DOCTOR OFFICE COLLABORATIVE CARE:
Orientation to Assessment & Initial Treatment

Pennsylvania Chapter
American Academy of Pediatrics

Pennsylvania Medical Home Program
Educating Practices In Community Integrated Care

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SKIP for PA Study

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INTRODUCTIONS

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Adjunct Psychology Instructor

Parent of a child diagnosed with ADHD

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WHAT IS THE COLLABORATIVE CARE MODEL?

- Patient-Centered Team Care
- Population-Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Care
- Accountable Care

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WHAT IS THE "SKIP FOR PA" STUDY? (SKIP – Service for Kids In Primary-care)

- A quality improvement initiative to treat children with early behavior problems and comorbid ADHD in 24 pediatric primary care sites using an evidence-based practice (Doctor Office Collaborative Care, DOCC)
- A randomized clinical trial to evaluate different strategies for supporting the implementation of DOCC.
- Provider surveys at baseline, 6mo, 12mo, 18mo, & 24mo; 4 surveys for caregivers (all are compensated)
- A secure caseload registry is used to monitor clinical & treatment status in case reviews and for research
- Track progress on personalized behavioral goals and Vanderbilt rating scales
- Funding from NIMH and in partnership with the PA Chapter of the AAP Medical Home Program

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DOCTOR OFFICE COLLABORATIVE CARE ROLES – LEADERSHIP

- **Senior Leader/Clinician (1)**
  - A staff member with an existing practice-level leadership role (Medical Director or a clinical/practice leader). This person should have administrative responsibilities related to patient care and/or practice management/operations.
  - Often also serve as primary care providers of health care services. The Senior Leader would simply continue to serve their patients and are encouraged to participate in scheduled provider care team meetings.
  - For the trial, they and their practice managers may also be involved in ongoing practice leadership facilitation meetings designed to strengthen practice leadership's capacity to lead change and overcome practice-level barriers to delivering Doctor Office Collaborative Care.

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DOCTOR OFFICE COLLABORATIVE CARE ROLES – LEADERSHIP

- **Practice Manager (1)**
  - Involved in supporting and managing day to day operations.
  - In this trial, practice managers may also be involved in ongoing practice leadership facilitation designed to strengthen practice leadership's capacity to lead change and overcome practice-level barriers to delivering Doctor Office Collaborative Care.

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DOCTOR OFFICE COLLABORATIVE CARE ROLES – CARE TEAM

- **Behavioral Health Care Manager ("CM") (1)**
  - A staff member who is mostly responsible for delivering and coordinating behavioral health services to children and their caregivers. This could be a person with any background – e.g., a social worker, clinician, nurse, or other staff member – whoever has provided or is willing to provide the majority of behavioral health care to identified families.
  - Provides treatment to patients with disruptive behavior disorders and/or ADHD. They will engage families in treatment, collaborate with PCPs to determine appropriate treatment options, provide brief evidence-based therapy to children and caregivers, and monitor treatment progress. Care Managers are responsible for documenting all services provided to patients in the study's patient registry.
  - Care Managers may be involved in ongoing implementation support meetings with the practice's PCPs and a DOCC trainer. This type of implementation support is designed to improve providers' skill in using Doctor Office Collaborative Care, teamwork quality, and team effectiveness.

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DOCTOR OFFICE COLLABORATIVE CARE ROLES – CARE TEAM

- **Primary Care Providers (1+)**
  - A main goal of this program is to support the prescribing medical provider (pediatrician, CRNP, PA, etc.) in the care of the patient's ADHD diagnosis.
  - Responsible for referring potentially eligible families to the study, ongoing management of medical care including medication treatment, overseeing treatments for comorbid or underlying medical problems, and making referrals to specialty care as needed. PCPs prescribing psychotropic medications can receive consultation and medication recommendations from a psychiatric consultant when desired.
  - may be involved in ongoing implementation support meetings with the practice's PCPs and a DOCC trainer. This type of implementation support is designed to improve providers' skill in using Doctor Office Collaborative Care, teamwork quality, and team effectiveness.
  - **There must be at least one other Medical Provider besides the Senior Leader. That is, the Senior Leader can not be the only PCP. ALL practice PCPs are encouraged to participate.**

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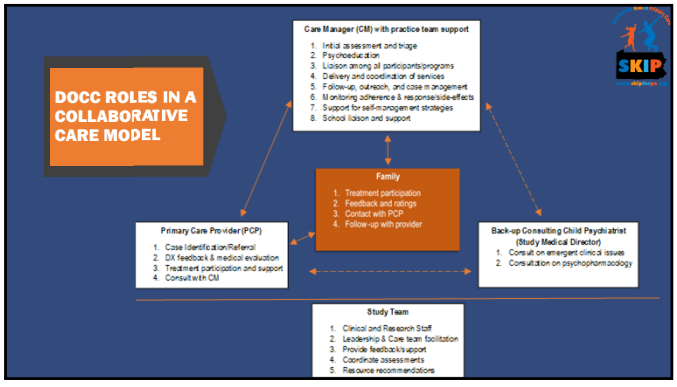

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STAFF & SITE READINESS

1. PCP & Staff Preparation
2. Environment Preparation
3. Advertisement/ PR

• CM meets with providers	• CM & PM work together to address environment needs (office space, unique needs of behavioral health, etc.)	• CM & PM work together to tailor study PR for specific practice needs
• CM & providers develop communication plans	• CM prepares office space with DOCC materials	• Determine best uses/locations of PR materials
• CM works with practice personnel to develop understanding & referral process		

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1. Identify & Screen Potential Participant
2. Schedule Intake Assessment
3. Complete Intake Assessment
4. Schedule 1st DOCC Treatment Session
5. WDX/Chart
6. Prep for & Meet with Collaborative Care Team

DOCC CASE INTAKE WORKFLOW

Agenda for the remainder of today's training:

1. Identification & Screening of Potential Participants
2. Scheduling Intake Assessment
3. Completing Intake Assessment
4. Scheduling 1st DOCC Treatment Session

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IDENTIFICATION & SCREENING

- SKIP for PA Study Criteria
  - Have a 5-12 yr. old child rated as having at least moderate behavior problems
    - (We use the 7-item PSC-17 Externalizing Subscale Score of >6)
    - Child must be at least 5 and under age 13 as of the date of study consent (child can turn 13 during the time of the study)
  - Are at least 18 years of age
  - Have parental rights for this child
  - Are not already enrolled in the study as caregiver of another child (sibling)
- **BRAINSTORM**: How will you identify potential participants?
- Caregiver Consent
- Baseline Assessment (Research & Clinical)

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		Please mark under the heading that best fits your child			For Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1	Fidgety, unable to sit still						
2	Feels sad, unhappy						
3	Daydreams too much						
4	**Refuses to share**						
5	**Does not understand other people's feelings**						
6	Feels hopeless						
7	Has trouble concentrating						
8	**Fights with other children**						
9	Is down on him or herself						
10	**Blames others for his or her troubles**						
11	Seems to be having less fun						
12	**Does not listen to rules**						
13	Acts as if driven by a motor						
14	**Teases others**						
15	Worries a lot						
16	**Takes things that do not belong to him or her**						
17	Distracted easily						
	(scoring totals)						

PSC-17 EXT SUB-SCALE

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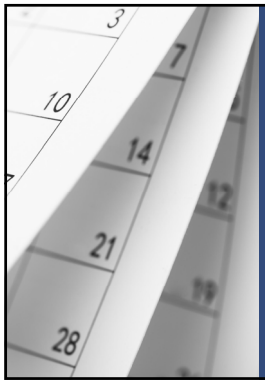

SCHEDULING AN INTAKE ASSESSMENT

- Discussion:
  - What is the purpose of an intake assessment?
  - How does your practice CURRENTLY handle scheduling of specialty appointments (if applicable)?
  - How do you anticipate this looking in your practice?
- Review Baseline Assessments (including VASP)
  - CM should collaborate with child's provider &/or referring provider
- Contact Caregiver and Explain Intake Appointment
- Schedule Intake

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ADDITIONAL CONSIDERATIONS

- **To Be Determined Per Practice:**
  - How long is assessment appointment?
  - How much diagnostic detail do you need?
    - Use other screening or diagnostic tools?
  - Will child be permitted to attend intake appt.?
    - How to keep child occupied while talking with caregiver?
  - How will your practice assess for safety concerns?

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COMPLETE INTAKE ASSESSMENT

BUILD RAPPORT!

Core Skills of Motivational Interviewing (MI):
- Utilizing open questions to draw out & explore person's experiences, perspectives, & ideas
- Affirming strengths, efforts, and past successes to help build the person's hope and confidence in their ability to change
- Utilizing reflection to demonstrate effective listening in order to express empathy

Fundamental Processes of MI:
- Engaging the client
- Focusing the client on the goals/purpose of treatment
- Evoking the client's "why" of change
- Planning the action of change

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COMPLETE INTAKE ASSESSMENT

REVIEW VASP/VAST

Vanderbilt Assessment Scale – Parent Informant:
- Should be available & scored in advance on the SKIP Patient Registry
- ADHD: 6/9 Inattention Symptoms &/or 6/9 Hyperactive-Impulsive symptoms + at least 1 endorsed Performance question present for 6+ months in more than one setting
- ODD: 4/8 symptoms + at least 1 endorsed Performance question present for 6+ months
- Conduct Disorder, Anxiety/Depression screener

Vanderbilt Assessment Scale – Teacher Informant:
- Preferably sent in by the teacher in advance or brought in by the caregiver
- ADHD questions the same as VASP
- ODD/CD combined into a 10-item screener, Anxiety/Depression screener same

***ASK ADDITIONAL QUESTIONS,** Clinical Interview skills: frequency, intensity, duration, symptom examples

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Inattentive Symptoms

1. Does not pay attention to details or makes careless mistakes in schoolwork or during other activities
2. Has difficulty keeping attention to tasks and activities
3. Does not seem to listen when spoken to directly
4. Does not follow through on instructions and fails to finish schoolwork and chores (not due to refusal or failure to understand)
5. Has difficulty organizing tasks and activities
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)
8. Is easily distracted by noises or other stimuli
9. Is forgetful in daily activities

ODD Symptoms

19. Loses temper
20. Is touchy or easily annoyed
21. Is angry or resentful
22. Argues with authority figures or adults
23. Actively defies or refuses to comply with requests or rules
24. Deliberately annoys people
25. Blames others for his or her mistakes or misbehaviors
26. Is spiteful and wants to get even.

Hyperactive/Impulsive Symptoms

10. Fidgets with or taps hands or feet or squirms in seat
11. Leaves seat when remaining seated is expected
12. Runs about or climbs too much when remaining seated is expected
13. Has difficulty playing or beginning quiet play games
14. Is "on the go" or often acts as if "driven by a motor"
15. Talks too much
16. Blurts out answers before questions have been completed
17. Has difficulty waiting his or her turn
18. Interrupts or intrudes in on others conversations and/or activities

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COMPLETE INTAKE ASSESSMENT

DIAGNOSTIC ASSESSMENT

- Demographics
  - Age, living arrangement, school, etc.
- Reason for referral
  - Referring pediatrician
  - Symptoms of concern
- Significant medical history (including behavioral health)
- Current medications
- Complete symptom presentation
  - VASP/VAST
  - Other screeners utilized by practice
  - Clinical Interview
- Consider comorbid disorders
  - Depression
  - Anxiety
  - Learning Disabilities
  - Trauma

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TRACKING INDIVIDUAL GOAL ACHIEVEMENT RATINGS (TIGAR)

- Clinician Interview
- Develop 3 behavioral targets for treatment focus
  - Specific, Measurable, Attainable, Relevant, Time-Bound
- Baseline rating is 1 – evaluated for improvement each session
- Clinical & Research measure

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EXAMPLE PROBLEM #1: JIMMY LOSES HIS TEMPER (HAS OUTBURST WHERE HE YELLS AND CRIES)
WHEN/CONTEXT: USUALLY WHEN HE'S ASKED TO DO SOMETHING OR WHEN I TELL HIM "NO"

1 = INITIAL STATUS AT BEGINNING OF PROGRAM (BASELINE)
FREQUENCY PER DAY (OR WEEK): 6-8 times a day

2 = MINIMAL PROGRESS TOWARD GOAL, SOME IMPROVEMENT, MOSTLY STILL A PROBLEM
What would be a minimal level of progress in your view – not really good enough, but better than what it was when you started services? 4-5 times a day

3 = GOOD/ADEQUATE PROGRESS TOWARD GOAL, MODEST IMPROVEMENT
What level would be good enough, or "OK?" 2-3 times a day

4 = DESIRED/EXPECTED PROGRESS – MET MY GOAL, ACCEPTABLE IMPROVEMENT
What level would meet your goal or would be acceptable to you? 1 time a day

5 = MORE PROGRESS THAN EXPECTED, SUBSTANTIAL IMPROVEMENT, EXCEEDS GOAL
What level would show terrific progress – a level of improvement that exceeds your expectations? 0 times a day (never)

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FINAL INTAKE STEPS

- Safety Assessment (as needed)
  - Practice safety procedures
  - Child abuse, suicidality, etc.
- Answer any caregiver questions/concerns
- Schedule 1st DOCC Treatment Session
  - How long will each session be?
  - Who should attend?

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TO WRAP UP THIS TRAINING …

- Questions/Concerns/Issues?
- Timeline Reminders
  - Confirm SKIP study roles for participant consent process ASAP
  - Next training covers the remainder of DOCC Methods:
    - Treatment workflows
    - ADHD med treatment
    - Collaborative Care Team meetings
    - Treatment completion
  - Final "live" training will review uses of the online technology & patient portal system
  - DOCC Treatment training videos available soon to complete at your own pace!

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