Perspectives On Integrated Child and Adolescent Mental Health Care in Oregon

Tan Ngo MD
Fellow, PGY-5
Child and Adolescent Psychiatry
Oregon Health and Science University
March 5th, 2013
Objectives

• Describe the basic levels of care in the current community mental systems in place for children and adolescents in Oregon

• Analyze various perspectives from mental health organizations of the potential impact of the formation of Coordinated Care Organizations (CCO’s) on these systems

• Describe different models of integrated mental health care for children and adolescents that may become more important in the future

• Take perspective on the evolution of the roles of a child psychiatrist with the emergence of integrated care

• Discuss new ideas about how to implement these new roles in training
Spectrum of Services

- Prevention
- Outpatient
  - And everything else in between...
- Intensive Children’s Treatment Services/Wraparound
- Day Treatment
- Residential/Behavioral Rehabilitation Services
- Sub-acute Inpatient
- Secure Child/Adolescent Inpatient Program
- Acute Inpatient
Spectrum of Services

- Mental health and addictions services for those with OHP are currently being provided by:
  - Mental Health Organizations ➔ county or groups of counties
    - e.g. Jefferson Behavioral Health ➔ Coos, Curry, Douglas, Jackson, Josephine, Klamath Counties
  - Community Mental Health Agencies
    - e.g. Trillium Family Services, Kairos

- Complex interweaving between these organizations and their services depending on contracts with OHP
Rise of CCO’s

• Oregon legislation → 2011
  o Coordinated Care Organizations → regional
    • ACO (Federal) → provider-driven
    • CCO (Oregon only) → all players involved in sharing risk
      o Representation from Primary Care, Specialty Care, Mental Health, Addictions, RN/NP’s, Dentists, Community Members, Reps from major health systems

• Triple Aim
  o **IMPROVE** the overall **HEALTH** of the population
  o Provide **BETTER QUALITY CARE**
  o **REDUCE COSTS** of health care service delivery
Hope of CCO’s

• Meet the Triple Aim → develop **integrated systems of health care**

• Definition of Integrated Care (for this talk)
  o Mental health and addictions **within** primary care and community
Hope of CCO’s

• Align and integrate care ➔ reduce administrative costs, waste, and duplication

• Primary care homes ➔ centralized coordination hub for physical, mental, and dental health, as well as addictions

• Focus on outcomes rather than services
  o Encourage prevention

• Engage community to address its own health needs
  o Address disparities
Hope of CCO’s

• Start with Medicaid, then move into Medicare, then PEBB/OEBB

• Single budget for CCO
  o Flexible and not tied to services provided (i.e. fee for service)

• Sharing risk all together
Targets for CCO’s

- At least for HealthShare…
- Align strategic initiatives to address high-risk populations → “low hanging fruit”
  - Highest acuity (and utilizers of resources) → patients with combined physical health, mental health, and addictions issues → divert away from the hospital
    - NICH program is addressing these kinds of kids and their families
  - Maternal and early childhood health
    - Roughly 50% of all kids born in Oregon are born into Medicaid

- Not as much focus has been placed on child and adolescent mental health
  - EXCEPT recent push by Oregon Senate President Peter Courtney
Why Child and Adolescent Mental Health Needs to Be Addressed by CCO’s

• ACE Study by Felitti et al. (1998)
  o Looked at adult population
  o Compared # of adverse childhood events (ACE’s) and adult risk behavior, health status, and disease
  o ACE’s
    • Psychological abuse
    • Physical abuse
    • Sexual abuse
    • Substance abuse in household
    • Mental illness in household
    • Mother treated violently
    • Criminal behavior in household
Why Child and Adolescent Mental Health Needs to Be Addressed by CCO’s

- ACE Study (1998)
  - ↑ ACE’s, ↑ risk for disease in adulthood

<table>
<thead>
<tr>
<th>Mental Health and Addictions</th>
<th>Physical Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed 2 weeks in last year</td>
<td>Ischemic Heart Disease (2.2)</td>
</tr>
<tr>
<td>Hx of suicide attempts</td>
<td>Cancer (any) (1.9)</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Stroke</td>
</tr>
<tr>
<td>Smoker</td>
<td>Obesity (BMI ≥ 35) (1.6)</td>
</tr>
<tr>
<td>Used illicit drugs</td>
<td>COPD (3.9)</td>
</tr>
<tr>
<td>IV drug use</td>
<td>Diabetes (1.6)</td>
</tr>
<tr>
<td></td>
<td>Sexually-Transmitted Infection (2.5)</td>
</tr>
<tr>
<td></td>
<td>Hepatitis or Jaundice (2.4)</td>
</tr>
</tbody>
</table>
Why Child and Adolescent Mental Health Needs to Be Addressed by CCO’s

- ACE Study (1998)
Why Child and Adolescent Mental Health Needs to Be Addressed by CCO’s

- ACE Study (1998)

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Diagram showing the pyramid of health outcomes from Adverse Childhood Experiences (ACEs), with layers indicating:
- Early Death
- Disease, Disability, and Social Problems
- Adoption of Health-risk Behaviors
- Social, Emotional, and Cognitive Impairment
- Disrupted Neurodevelopment
- Adverse Childhood Experiences

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

- Intervention by child and adolescent mental health providers

- Prevention
What I did with my elective time...

- **Goals:**
  - To understand how child and adolescent mental health services play into the development of CCO’s and into integrated care systems
  - To understand what the role of a child and adolescent psychiatrist will be with these new developments

- **Process:**
  - Interviewed administrators and staff of various mental health organizations and community mental health agencies, as well as others involved in CCO’s and policy, to see what they thought
    - Face to face or by phone
  - Attended talks about CCO’s and integrated care
  - Explored current models of integrated care being practiced with youth
    - Focus on homeless youth system (HYC in Multnomah County)
What do community mental health providers think of CCO’s?

• Concerns about what services will look like
  
  o “CCO’s will have to reconstruct the mental health system to focus on community-based care”
  
  o “Many physicians are not used to thinking in public health models”
  
  o “There is going to be less tradition child mental health services and more emphasis on educating primary care”
  
  o “Child psychiatrists are going to need to practice at the top of their license”
  
  o “A lot of this is going to be incumbent on us going out and shaking hands”
  
  o “There will never be enough child psychiatrists to be able to staff these integrated models”
What do community mental health providers think of CCO’s?

- Concerns about funding
  - “Payment needs to be aligned with how care is delivered”
  - “What models of care will be paid for?”
  - “Will prevention actually be funded by the CCO’s or will we still have to rely on grants?”
  - “Will child psychiatry have to fight other specialties for funding?”
  - “Will MHO’s really want to share their budgets?”
  - “When is this all going to stabilize so that we can make our budgets?”
What do community mental health providers think of CCO’s?

• Hopes

  o “Communication should be better, and that should make it easier to treat kids”

  o “Walls are going to be made more permeable”

  o “Over time, there should be more delineation of what can be managed by a PCP and what should be managed by a child psychiatrist”

  o “CCO’s should be able to provide for more creativity in terms of having patients and family access a wide continuum of care within a community base”

  o “CCO’s should be able to help with covering more kids and providing more resources”

  o “We might actually be able to effectively do prevention!”
What do community mental health providers think of CCO’s?

• My overall impressions
  
  o Nobody knows how this will all shake out with CCOs
    • Great discomfort with change
    • Wary, but hopeful
  
  o Everybody recognizes that models of care (and of reimbursement) will need to be changed
Spectrum of Services

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It’s at these levels where there is high focus on integrated care.
Models of Integrated Care

• Co-location in primary care clinics
  o Behavior specialist on-site
  o Child Psychiatrist on-site
  o Telepsychiatry
  o OPAL - K
Models of Integrated Care

- School-Based Health Centers → primary care home set up inside of school
  - Most (but not all have some co-location model)
Models of Integrated Care

- Outreach models → Focusing on assertively engaging youth and families where they are at
  - Novel Interventions in Children’s Health (NICH) program
    - “Medical ACT team”
  - Homeless Youth Continuum (Multnomah County)
Elements of Integrated Care

• Establishment of *stable, safe, positive, and trusting relationships* with child and adolescents is the highest priority
  - The more relationships, the better
  - No services without *engagement*

• *Outreach is critically important*
  - Connect to services
  - Circumvent barriers to accessing care
  - Avoid having youth get stuck in other systems (e.g. police, legal, gangs)
Elements of Integrated Care

• Connecting at-risk kids to a **community** is also a high priority
  - Helping youth make contributions to their society in what ways they can, e.g. art, music, education, job training, etc.
  - Connecting with others who have been able to overcome similar obstacles, e.g. bullying, addictions, etc.

• **Empowerment of members of a community** to engage with other members to **promote the health of their own**
  - **Peers** can help reach out to those who are afraid of the systems

• **Trained staff on-site within the community**
  - Know how to help kids (and families) transition into mental health or addictions treatment when they are ready
Elements of Integrated Care

- Need for higher level communications within and across organizations
  - Accessible and centralized data system
  - Vertical and horizontal flow of communication
  - Common framework and language
Elements of Integrated Care

• Flexible funding → Sharing and redistribution of resources to those services that need it the most

• Need to develop some way to keep the system self-sustaining

• There is a need for advocates for integrated systems of care for at-risk youth populations on a political level
School-Based Health Centers

Where they get help
Children with mental health troubles are just as likely to get help at school than in a doctor’s office.

Mental health service use in the past year among children aged 12 to 17

<table>
<thead>
<tr>
<th></th>
<th>Boys</th>
<th>Girls</th>
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<tbody>
<tr>
<td></td>
<td>Outpatient specialty mental health</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>Inpatient specialty mental health</td>
<td>2.6%</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

Source: 2011 National Survey on Drug Use and Health  
DAN AGUAYO/THE OREGONIAN
School-Based Health Centers

- Integration of mental health into school-based health clinics has high potential
  - “Schools are where the kids are at”
    - de facto mental health treatment centers
    - Reduce barriers to accessing care
    - Less disruptive to school day
  
  - Built-in community
  
  - Outreach and prevention efforts at schools can reach out to the wider community
  
  - Empowerment of students to help their own peers
  
  - Training of school staff to be aware of the social and emotional development of their students and to guide them to services when needed
School-Based Health Centers

- Difficulties fusing cultures of medicine, mental health, and academia
  - Child and adolescent psychiatrists will need to be “culturally-competent”

- Need to find ways to make these sustainable financially
  - Get off reliance on grants
  - Advocacy
Roles of a Child & Adolescent Psychiatrist in an Integrated System of Care

• Traditional office-based delivery → may not serve the needs of certain populations or of integrated care systems
  • Need to **outreach to both patient population and to system of care** to maximize effectiveness

• **More consultative/supervisory roles**
  • Liaison with physicians, case managers, therapists, and CADC’s to provide supervision and recommendations
  • For more complex patients, evaluate and treat more thoroughly as needed
Roles of a Child & Adolescent Psychiatrist in an Integrated System of Care

• Role as part of a treatment team will be more peripheral
  • Limited direct treatment with potentially less on-going psychotherapeutic work
  • Focus on consultative management of the patient with goal of returning treatment to manageable level for other team members

• Likely increased administrative roles
  • Working with system to optimize quality of care → QI projects, outcome measuring, training, oversight, utilization review
Roles of a Child & Adolescent Psychiatrist in an Integrated System of Care

- Need to be more active in advocacy and leadership
  - Desired by populations and integrated care systems
  - *On-going participation can help shape the delivery of care as it evolves*
  - Must be able to promote need for mental health and addiction services on systemic and political levels
  - The ability for a child and adolescent psychiatrist to provide a culturally-competent developmental perspective within a biopsychosocial model is a strong commodity when developing new systems
Why Child and Adolescent Mental Health Needs to Be Addressed by CCO’s

- ACE Study (1998)

Intervention by child and adolescent mental health providers

Prevention

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
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**Child and Adolescent Psychiatrists can advocate and guide both intervention AND prevention efforts***

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Impact on Child and Adolescent Psychiatry Training

• Need to set up opportunities to work in integrated models of mental health care
  o Learn how to be consultants to pediatricians and family practitioners
  o Learn how to be consultants to systems of care

• Allow opportunities for outreach to communities → learn about prevention

• Model and promote advocacy efforts from a hospital level to a community/state/national level
“Integration in our relationships create integration in our brains.”

-Daniel Siegel
Special Thanks

- Ajit Jetmalani MD, project supervisor and Division Director, OHSU
- Mike Franz MD, supervisor
- David Jeffery MD, Trillium Family Services
- Drew McWilliams, COO, Morrison Child and Family Services
- Margie MacLeod, Director of Quality, Program Development and Prevention Services, Morrison Child and Family Services
- Beth Putz, Director of Services for Children, Albertina Kerr
- David Pollack MD, OHSU
- Lisa Kaskan MD
- John Gale MD, Medical Services Director, LifeWorks NW
- Mary Monnat, CEO, LifeWorks NW; Member, Board of Directors, HealthShare
- Dennis Morrow, Executive Director, Janus Youth Programs
- John Duke, Clinical Director, Outside In
- C. Wayne Sells MD, MPH, Medical Director, Outside In
- Mollie Janssen, Program Manager, New Avenues For Youth
- Ashley Thistrup, Direct Services Manager of Youth Services, NAYA