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Welcome to Issue Two: A Focus on Integrated Care

Welcome to the second issue of Strengthening Appalachia's Children sponsored by the Appalachian Children Coalition (ACC). The mission of the ACC is, "Our mission is to improve the health and well-being of our region's children through collective advocacy and strategic investments." One method for achieving this mission is to integrate the best of science and practice to enhance the care provided by professionals working with children in Appalachia. This newsletter is intended to support that effort and will be distributed quarterly. This issue of the newsletter is focused on integrated care for children and we have two excellent articles including one by a leading

national researcher on the topic (Drs. Kristen Riem & Jodi Polaha) and another by Dr. Brian Merrill at Integrated Services for Behavioral Health which provides services throughout southeast Ohio.

ACC Announces New Data Dashboard!

As part of our commitment to providing access to the best health and well-being information related to Appalachian Ohio children, the Appalachian Children Coalition recently activated the Ohio Child & Family Health Data Dashboard. The dashboard, developed with funding from the Ohio Department of Mental Health and Addiction Services and in partnership with the Ohio University Voinovich School of Leadership and Public Service, is a one-stop source of Appalachian Ohio community health and wellbeing data. It includes over 200 child and adult health indicators with more to be added over time. The tools and data on this site are available to assist healthcare practitioners, health departments, ADAMH boards, school districts, social service agencies, policymakers, local leaders, researchers, and community members better understand and address root causes of inequities across Appalachian Ohio and improve the health and well-being of our region's children and families. The Dashboard can be accessed at this link.

The Dashboard includes data for the entire 32-county Appalachian Ohio region as well as separate data summaries for each of those 32 counties. Over the coming weeks, we will continue to add indicators to the dashboard as those data are made available to us. We will also be regularly updating the dashboard so you will know you are accessing the most current data available.

For those who may be interested in learning more about the Dashboard and/or

exploring how to use it, the Appalachian Children Coalition will be holding a webinar to provide guidance on how to use it and to highlight its features. This webinar will take place on Thursday, June 6th, from 12 to 1 p.m. You may register for this webinar by clicking here.

APPALACHIAN OHIO CHILD & FAMILY HEALTH DATA

APPALACHIAN CHILDREN COALITION

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Appalachian Ohio Child & Family Health Data

The Appalachian Ohio Child & Family Health Data dashboard, made available by the Appalachian Children Coalition (ACC), is a one-stop source of Appalachian Ohio community health and wellbeing data, consisting of over 200 community indicators. The tools and data on this site help healthcare practitioners, health departments, ADAMH boards, school districts, policymakers, local leaders, researchers, and community members better understand and address root causes of inequities across Appalachian Ohio and improve the health and well-being of our region's children.

Find data

Build a Custom Dashboard

Create a Custom Report

Promising Practices

FAQ

Background Information

Integrated Care for Children

Background

Integrated care for children is one tool used to address the serious health and wellness needs of children. Estimates indicate that 13% to 20% of those ages 3 to 17 years will experience a mental health disorder in any given year (Yonek et al., 2021) and 50% of adolescents have experienced a mental health disorder at some point, with over 20% experiencing severe impairment due to this disorder (Merikangas et al., 2010).

- Untreated mental health needs during this period are associated with severe psychosocial impairment, substance use disorders, physical comorbidities, increased suicide risk, and greater use of health care services in adulthood (Yonek et al., 2021)
- However, over 50% of youth do not receive adequate treatment for these mental health problems (Yonek et al., 2021)
- Families in low-income and/or rural areas (e.g., Appalachia) often have greater difficulty accessing these services because they are costly and time consuming to travel when there are few mental health providers in their area (Moore & Walton, 2013; Yonek et al., 2021)
- Even when a mental health provider is accessible, the needs of youth and their families may exceed what that sole provider can offer (Nooteboom et al., 2021)
- Mental health problems often emerge from a combination of risk factors at different ecological levels, including individual, family, peer, school, and neighborhood (Henggeler & Schaeffer, 2016).
- As a result, youth often require the services of multiple agencies (e.g., mental health, addiction services, juvenile justice, child welfare, education; Winters & Metz, 2009) to target these various risk factors, which fall outside the capabilities of any single provider.

- Existing models of integrated care promoted in the literature include the Collaborative Care model (e.g., Campo et al., 2018), the Primary Care Behavioral Health model (Reiter et al., 2018), wrap-around services (e.g., Yu et al., 2020), multi-systemic therapy (Henggeler & Schaeffer, 2016), and Ohio Rise (OhioRISE; Resilience Through Integrated Systems and Excellence, n.d.)

Integrated Behavioral Health in Pediatrics

Kristen Riem, PhD & Jodi Polaha, PhD

When parents have concerns about their child's behavior, development, or emotional well-being, their first visit is often to their primary care provider (e.g., Hodgkinson et al., 2017). In fact, 63% of parents surveyed in rural Appalachian pediatric clinics identified their pediatrician as their primary source of support for these concerns (Polaha, Dalton, & Allen, 2011). That said, many pediatricians feel unprepared to manage behavioral health concerns and lack the time and capacity to do so (Brisendine et al., 2024; Davis et al., 2012).

Integrating behavioral health services into primary care settings puts the care where patients are asking for it, reducing several well-known barriers (Hodgkinson et al., 2017). Integrated behavioral health (IBH) was first

pioneered in pediatrics over 5 decades ago (Schroeder, 1979) and has had a long germination period with increasing adoption in pediatric and adult primary care settings (e.g., Druss & Goldman, 2018). While there are various models or approaches, the overarching goals are improved patient access, stronger collaboration among providers, and an orientation to patients' "whole health" in primary care (Asarnow et al., 2015; Campo, Geist, & Kolko, 2018; Yonek et al., 2020). The aim of this paper is to define integrated pediatric behavioral health and review its evidence base, including in rural Appalachia.

Definition

We define IBH as the integration of behavioral health services into primary care practice (e.g., Asarnow et al., 2015; Briggs et al., 2016). Approaches to IBH vary widely, and have been described using a continuum, with less coordinated approaches on one end (e.g., primary care providers and specialty mental health providers developing a routine pathway or co-located approaches where the two services are in the same physical space but maintain their own separate service operations) and "fully integrated" approaches on the other end (Heath, Wise Romero, & Reynolds, 2013). Fully integrated approaches are innovative system re-designs that strive to maximize the impact of IBH on overall patient health.

Two of the best-known fully integrated approaches are the Collaborative Care model (e.g., Campo et al., 2018) and the Primary Care Behavioral Health model (Reiter, Dobmeyer, & Hunter, 2018). A review of these approaches is beyond the scope of this paper, but common elements across models (although implemented to varying degrees) include: 1) a focus on team-based care and interprofessional practice; 2) population-based care (e.g., a generalist practice that "sees all comers,"); 3) measurement-based care (e.g., routine screening to identify and track progress); and 4) the implementation of brief, evidence-based interventions (Yonek et al., 2020).

Patient outcomes

There is a growing body of evidence showing IBH improves pediatric patient outcomes; particularly mental health outcomes (e.g., lower rates of anxiety and depression, reduced ER visits for mental health crises; Asarnow et al., 2015; Pereira et al., 2021; Weersing et al., 2017). Asarnow et al. (2015) conducted a meta-analysis of 31 RCT studies and found that there was a 66% probability of better behavioral health outcomes across myriad target concerns (e.g., anxiety, depression, ADHD, disruptive behaviors) for children who were treated with an integrated care model compared to treatment as usual.

System outcomes

The promise in IBH is its potential to improve access to care by addressing structural barriers (e.g., access to providers and a team approach) and perception-based barriers (e.g., stigma and stereotypes about mental health and its interplay with overall health; Campo et al., 2018; Polaha et al., 2015). One study showed rural Appalachian parents with children who had significant psychosocial concerns were significantly more willing to seek help in integrated behavioral health than in any other setting (Polaha et al., 2015)—a finding that has been replicated in pediatrics more generally (Dunn et al., 2021). In addition, IBH improves the quality and efficiency of high-demand rural primary care, as it reduces the burden on physicians to address mental health concerns during their visits (Gouge et al., 2014). Finally, IBH has demonstrated potential to reduce demand and system-wide cost for emergency room visits to address mental health crises (Mancini et al., 2023; Pereira et al., 2021).

Discussion

There is a growing evidence base supporting IBH in terms of improved patient outcomes and access. In addition, there are strong working models (yet to be tested) that could show that IBH has a positive impact on the healthcare system more broadly (e.g., more continuity of care and reduced reliance on urgent/emergent care or reduced primary care provider burn-out). That said, there remain three key challenges to broad implementation and sustainment of

IBH. These include: 1) workforce shortage, especially in rural areas; 2) wide ranging approaches to and confusion about what constitutes integrated care; and 3) funding.

The need for mental health services in pediatric populations is growing (e.g., Axelson, 2019); however, there is not a commensurate increase in service providers (Kuehn, 2022). To intensify this workforce barrier, many common elements of IBH are not part of traditional training for specialty mental health practice; therefore, behavioral health professionals who wish to practice in primary care benefit from strengthening their skills in these areas (e.g., Briggs et al., 2016). There is recognition of this shift: HRSA has funded workforce development programming in this area for the past decade (Behavioral Health Workforce Education and Training for Professionals and Paraprofessionals programs).

Integrated care seems to have become a catchphrase for many different services or systems for patient care, such as care/resource navigators or state-level initiatives such as Managed Behavioral Health Care (MBHC). While these different services and systems also aim to increase access to care, they are not population-based and often focus on emergent, tertiary care (e.g., Coleman et al., 2005). While these are needed approaches, IBH must also be leveraged to address prevention and early intervention, with possible diversion from overburdened tertiary care (Mancini et al., 2023) for both mental health and overall health care needs.

Funding also limits broad IBH implementation and sustainability. As with any new service delivery model, cost is a factor when integrating behavioral healthcare into an already established system (e.g., Nagykaldi et al., 2023). Another logistical cost barrier relates to how behavioral services are coded and in turn reimbursed by insurance companies, which can be complex to administer and/or fail to deliver a full return on investment (Herbst et al., 2018; Lombardi et al., 2023). While there are cost considerations to implementing

IBH, many healthcare systems find the costs of IBH justified when exploring overall impact of services and indirect cost-savings (e.g., ER diversions; Mancini et al., 2023; Nagykaldi et al., 2023).

Despite these challenges, practitioners are continuing to explore ways to address barriers to sustainability and implementation (e.g., Herbst et al., 2018; Herbst et al., 2020) including increasing advocacy at the state and federal level. Indeed, a number of new policies have improved the outlook for sustainable IBH including same-day billing, the adoption of collaborative care (CoCM) and other codes, and federal funding to study and grow the workforce. Fully evolved, IBH represents a true transformation of the primary care system. While it's adoption may be slow, the potential impact to the health of rural Appalachian children is significant.

About the Authors

Kristen Riem, Ph.D. is completing her postdoctoral fellowship with the East Tennessee State University Institute for Integrated Behavioral Health. She provides integrated behavioral health services in Pediatrics and also completes brief, targeted psychological assessments for patients of all ages. Dr. Riem has her Ph.D. in School Psychology from the University of Tennessee- Knoxville.

Jodi Polaha, Ph.D. is the Director of the Institute for Integrated Behavioral Health in the Quillen College of Medicine at East Tennessee State University. Dr. Polaha's career has been dedicated to integrated behavioral health research, training, and practice. She is the outgoing editor for the journal Families, Systems, & Health.

Collaborative Care

Brian Merrill, M.D.

Collaborative care, as defined by the American Psychiatric Association (APA), is a model of healthcare delivery that integrates physical and mental health services within primary care settings. This team-based approach involves primary care teams and mental health professionals who work together to address the complex needs of patients. By bridging the gap between physical and mental health care, collaborative care seeks to enhance patient outcomes and improve access to comprehensive, integrated services. Furthermore, collaborative care empowers people to continue to consume health care services from their primary care team, though with a broader scope of clinical issues to include mental health and addiction disorders. There is robust evidence to support collaborative care including improved clinical outcomes, improved quality of life measures, improved adherence to recommended treatments, improved healthcare utilization patterns, (e.g., reduced hospitalization and emergency department visits), improved patient satisfaction, and improvement in health equity.

While the core tenets of collaborative care are articulated differently by different organizations, the APA describes the core principles as follows:

1. Patient-Centered / Team-Based Care: Implementing a multidisciplinary team approach ensures that patients receive comprehensive care that

addresses their physical, mental, and social needs. This team may include primary care providers, behavioral health specialists, care coordinators, and other healthcare professionals. This team thus embraces shared decision-making, patient education, and self-management, which then support and empower patients and families to take control of their health and participate in treatment decisions that align with their values and preferences.

2. Population Based Care: The care team uses a registry to track patients receiving services and clinical outcomes. When patients are not improving this is detectable through the routine review of the registry and steps are taken to provide more optimal care. This helps ensure people do not slip through the cracks.

3. Measurement Based Treatment to Target: Utilizing standardized assessments and outcome measures, which are tailored for individual patients allows for the systematic monitoring of patient progress and treatment effectiveness. Regular assessment of symptoms, functioning, and treatment response helps providers tailor interventions and optimize care plans based on individual patient needs.

4. Evidence-Based Care: This model aims to promote treatments with credible evidence. This helps to close the gap between what the literature demonstrates as effective (e.g. "state-of-the-art") and prevailing community practice, which can be delayed in the adoption of best practices and evidence-based treatments.

5. Accountable Care: Services are reimbursed based on outcomes and quality, not strictly volume. This helps ensure the fidelity of the collaborative care model to its own core principles.

Collaborative care is especially valuable in the context of service delivery to children and adolescents. This population is vulnerable to many mental health disorders and a collaborative care team can play a role in the early detection and treatment of those disorders, which is associated with improved outcomes. Moreover—many pediatric practices are incompletely equipped to screen, evaluate, and manage mental health disorders and engaging in the collaborative care model ensures that a program has the resources, team composition, and clinical processes to provide optimal mental health treatment.

Despite overwhelming evidence of the value of collaborative care in extending the primary care team's ability to improve outcomes and broaden their scope of practice many barriers exist. Workforce shortages, especially for behavioral health providers, make recruiting and retaining a quality team challenging. Moreover, stigma continues to impede progress for mental health services through hesitation to seek services for patients and families and hesitation to develop comprehensive behavioral health services by providers. Finally—reimbursement threatens the sustainability of collaborative care. Because much of the work may not be recognized in the traditional fee-for-service model, value-based reimbursement must incentivize the type of outcomes the collaborative care team is trying to achieve.

At Integrated Services for Behavioral Health, we embrace the Collaborative Care Model by providing services in multiple primary care locations around southeast Ohio. Access to mental health services through primary care integration is especially critical in rural areas where access to these services (and the consequent disparities that such reduced access engenders) may be critically limited. Our growing service line serves upward of 500 discrete patients annually across six offices in three counties; and we aim to continue growth in this space as opportunities for collaborative partnerships arise.

Finally, our commitment to collaborative care is evidenced by our participation as a Care Management Entity (CME) with OhioRISE through which we provide care coordination services for over 1,000 individuals across 19 counties. Our partnership with OhioRISE allows ISBH to offer wraparound care coordination services to enrolled children, adolescents, and families—fostering connections to community resources and helping to ensure some of the state's most vulnerable individuals have the best chance of success.

About the Author

Dr. Brian Merrill, M.D., is an Associate Professor and Director of the Psychiatry Residency Program, and Director of Community Psychiatry at Wright State University. He also serves as the Chief Medical Director at Integrated Services for Behavioral Health.

Upcoming Professional Development

Check out these upcoming professional development opportunities

- Mid-Ohio Psychological Services Public Trainings (MOPS; virtual)
    - For providers interested in receiving additional training in topics relevant to work with children and adolescents. Continuing education requirements are available.
    - **Working with disruptive, impulse-control, and conduct disorders** (06/10/24; 8:45am-4pm)

    - **Battles to boundaries: Working with families** (7/29/24; 8:45am-4pm)
    - To learn more, check out this link
- Ashtabula County **Suicide Prevention Coalition Meeting** (7/3/24; 3-4pm)
    - Open to all individuals interested in suicide prevention work
    - In-person option at Ashtabula County Mental Health & Recovery Services Board, 4817 State Rd. Suite 203, Ashtabula, Ohio 44004
    - Virtual option available upon request
    - To learn more, check out this link
- Montgomery County ADAMHS Board Trainings
    - For providers and educators interested in building knowledge and skills relevant to work with children and adolescents
    - **Mental Health First Aid Training for Youth** (6/5/24; 9am-3pm)
    - **Is Gender the New Gay? And Other Q+ Matters Found in School Settings** (6/25/24; 9am-12pm)
        - This workshop will explore strategies, frameworks, and approaches for including Q+ youth in curricula, classroom, and community programming so a new narrative of thriving can be achieved.
    - Continuing education requirements available for both programs
    - Both programs located in-person at ADAMHS — Montgomery County ADAMHS — Suite 201 (2nd floor), 409 E. Monument Ave, Dayton, OH 45402
    - For more information, check out this link

Want your professional development opportunity to be in the next newsletter?

- email SACnews@appchildren.org with details about your event.

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