Partners in Pediatrics and Pediatric Consultation Specialists

Coordinated care initiative final summary

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Project background

Beginning in 2008, Pediatric Consultation Specialists (PCS), a private mental health practice, and Partners in Pediatrics (PIP), a large multi-site pediatric primary care clinic, received funding from the Hennepin County Children's Mental Health Collaborative to implement an approach to provide co-located mental health services at one of the PIP clinic locations. This partnership was one of two projects funded by the Collaborative to enhance mental health screening practices in primary care settings, increase communication between primary care and mental health staff and, ultimately, increase access to mental health services.

This report provides an aggregate summary of the efforts made by PCS and PIP to provide co-located mental health services to youth during the past three years. More specifically, it describes the characteristics of youth served through this initiative, the types of referrals made following triage services, lessons learned, and plans for sustainability.

Program description

Screening practices

Developmental screening protocols were already established by PIP when the initiative began. Pediatricians at the PIP clinics administer the Parents' Evaluation of Developmental Status (PEDS) to parents of children ages 0-5, and the Pediatric Symptom Checklist (PSC) to parents of children ages 7-18. A youth version of the PSC (the PSC-Y) is also administered to youth patients ages 10-18 at well-child visits. When anxiety or depression concerns arise, pediatricians may also administer the Screen for Child Anxiety Related Emotional Disorders (SCARED), Children Depression Inventory (CDI) and Beck Depression Inventory (BDI), as needed. Providers may use the screening results to initiate a conversation with the parent about their concerns and inform their decision whether to refer the patient to other services, including the on-site mental health services, called BE-Care.

Co-located mental health services

Through the initiative, PCS rented space from the clinic to provide mental health triage services one day each week at the Maple Grove clinic. However, referrals to BE-Care could be made by providers at any of the PIP clinic locations. In addition to staffing BE-Care each week, a number of other activities were also pursued to improve service communication and coordination:

- Written consent forms were developed and used to allow for open communication between PIP and PCS when youth were referred to BE-Care services

- Regular webinar trainings were offered by PCS staff to provide topic-specific training on key mental health and developmental issues

- Emergency slots were held open at PCS to allow PIP patients more immediate access to mental health services

Evaluation approach

This evaluation was designed to respond to key questions identified by program stakeholders, the Collaborative, and Hennepin County. Over time, adjustments were made to the evaluation approach to ensure it was feasible to staff from both PCS and PIP. The evaluation addressed the following key questions:

- How many youth are referred to BE-Care for mental health, social-emotional, or developmental concerns? Why are youth referred?

- What types of referrals for ongoing services are made by BE-Care staff? When referred, how many youth seek ongoing mental health services?

- Are parents who attend BE-Care appointments satisfied with the services they receive?

- What do program stakeholders identify as the strengths and challenges of this integrated care model? What lessons learned are important for other programs to consider if implementing similar projects?

- How has the integrated care model led to changes in practice for medical and mental health providers?

A multi-method evaluation approach was developed to respond to these questions. Throughout the course of the project, program staff gathered information each month to describe the characteristics of youth served through BE-Care and other referrals made following the triage visit. In addition, every six months, staff participated in a brief key informant interview to discuss changes to their program activities, sustainability efforts, and changes in practice. Two short-term activities, an online survey of parents referred to BE-Care and review of screening and referral data captured by PIP providers, were also used in the evaluation.

BE-Care data summary

Screening data

During the first year of the project, when developmental screening was done during a pediatric appointment, providers were asked to document results from the developmental screening (e.g., elevated, non-elevated) and referrals made to BE-Care. The data demonstrated approximately one in five children screened (17%) had an elevated score on the PEDS or PSC. Of the 56 children with elevated scores, 9 percent were referred to BE-Care for additional services while 31 percent were not referred because the issue was identified as a medical issue (14%), the pediatrician provided guidance during the appointment (14%), or the child was already receiving mental health services (2%). However, the referrals made by pediatricians were not documented for over half of the children (59%) with elevated scores. This information was gathered during only the first year of implementation, so it is not known whether screening and referral practices have changed over time.

Referral data

Referral and patient demographic information are gathered by program staff and submitted to Wilder Research each month. The data included in this report describes referral patterns and characteristics of youth who received a BE-Care appointment throughout the duration of the project (October 2008-June 2011).

The largest percentage of referrals came from providers who practiced at the clinic where BE-Care is located. Since the project began, a total of 486 referrals were made by a PIP provider to BE-Care. The number of referrals made during each six-month period remained consistent over time. Forty percent of BE-Care referrals came from providers at the Maple Grove clinic location, while fewer were from providers at the Plymouth (19%), Brooklyn Park (19%), and Rogers (17%) clinics (Figure 1). Very few referrals were made from providers at the Uptown clinic (3%), which is located the furthest away. These referral patterns remained consistent throughout the course of the project.

1. PIP clinic referral source

	N	%
Maple Grove	196	40%
Plymouth	94	19%
Brooklyn Park	90	19%
Rogers	85	17%
Uptown (Minneapolis)	16	3%
Unknown/missing	5	1%
Total	486	100%

During the last 18 months of the project, the number of providers who referred patients to BE-Care remained fairly constant. Beginning in January 2010, the project also began to track the names of the providers who made referrals to BE-Care. During that time 36 different providers referred patients to BE-Care. Six providers made just one referral during that time, while others made at least two and up to 31 referrals during the 18-month period. The number of providers who referred to BE-Care during each six month period remained fairly constant over time, ranging between 23 and 27 providers making referrals during each of the last three six-month intervals.

Timeliness of services

Over time, fewer youth received a BE-Care appointment within one week of referral. In the first year of the project, approximately half of the youth referred to BE-Care (55%) received a triage mental health appointment within 7 days of their pediatric appointment (Figure 2). However, the percentage of youth who received BE-Care services that quickly has decreased over time, from 46 percent of patients in the project's second year to 40 percent of patients in the third year of the evaluation. In contrast, the percentage of youth seen more than two weeks between referral and the BE-Care appointment increased from 21 percent in the first year of the project to 34 percent in the project's third year.

2. Length of time between pediatric visit and mental health triage appointment

	Year 1: October 2008-June 2009 (N=143)		Year 2: July 2009-June 2010 (N=147)		Year 3: July 2010-June 2011 (N=168)	
	N	%	N	%	N	%
Same day	17	12%	9	6%	6	4%
1-7 days	62	43%	59	40%	58	36%
8-14 days	34	24%	39	27%	46	28%
15-30 days	20	14%	29	20%	36	21%
More than one month	10	7%	11	7%	22	13%

NOTE: *The referral and/or triage appointment date were not reported for 29 patients.*

These trends should be interpreted with caution, as there are a number of youth with unknown referral dates, and other factors (i.e., parent preferences for future appointment dates/times, winter weather conditions, holiday travel), may have delayed scheduling of appointments. Parents who receive a referral from their child's pediatrician for BE-Care may choose to schedule an appointment when they are at the clinic or call later to arrange a convenient appointment date. According to program stakeholders, same day appointments are rare because most parents have not set aside additional time to participate in a BE-Care

appointment after the child's visit to the pediatrician. Although BE-Care hours were expanded in the third year of the project, this trend may indicate a need for greater capacity.

Reasons for referrals

Approximately 40 percent of children were referred to BE-Care due to concerns related to depression or anxiety. The primary reason children were referred to BE-Care was captured by PCS staff during the last year of the project (July 2010 – June 2011). During that time, children were most commonly referred to BE-Care due to concerns related to depression or anxiety (42%), while fewer referrals were made due to aggressive behavior (19%), developmental concerns (7%), school concerns (6%), or sleep issues (2%) (Figure 3).

3. Reasons for referral, July 2010 – June 2011 (N=294)

	N	%
Depression/anxiety	123	42%
Aggressive behavior	57	19%
Developmental concern	20	7%
School concern	19	6%
Sleep issues	5	2%
Other	42	14%
Unknown/missing	28	10%

Note: *"Other" reasons for referrals were not specified.*

Demographic characteristics of youth served

Nearly one-third of the children who received BE-Care services were 5 years of age or younger. Children and youth referred to BE-Care ranged in age from less than 1 year to 23 years old. Nearly one-third of the children (31%) were young children (age 5 or younger) while over half of youth referred were male (55%) (Figure 4). Most children referred for triage were White/Caucasian (80%), though some were identified as African-American (3%), Asian-American (3%) or bi-/multi-racial (6%). A few children (2%) were identified as Hispanic/Latino. These demographic characteristics of youth who received BE-Care services were considered by the clinic to be fairly reflective of its patient population.

4. Demographic characteristics of youth referred for BE-Care (N=486)

Age	N	%
0-5	150	31%
6-8	128	26%
9-11	90	19%
12-17	109	22%
18+	8	2%
Unknown/missing	1	<1%
Gender		
Male	267	55%
Female	215	44%
Unknown/Missing	4	<1%
Race		
White/Caucasian	400	82%
African-American	14	3%
Asian-American	15	3%
American Indian	0	0%
Bi-/multi-racial	29	6%
Unknown/Missing	28	6%
Ethnicity		
Hispanic	9	2%
Non-Hispanic	456	94%
Unknown/Missing	21	4%

Services provided

Nearly four out of every five children seen for a BE-Care appointment were referred for ongoing psychotherapy. Patients referred to BE-Care receive a 40-minute referral to discuss their concerns. Most patients (85%) receive education during the appointment and many (67%) are referred for ongoing psychotherapy. Fewer youth were referred for a psychological/diagnostic assessment during the triage appointment (15%) (Figure 5).

5. Referrals made by triage mental health provider

	N	%
Education provided	412	85%
Psychotherapy	325	67%
Psychological testing (diagnostic assessment)	71	15%
Physical/occupational therapy	10	2%
Other	55	11%

Note: *Children may have received multiple referrals/services during the triage mental health visit. Common examples of "other" referrals included referrals to parenting support groups or education (N=8), skills groups (N=6), suggestions for books/handouts (N=6), and school-based services such as tutoring (N=3).*

A total of 75 youth attended follow-up appointments with a PCS mental health provider. Over three-quarters (77%) of these youth received a formal diagnostic assessment from PCS. Many of the youth seen at the PCS clinic have diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), anxiety disorders, depressive disorders, or adjustment disorders. The total number of youth reported to have received follow-up mental health services in this report may under-represent all youth that received ongoing care. Although PCS providers staff BE-Care, patients who receive a referral for mental health services are given a more comprehensive list of mental health providers in the area and may select a provider of their choice. Only youth who received follow up services from PCS could be tracked in this evaluation.

Allocation of PCS staff time

A considerable amount of PCS staff time was spent providing unbillable services. Overall, one-third of the hours (33%) spent on-site by a mental health provider at the BE-Care clinic were not reimbursable because the family did not have insurance, PCS was not an accredited provider for the family's insurance plan, or that the services provided were outside the scope of reimbursable services. In addition, there were unbillable hours spent by PCS staff to develop referral and documentation forms, provide consultation to medical providers from the PIP clinics, and offer topic-specific webinars. According to PCS staff,

consultation was provided to PIP providers on a variety of topics, including concerns related to anxiety or depression, behavioral issues at home or in school and school concerns, the development of an Individualized Education Plan or IEP (a treatment plan developed by the school). The total number of hours spent by PCS staff to provide consultation to PIP providers was not tracked.

Patient satisfaction

In 2010, an online survey was administered to parents who attended a BE-Care appointment. The survey was completed by a total of 26 parents, representing approximately 30 percent of patients who attended a BE-Care appointment while the survey was available. Some of the key findings from the parents satisfaction survey are summarized below, while a complete summary of the results can be found in the August 2010 report.

Overall, parents who completed the survey were satisfied with the services they received. With few exceptions, the parents "strongly agreed" or "agreed" the mental health professional communicated with them in a positive manner, provided them with useful suggestions, and met their expectations. Most of the parents who completed the survey (93%) agreed they would recommend BE-Care to others who need similar services.

Most parents felt the BE-Care appointment helped them learn about the services available to them, but fewer felt they were better able to understand their child's behavior. The parents were also asked to consider how the services they received helped them understand and respond to their child's behavior. Most parents "strongly agreed" or "agreed" that as a result of the services they received, they are aware of resources or services that can help their child (100%) and know how to get information to help them understand their child (96%) (Figure 6). While still positive, fewer parents "strongly agreed" or "agreed" they know more about what to do if problems arise with their child (81%) and understand their child's behavior better (69%). A few parents (15%) agreed their child's behavior had improved after the BE-Care appointment, but most (69%) were unsure when they completed the survey.

6. Parent perceptions of BE-Care service impact (N=26)

As a result of the services I received:	Strongly agree	Agree	Undecided/ Unsure	Disagree	Strongly disagree
I understand my child's behavior better.	8 (31%)	10 (39%)	6 (23%)	2 (7%)	0 (0%)
I know more about what to do if problems arise with my child.	6 (23%)	15 (58%)	4 (15%)	1 (4%)	0 (0%)
I know how to get information to help me understand my child.	7 (27%)	19 (69%)	1 (4%)	0 (0%)	0 (0%)
I am more aware of my child's good behavior and other strengths.	8 (31%)	13 (50%)	4 (15%)	1 (4%)	0 (0%)
I am more confident I can help my child grow or develop.	9 (35%)	12 (46%)	4 (15%)	1 (4%)	0 (0%)
I am aware of other resources or services that may help my child.	10 (39%)	15 (58%)	0 (0%)	1 (4%)	0 (0%)
My child's behavior has improved.	2 (9%)	2 (9%)	18 (78%)	1 (4%)	0 (0%)

Many parents appreciated being able to schedule a BE-Care appointment quickly, but some felt longer appointments would be helpful. When asked to describe how the BE-Care appointment was helpful to their child and family, the parents provided a range of responses. A number of parents felt the information they received was helpful and appreciated being able to schedule an appointment quickly. Two parents expressed needs for additional or more comprehensive information. One of these parents noted the information they received was not any different than what they had learned from the school, while another felt it was helpful to know they should have their child evaluated, but still needed more information to understand their child's behaviors. When asked to suggest improvements to the BE-Care appointments, five parents noted the length of the appointment could be longer and three suggested making the service more accessible through extended clinic hours or additional clinic locations.

Impact

Through this initiative, nearly 500 youth received mental health triage services and 75 youth attended at least one follow up mental health appointment at PCS. While some of these families may have sought mental health services regardless of whether BE-Care was an option for them, PCS staff feel the co-located service reduced the stigma of seeking services and also allowed them to offer families who have concerns, but do not have a child in need of therapy, with early intervention and prevention services.

Sustainability

BE-Care will be sustained after Collaborative grant funding ends. PCS plans to continue providing BE-Care services at the Maple Grove clinic and are exploring also providing co-located services at the PIP clinic located in the Uptown neighborhood of Minneapolis. Grant funding made available through the Collaborative allowed PCS to develop and implement a feasible model for co-located services. While they will no longer be able to cover some program costs, PCS plans to continue providing sliding fee services to families who cannot otherwise afford their insurance plan co-pay and offering webinar trainings to the PIP medical providers on mental health topics of interest.

Limitations

There are a number of questions of interest to the Collaborative, as well as to the partner agencies, that could not be answered through this evaluation. For example, there is wide variation in the number of referrals made by individual providers to BE-Care, but it not known whether this is a reflection of differences in patient caseloads, different levels of familiarity with BE-Care staff and services, or other factors. In addition, it is not known how many youth referred by BE-Care staff for additional mental health assessment or therapeutic services do receive these services. While the initiative has led to improved access to preventive mental health services, including education and consultation, it is not clear whether this co-location model has resulted in a greater number of youth and families accessing therapeutic mental health services than who would have sought services independently or in response to a more traditional referral from a provider.

Lessons learned

Throughout the project, brief interviews were conducted with PCS staff to discuss lessons learned through recent project accomplishments and implementation challenges. This information documents the work completed through this project and may also be useful to other clinics and mental health agencies interested in providing similar services.

- Through the initiative, PCS staff felt relationships and communication between medical providers and mental health staff were improved. PCS staff made a number of efforts to accommodate the needs of medical providers and offer consultation and training on mental health topics of interest. For example, PCS staff developed a follow-up form that is completed after each BE-Care appointment to summarize the visit and describe referral recommendations. PCS staff also made a number of efforts to meet providers during their scheduled clinic meetings to introduce themselves and the services they provide. Through these efforts, as well as the use of monthly webinars on key topic areas, PCS staff felt they built stronger relationships with the medical providers.

- Provider consultation did occur, but not as initially envisioned. PCS staff anticipated the mental health provider located at the clinic would receive questions and provide formal and informal consultation to medical providers during BE-Care hours. However, BE-Care appointments are usually filled each week and medical providers with busy daily schedules don't often have time to consult with PCS staff while they are on-site. Instead, PIP providers call PCS staff to discuss cases or ask questions outside of BE-Care hours. PCS staff feel they are still providing a useful and timely consultation service to the medical providers, though not as initially anticipated.

- Insurance contracts proved to be the most significant implementation barrier. In order for PCS staff to bill for insurance companies for their services, they must be a contracted provider through each health insurance plan. The application process is long, and insurance companies are not always interested in expanding their provider network. Although PCS is a contracted provider through Blue Cross Blue Shield, a common insurance plan among PIP patients, they are not contracted through all plans. PCS had looked into seeking contracts through other health insurance programs, but most required a supervising mental health practitioner to also be a contracted provider or specified that the entire provider group, rather than an individual, would need to seek status as a contracted provider in the insurance plan's network. PCS did not feel it would be possible to try to meet the requirements necessary to become certified by other health plans.

- Grant funds were used primarily to subsidize BE-Care appointments, but also covered the staff time needed for early intervention activities and ongoing training. Although PIP and PCS have worked in partnership on this co-location initiative, the financial risk for these efforts has been shouldered primarily by PCS. PCS staff felt medical providers were more likely to refer families to BE-Care because the appointment would cost only $30. Grant funds were used to subsidize services in order to ensure all families pay a small co-pay, regardless of their current insurance coverage. When the grant period ends, PCS plans to continue offering hardship discounts to families who are interested in, but cannot afford, to attend a BE-Care appointment. Their staff will need to increase their hours of billable therapy hours to ensure these discounts can be provided without leading to a financial loss for the agency. While the staff costs associated with initial program development and implementation activities were short-term expenses, PCS also used grant funding to provide webinar training to the medical providers and improve their own staff capacity in key areas.

- Grant funds supported PCS in implementing a co-located service model that they plan to sustain over time. When new initiatives are supported through grant funding, there is always concern that services will diminish when financial support ends. However, PIP and PCS providers feel that BE-Care offers clinic patients with greater access to services that help families address concerns related to their child's mental health and social-emotional development. Although some changes will need to be made to the BE-Care model, the partners are committed to identifying strategies to continue providing these services and potentially expanding their efforts.