Commentary: Integrated Pediatric Primary Care: Moving From Why to How

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Received August 1, 2016; revisions received August 3, 2016; accepted August 3, 2016

Abstract

Whether to address behavioral health issues in pediatric primary care is no longer debated; instead, we are challenged to determine “how” and who can best deliver services in an effective and sustainable manner. This commentary explores how pediatric psychology can contribute to this discussion by developing and evaluating innovative clinical models (such as a hybrid Collaborative Care/Primary Care Behavioral Health model) and expanding workforce and teaching initiatives.

Key words: child behavioral health; pediatric integrated care; primary care.

My interest in primary care was prompted not from pediatric psychologists but from pediatricians, at least initially. Committed to working in a pediatric setting after completing my PhD in clinical psychology in 1986, I eagerly (and naively) accepted a position at an academic medical center in Cleveland, Ohio (now MetroHealth Medical Center), where one of my major responsibilities was teaching pediatric residents how to address developmental and behavioral needs of children in primary care (described in Drotar, 1995). By then, pediatric psychology had become closely associated with specialty medical care with an emphasis on research and interventions for children with chronic and acute medical issues (e.g., diabetes, pain management, cancer; see Drotar, 2015). With some exceptions (e.g., Christopherson, 1982; Roberts & Wright, 1982; Smith, Rome, & Freedheim, 1967; Schroeder, 1979), few pediatric psychologists seemed enthusiastic about primary care, or at least there were few published research reports and even fewer descriptions related to training for primary care work. However, the pediatric literature was replete with growing concerns about the high rate of unidentified and unmet behavioral disorders in children in primary care (e.g., Costello et al., 1988) and the need for pediatricians in primary care to be better prepared to address them (e.g., Haggerty, 1979). The focus on the need to provide behavioral health services in pediatric primary care settings—the “why”—continued to be a dominant theme between the 1980s and 1990s (e.g., Lavigne et al., 1993), along with emerging discussions about models to better address prevention, screening, and intervention of developmental and behavioral problems of children in primary care (e.g., Perrin, 1999).

The first special issue of the Journal of Pediatric Psychology (JPP) addressing pediatric psychology and primary care consisted of six research papers and three invited commentaries (Stancin, 1999). Carolyn Schroeder’s (1999) commentary in that issue described the historical context of pediatric psychology, which had always noted the importance of practice in community settings, and Schroeder called on pediatric psychology “to more forcefully expand our research and service delivery efforts beyond medical hospitals and educational settings to the ‘front lines’ of community-based primary settings” (p. 448). Among the lessons she shared in that commentary were that shifts in health care finance reform impacted services (in the 1990s, it was managed care) and the critical importance of psychologists remaining embedded on-site in the practice. Schroeder recommended that we become more knowledgeable about the business aspects of...
integrated practices. She encouraged more training of psychologists in primary care (which she noted was different from traditional child clinical and pediatric psychology in hospital settings), and suggested we become more active in advocating for public health issues that influence child development and health. I wish to echo her wise recommendations that are as relevant today as ever.

But what has changed in the past two decades since the last Special Issue? Pediatricians and pediatric organizations, such as the American Academy of Pediatrics and the American Board of Pediatric, continue to express concerns about unmet developmental, behavioral, and social needs of children and clamor for help addressing them (e.g., https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health; https://blog.abp.org/blog/mental-health-crisis-among-americas-children-what-should-we-do). How well have pediatric psychologists responded to these requests with innovative clinical models? Talmi et al., (2016) examined electronic health records over a 6-year period of an integrated primary care program in an urban, residency training clinic and described a wide continuum of services delivered in this practice. Not unlike descriptions dating back to Schroeder (1979), they describe the provision of a variety of services to children and families ranging from prevention and health promotion activities, screening and identification processes, and interventions around mental health issues.

However, health care discussions in the United States have changed since 1999, which are noteworthy. A focus on achieving better health for all, better quality health care for individuals, at lower cost (the Triple Aim) is driving health care transformation initiatives (Berwick, Nolan, & Whittington, 2008). Evidence that these health goals cannot be achieved without addressing behavioral health has led to general acceptance of the necessity of bringing behavioral health and primary care together as “integrated care” (Patient Protection and Affordable Care Act, 2010). Thus, it would appear that we no longer need to demonstrate “why” we need to provide integrated care; instead, we are challenged with determining “how” to best address behavioral health issues in pediatric settings. What evidence supports clinical models that are most effective and economical?

Compared with the 1999 issue, we see in the current JPP Special Issue a maturing of research and topics. Previous research on screening in primary care tended to focus on practical matters: validation of measures, feasibility, and impact (e.g., Riekert, Stancin, & Drotar, 1999), whereas the papers by Lavigne et al. (Lavigne, Feldman, & Meyers, 2016; Lavigne, Meyers, & Feldman, 2016) encourage a more critical examination of screening practices in primary care. Additionally, Kiing, Raigor, and Toh (2016) describe complexities in adapting developmental screening measures for different languages and cultures and outlines recommendations for a systematic approach to translating instruments for an international community.

Although there has been some progress, we must continue to grow the evidence base for work in primary care. Randomized controlled trials are needed, yet there are none in this special issue. A recent meta-analysis (Asarnow, Rozenman, Wiblin, & Zeltzer, 2015) identified just 31 randomized controlled studies in pediatric primary care settings comparing any integrated behavioral health care intervention with usual care since 1960. Although results from that meta-analysis supported better outcomes for integrated versus usual care, there was much variability in the nature of interventions studied, leading to few specific recommendations. Pediatric psychologists have the requisite research skills to lead research efforts needed to demonstrate effectiveness of innovative clinical models and quality improvement in primary care.

We need to continue to explore the clinical practice, training, and roles of psychologists in primary care. Psychologists are not the only behavioral health professionals to be interested in expanding opportunities in primary care. Although we psychologists may rightly claim to be behavioral health specialists trained in the broad spectrum of developmental, mental health, and health care issues with added expertise in research, screening, psychometrics, psychological testing, and evidence-based interventions—and therefore should be at the forefront of integrated care—there is little evidence to date that those skills are essential to improving outcomes. Research is needed on comparisons of models, effective team functioning, and appropriate role definitions for team members.

In a recent document by the American Psychiatric Association (APA/APM, 2016), psychiatrists strongly endorsed the “Collaborative Care Model (CC)” for delivering specialty psychiatric care for adults in primary care because of results of several randomized controlled trials. According to this team-based model, the primary care physician is the clinical leader with support from a “care manager” (e.g., a nurse or mental health specialist for screening, obtaining relevant clinical information, and linking services) with consultation with a psychiatrist (usually remotely) (APA/APM, 2016). The document notes “other members of the Collaborative Care team may include a primary care-based psychologist or social worker for the purpose of patient assessment, enhancing access to evidence-based psychotherapies, and urgent assessment of a patient’s potential to harm themselves or others” (p. 14), and that care managers can assist with management of chronic disease issues.
the findings of Talmi et al. (2016) that medication consultation accounted for just 5% of behavioral health services in their integrated primary care program, a CC model that focuses on medication consultation would not sufficiently address the scope of behavioral concerns in pediatric settings.

The CC Model can be contrasted with a more psychologist favored “Primary Care Behavioral Health (PCBH)” model (Reiter & Robinson, 2015). This model describes having an on-site, full-time psychologist (or licensed mental health professional), who is available to address mental health issues, health behaviors, and substance abuse. The scope of services usually includes evaluations, short-term therapy, and health/mental health promotion and prevention, with demonstrated effectiveness and cost-offsets.

Recently (APA, 2016), APA President Susan McDaniel, PhD, convened an interprofessional Integrated Primary Care Alliance Meeting of leaders from a number of health and primary care organizations. The purpose of this meeting was to review and discuss current critical issues related to successful implementation and outcomes of integrated primary care, and to develop an inter-organizational action plan to move integrated primary care forward. At this meeting, APA proposed a hybrid Behavioral Health Care Model that blends CC and PCBH. In this hybrid model, psychiatrists and care managers may provide specialty CC, while on-site psychologists provide consultation regarding prevention, health behavior change, and mental health interventions.

In pediatric primary care, this hybrid model might include PCBH services (e.g., prevention, screening, targeted health behavior change interventions, addressing developmental and academic concerns, assessment and targeted interventions for behavior disorders) along with remote psychiatric consultation for more serious psychiatric disorders requiring medication consultation. Care managers (nurse, social worker) could then provide care-coordination and connect patients with community resources. What is important about this shift in model description is the clearer articulation of possible roles of health care team members to address the range of needs in the clinic setting. However, randomized controlled trials to test the various models are essential to move the discussion forward.

Undoubtedly, however, we will need to define more clearly the role of psychologists in primary care, and differentiate competencies and skill sets from other behavioral health providers. Psychologists continue to be grouped with behavioral health coordinators, nurses, therapists, and other non-doctoral providers when describing potential roles and services in documents (e.g., APA/APM, 2016). At the same time, we must question whether we are adequately preparing a workforce of pediatric psychologists to provide evidence-based services in primary care settings. The work of Woods et al. (2016) on specific competencies may serve as a blueprint for training psychologists to function in pediatric primary care settings. By delineating behavioral anchors, the authors define many of the important ways that psychology skill sets differ from those of other members of an integrated care team of professionals. We will need to expand opportunities for psychology trainees at all levels to develop skills needed to serve as leaders in the integrated health team.

The business and economic aspects of integrated care practice are by no means trivial and often dominate discussions about challenges to effective service delivery. The Cederno-Mako, Ellens, Burrell, Perry, and Rafiq (2016) retrospective review of behavioral health productivity and billing data within an underserved, urban primary care practice revealed significant threats to integrated care sustainability in a fee-for-service market related to suboptimal productivity and low billing rates. The economic feasibility of pediatric psychology in primary care in the future will likely rely on a different business model that emphasizes quality outcomes and team-based performance (Tynan, 2016). Quality metrics that demonstrate higher utilization of effective care delivery (e.g., number of patients administered a standardized developmental screening tool; body-mass index calculations on each patient) and outcomes (e.g., reduction in emergency room visits, younger age at autism spectrum disorder diagnosis) may be linked to payment instead of volume-based fees for services (Stancin, Sturm, Tynan, & Ramirez, 2016; Tynan, 2016).

Opportunities for psychologists to impact children’s health in primary care settings have been recognized for >50 years (Wilson, 1964). However, there has been limited attention to primary care in pediatric psychology (Stancin & Perrin, 2014). Recently, Drotar (2015) highlighted the underemphasis of primary care in the history of pediatric psychology and suggested that pediatric psychology needs to enhance capacity and competency in primary care services, training models, and research. I am pleased to note a growing enthusiasm for integrated care among pediatric psychologists. Now there is a large, thriving Integrated Care Special Interest Group of the Society of Pediatric Psychology with 141 members, many of whom are trainees and early career pediatric psychologists. The number of training programs, internships, and postdoctoral fellowships that aim to address the need for preparing a primary care workforce seems to be growing. This second Special Issue and a surge in attention at national meetings is further indication that there is momentum in our field. It is my hope this signals that we may have the critical mass of
enthusiastic pediatric psychologists needed to contribute more meaningfully to discussions about “how” to best serve children and adolescents in primary care.

Funding

Conflicts of interest: None declared.

References


