OPTIMIZING IMPLEMENTATION OF PEDIATRIC INTEGRATED CARE THROUGH COMMUNITY ACADEMIC PARTNERSHIPS

NICOLE STADNICK, PH.D., M.P.H.
ASSISTANT PROFESSOR
LICENSED PSYCHOLOGIST (PSY27322)
UCSD, DEPARTMENT OF PSYCHIATRY
CHILD AND ADOLESCENT SERVICES RESEARCH CENTER
HEALTH PROBLEM: MULTIPLE SYSTEMS FOR AUTISM

- Early Intervention
- Community Mental Health
- General Pediatrics
- Education/Special Education
CHILDREN WITH ASD HAVE HIGH RATES OF MENTAL HEALTH COMORBIDITY AND UNMET MENTAL HEALTH NEEDS

- 92% with Any
- 78% with ADHD
- 58% with ODD
- 56% with Anxiety
- 30% with Mood
- 17% with ADHD + ODD + Anxiety

• Children met criteria for an average of 2.80 (SD = 1.91) Axis I non-ASD diagnoses

n=201 children receiving community mental health services

Brookman-Frazee, Stadnick, Chlebowski, Baker-Ericzen & Ganger, 2017; Farmer et al., 2014
IMPLEMENTATION GAP: NEED FOR SERVICE LINKAGE BETWEEN PRIMARY CARE AND MENTAL HEALTH

- Pediatric primary care is well-positioned to facilitate mental health screening and access to care
- Increasing screening efforts for *early autism* identification in infants and toddlers
- However, timely identification of mental health problems and linkage to care for school-age children with autism diagnosis is challenging:
  - Complex service needs
  - Diagnostic overshadowing
POTENTIAL SOLUTION:

Improving Access to Mental Health Care through Behavioral Health Integration

Behavioral Health Integration (BHI) is an approach to delivering mental health care that makes it easier for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practice. It can take different forms, but BHI always involves collaborations between primary care providers and specialized care providers for mental health.

BHI can result in
- Better outcomes for children and youth
- More efficient and coordinated care
- Higher treatment rates
- Reduced parental stress
- Improved consumer satisfaction

Practicing together
The primary care practice has a care provider for mental health practicing on-site who is responsible for screening and referrals and may provide therapy. This is often called co-location.

Improving referrals and communication
A care coordinator manages referrals to care providers for mental health and needed social services, and maintains communication between the primary care practice and care providers for mental health.

Phone consultation
The primary care provider can receive consultation by phone about a diagnosis and treatment plan from the care provider for mental health.

Learn more at www.cdc.gov/childrensmentalhealth/access.html
STARTING POINT: GENERAL COMPONENTS OF MH SCREENING AND REFERRAL IN PRIMARY CARE

MH screening presented as universal and confidential

Computerized, completed pre-appointment using valid screener

Trained provider reviews results

Tracking of MH referral completion

Use of EHR to facilitate MH referral
NEED TO ADAPT PROCESS FOR CHILDREN WITH AUTISM+
STUDY OBJECTIVE AND DESIGN: MIXED-METHODS TO ADAPT AND IMPLEMENT AN INTEGRATED MENTAL HEALTH CARE MODEL FOR CHILDREN WITH AUTISM+
Exploration, Preparation, Implementation, Sustainment (EPIS) Model

(Aarons et al., 2011)

Model of Community Academic Partnership

(Brookman-Frazee et al., 2011)
IMPLEMENTATION STRATEGIES

1. Develop community academic partnerships
2. Conduct local needs assessment
3. Tailor strategies
4. Promote adaptability

Powell et al., 2015
STAKEHOLDER ENGAGEMENT #1: COMMUNITY-ACADEMIC PARTNERSHIPS

Organization 1
- Kern County
- Los Angeles
- Riverside
- San Bernardino
- San Diego
- Ventura

Organization 2

Organization 3

[Map showing locations in California with markers for different organizations]
STAKEHOLDER ENGAGEMENT #2: ATTAIN ADVISORY GROUP

~8 members:

- Pediatric providers
- Organizational leadership
- Caregivers
- ASD services & CAP researchers
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## Organizational Characteristics of Community Partner Sites

<table>
<thead>
<tr>
<th></th>
<th>Non-profit, Children’s Hospital and Affiliated Physician Network</th>
<th>Private, For Profit Integrated Health Care System</th>
<th>Federally Qualified Health Center</th>
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<tbody>
<tr>
<td><strong>Funding</strong></td>
<td>Self-pay, private insurance, Medicaid</td>
<td>Self-pay, private insurance, Medicaid</td>
<td>Medicaid</td>
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<tr>
<td><strong>Standardized MH</strong></td>
<td>✗</td>
<td>✗</td>
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<tr>
<td><strong>Screening and Linkage</strong></td>
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<td></td>
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<tr>
<td><strong>EHR Available</strong></td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td><strong># Pediatric PCPs</strong></td>
<td>120</td>
<td>423</td>
<td>35</td>
</tr>
<tr>
<td><strong># Children</strong></td>
<td>~900,000</td>
<td>~1,000,000</td>
<td>~34,000</td>
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AIM 1: Identify targets to improve MH screening and access to MH care for children with an existing ASD diagnosis served in primary care

- Sequential QUANT + QUAL mixed-methods design
- Examines current mental health screening and referral processes in primary care for children with ASD
Organization 1: Non-profit, Children’s Hospital and Affiliated Physician Network

Organization 2: Private, For Profit Integrated Health Care System

Organization 3: Federally Qualified Health Center
PRELIMINARY QUALITATIVE FINDINGS: LEADER AND PEDIATRICIAN PERSPECTIVES (N = 27)

- Discovery-oriented qualitative analyses revealed preliminary themes:

  - Most of their school-age patients with ASD exhibit symptoms of co-occurring psychiatric conditions.
    - Notably disruptive behaviors and anxiety
  
  - Paucity of mental health screeners administered.
    - Burden placed on caregivers or providers to express psychiatric concerns
  
  - Providers spend significantly more time supporting caregivers to follow through on a mental health referral.
    - Strong desire for MH navigation support
AIM 2: Guided by the ATTAIN Advisory Group, adapt steps into the ATTAIN model

- MH screening presented as universal and confidential
- Computerized, completed pre-appointment using valid screener
- Trained provider reviews results
- Use of EMR to facilitate MH referral
- Tracking of MH referral completion
AIM 3: Pilot test and examine acceptability, feasibility, and use of ATTAIN in pediatric primary care
LESSONS LEARNED FOR D & I

1. Partnership-building takes time

2. Alignment of research goals/priorities with community partners/stakeholders is essential

3. Community partners/stakeholders are context experts: they are critical for sustainable implementation

THANK YOU!