Perspectives On Integrated Child and Adolescent Mental Health Care in Oregon

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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

Least restrictive

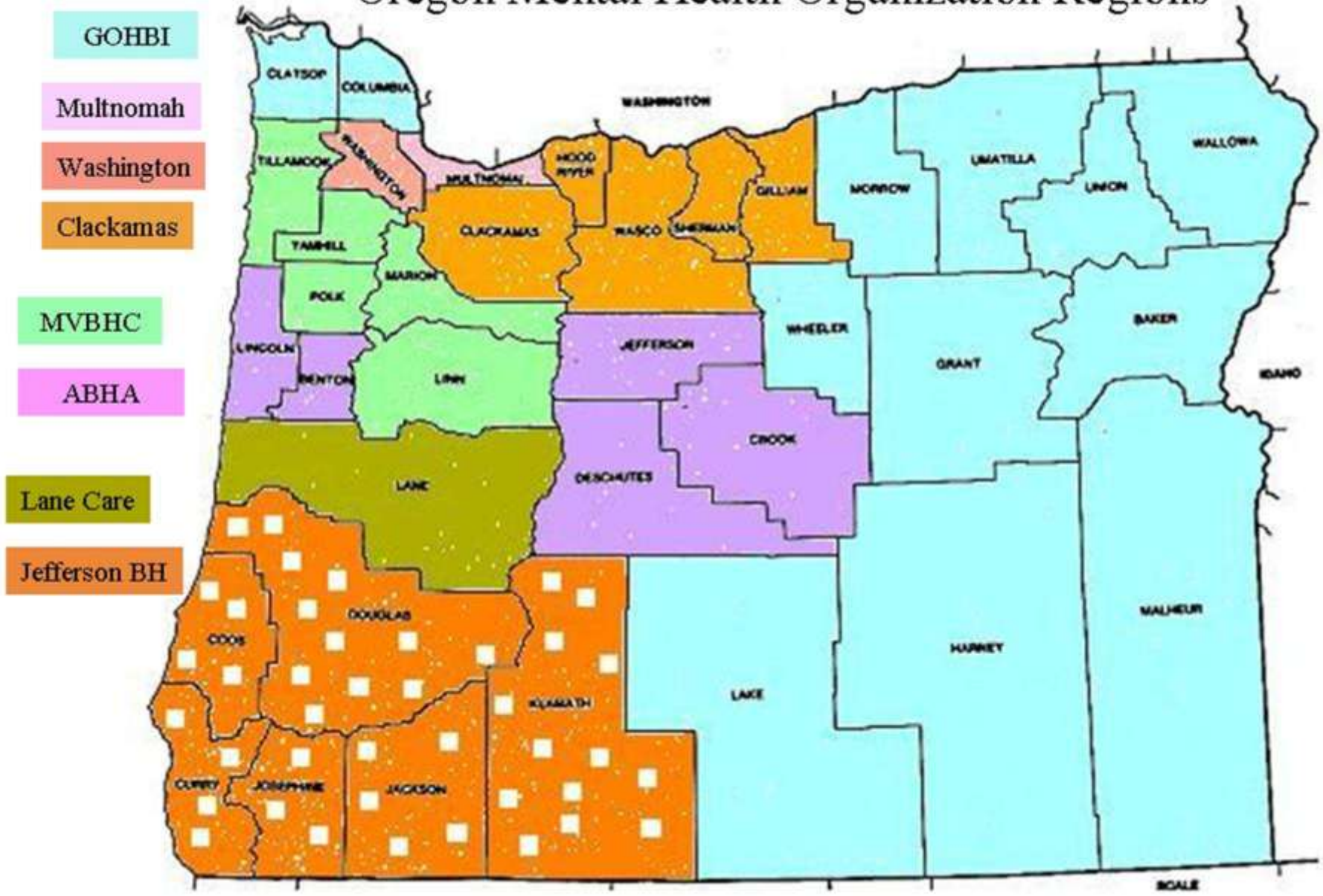
- Prevention
- Outpatient
  - And everything else in between…
- Intensive Children's Treatment Services/Wraparound
- Day Treatment
- Residential/Behavioral Rehabilitation Services
- Sub-acute Inpatient
- Secure Child/Adolescent Inpatient Program
- Acute Inpatient

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

Oregon Mental Health Organization Regions



Rise of CCO's

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

- Triple Aim
  - **IMPROVE** the overall **HEALTH** of the population
  - Provide **BETTER QUALITY CARE**
  - **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)
  - Mental health and addictions ***within*** primary care and community

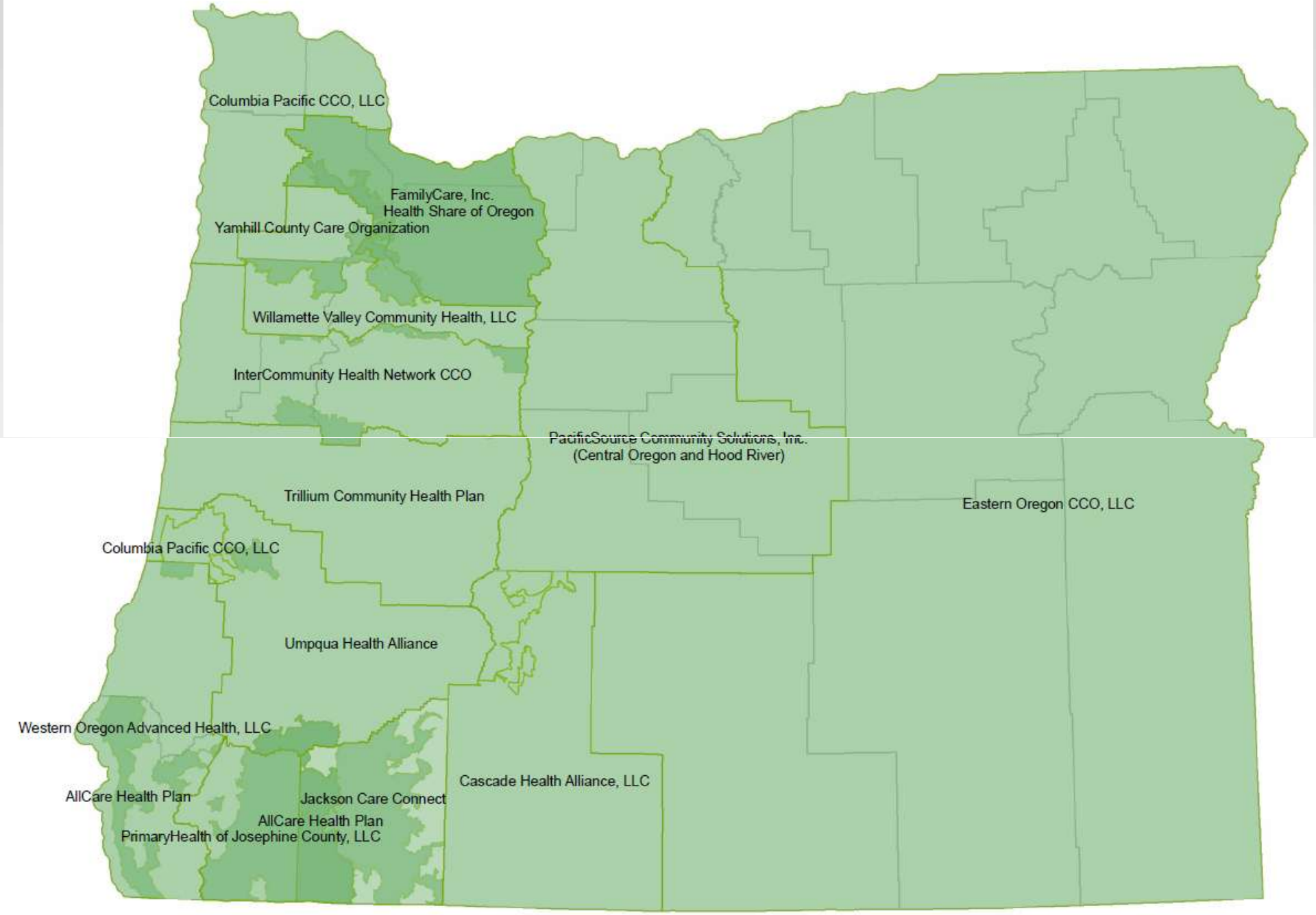
Hope of CCO's

- 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
  - Encourage prevention
- Engage community to address its own health needs
  - Address disparities

Hope of CCO's

- Start with Medicaid, then move into Medicare, then PEBB/OEBB
- Single budget for CCO
  - Flexible and not tied to services provided (i.e. fee for service)
- Sharing risk all together

Coordinated Care Organization Service Areas



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)
  - Looked at adult population
  - Compared # of adverse childhood events (ACE's) and adult risk behavior, health status, and disease
  - 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

Odds ratios for disease with 4+ ACE's			
Mental Health and Addictions		**Physical Health**	
Depressed 2 weeks in last year	4.6	Ischemic Heart Disease	2.2
Hx of suicide attempts	12.2	Cancer (any)	1.9
Alcoholism	7.4	Stroke	2.4
Smoker	2.2	Obesity (BMI ≥ 35)	1.6
Used illicit drugs	4.7	COPD	3.9
IV drug use	10.3	Diabetes	1.6
		Sexually-Transmitted Infection	2.5
		Hepatitis or Jaundice	2.4

Why Child and Adolescent Mental Health Needs to Be Addressed by CCO's

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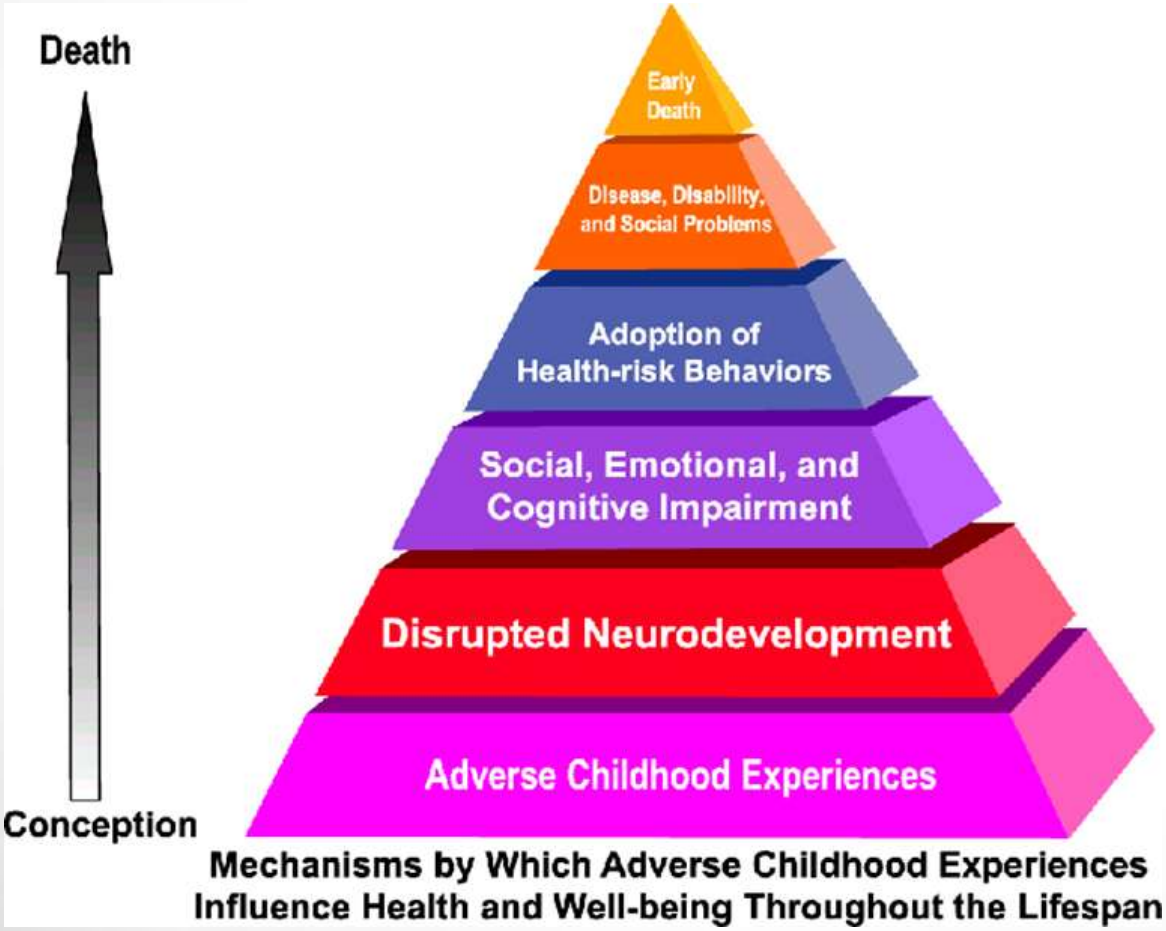

Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Why Child and Adolescent Mental Health Needs to Be Addressed by CCO's

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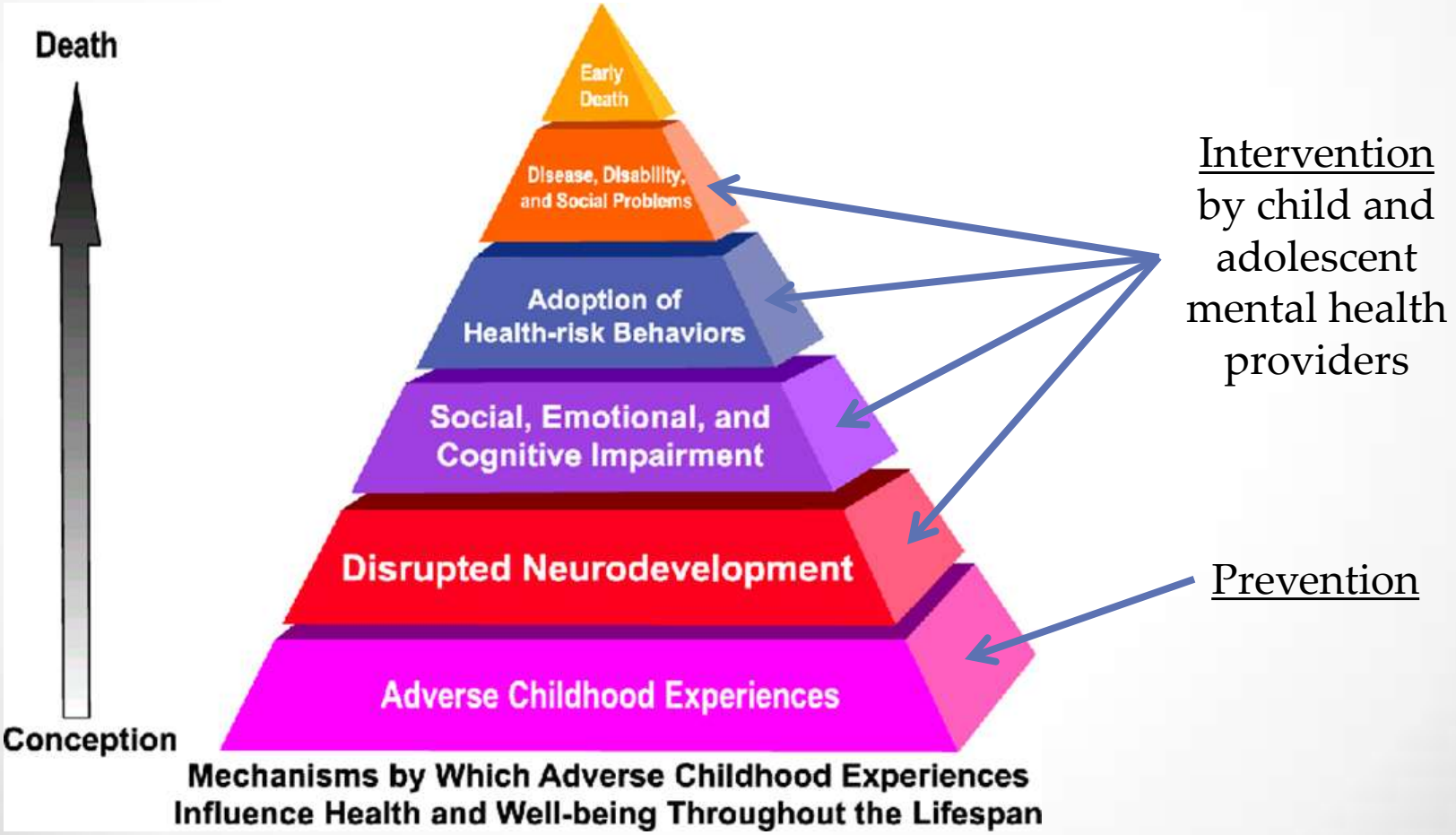


What I did with my elective time…

- 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
  - "CCO's will have to reconstruct the mental health system to focus on community-based care"
  - "Many physicians are not used to thinking in public health models"
  - "There is going to be less tradition child mental health services and more emphasis on educating primary care"
  - "Child psychiatrists are going to need to practice at the top of their license"
  - "A lot of this is going to be incumbent on us going out and shaking hands"
  - "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?"

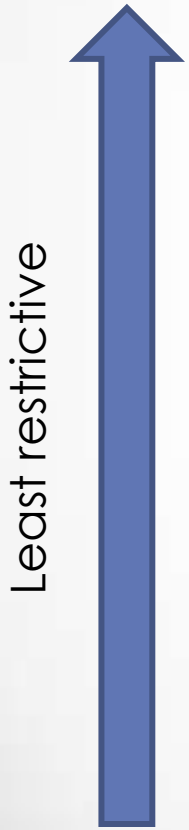
What do community mental health providers think of CCO's?

- Hopes
  - "Communication should be better, and that should make it easier to treat kids"
  - "Walls are going to be made more permeable"
  - "Over time, there should be more delineation of what can be managed by a PCP and what should be managed by a child psychiatrist"
  - "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"
  - "CCO's should be able to help with covering more kids and providing more resources"
  - "We might actually be able to effectively do prevention!"

What do community mental health providers think of CCO's?

- My overall impressions
  - Nobody knows how this will all shake out with CCOs
    - Great discomfort with change
    - Wary, but hopeful
  - 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

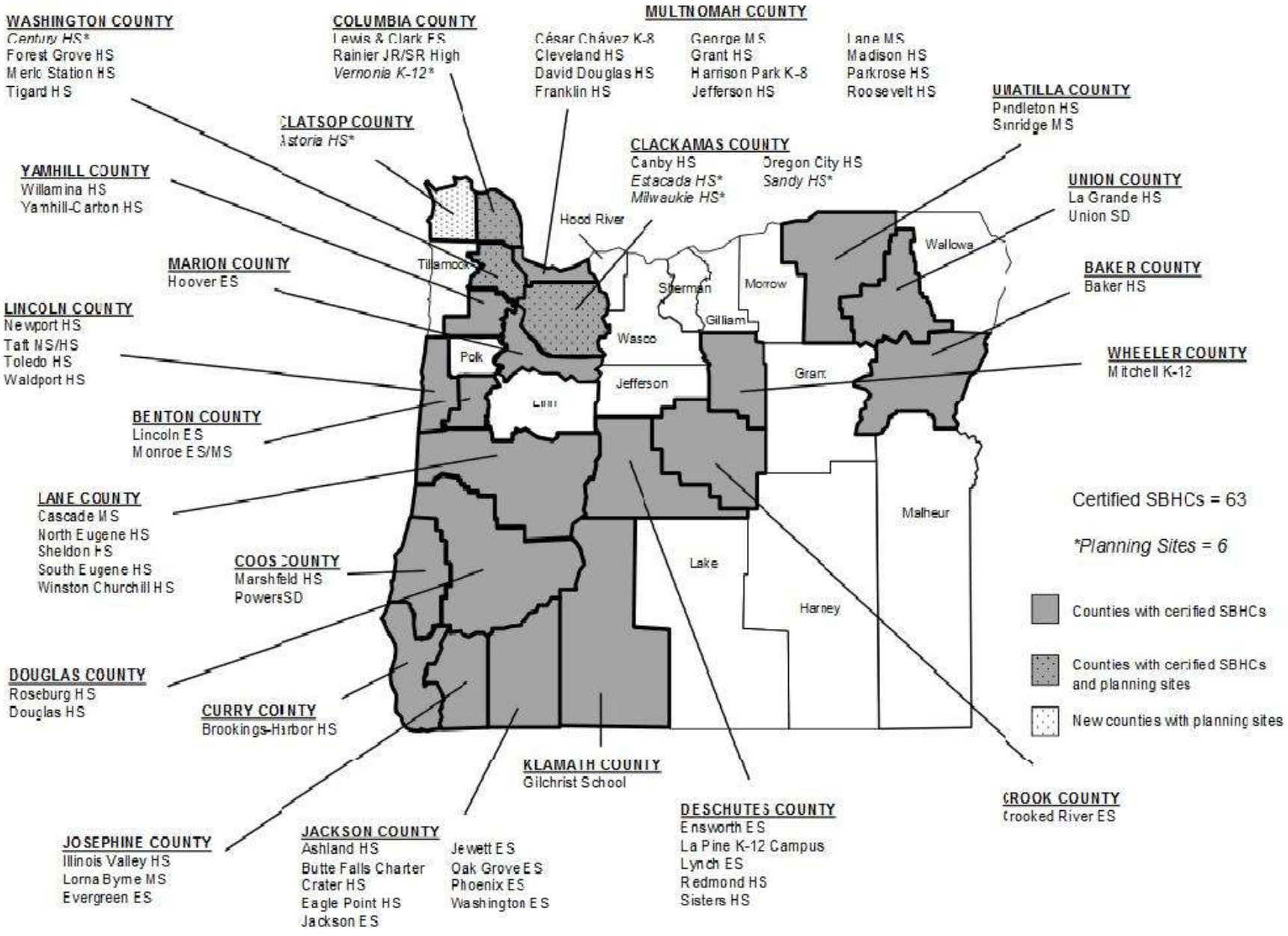
- Co-location in primary care clinics
  - Behavior specialist on-site
  - Child Psychiatrist on-site
  - Telepsychiatry
  - OPAL - K

OPAL - K
Oregon Psychiatric Access Line About Kids

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)

OREGON SCHOOL-BASED HEALTH CENTERS 2012



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

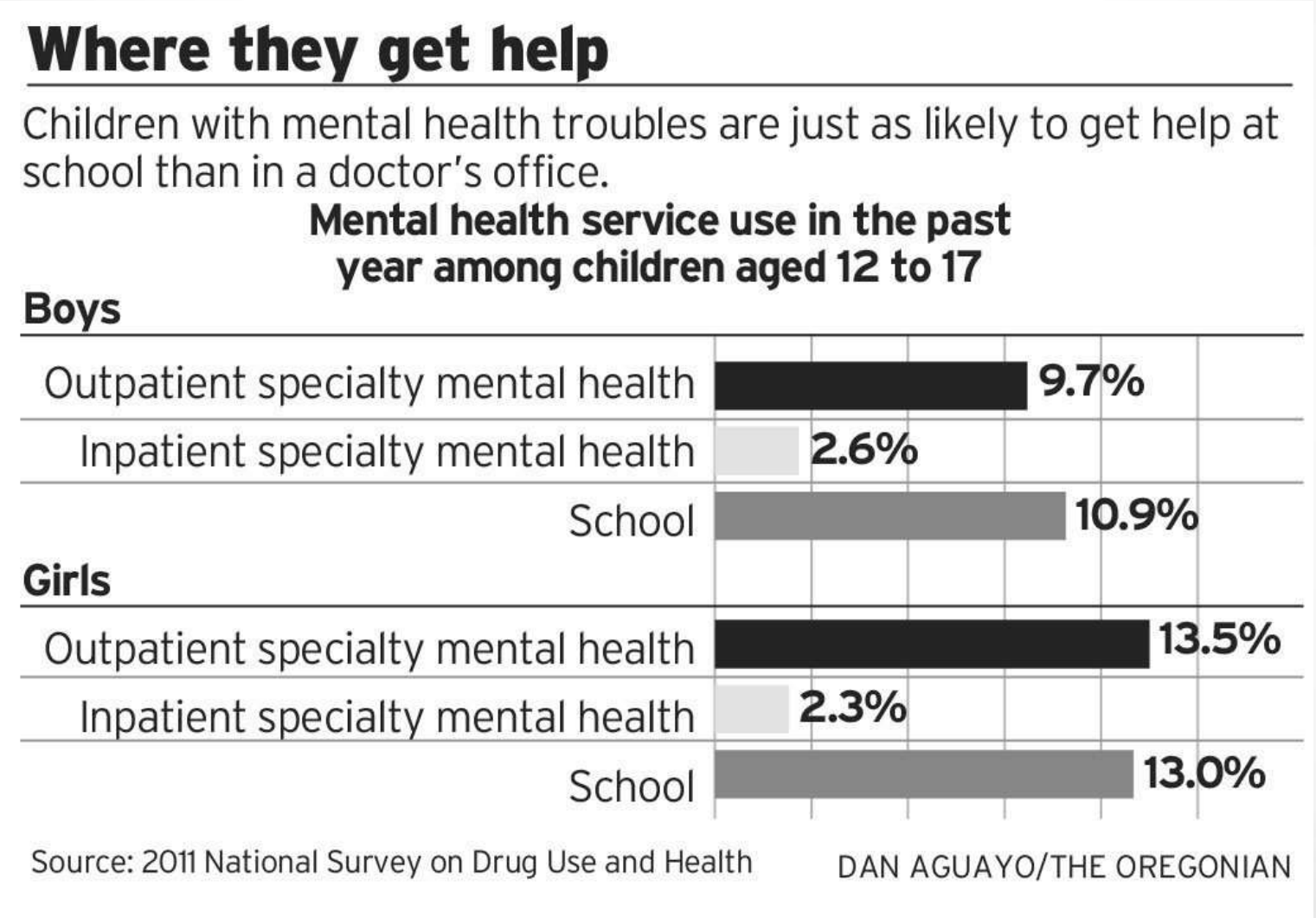
Elements of Integrated Care

- ***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



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 <u>more active in advocacy and leadership</u>**
  - Desired by populations and integrated care systems
  - ***<u>On-going participation can help shape the delivery of care as it evolves</u>***
  - 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 ***<u>strong commodity</u>*** when developing new systems

Why Child and Adolescent Mental Health Needs to Be Addressed by CCO's

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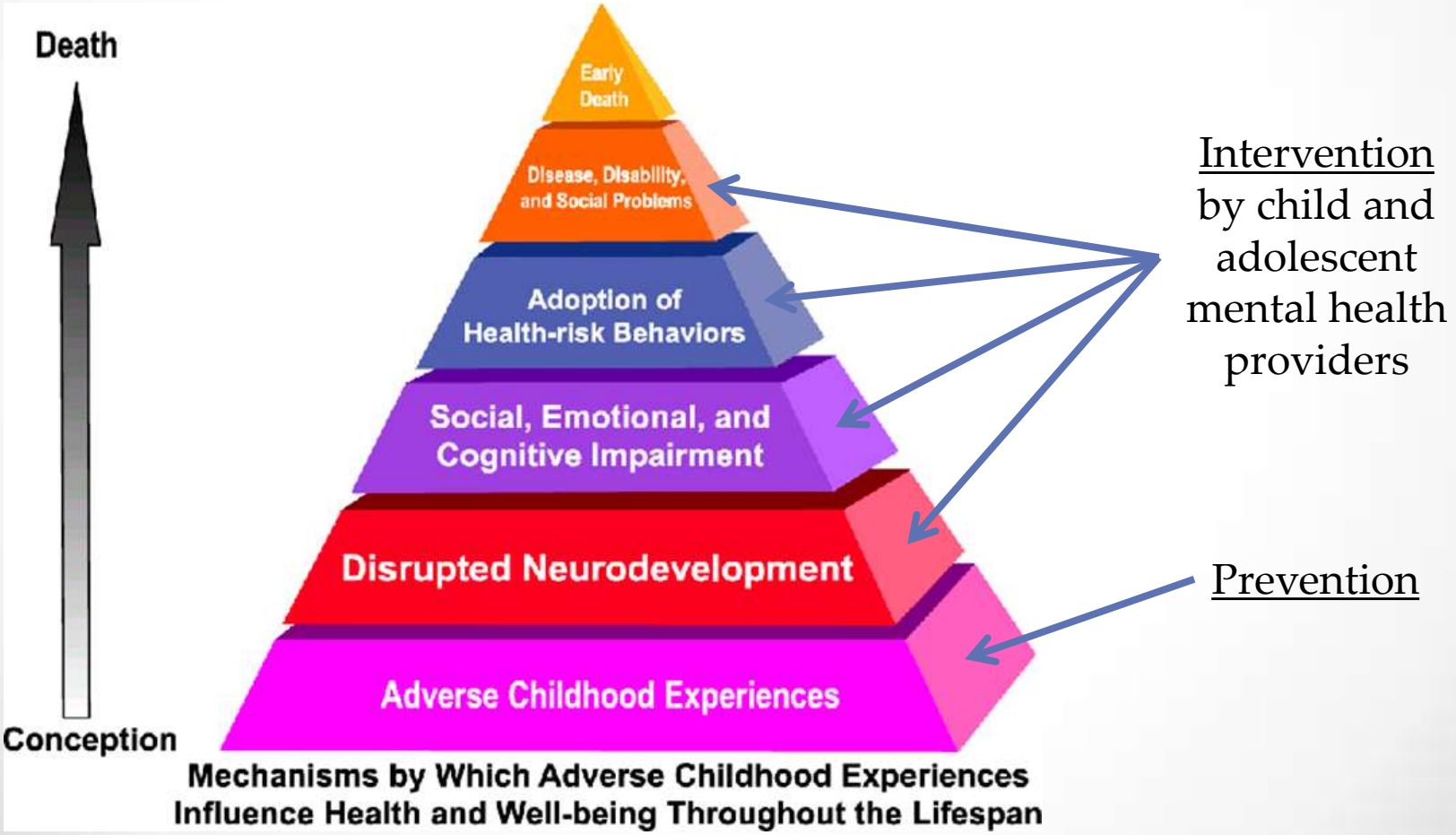

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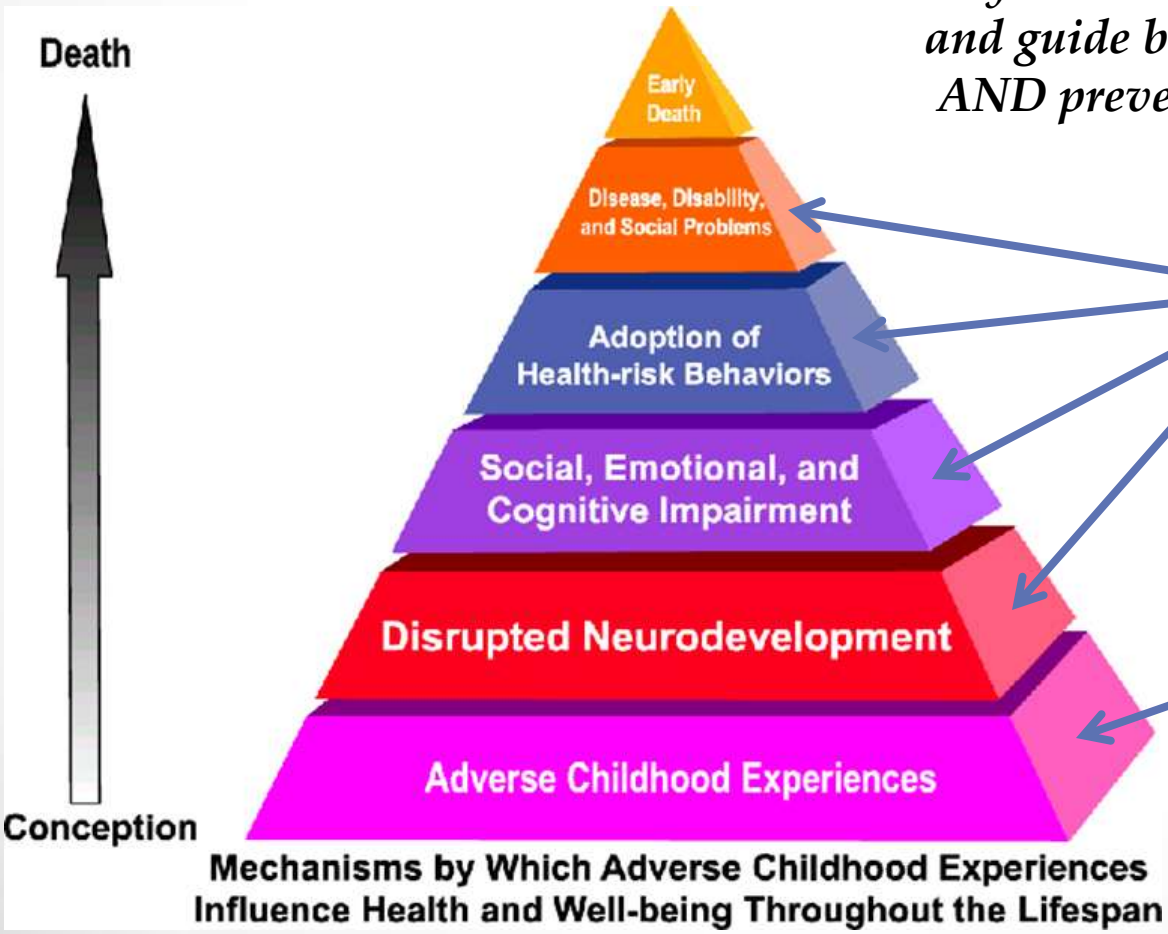
Child and Adolescent Psychiatrists can advocate and guide both intervention AND prevention efforts



Intervention by child and adolescent mental health providers

Prevention

Impact on Child and Adolescent Psychiatry Training

- Need to set up opportunities to work in integrated models of mental health care
  - Learn how to be consultants to pediatricians and family practitioners
  - 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 Thirstrup, Direct Services Manager of Youth Services, NAYA