Implementation:
Behavioral Health Services
and the
Primary Care Setting

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Disclosure

• No relevant commercial interests
Barriers

- Financial
- Time
- Knowledge base and confidence
AAP Clinical Practice Guideline

• Key Action Statements for the Evaluation, Diagnosis, Treatment and Monitoring of ADHD in Children and Adolescents

• Action statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity
Key Action Statements 2.

- In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD
- including emotional or behavioral (eg, anxiety, depressive, oppositional defiant, and conduct disorders),
- developmental (eg, learning and language disorders or other neurodevelopmental disorders)
- physical (eg, tics, sleep apnea) conditions
Overview of the ADHD Care Process

**Perform Diagnostic Evaluation for ADHD and Evaluate or Screen for Other/Consorting Conditions:**

**See action statement 1**

- **Family:**
  - Parents, guardian, other frequent caregiver
  - Chief concerns
  - History of symptoms (age of onset and age most severe)
  - Family history
  - Physical and mental development history
  - History of systems
  - Validated ADHD instrument
  - Evaluation of care conditions
  - Report of functional, both strengths and weaknesses

- **School:**
  - Important community information
  - Concerns
  - Validated ADHD instrument
  - Evaluation of care conditions
  - Report on how well patients function in academic, work, and social interactions
  - Academic records (e.g., report cards, standardized testing, psychological evaluation)
  - Administrative reporting (e.g., disciplinary action)

- **Child/adolescent:**
  - Appropriate for child's age and developmental level
  - Interaction, including concerns regarding behavior, family relationship, peers, school
  - For adolescents, validated self-report instrument of ADHD and care conditions
  - Report of child's self-stated impression of function, both strengths and weaknesses
  - Caregivers' observations of child's behavior
  - Physical and neurological examination

**See action statements 2-5**

**Assess impact on treatment plan:**

**See action statement 6**

1. **3rd-5th Grade:**
   - Diagnosis of ADHD

2. **Other conditions:**
   - Learning disorder
   - Sensory processing disorder
   - Any other disorder
   - Identify next steps

3. **Establish management by team:**
   - Identify child as CYSHCN
   - Collaborate with family, school, and child to identify targets
   - Establish plan including coordination plan

4. **Begin treatment:**
   - Option: Medication (ADHD only and past medical history and history of cardiovascular disease considered)
     - Initiate treatment
     - Taper as symptoms improve, minimum adverse effects
     - Monitor target outcomes
   - Option: Behavior management (developmental variation, problem or ADHD)
     - Identify parent or approach
     - Monitor target outcomes

5. **Follow up and evaluation:**
   - Review progress
   - Re-evaluate treatment plan including behavioral and medication considerations
   - Re-evaluate treatment plan including additional strategies

6. **Supplemental Appendix Figure 2:**

An ADHD process of care algorithm. TFCM indicates Task Force on Mental Health; CYSHCN, child/youth with special health care needs.
### Supplemental Appendix

**Supplemental Table 3** FDA-Approved Medications: Dosing and Pharmacokinetics

<table>
<thead>
<tr>
<th>Medication</th>
<th>Brand</th>
<th>Initial Titration Dose</th>
<th>Frequency</th>
<th>Time to Initial Effect</th>
<th>Duration, h</th>
<th>Maximum Dose</th>
<th>Available Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed amphetamine</td>
<td>Adderall®</td>
<td>2.5-5.0 mg</td>
<td>QD-BID</td>
<td>20-60 min</td>
<td>6</td>
<td>40 mg</td>
<td>5.0-, 7.5-, 10.0-, 12.5-, 15.0-, 20.0- and 30.0-mg</td>
</tr>
<tr>
<td>salts</td>
<td>Adderall XR®</td>
<td>5 mg</td>
<td>QD</td>
<td>20-60 min</td>
<td>10</td>
<td>40 mg</td>
<td>capsules, 5-, 10-, 15-, 20-, 25-, and 30-mg</td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>Dexedrine®/</td>
<td>2.5 mg</td>
<td>BID-TID</td>
<td>20-60 min</td>
<td>4-6</td>
<td>40 mg</td>
<td>and 10-mg (Dextrostat only) tablets, 5-, 10-, and 15-mg</td>
</tr>
<tr>
<td></td>
<td>Dextrostat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>capsules</td>
</tr>
<tr>
<td></td>
<td>Spansule®</td>
<td>5 mg</td>
<td>QD-BID</td>
<td>≥60 min</td>
<td>≥5</td>
<td>40 mg</td>
<td>5-, 10-, and 15-mg capsules</td>
</tr>
<tr>
<td>Lisdexamfetamine</td>
<td>Vyvanse</td>
<td>20 mg</td>
<td>QD</td>
<td>60 min</td>
<td>10-12</td>
<td>70 mg</td>
<td>20-, 30-, 40-, 50-, 60-, and 70-mg capsules</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Concerta</td>
<td>18 mg</td>
<td>QD</td>
<td>20-60 min</td>
<td>12</td>
<td>54 mg (&lt;15 y); 72 mg (≥15 y)</td>
<td>18-, 27-, 36-, and 54-mg capsules</td>
</tr>
<tr>
<td></td>
<td>Methyl ER</td>
<td>10 mg</td>
<td>QD</td>
<td>20-60 min</td>
<td>8</td>
<td>60 mg</td>
<td>10- and 20-mg tablets</td>
</tr>
<tr>
<td></td>
<td>Methyllin</td>
<td>5 mg</td>
<td>BID-TID</td>
<td>20-60 min</td>
<td>3-5</td>
<td>60 mg</td>
<td>5-, 10-, and 20-mg tablets and liquid and chewable</td>
</tr>
<tr>
<td></td>
<td>Daytrana</td>
<td>10 mg&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Apply for 9 h</td>
<td>60 min</td>
<td></td>
<td>30 mg</td>
<td>forms 10-, 15-, 20-, and 30-mg patches</td>
</tr>
<tr>
<td></td>
<td>Ritalin®</td>
<td>5 mg</td>
<td>BID-TID</td>
<td>20-60 min</td>
<td>3-5</td>
<td>60 mg</td>
<td>5-, 10-, and 20-mg tablets</td>
</tr>
<tr>
<td></td>
<td>Ritalin LA</td>
<td>20 mg</td>
<td>QD</td>
<td>20-60 min</td>
<td>6-8</td>
<td>60 mg</td>
<td>20-, 30-, 40-, and 40-mg capsules</td>
</tr>
<tr>
<td></td>
<td>Ritalin SR&lt;sup&gt;a&lt;/sup&gt;</td>
<td>20 mg</td>
<td>QD-BID</td>
<td>1-3 h</td>
<td>2-6</td>
<td>60 mg</td>
<td>20-mg capsules</td>
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<tr>
<td></td>
<td>Metadate CD</td>
<td>20 mg</td>
<td>BID</td>
<td>20-60 min</td>
<td>6-8</td>
<td>60 mg</td>
<td>10-, 20-, 30-, 40-, 50-, and 60-mg capsules</td>
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<tr>
<td>Dextroamphetamine</td>
<td>Focalin®</td>
<td>2.5 mg</td>
<td>BID</td>
<td>20-60 min</td>
<td>3-5</td>
<td>20 mg</td>
<td>2.5-, 5.0-, and 10.0-mg tablets</td>
</tr>
<tr>
<td></td>
<td>Focalin XR</td>
<td>5 mg</td>
<td>QD</td>
<td>20-60 min</td>
<td>8-12</td>
<td>30 mg</td>
<td>5-, 10-, 15-, and 20-mg capsules</td>
</tr>
<tr>
<td>Atomoxetine</td>
<td>Stratter®</td>
<td>0.5 mg/kg per d, then increase to 1.2 mg/kg per d; 40 mg/d for adults and children at &gt;154 lb, up to 100 mg/d</td>
<td>QD-BID</td>
<td>1-2 wk</td>
<td>At least 10-12 h</td>
<td>1.4 mg/kg</td>
<td>10-, 18-, 25-, 40-, 60-, 80-, and 100-mg capsules</td>
</tr>
<tr>
<td>Extended-release</td>
<td>Intuniv®</td>
<td>1 mg/d</td>
<td>QD</td>
<td>1-2 wk</td>
<td>At least 10-12 h</td>
<td>4 mg/d</td>
<td>1-, 2-, 3-, and 4-mg tablets</td>
</tr>
<tr>
<td>guanfacine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended-release</td>
<td>Kapvy&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.1 mg/d</td>
<td>QD-BID</td>
<td>1-2 wk</td>
<td>At least 10-12 h</td>
<td>0.4 mg/d</td>
<td>0.1- and 0.2-mg tablets</td>
</tr>
<tr>
<td>clonidine</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

QD indicates daily; BID, twice daily; TID, three times daily.

* Available in a generic form.

<sup>a</sup> Dosages for the dermal patch are not equivalent to those of the oral preparations.
Overcoming Barriers
• Emphasized systematic ways to assess children with mental health concerns including differential diagnoses
• Education about the science behind the treatment options
• Interactive, case-based, practice using algorithms for initiating treatment and managing the condition
• Provided materials that could be used in practice
• **Virtual Team**: real-time access to a mental health provider for advice and guidance on assessment, management and accessing care in the community
Implementation

**Buy-In**
- Staff: Front-line and Providers
- Parents

**Screening Tools**
- Universal use of the Pediatric Symptom Checklist 17
- Diagnosis Specific Tools: SCARED, Vanderbilt, PHQ9M

**Diagnosis and Management**
- Phone Consultation with Project TEACH providers
- Psycho-educational materials for Providers and Parents
- Consultation with Social Work and Outreach for Community Resources
Implementation: Elements to Remember

• Importance of proving to your institution that behavioral health care can be delivered without derailing throughput

• Clear documentation of all interventions to meet the requirements of DSRIP and NCQA-PCMH
  – Standardizing forms in the electronic medical records
  – Creating a registry

• Team Building by presenting success stories at practice meetings
Success and Spread
Meta-analysis of Depression Assessment and Management

- Twenty-one studies showed positive results for the intervention.
- Strategies that were successful in improving patient outcomes were generally more complex interventions that included:
  - Elements of clinician education and more integration between primary and secondary care.
  - Interventions of medication counselling delivered over the telephone by practice nurses or trained counsellors were also successful.

**Integrated Model**

- **Goal:** to provide continued access for our patients to the behavioral health providers
- **Education remains essential**
  - Collaborative Office Rounds
  - Bi-directional feedback between mental health team and providers
- **Empowering pediatricians to do more**
  - Prescribing practices
  - Curbside consultations
  - Coaching
Collaborative Care Model

• Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial
• David J. Kolko, John Campo, Amy M. Kilbourne, Jonathan Hart, Dara Sakolsky, Stephen Wisniewski
• Unlike our pilot study, this study included PCP training in an expanded ADHD care management protocol, practice-based randomization to optimize PCP participation, technology to collect and share patient progress, and greater communication among CMs, PCPs, and families.
### Appendix A. An Evidence-Based Framework for Primary Care–Behavioral Health Integration

<table>
<thead>
<tr>
<th>Component</th>
<th>Preliminary</th>
<th>Intermediate</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case finding, screening, and follow up</strong></td>
<td>Patient/clinician identification of those with symptoms—not systematic</td>
<td>Systematic screening of target populations (e.g., diabetes, CAD), with follow up for assessment</td>
<td>Systematic screening of all patients, with follow up for assessment and engagement</td>
</tr>
<tr>
<td><strong>Referral facilitation and tracking</strong></td>
<td>Referral to external BH specialist/psychiatrist</td>
<td>Enhanced referral to outside BH specialist/psychiatrist through a formal agreement, with engagement and feedback strategies employed</td>
<td>Clear process for referral to BH specialist/psychiatrist (co-located or external), with &quot;warm transfer&quot;</td>
</tr>
<tr>
<td><strong>Care team</strong></td>
<td>PCP and patient</td>
<td>PCP, patient, and BH specialist</td>
<td>PCP, patient, CM, and psychiatrist (consults and engages in CM case reviews)</td>
</tr>
<tr>
<td><strong>Multi-disciplinary team (including patients) used to provide care</strong></td>
<td>Communication with BH specialist driven by necessity or urgency</td>
<td>Formal written communication (notes/consult reports) between PCP and BH specialist on complex patients</td>
<td>Regular formal meetings between PCP and BH specialist</td>
</tr>
<tr>
<td><strong>Ongoing care management</strong></td>
<td>Limited follow up of patients provided by office staff</td>
<td>Proactive follow up to assure engagement or early response to care</td>
<td>Maintenance of a registry with ongoing measurement and tracking, and proactive follow up with active provider and patient reminder system</td>
</tr>
<tr>
<td><strong>Systematic quality improvement</strong></td>
<td>Informal or limited review of BH quality metrics (limited use of data, anecdotes, case series)</td>
<td>Identified metrics and some ability to review performance against metrics</td>
<td>Identified metrics and some ability to review performance against metrics, with designated individual to develop improvement strategies</td>
</tr>
</tbody>
</table>

**Notes:** BH Specialist refers to any provider with specialized behavioral health training; CM can refer to a single person or multiple individuals who have training to provide coordinated care management functions in the PC practice; Ancillary staff member refers to non-clinical personnel, such as office staff or receptionist; EBP refers to evidence-based psychotherapy.
<table>
<thead>
<tr>
<th>6</th>
<th>Self-management support that is culturally adapted</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Decision support for treatment of common behavioral health disorders and treatment guidelines: evidence-based guidelines, treatment protocols</td>
</tr>
<tr>
<td>4</td>
<td>Access to evidence-based treatment with BH specialists/treatment specialists</td>
</tr>
<tr>
<td>3</td>
<td>Tools utilized to promote patient activation and recovery</td>
</tr>
<tr>
<td>2</td>
<td>Clinical registries or electronic health records that track the entitlement and utilization of services</td>
</tr>
<tr>
<td>1</td>
<td>Sharing of treatment information among providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>Linkages with community/social services</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Linkages to housing and other social support services</td>
</tr>
<tr>
<td>6</td>
<td>Linkages to entitlement and social services</td>
</tr>
</tbody>
</table>

- **Key Domains of Integrated Care**
- **Components**
- **Domains**

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**Integration Continuum**

- Preliminary
- Intermediate
- Advanced

**Monte Kids.org**

(Appendix A cont'd. An Evidence-Based Framework for Primary Care-Behavioral Health Integration)
Thank you from Team FCC