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The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated:
INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH TO IMPROVE ADHD CARE

Kara Tucker, LCSW-R
Youth Coordinator/Institute for Family Health
The Institute for Family Health has 27 locations in Manhattan, the Bronx and the Mid-Hudson Valley. The Institute is committed to high-quality, affordable health care for all.
Services we provide:

- Primary Care
- Behavioral Health
- Dental Care
- Case Management
- Care Management
- Insurance Enrollment
Why Improve ADHD Care?

- Underserved populations are less likely to get ADHD treatment.
- ADHD is one of the most prevalent diagnoses in children.
- Young adults with ADHD have:
  - twice as many injuries
  - higher emergency room use and hospital inpatient stays
  - greater risk of involvement in motor vehicle crashes, drinking and driving, and traffic violations
- DSM 5 changes include improving care for adults since many children continue to have symptoms into adulthood.
- Providers are not consistently following guidelines.
What are the quality improvements based on?

- American Academy of Pediatrics guidelines
- The ADHD Collaborative Intervention (Cincinnati Children’s Hospital Medical Center) designed to promote adherence to the American Academy of Pediatrics guidelines
- Successful practices we have been using with adults
- Internal chart audits and reports
- Provider feedback
Developing a Chart Audit Tool

### The Institute for Family Health
Attention-Deficit/Hyperactivity Disorder Chart Audit Tool

<table>
<thead>
<tr>
<th>Patient MRN</th>
<th>Provider Last Name and/or Group</th>
<th>Provider ID</th>
</tr>
</thead>
</table>

#### PART 1: SCREENING AND EVALUATION

<table>
<thead>
<tr>
<th>1.</th>
<th>Patient was screened for symptoms meeting DSM-V criteria for ADHD. Assessed whether child/adolescents met 6 or more DSM-V symptoms criteria. Older adolescents and adults aged 17 and older met at least 5 of the DSM-V symptoms criteria.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Clinician noted the duration, severity and frequency of symptoms—in particular whether symptoms have lasted for 6 months.</td>
</tr>
<tr>
<td>3.</td>
<td>A developmental, medical, and family history of the patient was taken.</td>
</tr>
<tr>
<td>4.</td>
<td>Family history included questions about parental ADHD and cardiac history.</td>
</tr>
<tr>
<td>5.</td>
<td>Age when patient developed onset of symptoms was noted. Provider determined whether inattentive, impulsive, or hyper-active impulsive symptoms were present in the patient prior to 12 years of age.</td>
</tr>
</tbody>
</table>
Quality Improvements

Development of:

- Standardized assessment note
- Pathways and workflows
- Letter to schools to improve collaboration
- Psychoeducational materials
### NICHQ Vanderbilt Assessment Scale—TEACHER Informant

**Teacher’s Name:**

**Class Time:**

**Class Name/Period:**

**Today’s Date:**

**Child’s Name:**

**Grade Level:**

**Directions:** Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child’s behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: 

**Is this evaluation based on a time when the child** □ was on medication □ was not on medication □ not sure?

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fails to give attention to details or makes careless mistakes in schoolwork</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Has difficulty sustaining attention to tasks or activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Does not seem to listen when spoken to directly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Has difficulty organizing tasks and activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things necessary for tasks or activities (school assignments, pencils, or books)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Is easily distracted by extraneous stimuli</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Is forgetful in daily activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Fidgets with hands or feet or squirms in seat</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Leaves seat in classroom or in other situations in which remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Runs about or climbs excessively in situations in which remaining seated is expected</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Has difficulty playing or engaging in leisure activities quietly</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Is “on the go” or often acts as if “driven by a motor”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Talks excessively</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Blurs out answers before questions have been completed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Has difficulty waiting in line</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Interrupts or intrudes on others (eg, butts into conversations/games)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Loses temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Actively defies or refuses to comply with adult’s requests or rules</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Is angry or resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Is spiteful and vindictive</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
ADHD Standardized Assessment Note

Symptoms are present in multiple settings

- School? Yes, No, N/A
- Work? Yes, No, N/A
- Home? Yes, No

Six criteria from either inattention or hyperactivity and impulsivity included, or 5 criteria for patients over 17 years old.

Symptoms were present before age 12: yes/no, and for longer than 6 months: yes/no, and create a functional impairment: yes/no

Smoking and alcohol assessment completed: yes/no

Family History of ADHD: yes/no  Notes

Cardiac history completed: No cardiac history/cardiac history noted
Patient presents in primary care and has ADHD on the problem list or wants to be assessed for ADHD

MA/Nursing:
Children: Vanderbilt parent given while waiting for doctor and entered by Nursing/MA staff. Releases for school given for parent to fill out and sign. Top portion of Vanderbilt teacher filled out and given to medical records to fax with signed releases. Parent also given teacher version to make sure school receives and to increase collaboration.

Adults: ASRS given while waiting for provider.

Providers: Assessment process and treatment options explained.

PSR: Schedule appointment with behavioral health consult clinic or behavioral health as needed. Medication can be prescribed when full assessment is completed (including both Vanderbilt's for children).

Providers: Interpretation of screening instruments (Vanderbilt's and ASRS).

Assessment tools (Vanderbilt parent/teacher and ASRS used to assess progress in treatment) Patients re-assessed annually using assessments note and tools.

If medication is prescribed, patient will be scheduled within 30 days for follow-up. If controlled substance is prescribed, then controlled substance agreement is signed by patient or parent and scanned to chart by medical records.

PSR/Medical Records: Releases signed, scanned to chart and faxed to get records from any previous providers and school (ex. psychological evaluations and IEP). Vanderbilt teacher forms faxed to school. Teacher forms will be given to MA/nursing to be entered once returned.
Behavioral Health Consult Clinic

Using primary care physicians and family medicine residents to work with psychiatric providers and social workers to do assessment and follow up with patients with ADHD. Treatment decisions are made by the team, which includes the patient and parents, teachers and others, when appropriate.
Success of the Adult Consult Clinic

Since January 2014 over 220 patients were seen during the pilot of the behavioral health consult clinic.

![Pie chart showing the distribution of patients: 80% Primary Care, 15% Other Services, 5% Behavioral Health.](chart.png)
Behavioral Health Consult Clinic

- Can use telepsychiatry or onsite psychiatric providers
- Frequency: 2 afternoon sessions per month
- Shorter follow up sessions available as needed
- Behavioral health providers are part of the assessment and assist in discussing treatment options
- Follow up appointments with PCP/resident are scheduled when a behavioral health provider is available
- Training to providers on ADHD assessment and treatment
ADHD Treatments
For Children and Teens (ages 6-17)
Be sure they get what’s best!

Where we have been:
(Treatment practices, 2009-2010)
Less than 1 in 3 children with ADHD in this age group got both behavioral therapy and medication.

Where we need to go:
(Treatment guidance, 2011)
Provide both behavioral therapy and medication.

What can you do?

Parents:
Talk to your doctor about the recommendations for ADHD treatment and about what’s best for your child.

Healthcare professionals:
Be aware of the psychological resources in your community and be prepared to refer children for behavioral therapy as recommended by the American Academy of Pediatrics (AAP).

FOR MORE INFORMATION:
www.cdc.gov/adhd
Twitter: @CDC_NCBDDD
In a study of ADHD in adults, those with ADHD symptoms were at increased risk for divorce, unemployment and substance abuse. In addition, the study found that while many people with ADHD are in treatment for other mental disorders and substance abuse, a small proportion received treatment for their ADHD symptoms.
Benefits of an Integrated Care Model

- Assists the strained psychiatric systems, especially in rural areas
- Allows more patients to access care and get appointments faster
- Decreases the stigma of mental health problems when seen in a primary care setting
- Supports primary care providers to feel more comfortable in assessing and treating ADHD
- Allows for the next generation of doctors to be better equipped to handle mental health issues
- Increases possibilities to connect people to care since these issues usually first come up in primary care
Contact: Kara Tucker, LCSW-R
Ellenville Family Health Center
6 Healthy Way
Ellenville, NY 12428
ktucker@institute.org
Phone: 845-647-4500
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Adverse Childhood Experiences (ACE)

- Kaiser & CDC 1995-1997
- 17,000 patients
- Mostly white, well-educated, middle class
- Defined 10 types of ACE
Adverse Childhood Experiences Are Common

- **Household Dysfunction**
  - Substance Abuse: 27%
  - Parental sep/divorce: 23%
  - Mental Illness: 17%
  - Battered Mother: 13%
  - Criminal Behavior: 6%

- **Abuse**
  - Psychological: 11%
  - Physical: 28%
  - Sexual: 21%

- **Neglect**
  - Emotional: 15%
  - Physical: 10%
Adverse Childhood Experiences Are Common

- 25% of women and 16% of men had experienced contact sexual abuse
- 30% of men had been physically abused
Adverse Childhood Experiences Cluster

- 52% had $\geq 3$ types of ACE
- 39% had $\geq 4$ types of ACE
ACE’s ARE A TOXIN!

Healthy Brain
This PET scan of the brain of a normal child shows regions of high (red) and low (blue and black) activity. At birth, only primitive structures such as the brain stem (center) are fully functional; in regions like the temporal lobes (top), early childhood experiences wire the circuits.

An Abused Brain
This PET scan of the brain of a Romanian Orphan, who was institutionalized shortly after birth, shows the effect of extreme deprivation in infancy. The temporal lobes (top), which regulate emotions and receive input from the senses, are nearly quiescent. Such children suffer emotional and cognitive problems.
The ACE Score and a Lifetime History of Depression or Suicide Attempts

Percent depressed or attempted suicide (%)
ACE Score and HIV Risks

ACE Score

Ever Injected Drugs
Had 50 or More Intercourse Partners
Ever Had an STD

Percent With Health Problem (%)
ACE Effect Health!

ACE Score:

- 0
- 1
- 2
- 3
- 4 or more

Percent With Problem

Initiated smoking by age 14

COPD
## ACE Effect Health!

People with $\geq 4$ ACE:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Adjusted Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease</td>
<td>2.2</td>
</tr>
<tr>
<td>Any Cancer</td>
<td>1.9</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.6</td>
</tr>
</tbody>
</table>
ACE Study Findings

- >80% of people in psychiatric hospitals have experienced physical or sexual abuse
- >66% of people in substance abuse treatment report childhood abuse or neglect
- >90% of women with alcoholism were sexually abused or suffered severe violence from
ACE Study Findings

- Attributable to ACE:
  - > 67% of all suicide attempts
  - > 64% of adult suicide attempts
  - > 80% of child/adolescent suicide attempts
Children & Families in ACTTION  
(Addressing Childhood Trauma Together in Our Neighborhoods)

**CBHCare**

- **Executive Leadership**
  - Roberta Leiner
    - Chief of Patient Engagement, Population and Community Health Planning
  - Allison DuBois
    - Chief Operations Officer
  - Sophia McIntyre, MD
    - Chief of Clinical Quality and Medical Education
  - Daniel Miller, MD
    - Chief of Clinical Integration & Graduate Medical Education (ACTTION Program Lead)
  - Katherine Bringer
    - Chief of Patient Experience and Staff Training and Development
  - James Sinkoff
    - EVP CFO
  - Carmen Chinea, MD
    - Chief Medical Officer

- **Board of Directors**
  - Anne Nolan
    - President & CEO

- **Clinical Support**
  - LPN / MA

- **MD**

- **Pediatric Care Manager**

- **Cross-Sector Supports**: CBHCare; WCA

- **Pediatric LMSW**
  - Anu Gramlich

- **Parent Advocate**
  - Wilhelmina Harris

- **Regional Administrator of Mental Health Services for Southern Westchester**
  - Aaron Newman

- **Multidisciplinary Care Team with Cross-Sector Supports**

**HRHCare**

- **Westchester Jewish Community Services**

**Chief of Clinical Integration & Graduate Medical Education (ACTTION Program Lead)**

**Chief Operations Officer**

**Chief of Clinical Quality and Population and Community Health Planning**

**Chief of Patient Engagement, Staff Training and Development**

**Regional Administrator of Mental Health Services for Southern Westchester**

**EVP CFO**

**Chief Medical Officer**

**President & CEO**

**President & CEO**
WJCS LMSW is co-located in practice 1 day/week.
– Handles all HRHCare referrals
LMSW, pediatricians and ALL staff have AM huddle to review all of day’s patients
“Closing the loop” with referrals
Family Advocate has given pediatrician tour of neighborhood re: stresses & resources
ACTTION Team Effects: Integration

- Full-site Trauma-Informed Care Training
- Frequent warm hand-offs and coordinated care plans
- Staff experiences greater involvement and teamwork
ACTTION Team Plans (Plan A): Integrated Visits

- 2,190 children age 12 and under
- Fully Integrated WCV with Pediatrician and ACTION Care Manager
  - Care Manager assesses family’s strengths & challenges
    - ASQ-SE (Ages & Stages Questionnaire, Social-Emotional)
    - ACES (Adverse Childhood Experiences Score)
  - Care Manager determines family need for more intensive services re: Trauma, SDH, etc.
- LCSW Integrated in Practice Full Time
- Parent Aide – CHW trained in parenting
  - Home visits
  - Participate in Parenting Groups
ACTTION Team Plans (Plan B): Integrated Visits

Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Date:
Child’s Name:
Your Name:
Relationship to Child:

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child’s doctor in assessing their health and determining guidance. Please read the statements below. Count the number of statements that apply to your child and write the total number on the line provided.

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box.

Section 1. At any point since your child was born...

- Your child’s parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member was violent, punished, or put down your child in a way that scared your child. OR a household member acted in a way that made your child afraid that she might be physically hurt
- Someone touched your child’s private parts or asked your child to touch these private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child. OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child felt unsupported, unloved, and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box.

Section 2. At any point since your child was born...

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion
ACTTION Team Plans (Plan B): Integrated Visits

● “New Mexico 3” Questions:
  – “Have there been any major stressful events since the last time you were here?”
  – “How much are these still impacting you?”
  – “What are some positive things about your child that you would like to share? Tell me what has been going well for you?”
ACTTION Team Plans (Plan B): Integrated Visits

- Waiting Room Literature and Handouts
- Financial Logistics of WJCS Social Worker
  - WJCS will determine financial logistics of integrated LCSW’s in pediatric practice
  - What are requirements for billable visits
  - How many are need to make this viable.
- Parent Survey
- METRICS!
  - # of families screened
  - # positive
  - # referred and seen
  - # co-managed
In similar model MMC noted parent ED utilization 2.4/year → 0.9/year

- Kaiser added trauma questions to ROS for 444,000 adults
  - 11% reduction ER visits
  - 3% reduction in hospitalization
HRHCare Integrated Care Vision

**Within Medical Practice**

- CBHCare Partners
- Urgi
- Outreach
- Cognos-Identified
- ED/Admissions

**Clinical Team**

- Patient Navigator
- Care Manager
- Social Worker (IMPACT, etc.)

**Screenings**:
- Cancer Screenings (Colon, Cervical, Breast)
- Medical Screening
- Depression
- SBIRT
- ACE Score
- Sexual History
- PAM
- ACO Adult Wellness visit*

**Standing Orders**:
- Define who does this?
- Who? MA, MD/NP, CM?
- Motivational Interviewing training

**Referral Resources & Tracking**
- Identify preferred referrals and consultants
- Identify other care managers
- Care Plan as needed
- Train in Resources
- SDH
- Housing
- Transportation
- Employment
- Food
- HHAs, etc.
- VNS
- Train in Motivational Interviewing

**Case Conferencing**
- Fill in with Expectations, Guidelines, etc.
- Important to emphasize this from the beginning.

**Within or Outside of Medical Practice**

- Hospital
- SNF

**Models of Intervention**
- UMass
- Cherokee

**Models of Treatment**
- Consent for Sharing
- Referral Closing
- Co-location & Integration
- Huddle/Case Conferences

**Community Outreach**
- CHW - Asthma, etc.
- Greeters in Waiting Room
- Reading to Children
- Comite Latina, etc.

**Health Home Coordination**
- SPMI, Depression, Substance Abuse, Chronic Illness, Coordination with Clinical & Case Manager, Streamline Case Managers

**Consent for Sharing**
- Co-location & Integration
- Huddle/Case Conferences

**Impact enactment**
- Psychiatry training

**Hospice Liaison**
- Proxies/Living Wills

**Models of Intervention**
- UMass
- Cherokee

**Community Case Managers**
- CBHCare Clinical Model
- Draft 7/27/15
Integrated Health Systems

Figure 1: Comparison of CHS utilization with regional providers
Thank You