



TEXAS
Health and Human
Services Commission



Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT)

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Texas Background

- 2.6 million Medicaid enrollees (1.8 million children)¹
- An estimated 5 – 9% have a serious emotional disorder (up to 162,000 children)²



(1) Texas Medicaid Enrollment Statistics, September, 2007. Available online:
<http://www.hhsc.state.tx.us/ResearchMedicaidEnrollment/MedicaidEnrollment.asp>

(2) Farmer, E.M.Z., Mustillo S., Burns, B.J. and Costello, E.J., 2003. The epidemiology of mental health programs and service use in youth: Results from the Great Smokey Mountains Study. In M.H. Epstein, K. Kutash and A. Duchnowsk (Eds.), Outcomes for Children and Youth and their Families: Programs and Evaluations Best Practices 2nd edition.

Texas Background, cont.

- 408 active Child and Adolescent Psychiatrists (CAPs)
 - Texas has 1/3 the national supply of child and adolescent psychiatrists
 - 80 percent of counties have no CAP
- 6, 400,000 children in Texas, 10% w/ SMI or 640,000
- 1568 SMI/ CAP



One Solution

- Integrated Pediatric Mental Health Care
 - Puts licensed practitioner of the healing arts (LPHA) in each pediatric/ PCP office
 - LPHA to be supervised by child psychiatrist
 - Pediatrician/ PCP can consult directly with child psychiatrist



LPHA functions

- Screening and assessment
- Brief therapy (20 minute visits)
- Triage referrals to psychiatrist
- Medication information
- Groups
- Family education



Strosahl Model

- Strosahl (2000) has suggested that when the psychologist is located in primary care, mental health is “normalized” and families may be more likely to follow through with the physician’s recommendation to attend behavioral health services.



Advantages

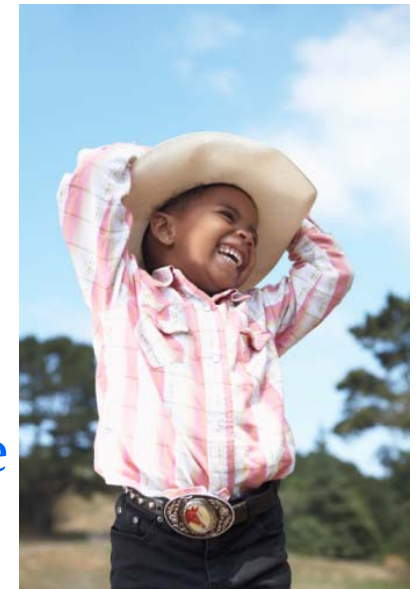
- Improves medical outcome
 - fewer medical specialist referrals
 - fewer ER visits

- Improves mental outcome
 - fewer referrals to child psychiatrist



Advantages, cont.

- Treats mild to moderate mental illness before it becomes severe
- Reduces stigma
- Same chart
- Handles bulk of morbidity of mental illness- those sick enough to be beyond the ken/ time constraints of pediatricians, but not sick enough to merit child psychiatrists

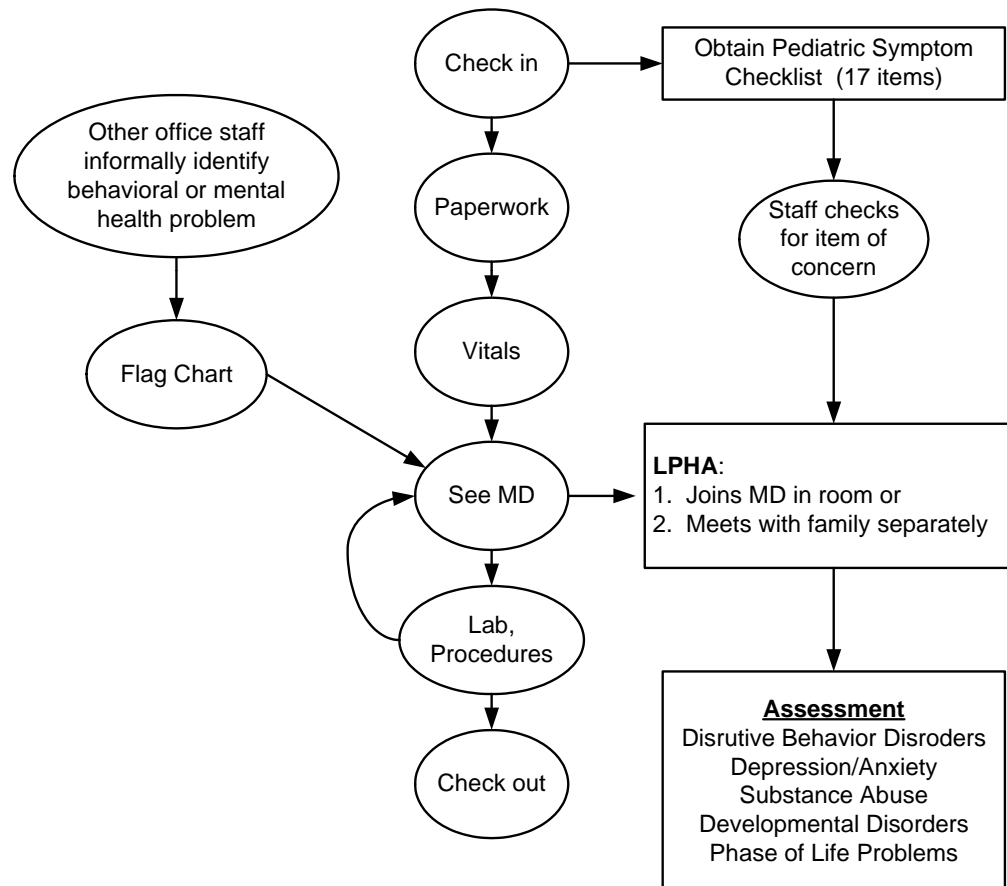


Sample patients

- Overweight adolescent with diabetes bullied at school and noncompliant with medications
- Oppositional preschooler about to be kicked out of day care
- Frequent stomach-aches
- Toddler with poor sleep



Intake Procedures



Types of Problems

- Phase of Life issues
 - Sleep
 - Diet/Weight/Body Image
 - Elimination Issues
 - Dating/Sexual activity
 - Peer relationships
 - Activities (sports, video games, etc)
 - Academic Issues (grades)

Types of Problems

- Health Related Concerns
 - Weight, Obesity, Diabetes
 - Asthma
 - Multiple Somatic Complaints

Types of Problems

- Specific psychiatric disorders
 - ADHD
 - ODD/CD
 - Aggression
 - Depression/Anxiety
 - Post traumatic stress disorder (PTSD)
 - Bipolar
 - Screen for Autism Spectrum Disorders
- Use modular assessment package combined with specific rating scales

Assessment, cont'd

- Vanderbilt Teacher and Parent Rating Scales(AAP guidelines)
- Children's Mania Rating Scale
- Mood and Feeling Questionnaire
- Self rating of Child Anxiety and Related Disorders (SCARED)
- Gilliam Autism/Asperger Rating Scales (when indicated)

Interventions

- Brief sessions (15 to 30 minutes the norm, extend to 1 hour when necessary)
- Use behavioral and cognitive behavioral principles
- Strong family orientation
- Focus on infant/mother interactions (Stanley Greenspan's DIR model)
- Assessment tools help PCP assess need for psychotropic medication
- Consult Child Psychiatrist assists PCP

Typical Medication Intervention

- Treatment of ADHD
- SSRI administration to adolescent with uncomplicated Major Depressive Disorder or Anxiety (when therapy does not bring about remission)
- Low dose Second Generation Antipsychotic for:
 - Autism Spectrum Disorders
 - Explosive Aggression unresponsive to therapy

What it is not

- **Co-location** – in integrated care, the doctor and LPHA are not merely in the same location but are part of the same team, working to identify and treat behavioral health issues
- **Traditional therapy:** in integrated care, LPHAs do not see patients for one hour therapy sessions over several months but work quickly, with very brief screening, education, and skills training



Sustainability

- Encouraging Texas Medicaid to pay for consults between primary care physicians and child psychiatrists
- Encouraging Texas Medicaid to pay for Health and Behavior codes (96150-96155) allowing non physician providers to be paid for behavioral assessments and/ or interventions with patients who have medical (not psychiatric) illness
- Allowing primary care physicians to bill for psychiatric services



Challenges

- Widespread perception in primary care that emotional/behavioral problems are widespread, but
 - Are they really that common, or does the squeaky wheel get the grease?
 - Are parents wanting the service as much as the PCP? Can they be offered at convenient time?
 - Will PCP be willing to expand their psychopharmacological reach?
 - Can primary care practices alter practices to identify patients for program?