Integrating Care Between Behavioral Health and Outpatient Pediatrics

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Project Description

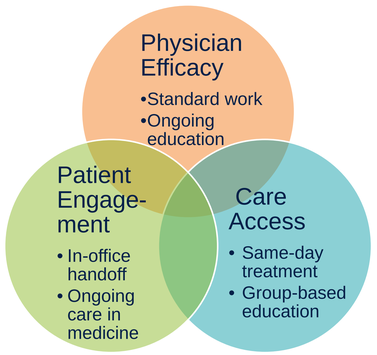
This project aims to increase a primary care patient's ability to quickly access mental health services through in-clinic health consultation, assessment and treatment.

Problem Statement:

There are clear gaps in the treatment pipeline from outpatient pediatrics to behavioral health, particularly when it comes to timely appointment access, patient engagement, and physicians' abilities to connect patients to these services.

Discovery:

1. The embedded treatment model would not be new to KP NorCal & several teams (Central Valley, Sacramento, Union City) have already adopted it, but there is wide variation between programs.
2. Physician education and physical space were seen as the most critical – yet insurmountable – barriers to overcome.
3. Narrowing the scope of the project to a 1-year pilot (aimed at patients 0-5 yrs old) comprised of 1 psychology trainee, 2 physicians and 1 medical assistant made sense given the constraints.
4. Efforts to engage in planning & program development were hampered by resource challenges in pediatrics.



Key Pivots:

1. Adult Family Medicine was initially approached but deferred due to departmental, as well as partnership challenges.
2. All pediatricians were initially included but given the culture and lack of space in medicine, a subset of early adopters were chosen.
3. Therapy staff demonstrated interest but trainees were selected as the pilot would fulfill internship goals and trainees were not subject to union constraints.

Goal:

Pilot an embedded behavioral health treatment service in pediatrics that will support a patient's ability to access mental health services in a timely and convenient manner – and ultimately lead to better mental health outcomes.

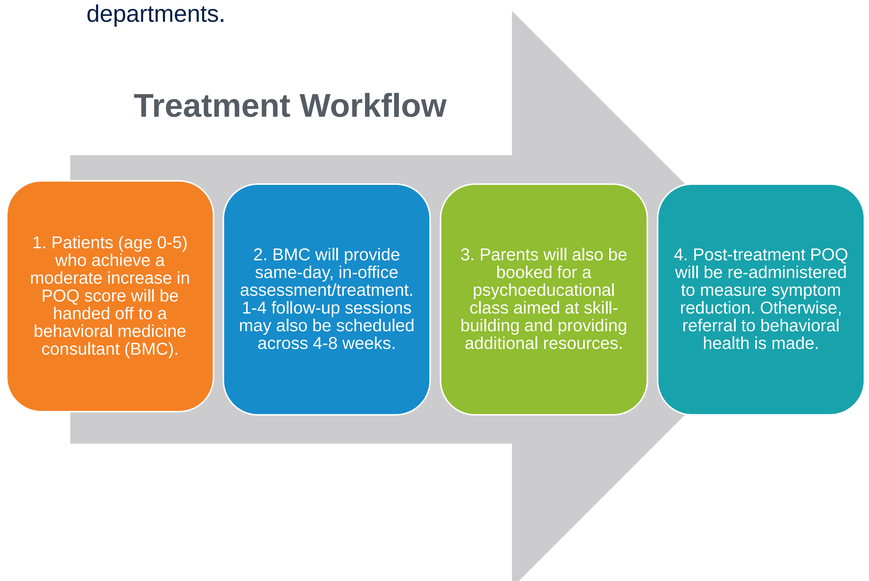
Outcome-Oriented Objectives:

1. Physician utilization of embedded services (70% or better)
2. Initial & return access (80% or better)
3. Patient service engagement (FTKA 15% or less)
4. Patient satisfaction (MPS 67% or better), decreased complaints
5. Stretch Goal: Patient outcomes (50% decrease in MOOD metric)

Results

Outcome:

1. *The unexpected happened*: Ultimately the pilot was put on hold because the Behavioral Health role could not be filled by existing staff or psychology trainees.
2. *There were unanticipated stakeholders*: Absence of RN manager in primary care continued to hamper efforts to move forward with workflow refinement & MD education.
3. *Timing is everything*: Global barriers included current NUHW contract negotiations and competing priorities between the two departments.



Lessons Learned

- Front-running a project too early in the development process creates its own set of challenges.
- Even when executive leadership has set forth a clear goal and data support this, significant time must still be spent on highlighting the value proposition for local leadership and stakeholders.
- Leadership buy-in is essential – but be careful to clearly identify the local stakeholders who will actually implement the work.
- The need for flexibility and contingency planning cannot be underestimated, particularly in union environments.
- **Immediately addressing the "elephant in the room" – cultural differences – while highlighting common ground, can go a long way in building a foundation for partnership.**
- Keep the situational barriers in perspective – once these have shifted, capitalize on previous learnings and move forward.

Next Steps:

- Project development will re-start this fall given renewed urgency from executive leadership.
- Completing a joint A3 with local leaders within primary care will be the next major step in moving the pilot forward.
- Treatment model/scope will again shift given the forthcoming regional initiatives addressing initial access for patients with mild-to-moderate mental health issues.

Mission Model Canvas

Key Partners
- Outpatient Pediatrics – Chief
- Mental Health – Child & Family Service Line Manager
- Mental Health/Physician Partner - Child Psychiatrist
- WCR Psychology Postdoctoral Training Program
- Regional Team – Data generation

Key Activities
- Meet with Chiefs as I continue to meet with physicians in Peds
- Design surveys/education & roll them out w/ MD partner
- Operationalize/refine the changes via psych/med workflows
- Identify key stakeholders re: info that will support "cost" impact

Key Resources
- Time carved out of MD/Psych provider meetings to intro ideas, conduct education, etc.
- Time (=$$) and commitment from several pediatricians, trainee/sup to participate in pilot
- Therapy access, complaint, MPS reports

Value Propositions
- **Patients** – Better care that considers medical and mental health needs concurrently and decreases the number of "handoffs" to psychiatry and lag in time in referred-to-seen (MH Access)
- **Pediatricians** – Ease of transfer, decision-making (complaint metric, peer review, Survey Monkey)
- **MH Providers** – Over long-term: Less burden on MH system (Access)
- **KP** – Decreased risk, increased productivity (complaint metric, peer review, impact of changes on access)

Buy-in & Support
- Work directly with Chiefs of Peds and Psychiatry to ensure that the direction aligns with department goals (productivity, MOOD)
- Ensure that MD/MH feedback drives education and workflow redesign
- Provide coaching & consultation for MDs to ensure workflow adoption

Deployment
- **Mental Health/Training** – By "lending" trainee/supervisor resources for pilot
- **Pediatrics** – By providing ongoing education, tip sheets to support rollout/increase utilization of improved workflows
- **Pediatrics** – Pilot changes at outset with small # of MDs

Beneficiaries
- **Patients in Primary Care** – They want/deserve the best, most seamless ("whole person") care KP has to offer – without the extensive wait time & logistical hurdles
- **Pediatricians in Primary Care** – They want to be able to increase the quality/timeliness of their medical decision-making and leverage MH services in an easy way
- **Providers in Mental Health** – They want patient-centered solutions that will not increase pipeline volume
- **Mental Health Leadership** – They want to se better patient outcomes achieved at a lower levels of care.

Mission Budget/Cost

For this program, the only cost is the time commitment from service providers (MDs, MH "partners") to engage in the preparatory work – much of this time (e.g., filling out surveys, practicing workflow changes) will be difficult to quantify but can be reasonably estimated at 1.0 FTE over the next year. For the psychology trainee it will be 50% of his/her time (20 hrs/wk) and for the clinical supervisor it will be 2-3 hrs/wk.

Mission Achievement/Impact Factors
- Expansion of Behavioral Health into Primary Care (i.e., begin with workflows → create pathway for more consultation, greater partnership/integration)
- Creation of a local, working model for scaled-in care integration between Behavioral Health and other primary care settings (AFM, Women's Health, etc.) that can be replicated
- Increased timeliness with MH treatment - ultimately leading to better patient outcomes