

## **AMCHP 2007 ANNUAL CONFERENCE**

### **HEALTHY COMMUNITIES**

March 3rd to 7th, 2007

#### **Leveraging Partnerships to Address Cross-Cutting in Maternal and Child Health**

FOUAD BERRAHOU: ADHD they account for more preventive deaths, illnesses and disability than any other conditions in specifically adolescent population. Family member often and including primary care providers they don't feel like prepared or they feel inadequate to assist adolescent in confronting these challenges, these disorder. And at the end if this disorder, they're not detected early and addressed, might result into violent (unintelligible) and juvenile detention and all kind of problems.

What you have also is some (unintelligible) interms of accessing care in Texas that you have, you see how millions of children there live in poverty. And those, how many kids, they do no have insurance.

And my last slide here it just -- I want to just pin point the shortage of mental health provider in Texas and that's why we are trying, through this project, to train the primary care clinicians to help us screen and assess and provide treatment for some mental health disorders. As you see the child psychologist the ratio is 2.9 per 100,000 kids. Just to put that into perspective, you have in Texas, based

on 2005, you have a ratio of 63 school age children to one family practice physician. So a ratio of 63 to 1. If you take the same ratio between children, school age and the child psychiatrist is almost 1500. So in Texas for example in some part of the state even the referrals don't help. Because the patient they have to travel more than 200 miles to see a mental health provider. So many things, barriers and challenges such as transportation and so forth. So that's why this project is kind of addressing that issue by training the primary health care providers to address this issue. And I'm going to let Dr. Gee to speak on where we are with the project right now. Thank you.

DR. ROBERT GEE: Thank you Fouad. I really appreciate you all being here today. It is a pleasure to be here and it is an honor for me to be here to talk to you about this project. This project really is a top down project, beginning with the six founding members and then radiating out to all of their contacts and their influences in the state in bringing all of these resources to bear. But it is also a bottom up project in -- I think you'll see in just a few minutes. Now the challenge here for us was, you know, you know the goal of improving health for adolescents in Texas, how broad is that, I mean, really what can we do to improve the health of adolescents in Texas. So the challenge for us was to really make this a practical, meaningful and sustainable project that is -- that really impacts adolescents and their family members. I think -- I know that I have been involved with projects that seem to maybe the grant money comes in and then it goes. And we didn't want this to be a project like this. We want this to be a really

viable project that primary care providers could grab a hold of and make an impact in these adolescents and families lives. And so, as I mentioned, there's phases to this project. Right now we are completing the feasibility study, and the feasibility study is really two pieces of the project. This is giving me fits. But the feasibility study is really two pieces one when you are looking at translational research, um, you're looking at evidenced based interventions moving into practical real life settings and that can be very difficult. What the evidence shows, the Institute of medicine reports, etcetera in their quality chasm -- quality chasm reports it shows that evidence based practices usually sit on the shelf for 15 sometimes 20 years before they're moved into practice. And what we wanted to do is close that gap and move this into real life practice. And so really we conceptualized two populations. We have the implementation piece which centers on primary care providers, but not just providers, primary care staff, clinic staff in these settings. And then the clinical piece or the clinical protocol or the evidence based practice situation. And so I'm going to talk about both of those. And the challenge for us was also, and I hate to say necessary evil, so I'll say the necessary challenge is the research piece of this. This is and you can imagine because the larger committee we have around 30 to 40 members of the larger committee and these are high level stake holders at the state level and across the state and Texas is a big state. And so just coming to agreement on the common language was a challenge for us. So we went to the literature and defined what does screening mean, what does assessment mean. Screening for us means does this, just answers a simple yes or no question, does this

adolescent need further assessment? And assessment means identifying the issue at hand and then what can, most importantly, not only identifying what may be the issues but also providing treatment or intervention for those issues. And the so the evidence based protocol over a period of several months that the committee agreed upon is this screening, assessment and treatment protocol. For the screening piece we went with Pediatric Symptom Checklist. And these instruments that we choose or the committee choose we really -- there were, you know, certain challenges to those because in primary care settings there's economic factors, there's time pressure factors, and then there's staffing factors as well. And so the Pediatric Symptom Checklist is a public domain instrument as are all of the other instruments and interventions. These are public domain instruments so there's little to no cost to the providers for this. The Depression Severity Index, Suicide Subscale -- the pediatric symptom checklist is 39 items it's fairly brief. It looks at salient issues surrounding behavioral health. And I might be wrong on the number of items it might be 54. But anyway it is fairly brief. The depression severity index is four items. And we put the suicide subscale right up front because we wanted to capture any kind of issues that that may be acute issues regarding that adolescent.

The assessment we identified targets that were evidenced based and the most commonly occurring disorders in adolescents that includes depression, ADHD, substance abuse, suicidality. For substance abuse we put a screening instrument into the assessment slot, because oftentimes it's beyond the primary care

providers ability to provide a full psychosocial assessment for substance abuse and so we wanted to capture that screening in a very brief screening instrument. We went with the Vanderbilt rating scale and then the patient health questionnaire nine. Now for treatment we went with the Children's Medication Algorithm project brief intervention and referral for depression and ADHD. Now the Children's Medication Algorithm project was developed by -- with not just by but a consensus conference of experts in adolescents with Lynn Crismon at the University of Texas, school of pharmacy and that literature is certainly available on -- on the department of state health services website. But basically what it does is it's a step by step way of addressing this issues in adolescents. Brief intervention and referral and that is the evidence based protocol.

Now, I'm going to switch from the clinical piece to the implementation piece. By far the most important document that we found in looking at implementation is Dean Fixsen monograph on implementation research at the University of South Florida. This monograph is available online in a PDF format and it is public domain and so you all can download this monograph. And it talks about the stages of implementation process. It talks about community readiness. It talks about attitude and believes of providers, staff selection, by far the most important document that we've found.

Now, another issue is in doing the necessary evil, I mean, challenge is the RB -- the associated RBs with the feasibility study sites. And you can see that are five

feasibility study sites are scattered across the state we have two in El Paso. We have a school base clinic called the Fabens clinic. We have an academic family practice center in El Paso as well. We have the Brooke army medical center pediatric clinic at Brooke army hospital in San Antonio. We have the Longview Wellness center it's an FQHC look alike in Longview, Texas. And then we have the Gonzales -- the community health centers of south central Texas in Gonzales, Texas. And just going through that process is -- can be arduous but it is very doable and RBs -- my experience has been that they are very willing to work with collaborative in developing a sustainable project, a meaningful project. This timeline really looks at the implementation piece -- or the clinical protocol along with the implementation protocol. So 21 days before we had our initial intervention we sent out our pretraining surveys and then we had our initial intervention and on site focus groups and then we had seven days before -- or after the initial intervention or training we had post training surveys and then we had clinical intervention start dates and we had fidelity check 14 days after they started to see if they are adhering to the protocol. And then the clinical intervention data close and follow-up survey and focus groups.

I will say the lessons that we have learned -- this is a feasibility study and we have learned a lot of lessons. The most important lesson is that the provider population or the clinic staff is an important player. We did one site visit before we went out and actually did the training. We would increase that as purveyors of

a clinical intervention we would increase that to several site visits in preparation for implementing a protocol like this on site.

The intervention itself is education, education to the primary care providers regarding screening, assessment. And then the worksheets that we used or the data collection instruments that we used were both qualitative and quantitative measures. And putting prevention into practice from the agency of healthcare quality and research is the model that we used in capturing this data. Those were some of the pretraining and post training surveys. To date we have trained over 181 primary care staff in these clinics, interestingly about half and half, 90 prescribers and 90 allied health professionals including support staff, case workers, etcetera.

Just organizing something like this can be challenging and each clinic brings its own challenges. The academic health care center -- clinic is very very different than the federally qualified look alike center in Longview, Texas. And so we have found each one of them require different levels of motivation or different levels of intervention.

The training program, screening and assessing youth for behavioral health issues, focus groups, education on the Children's Medication Algorithm, the education on patient and family education is -- was -- has been, from our experience, a critical component of the education part of this. Brief intervention,

motivational interviewing has been very critical and very well received by the clinic staff.

And then just wrapping up, we have had a total of 11 focus groups and some of the things that we heard from the focus groups, from the providers themselves was they were afraid of opening Pandora's box on one hand. If they ask then we are going to have to do something about it, and what do we do about it, we're not trained to do anything about it. So one of the things that has been an important process of this is building the local community network. And that's what I'm say is from a bottom's up. Because they are informing the literature at that level going back up and that's true translation research as I understand it. And so some of the other things obviously that have been published already in the literatures is just the lack of time, lack of resources, and then parental factors and broad category of parental factors. Some of the things that were facilitating factors were a sense of responsibility. They are very caring. They want to help adolescents in their community. They want to help families in their community. And so they have a deep sense of responsibility to provide those services. And many of them were already providing those services.

And so I think at this point what I'm going to do, in the interest of time because I'm running short on time, I'm going to just flip over to date and talk about where we are in the overall project. To date each of the clinics are in different stages of collecting the data. The Longview Wellness center is about to go to data close.

The family practice center is about to go to data open. The Fabens clinic is about to go to data close. Because there is competing philosophies in these clinics you have competing philosophies of the physicians, competing philosophies of the nurses, competing philosophies of the front desk staff, competing philosophies of the different organizations involved. For example, in the academic practice center they're installing an electronic medical record, and so that is something that is very important and so they had to put our project on their back end. Now after all is said and done, and this will be the true test for us the research is going to go away. They won't be required to get informed consent, they won't be required to do all this, but what will the clinics be doing to screen, assess and treat adolescents in that clinic. And so it will be interesting as we move into the comparative study to see how these clinics handle this issues and address these issues.

And I think with that I'll turn it back over to Leslie. Leslie thank you very much.