
- Subspecialty coordination
- 24/7 response system
The Medical Home

- A *Medical Home* is not a building, house, or hospital, but rather an *approach* to providing health care services in a high-quality and cost-effective manner.

American Academy of Pediatrics, 2004
Evidence for…

• “International and within-nation studies indicate that a relationship with a **medical home** is associated with better health, on both the individual and population levels, with lower overall costs of care and with reductions in disparities in health between socially disadvantaged subpopulations and more socially advantaged populations. Although important in facilitating use overall, insurance does not guarantee a medical home.”

(Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004; 113 (5):1493-1498.)
Future studies…

• “The evidence provides moderate support for the hypothesis that medical homes provide improved health-related outcomes for children with special health care needs. Additional studies with comparison groups encompassing all or most of the attributes of the medical home need to be undertaken.”

CHF Mission

• The CHF is committed to providing health care to the nation’s most medically underserved children and their families –
  – Through the development and support of innovative primary care medical programs;

  – Response to public health crises;
Public Health Emergency Preparedness and Response

- Hurricane Andrew (1992)
- 9/11 (2001)
- Hurricanes Katrina & Rita (2005)
- Hurricane Ike (2008)
Studying Katrina’s Impact:
Gulf Coast Child & Family Health Study
Studying Katrina’s Impact: Gulf Coast Child & Family Health Study

- Method: multi-stage cluster sample
- Sample: 1,079 randomly selected LA & MS displaced or greatly impacted households
- Interviewed
  - Baseline – within 1st year after Katrina
  - At 2nd year anniversary
  - At 3rd year anniversary
- Group is representative of 60,000 – 100,000 displaced and greatly impacted Katrina survivors

CAFH Study measures

- Housing and relocation status
- Health status (physical + mental health)
- Access and use of health services
- Attitudes & behaviors regarding social institutions (justice, health, faith-based)
- Personal sense of self-efficacy, resilience, and recovery
Rate of movement into stable housing among displaced Katrina survivors

Percent stably housed

1 year 2 year 3 year 4 year 5 year 6 year

Actual rates

Projected rates
Impacts & Consequences of Unstable Housing

- Unstably housed adults and caregivers are...
  - 2.3 times as likely to report mental health disability
  - 1.9 times as likely to report a child with emotional problem
  - 3.1 times as likely to have a poor sense of community
  - 1.8 times as likely to have a child whose academic performance was worse after the hurricane
  - 1.9 times as likely to not have adequate social support

Key Point: All of these are equally true of people living in households with incomes below $20,000 as those above
Academic Achievement: Age-Appropriate Grade Levels

<table>
<thead>
<tr>
<th>Region (year)</th>
<th>National Center for Education Statistics¹</th>
<th>Gulf Coast Child &amp; Family Health Study²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total children surveyed, grades 6-12</td>
<td>3,081</td>
<td>242</td>
</tr>
<tr>
<td>% one or more years older than appropriate age for grades 6-12</td>
<td>18.5%</td>
<td>33.9%</td>
</tr>
</tbody>
</table>

¹ Based on random-digit dial National Household Education Survey, US Dept of Education
² Based on Columbia’s longitudinal cohort study of 1,079 randomly sampled displaced households in Louisiana and Mississippi post-Katrina
The CHF is committed to providing health care to the nation’s most medically underserved children and their families –

- Through the development and support of innovative primary care medical programs;

- Response to public health crises; and

- Promotion of guaranteed access to appropriate health care for all children.
Enhanced Medical Home
Enhanced Medical Home: Key Components

- More time than typical pediatric visit
- *Intensive* primary care
- Bringing primary and sub-specialty care into the community
- Integration of traditional sub-specialty care services (Mental and Oral health care, e.g.)
- Effective use of Health Information Technology

Health Information Technology: Electronic Health Records

- Pediatric needs*
  - Immunization management
  - Growth tracking
  - Medication dosing
  - Data norms
  - Privacy in special populations

With appropriate pediatric content, Electronic Health Records.....

- Facilitate use of evidence-based & linked protocols

- Include templates for:
  - Pediatric-focused screening (e.g., developmental, psychosocial and maternal depression)
  - Special Population needs
  - National standards (e.g., NHLBI asthma guidelines)

- Facilitate integration of mental, medical & oral health services (shared EHR model)

- Link directly to, for e.g., municipal immunization and newborn screening registries

- Generate reports for applied research
  - Descriptive, CQI and outcome/efficacy studies
Health Information Technology: Telemedicine

• Bridges geographic barriers
  – Transportation
  – Health professional shortages
  – Especially effective in rural communities

• Synchronous (real time) [1]

• Asynchronous (store-and forward) [2]


Special Initiatives

- Referral Management Initiative (RMI)
- Asthma Initiative
- Starting Right
- Transportation Initiative
CHF Referral Management Initiative: Essential Elements

- Facilitated communications appointments
- Timely appointments
- "Navigational" assistance
- Phone, mail, in-person reminders
- Transportation

RMI dramatically improves adherence with specialist appointments

Before 1997: 7%

2005: 61%
Canadian Collaborative Mental Health Initiative

• Degree of collaboration does not necessarily predict clinical outcome;
• Major depressive disorders respond best to respond to collaborative efforts; and
• One of the most powerful predictors of positive clinical outcomes: inclusion of systematic follow-up.

Reference: www.ccmhi.ca
Collaboration models

- (External) Consultation
- Co-location
- Integration
- Key Point: These are not mutually exclusive, but represent a continuum.

**Enhanced Referral (RMI)**

- Fortifies the three models
- Useful (necessary?) for external and internal referrals
- In accordance with team-based care concept
- Supports the concept of care management and coordination
Patient-centered Medical Home (PCMH)

- Primary care
- Patient-centered care
- New-model practice
- Payment reform

External consultation

• Formal arrangements between primary care clinic and mental health specialists
• Modes: face-to-face, phone, email, telemedical
• Content: Assessment interpretation, psychotropic medication, further evaluation
• When: Limited resources, low caseload, specific mental health disorders
Co-location

• Mental Health provider works in the primary care setting
• Modes: face-to-face, phone, email, telemedical
• Content: Assessment interpretation, psychotropic medication, further evaluation
• When: Relatively high prevalence of mental health disorder(s) in patient population
Integration

• Bidirectional communication between primary care and mental health providers
• Collaborative protocol development (screening, assessment and management)
• Sharing pertinent components of the patient records (Paper or EHR)
• On-going communication (case discussions, educational meetings, etc.)
CHF National Network Models
The South Florida Children’s Health Project
The South Florida Children’s Health Project

- Established in response to Hurricane Andrew (1992)
- Affiliation: University of Miami Miller School of Medicine
- Today’s focus: Uninsured in Miami-Dade County
- Population: Immigrants (70% Hispanic; 20% Hatian)
- Barriers: Language, culture, legal, transportation
SFCHP Mental Health

Triage & Prioritization

Positive screens: Consult form to LCSW

Medical team: Developmental/Behavioral assessments and follow-up

Refer back to medical team

Possibilities:
F/U w/LCSW
F/U w/psychologist
Consult w/medical team
Classroom observation
Referral to outside agency

Triage & Prioritization
The New Orleans Children’s Health Project

- Established in response to Hurricane Katrina
- Mobile Medical Clinic (MMC) & Community Support and Reliency Unit (CSRU)
- Affiliation: Tulane University School of Medicine
- Barriers to health care: financial & housing instability, lack of insurance, transportation, “temporary” provider shortage
- Special Initiative: Transportation
The New Orleans Children’s Health Project: Mental Health

• Medical and Mental health teams work in an integrated fashion

• 2 recent initiatives highlight collaboration:
  – Adolescent depression screening initiative
  – Weight management initiative
Tele-Mental Health

• Mississippi Gulf Goast Children’s Health Project
  – Based at an FQHC (Coastal Family Health Center)
  – Telepsychiatry

• Memphis Regional Children’s Health Project
  – Based at a children’s hospital (Le Bonheur)
  – Collaboration with UT-Memphis
  – Real-time (Tele-mental health)
  – Store-and-forward (Pediatric sub-specialty care)

Key Point: These are external consultation models with elements of integration.
The South Bronx Health Center for Children and Families

- Developed from the original New York Children’s Health Project
- Primary care & mental health providers, outreach workers and other support staff work collaboratively on the screening, assessment and management of mental health problems
- Bidirectional consultation (Primary care and mental health providers)
- Model of Integrative care
The South Bronx Health Center for Children and Families

• Established 1993
• Affiliation: Montefiore Medical Center, Albert Einstein College of Medicine
• Community Based Health Center
• Population: Underserved community (53% Medicaid, 19% Uninsured)
Choosing models

• Scientific evidence
• Clinic staff, areas of expertise
• Resources (clinic and community)

• Key Point: Different models can co-exist at the same clinic site.
Operational Considerations

- Space
- Staffing supervision
- Provider communication
- Reimbursement issues
- Continuous quality improvement (CQI)
Discussion...

www.childrenshealthfund.org