Partnership Access Line
Community Consultation

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Disclosures

• I have no financial conflicts of interest to disclose
Child Mental Health is a National Issue

- Access to care
- Quality of care
- Appropriate use of psychiatric medications

- Primary Care medical home a growing focus for kids
Why the Focus on Primary Care?

- 1 in 5 Primary Care Clinician (PCC) appointments are for a behavioral health complaint
- PCCs provide ~half of common mental disorder care
- PCCs prescribe the majority of psychotropic medications
- Nearly every child with a mental health issue has a PCC
  - Like schools, a public mental health access point

W Gardner and K Kelleher, 2000
New Freedom Commission, 2003
Not Enough Specialists to Meet Care Demands

- Nationwide shortage of child psychiatrists
  - about 1 child psychiatrist for every 800 children with serious emotional disturbance (CGAS <50)
    - OR: about 1 per 900
    - WA: about 1 per 1100
    - WY: about 1 per 1500
Our Similar Workforce Distributions

Source: AACAP.org
Addressing the shortage

• Some increase in child psych trainees
  ▫ Not sufficient to resolve the shortage

• Even if more specialists, doesn’t solve everything
  ▫ Families may resist use of specialist care
    · ~60% mental health center no show rate for new referrals from PCC
  ▫ Rural access would be the last thing to improve

Kelleher K 2000
WJ Kim, 2003
Working with Primary Care

“Safe and effective mental and physical health care requires collaboration and communication between child and adolescent psychiatrists and other medical professionals”

-Excerpt from “Collaboration with Pediatric Medical Professionals” Policy (2008)
Appropriateness of PCC providing the first tier of mental health services

• Not every headache requires a neurologist...

• Goal is a system where:
  ▫ PCP treats majority of the less complicated cases
  ▫ Specialists more available to treat the more complicated children and families
Primary Care Clinician’s Advantages

- No Stigma
- Family has high level of trust/respect
- PCC is familiar with family and past development
- Location accessible to family
- Referral away often translates to lack of care

Barriers to PCC Providing MH Services

- Lack of time
- Lack of comfort, training, expertise
- Insufficient reimbursement
- Lack of knowledge about local resources
- Lack of local mental health specialists
- Insufficient referral feedback or shared decision making with specialists
  - Psychiatry gets referred to as “the black hole”

AAP Task Force on Mental Health Chapter Action Kit, 2007
Effective Collaboration Components

- PCC has timely access to consultation
  - Assistance available when it is needed, not weeks later
- Care coordination assistance
  - to help family access services, and help PCC and psychiatrist to connect
- Access to traditional psychiatric services
  - PCC should not be expected to be the lead ongoing provider for children with complex mental health needs
- PCC gets education on mental health care
  - case based learning, or other means

Advantages of Telephone Consultations

- “Just in time” processing
  - offer assistance only when PCC wants it
- Create teachable moments
  - problem based learning on provider’s own patient
- Can reach a large audience easily
- Match intervention to level of primary care provider engagement
  - call as often as you want
  - Even if not committed to MH training, still want to help own patient
Massachusetts Example

- Statewide, insurance blind and generously funded system
- 6 regional, separate hotlines
- Business hour availability
- Each hotline has its own:
  - child psychiatrists
  - MSWs
  - administrative assistants
Creating our Phone Consult Service

• Created a realistic service proposal
• Building alliances
  ▫ Pediatricians
  ▫ Legislators and staff
  ▫ Medicaid administrators
  ▫ Hospital government relations
• Timing
• Bill passed creating the pilot program
  ▫ Later continued as a Medicaid program
Program Development in WA

• Law passed in April 2007
  ▫ Contract signed to provide the new service in March 2008
• Initial plan was for 2 programs:
  ▫ Learning collaborative
    • later discontinued due to enrollment problems
  ▫ Partnership Access Line
PCC Survey Re-confirmed our Impressions

<table>
<thead>
<tr>
<th>Primary Care Provider BASELINE Needs Assessment (253 respondents)</th>
<th>Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>With existing resources I am usually able to meet the needs of children with psychiatric problems</td>
<td>23%</td>
</tr>
<tr>
<td>For my MEDICAID patients I can find a psychiatrist when needed</td>
<td>21%</td>
</tr>
<tr>
<td>For my PRIVATE INSURANCE patients I can find a psychiatrist when needed.</td>
<td>38%</td>
</tr>
</tbody>
</table>
Factors in the Planning Process

- Rural versus urban needs
- Variations in prescribing patterns
- Foster Care population concentrations
How to do more with less $ ?

Washington State

$ 0.38 per child covered life/yr

Massachusetts

$2.26 per child covered life/yr
**PCP calls**

PAL consult team with a mental health question on any patient (8AM-5PM)

**PAL CAP provides a rapid access phone consult**

**PAL CAP EMR entered advice is faxed to PCP (by next day)**

**PAL rapid televideo consult scheduled if both A) desired by PCP B) Medicaid child**

**PAL SW offers resource assistance or a phone consult (by PCP or CAP request)**

**Same day PCP feedback, then a dictated note**

PCP=primary care provider

PAL=Partnership Access Line

CAP=child & adolescent psychiatrist

SW=social work

EMR=electronic medical record
Telemedicine Equipment
Other Aspects of PAL Services

- Free psychiatric care education conferences
  - 4 times a year in WA
  - 3 times a year in WY
- Free, expert reviewed care guide
  - At palforkids.org and wyomingpal.org
- Quarterly fidelity audits and team consult approach to ensure advice is consistent
Dear Exxxx Bxxxxxxx,

On 1/4/2013 you had a telephone discussion with xxx xxxx of the Partnership Access Line regarding your patient XXXX XXXXX. Based on the information you provided to our program, we offered some suggestions for how to better help XXXX. Below is a summary of those care suggestions as recorded by XXXX XXXXX, which you might find helpful for future reference.

Particular non-medication interventions we recommended:
- Psychiatric Evaluation - referrals already provided to family
- Cognitive Behavior Therapy - for depression and anxiety; if self-harm is more chronic and prominent, consider Dialectical Behavioral Therapy

Psychosocial treatment advice discussed:
1. Pursue the excellent treatment plan that you have already laid out by obtaining a comprehensive psychiatric evaluation and follow up with the therapist to ensure evidence-based therapy is being conducted
2. Encourage the family to follow a crisis prevention plan: if one is not already in place, they should work with the therapist on one right away

Medication to consider stopping (in the next month), or to cancel plans to start:
- Paxil - although the plan now is to stop it given more concerns about increased suicidality with Paxil and XXXX’s perception that it is not helpful, Paxil can be reconsidered at a higher dose in the future if other antidepressants prove ineffective

Medication to consider starting (in the next month):
- Prozac - can be helpful for depression and anxiety and potentially bulimia if there’s significant binging and purging to qualify for the diagnosis

Ideas that were discussed for monitoring your patient:
1. Stop Paxil as planned and replace with Prozac as recommended: please refer to PAL Care Guide for details. If Prozac is not tolerated or ineffective, please call PAL for further recommendations if Cleo does not already have a psychiatrist in place
2. Administer screening questionnaires from PAL Care Guide for depression, anxiety and eating disorder

Care Guide Components Recommended:
- Depression, Anxiety, Eating Disorder
PAL was the 2nd statewide child mental health consult service created (after MCPAP)

Now 24 states with some version of PCC consults...
PAL Program Lessons Learned

• Lesson 1: PCPs manage very complex issues in rural areas
  ▫ Usually call PAL at a point of crisis in care
  ▫ Complex problems
    • ~2/3rd with “Serious Emotional Disturbance” (CGAS < 50)
    • ~3 MH related problems per patient
  ▫ Rural PCPs often don’t feel they need/want that full consult appointment but DO want to know it is available

*See Hilt et al., Feb 2013, JAMA Pediatrics*
PAL Program Lessons Learned

• Lesson 2: Despite high complexity, care often can remain in the medical home
  ▫ ~2/3 of the time, we recommended care to remain with the PCP (± a therapist)
• Lesson 3: Care coordination is necessary component
  ▫ ~1/2 of all callers receive PAL Social Work assistance
    • Connect to therapists and other resources
• Lesson 4: PAL program impacts different part of care system than Second Opinion Reviews
  ▫ minimal patient overlap
Lesson 5: **Actually recruiting providers to use the service is a challenge in rural, very underserved areas**

- i.e. impractical to set up lunchtime meetings to meet all PCPs
- CME meetings and word of mouth among colleagues recruit participants/ mailings not so great
PAL Program Lessons Learned

• Lesson 6: A small “virtual” team can work
  ▫ 2 PAL offices, 300 miles apart, televideo connected
  ▫ Using 2 child psychiatrist FTEs and 2 MSW to serve a 1.7 million child region
PAL Program Lessons Learned

• Lesson 7: **PCPs that use the service love it (though not everyone will use it)**
  ▫ Very positive PAL feedback survey data after the calls
  • Increased the PCP’s mental health care skills
  • Helped the PCP to manage their patient’s care
  • More PAL contacts → higher feedback survey scores
Lesson 8: **Consults steer kids into more psychosocial services (EBP therapies)**

- ~9/10 calls recommend new psychosocial treatments
- CBT and behavioral therapy recommendations and referral assistance
- Significant increase in foster children utilizing psychotherapy appointments after the PAL call (WA FFS Medicaid data)
PAL Program Lessons Learned

• Lesson 9: **If open the door to accepting all calls, Medicaid issues still predominate**
  ▫ ~2/3 of calls about Medicaid kids

• Lesson 10: **PCPs usually call because they seek medication advice**
  ▫ ~½ PAL recommended to start a medication
  ▫ ~¼ PAL recommended to stop a medication
PAL Program Lessons Learned

• Lesson 11: Do QI evaluations rather than a full IRB submitted process
• Lesson 12: If grow the program size large enough, service delivery improves
  ▫ 2 docs on duty (or more) creates great flexibility
  ▫ Med review and PAL can support each other
  ▫ Two states working together Greatly helped overall service responsiveness
Baseline Prescription Rates Rising

- All psychiatric prescribing to U.S. children increased by ~20% from 2001 to 2010

- 2004→2007 Medicaid antipsychotic use ↑10%
- Foster Care had larger increases (2002-2007)
  - Washington: ↑ antipsychotic use by 68%
  - Wyoming: ↑ antipsychotic use by 45%

Medco Health Solutions Report
Rutgers 16 state study
Rubin D et al 2012
WA Medicaid identified:
- High, rising expenses for child MH drugs
- Outlier prescribing on child MH drugs
  - Including unsafe regimens
WA Medication Reviews

• State workgroup decided on review “flags”
  ▫ Prescription arriving at pharmacy would trigger review if beyond a threshold
  ▫ Examples:
    • methylphenidate (Ritalin) at >120mg/day
    • dextroamphetamine at >60mg/day
System of Med Reviews

Prescription arrives at pharmacy triggering review

Medicaid requests supporting information from prescriber

Prescriber does not respond to Medicaid

Prescription is not authorized by Medicaid

Prescriber does respond to Medicaid

Second Opinion CAP has telephone discusses case with prescriber

CAP advice and recommendation on authorization sent to Medicaid

New antipsychotic is provided for up to 60 days during the review process

Medicaid makes final authorization decision

Key: CAP=child and adolescent psychiatrist
Medication Review Evolution

- Washington
  - ADHD medication reviews started 2006
  - Antipsychotic medication reviews started 2009
  - Reviews for >5 psych meds, and >2 AAP’s for >60 days started 2012
- Wyoming
  - ADHD and antipsychotic med reviews started 2011

- >2000 reviews completed since 2006
Selected Lessons from Running a Medication Review Program

• **Lesson 1:** Prescriber’s written rationale is usually insufficient to support an authorization
  ▫ doc-to-doc reviews for better communication
  ▫ more able to discuss best practices

• **Lesson 2:** If a “stop” at the pharmacy, rapid processing time is vital
  ▫ Delays undermine collaboration, can interfere with best patient care
Running a Medication Review Program

• Lesson 3: **Delivering a consistent message is a major challenge**
  - Initial multi-center design had to be abandoned
    • Audits kept finding diverging approaches
  - Collaborative/educational approach more valued than just “approve vs. deny”
  - Found a review leader needs to be regularly present
  - Quarterly audits ensure consistency
Running a Medication Review Program

- **Lesson 4**: Even high risk regimens can be fiercely defended
  - i.e. methylphenidate 450mg, or using 9 medications
- **Lesson 5**: You can’t please everyone
  - Second Opinion program feedback surveys:
    - Review was “useful” 53% of the time
    - Review was “not useful” 27% of the time
    - (other s reported a “neutral” opinion)
Running a Medication Review Program

• Lesson 6: Faculty resistance is a factor
  ▫ Some senior faculty may refuse to do it
• Lesson 7: No one is above the law
  ▫ Even the reviewers get reviewed
• Lesson 8: Consultant flexible availability is a challenge
  ▫ Need to pair this activity with some other program that provides flexible timing
Existence of Review System Alone changes practice

- For ADHD prescriptions altered after state’s request is made for a 2nd opinion review:
  - 50% were changed prior to the scheduled review
    - Hawthorne effect
  - 28% were denied due to prescriber non-response
  - 20% altered due to the 2nd opinion reviewer’s recommendation to deny the prescription
    - Remaining 2% altered later

Thompson J. et al, 2009
Wyoming MDT Consultations

To improve dependent child care planning through telemedicine
Challenges per Wyoming DOH

• Foster care and CHINS children have MH placement plans made at local court hearings
  ▫ “MDT Evaluations”

• Historically difficult to arrange mental health evaluations prior to court’s clinical placement
  ▫ Sometimes placed long term in order to obtain an “assessment”

• Concerns about the appropriateness of many out of home mental health placements

Source: Dr. Jim Bush with DOH
Looking for Access

• Wyoming has shortage of child/adolescent psychiatrists (now 6 total)
  ▫ In-state child psychiatrists reported having no evaluation capacity for the rapid MDT hearing process

  ▫ We had a University based consulting team with telemedicine experience, so ...

Source: Dr. Jim Bush with DOH
MDT Psychiatric Consult Process: goal of speed and quality

1) DFS case worker or GAL faxes appointment request
   --Collateral data documents for the consultant
2) Coordinator sets up appointment, usually within 1 week
3) Case worker and consultant speak for ~30min prior to meeting patient
4) Televideo consult appointment in local DFS office
   --With caregiver, when possible
5) Final opinion report dictated by the next day
What the MDT Gets

• 6-8 page report
• Gestalt impression, diagnoses, and general care recommendations
  ▫ We describe child’s care needs, and the local team decides where that can best happen
  ▫ Judge and the MDT remain the final arbiter of the placement plan

• Our role, and acceptance of it, took a lot of work and time to develop
What we found by doing these televideo consultations

- Children often had:
  - Unrecognized problems (i.e. anxiety)
  - High complexity (i.e. mean of 4 diagnoses per child)
  - Frequent desire by teams for inpatient placements
    - ~80% of our initial referrals
  - Less frequently found need for inpatient placements
    - ~25% of our initial referrals
    - Translates to more care within community & financial savings
MDT Psychiatric Consult Feedback

- Initially: local team wariness about the program
- Now the DFS case workers praise the service
- Encouraging appropriate use of local services
Questions?

- Contact info:
  - Robert.hilt@seattlechildrens.org

  Note: All programs described were co-developed with WA and WY Medicaid divisions, the support of Dr. Jim Bush and Dr. Jeff Thompson