Building Mental Wellness: Using an integrative approach to building mental wellness into primary care

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Background

Between 10 and 20% of children/youth are living with a mental health condition, and less than half of those receive appropriate services. Of those who do receive services, most receive them from primary care providers (PCPs) or from schools. PCPs are in a unique position to assess and manage mental health concerns, because they have developed a longitudinal relationship with the youth and family. Through this relationship, Building Mental Wellness (BMW) Wave III sought to integrate mental health services into primary care. By addressing individual and organizational factors in tandem, BMW increased skills and confidence in managing mental health concerns, promoted appropriate prescribing, and fostered client recovery.

Methods

BMW Intervention

• Using an adapted IHI Breakthrough Series (BTS) model, 29 pediatric primary care practices and school-based health centers were recruited through the Ohio Chapter AAP and self-selected to participate in BMW in implementation beginning in Nov 2013, Feb 2014 or Apr 2014.
• Learning session was comprised of evidenced-based training on screening for behavioral, emotional, and developmental concerns; common factors and common elements (CF/CE); approaches to mental health and primary care integration; and QI science.
• Teams participated in monthly action period calls and four on-site academic detailing sessions and received CME, MOC Part IV, and practice stipends for meeting requirements.

Research Design & Data Analysis

• Quasi-experimental baseline and post-intervention analysis of data was used to evaluate the effects of BMW on implementation, service, and client outcomes (see Figure 1). Qualitative in-depth interviews with 24 participants from 18 practices complemented quantitative analysis and situated findings in experiences of primary care staff.
• Implementation outcomes: measured using multilevel models of data from Office Inventory (inner context, attitudes); progress reports (outer context); and self-report (confidence)
• Service outcomes: rates of diagnosis and prescribing by BMW-participating clinicians for clients having encounters were analyzed using Medicaid/OCHP claims
• Client outcomes: improvement in Strengths and Difficulties Questionnaire (SDQ) scores for clients in Cohort 1 (baseline) was compared to improvement in scores for Cohort 2 (post)

Results

Implementation Outcomes

• Twenty-six of 29 practices completed BMW, all fully engaging in BTS and academic detailing.
• Uptake of online learning modules was comparatively low, with only 44 staff engaged.
• Participants experienced positive changes in attitudes toward mental health, confidence using CF/CE, and organizational context (culture, climate, structure, technology), based on survey data. They described a change in focus from sick care to whole health and wellness.
• Changes in inter-rater agreement on context pointed to a fostering of cross-role consensus
• Survey and interview data both demonstrated that changes in climate were driven by improved perceptions of role clarity and job importance. Multilevel models revealed individual psychological climate and organizational climate influenced attitudes equally.

Service Outcomes

• The 131 participating clinicians demonstrated greater rates of screening, diagnosis, and treatment: The proportion of clients for whom one or more visits was for a mental health condition increased significantly from 8.3% in the six months pre to 10.2% post.
• Significant increases were seen in diagnoses of disruptive behavior (25% increase), ADHD (19% increase), and anxiety/depression (59% increase) (p≤0.001).
• Clinicians demonstrated a 37.4% decrease in rates of typical antipsychotic prescribing and shifts toward more appropriate prescribing of typical antipsychotics and stimulants, atomepine, or alpha agonist medications to clients with potentially appropriate condition.

Results (continued)

Client Outcomes

• Mental health symptoms scores on the SDQ improved an additional 0.981 points (95% CI: 1.95, 0.006) from 0 to 3 months, and 1.19 points (95% CI: -2.75, 0.164) from 0 to 6 months, for Cohort 2 compared to Cohort 1, as illustrated by multivariable linear regression results:

Service Outcomes

• Improved prescribing of mental health services for children/youth accessing mental health care and findings suggest the potential to combine such a model with a value-based payment system for broader scale-up.

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