Integrating Mental Health Screening in Pediatric Primary Care
Mental health disorders have become the chronic disease of children and adolescents

- 30% of children seen in primary care settings exhibit signs of emotional disturbance
- 17% to 26% of children have active mental health problems; 22% of adolescents age 13-18 have severe impairment &/or distress
- 20% of children/adolescents have mental health problems (15% mild to moderate, 5% severe)
- Use of psychotropic medication with children and adolescents has risen dramatically
Lifetime Prevalence Data, US*

Face to face household survey, 2001-2003 using the WHO survey version

- Anxiety: 28.8%
- Mood disorders: 20.8%
- Impulse control disorders: 24.8%
- Substance use: 14.6%
- Any disorder: 46.4%

*The National Co-Morbidity Survey Replication- Kessler, 2005
Consequences of Untreated Mental Illness in Children and Adolescents

Suicide

• Approximately 90% of children and adolescents who commit suicide have a mental disorder.
• States spend nearly $1 billion annually on medical costs associated with completed suicides and suicide attempts by youth up to 20 years of age.

Higher Health Care Utilization

• Youth that are experiencing emotional and behavioral problems, or with higher levels of psychosocial distress, are likely to be more frequent visitors to their primary care provider.
• When youth go untreated for mental illness, they use more health care services and incur higher health care costs in their adult years than others their age.

School Failure

• Approximately 50% of students age 14 and older who suffer from mental illness drop out of high school; this is the highest dropout rate of any disability group.

Juvenile and Criminal Justice Involvement

• Many youth with unidentified and untreated mental illness also end up in jails and prisons. 65% of boys and 75% of girls in juvenile detention suffer from mental illness.

Long Term Disability

• Mental illness is the 2nd leading cause of disability and premature mortality in the U.S.
Adverse Childhood Experiences

- Physical abuse
- Emotional abuse or neglect
- Sexual abuse
- Substance abuse in the household
- Incarcerated household member
- Household member with mental illness
- Mother treated violently
- Parental separation or divorce
Impact on Families

- Families are completely unprepared to have Mental Illness (MI) hit - the topic alone is loaded – stigma, blame and shame.

- The path from onset to acceptance of MI in a child can be long and difficult.

- The diagnosis impacts the whole family.

- There are predictable stages of emotional reaction for families.
Impact on Families continued

- Parents often miss or leave work – get called to come and pick up their child.

- Families face challenges in finding resources to help them cope.

- Families are often isolated and feel very alone when their child is diagnosed with a MI.
Gaps in Care

Identification

- Less than 50% of children and adolescents receive developmental and psychosocial surveillance
- 20% - 40% identified in PC (Kessler; Dulcan)

Referral and treatment

- 70% of children/adolescents in need of treatment do not receive mental health services
- 1 in 3 youth needing services is referred to a mental health provider (MHP)
  - Of those referred, less than ½ reach a MHP and are treated
- Less than 30% of children with SED receive treatment
Problem Overview

Gaps in the Area of Mental Health Services:

Identification:
- Over 2/3 of pediatricians not comfortable or competent to conduct child mental health assessments
- Lack of early identification, results in less-effective treatment and poor care-management

Infrastructure:
- No system in place to track & follow chronic problems
- Lack of community-based coordination hinders access to care
7 reasons supporting integration of mental health treatment into primary care:

- Burden of mental illness is great
- Mental & physical health problems interwoven
- Enormous treatment gap for mental health issues
- Primary care settings for mental health services enhance access
- Delivering mental health services in primary care settings reduces stigma & discrimination
- Treatment of mental health disorders in primary care settings is cost-effective
- The majority of people with mental health disorders treated in collaborative primary care have good outcomes
“The Primary Care Advantage”

Treat mental health disorders where the patient feels most comfortable receiving care

- Better coordination of care
- Mind and body connection
- Physical health is comorbid with mental health
- More likely to keep appointments where multiple issues are being addressed
- The majority of mental health treatment will occur in community health settings- with focus on preventive care and integration.
Why Integrate Mental Health In Primary Care?

- Strong evidence has emerged for collaborative/integrated care for treatment of common mental disorders
  - The IMPACT (Improving Mood Promoting Access to Collaborative Treatment) Model
  - The Three Component Model (3CM)
- Insurance does not provide adequate coverage for mental health services
Integrated Models Compared with Usual Care from Case Reports

- Greater likelihood of consultation and referral
- Improved HEDIS indicators for depression
- Lower utilization of MH specialty services, lower overall costs per patient, lower ED use, lower hospital admissions
- Cost-neutrality, lower psychiatric in-patient admissions and length of stay, lower medical in-patient length of stay
Does Screening Mean Becoming an Expert in Development or Mental Health?

Screening is looking at the whole population to identify those at risk. Identified children are referred for assessment. Assessment determines the existence of a developmental delay or mental health issue which generates a decision regarding intervention.
Strengths of Tools Using Parent Report

- Gives parents and providers information on children’s actual skills
- Helps parents learn important developmental, behavioral, and emotional milestones
- Educates parents on common behavioral and mental health issues, improving identification of symptoms
- Illustrates strengths and weakness in development
- Frees up professional time for more important things...like helping families
- Gives providers confidence in decision-making

Setting the Stage for Success. Presentation by Marian Earls, MD, FAAP, Guildford Child Health, Inc., Greensboro, NC, 2007
Strengths of Tools Relying on Parent Concerns

- Helps focus encounters on issues of importance to families
- Creates a “teachable moment”
- Enhances parents’ sense of a true collaboration with professionals
- Increases positive parenting practices
- Makes it easier to give difficult news
- Reduces “doorknob/oh by the way” concerns
- Increases attendance at well-visits
Principals of Practice

- The parent is the expert on his or her child
- All parents want to do well by their child
- All parents have strengths
- All parents have something critical to share at each developmental stage
- All parents have ambivalent feelings
- Parenting is a process built on trial and error

Brazelton’s Touchpoints -
http://www.brazilontouchpoints.org/
Coding & Payment
Coding - 90792

Definition

- Psychiatric Diagnostic Evaluation is an integrated bio-psycho-social assessment, including history, mental status and recommendation, including history, mental status, other physical examination elements as indicated and recommendations.

- The evaluation may include communication with family or other sources, and review and ordering of diagnostic studies.

- Prescriptions of medications, and review and ordering of laboratory and other diagnostic studies.

Sherry Barron-Seabrook, MD, AACAP RUC Advisor
Why Choose 90792?

- It can be used when someone other than the identified patient is seen
  - Parent interviews or interviews with other people involved in the patient’s care
- It can be used more than one time to complete the evaluation
- It can be used on different days
Coding Choices for Diagnostic Services

- **E/M – 99215 and 99214**
  - Code using time rule and prolonged services, if necessary
  - 99215 – code for <40 minutes spent on counseling
  - (w/more than 50% face-to-face counseling)
  - 99214 – code for <25 minutes spent on counseling (w/more than 50% face-to-face counseling)

- **Psychiatric - 90792**
  - Code is not timed, but typically at least 60 min
  - No specific components or elements required, but medical thinking must be present and documented
  - May be used by any health care professional who is qualified to do the procedure
Additional Codes for Developmental Screening/ Behavioral Assessment

- **96110** – Used for conducting developmental screenings including M-CHAT, ASQ, PSC.

- **96127** – NEW CODE for conducting a brief emotional/behavioral assessment
Payment by Insurers

- 96110 – developmental screening
  - Horizon: $13.65
  - Aetna: $14.09
  - AmeriHealth: $15.97

- 96127 – brief emotional/behavioral assessment
  - Same range of payment can be expected
QUESTIONS?