Managing Common Mental Health Issues in Pediatric Primary Care

NJAAP MOC Part II

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Learning Objectives

1. Describe the current state of mental and behavioral issues facing children and adolescents, and the role that pediatricians and their staff can play in meeting the comprehensive healthcare needs of patients and families.
2. Understand the myriad standardized screening tools, treatment options, and referral sources available to providers to aid in ensuring children with mental and behavioral health issues are identified and helped as early as possible.
3. Describe positive communication strategies for speaking with families about their children's mental health issues, and some strategies for making this work in a practice setting.
4. Identify best practices for implementation of care coordination and share examples of practice strategies and processes for effective care coordination between pediatric medical staff, mental health providers, and families.
5. Identify resources for practice process and office flow, as well as codes for payment to facilitate addressing mental/behavioral health care provision in pediatric primary care.

How are the kids?

A National Epidemic

Mental health disorders as 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
- Use of psychotropic medication w/children & adolescents has risen dramatically
- 21% of children & adolescents in the U.S. meet diagnostic criteria for MH disorder with impaired functioning
- 16% of children & adolescents in the U.S. have impaired M.H. functioning and do not meet criteria for a disorder
Scope of Mental Health Disorders

Median age of onset of . . .

- Anxiety disorder = 6 years old
- Behavior disorder = 11 years old
- Mood disorder = 13 years old
- Substance abuse = 15 years old

Service Gaps in Mental Health Care Services

Identification:
- Less than 50% of children & adolescents receive developmental & psychosocial surveillance
  - 20% - 40% identified in primary care (Kessler; Dulcan)
- Over 2/3 of pediatricians are not comfortable or competent to conduct child mental health assessments
- Lack of early identification results in less-effective treatment and poor care management

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 severe emotional disturbance (SED) receive treatment

Service Gaps in Mental Health Care Services (continued)

Infrastructure:
- No system in place to track & follow chronic problems
- Lack of community-based coordination hinders access to care

Service Gaps
- Many Forces Leading Families to Seek Help for MH Issues in Primary Care (e.g. Trust vs. Stigma & Unfamiliarity, Lack of Access)
- Little Support for Prevention, or Services to Children w/ Emerging, or Mild to Moderate Conditions

Workforce Issues
- Under-funded Public Mental Health (MH) System, focus on Severe Impairment
- Insufficient # of MH Specialists, esp. Child Psychiatrists
- Administrative Barriers in Insurance Plans Limit Access to Existing Providers
Social Determinants of Health

- The “social determinants of health” play a role in the development of mental illness, as well as in identifying and accessing treatment for it:
  - Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live.

- Pediatricians beginning to screen for poverty and food insecurity, with simple 2-3 question surveys, and accompany this with referral to community resources for services.

Impact on Primary Care

"By 2020-2030, it is estimated that up to 40% of patient visits to pediatricians will involve long-term chronic disease management of physical and psychological/behavioral conditions."

"In 2020 pediatricians have a wider array of skills including more in-depth knowledge of, and comfort treating, behavioral, developmental, and mental health concerns. Medical education includes mental health interventions, which are now an established aspect of pediatric care."

-AAP Task Force on the Vision of Pediatrics 2020

Impact on Families’ Attempts to Access MH Services:

- Silos lead families to seek services from multiple systems, often unsuccessfully;

- Workforce shortage and wait lists lead to lag time in getting a child services and support; and

- A full array of effective services are rarely available and are often targeted at the child and not at the whole family.
Impact on Families of Undiagnosed and Untreated Mental Illness

- Symptoms cause poor functioning at a critical developmental time (in school, with friends and at home);
- Children often fail to develop the social, functional and academic skills they need to succeed in life;
- Behaviors are often unpleasant and irritating and,
- Ultimately, children with MI are robbed of their childhood.

Consequences of Untreated Mental Illness in Children and Adolescents

**Suicide**
- Approximately 90% of children & adolescents who commit suicide have a mental disorder
- States spend nearly $1 billion/year on medical costs associated w/ completed suicides and suicide attempts by youth up to 20 yrs. of age

**Higher Health Care Utilization**
- Youth experiencing emotional & behavioral problems, or w/higher levels of psychosocial distress, are likely to be more frequent visitors to their PCP
- When youth go untreated for mental illness, they use more health care services & incur higher health care costs in adult years than others their age

Consequences of Untreated Mental Illness in Children and Adolescents - continued

**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.

Mind over Matter

**Brain Development, Epigenetics, and ACEs (Adverse Childhood Experiences)**
Critical Concept #1: **Epigenetics**

- Inherited genetic program provides a general blueprint for brain architecture.
- Ecology (environment/experience) influences how the genetic blueprint is read and used, including:
  - Which genes are used
  - When they are used during the course of development,
  - Where they are used in developing brain
- Stress-induced changes in epigenetic markers lead to long-lasting, and sometimes intergenerational changes.

[http://pediatrics.aappublications.org/content/132/Supplement_2/S65.full.html](http://pediatrics.aappublications.org/content/132/Supplement_2/S65.full.html)

Critical Concept #2: **Developmental Neuroscience**

- Synapse and circuit formation are experience and activity dependent.
- Ecology (environment/experiences) and the neural activity that these generate influence how brain architecture is formed and remodeled.
- Diminishing cellular plasticity limits remediation.
- Potentially permanent alterations in brain architecture and functioning mediate the relationship between adversity and altered life-course trajectories.

Dr. Colleen Kraft, "The First 1000 Days: The Importance of Early Brain & Childhood Development"
Adverse Childhood Experiences Study

- Analyzed the relationship between multiple categories of Adverse Childhood Experiences (ACEs), and health and behavioral outcomes later in life
- Data on over 17,000 participants gathered from various sources including outpatient medical records, pharmacy utilization records, and hospital discharge records to track the health outcomes and health care use of ACE study participants

http://www.cdc.gov/ace/about.htm

Categories of ACEs

- 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

http://www.cdc.gov/ace/about.htm

How ACEs Impact Health

- The impact of violence in childhood manifests throughout the entire life course.
- Intervention is most effective when issues are identified and treated in early childhood.

Prevalence of ACE Scores & Associated Health Problems

- You get one point for each type of trauma. The higher your ACE score, the higher your risk of health and social problems.
- With an ACE score of 4 or more, things start getting serious. The increased likelihood of:
  - Depression - 460%
  - Suicide - 1,220%

http://www.cdc.gov/ace/about.htm
Critical Concept #4:
For young children, **parent/caregiver support is critical**

- Turns off physiologic stress response by:
  - addressing physiologic and safety needs
  - promoting healthy relationships and attachment
- Notes and encourages foundational coping skills as they emerge

Pediatricians are ideally placed to:
- Promote this sort of “Purposeful” Parenting
- Advocate for a public health approach to address toxic stress

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**Why Address Mental Health Issues in the Pediatric Medical Home?**

The majority of mental health disorders in adults emerge before adulthood:
- 50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24
- The average delay between onset of symptoms and intervention is 8 to 10 years

**Overall goal:**
To identify mental health concerns of your patients earlier and reduce the gap between identification of a problem and treatment initiation.

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**Mental Health 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
“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.

Impetus for Development of Collaborative Care Model

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

Integrated Models Compared with Usual Care from Case Reports

- Greater likelihood of consultation and referral
- Improved Healthcare Effectiveness Data and Information Set (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
Strategies: What Works for Primary Care

New Models of Care:
- New roles of staff within primary care
- New applications of technology
- Collaborative arrangements with community-based MH / SA / developmental specialists
- Co-location of specialist(s)
- Integration of a specialist(s)
- Child psychiatry consultation by telephone, telemedicine, face-to-face

What Can Pediatricians Do?

The Pediatrician’s Role

Pediatrician’s Role:
- Messaging to Caregivers & Families to:
  - Reduce Harmful Stigma of Mental and Behavioral Problems
  - Promote Positive Parenting
- Implement Universal Mental/Behavioral Health Screening
- Implement Universal Mental/Behavioral Health Anticipatory Guidance

MH Competencies for Primary Care
- Fit mental health care into pace of primary care practice
- Promote mental health
- Elicit concerns (screening, acute care, chronic care)
- Identify risks, intervene to prevent MH problems (acknowledging strengths)
- Overcome resistance, stigma, conflict and other barriers to help-seeking
- Assess and/or triage children with MH/SA symptoms
- Address emerging or undifferentiated problems and problems not rising to level of diagnosis
MH Competencies for Primary Care

- Screen/manage children with ADHD, anxiety, depression, and substance use disorders (mild to moderate levels of impairment)
- Refer, co-manage, and coordinate care for children with other conditions, those severely impaired, and those beyond our comfort level
- Provide care while awaiting subspecialty care
- Apply chronic care model to children with MH/SA problems
- Assure practice systems and payment to support our MH/SA services

Your Role in Primary Prevention

Using Mental Health Anticipatory Guidance to Reduce Stigma & Promote Positive Parenting

Purposeful Parenting

Goal — A positive parent-child relationship.

Six parts:
1) Protective
2) Personal
3) Progressive
4) Positive
5) Playful
6) Purposeful

Anticipatory Guidance: Infancy

Face Time and Emotional Health — Initial Visit
- Meeting basic needs — safety and connection
- Make time for face time — social smiles lead to conversations — smiling, cooing, laughing.
- Parent Self-care- making sure to meet your own needs

Feelings are an Early Language — 9 month Visit
- Reading your Signals
- Your Feelings Affect your child
Anticipatory Guidance: Early Childhood

Tantrums, time out, and time in – The 18 month Visit
- Encouraging children to use words, how to use time-out effectively (not punishment), and time-in – making child the center of attention.

Building Emotional Health – The 36 month Visit
- Emotional overload – dealing with poor choices and bad behavior
- Naming feelings – teaching that feelings are real and normal, giving words to explain feelings.
- Dealing with strong feelings – managing strong feelings in healthy ways, learning to cope

Reinforce Every Day, Every Child – 5 Rs of Early Childhood

**Routines** help children know what to expect of us and what is expected of them

**Reading** together daily

**Rhyming**, playing and cuddling

**Rewards** for everyday successes – PRAISE (for effort) is a powerful reward

**Relationships**, reciprocal and nurturing – foundation of healthy children

Assess Strengths - H.E.A.D.S.S.

A Psychosocial Interview for Adolescents:

H: Home & Environment
E: Education & Employment
A: Activities
D: Drugs
S: Sexuality
S: Suicide/Depression

Adapted from Contemporary Pediatrics, Getting into Adolescent Heads (July 1988), by John M. Goldenring, MD, MPH, & Eric Cohen, MD

Resources for Anticipatory Guidance
Additional Parenting Resources

- Dr. Laura Markham, PhD: Aha Parenting [http://www.ahaparenting.com/](http://www.ahaparenting.com/)
- The Incredible Years: [http://incredibleyears.com/](http://incredibleyears.com/)

Your Role in Secondary Prevention

Identifying & Managing M.H. Issues:
Screening & Referral

Surveillance vs. Screening vs. Evaluation

**SURVEILLANCE**
Informal way to see what is going on with a family.
- Eliciting and attending to parent concerns: “How are things going at home, at school, with friends?”
- Making informed observations
- Identifying risk & protective factors

**SCREENING**
Using a validated, standardized screening tool at designated intervals to help identify children with developmental delays, social, emotional and/or behavioral issues.

**EVALUATION/ASSESSMENT**
Aimed at identifying specific mental health disorder affecting child – diagnostic!

The Importance of Standardized Screening

1) Not all cases will be identified via routine interview, or “eye-balling” patient/family . . .

- 70-80% of children with developmental and/or mental health problems will be missed if a standardized approach is not applied.
- Alternatively, if a structured, standardized instrument is used, 70-80% will be identified.

2) Parents Often Underestimate Symptoms

AAP Periodic Survey #53, 2002
Does Screening Mean Becoming an Expert in Mental Health?

No! Screening is looking at the whole population to identify those at risk. Identified children are referred for assessment. Assessment determines the existence of a mental health issue which generates a decision regarding intervention.

Social Emotional Screening for Babies, Toddlers, and Preschoolers

SWYC - Survey on the Wellbeing of Young Children:

- Comprehensive surveillance or first-level screening instrument for routine use in regular well child care
- Covers developmental milestones and social/emotional development
- Combines what is traditionally “developmental” with traditionally “behavioral” screening
- Freely-available, takes 10-15 minutes to complete, for ages 2 months – 5 years

Tufts University School of Medicine, http://www.theswyc.org/

Social-Emotional Screening – Parts of the SWYC

- Baby Pediatric Symptom Checklist (BPSC) – a social/emotional screening instrument for children under 18 months of age.
- Preschool Pediatric Symptom Checklist (PPSC) – a social/emotional screening instrument for children 18-60 months of age.
- Parent’s Observations of Social Interactions (POSI) – a 7-item screening tool for Autism Spectrum Disorders.

Using the SWYC (Ex.: PPSC for 18-60 month olds)

Score: 16
Social Emotional Screening for Older Children & Adolescents

**Pediatric Symptom Checklist (PSC-35, Y-PSC):**

- Psychosocial screen and functional screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems
- Parent version (PSC-35) available for young children ages 6 to 18
- Youth version for self-assessment (Y-PSC) from age 11 and up
- Designed by Michael Jellinek, M.D., Pediatrician and Child Psychiatrist, Mass. General, and colleagues
- Available in multiple languages and a pictorial version

[http://www.massgeneral.org/psychiatry/services/psc_scoring.aspx](http://www.massgeneral.org/psychiatry/services/psc_scoring.aspx)

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**Secondary Screens**

If needed, secondary screening may be considered:

- Personal Health Questionnaire-9 (PHQ-9) or PHQ-4 (Adolescents) for Depression
- Screen for Child Anxiety Related Disorders (SCARED) or Generalized Anxiety Disorder (GAD-7)
- Mood Disorder Questionnaire (MDQ) for Bipolar
- Swanson, Nolan, Pelham (SNAP-IV-18) screen for ADHD
- SADS
- Substance abuse screener – CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble)
- Others: Yale-Brown Obsessive Compulsive Scale (Y-BOCS-C) for OCD; Eating Attitudes Test (EAT-26) for eating disorders, etc.

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**Other screenings to consider – social determinants of mental health**

Other screenings to consider from the impact of the social determinants of health:

- ACES
- Food insecurity
- SEEK (safe environment for every kid)
How might screening look in your practice?

**Pediatric Well Visit**

**Initial MH Screening**
- Front desk hands out the screening tool
- Nurse scores it before doctor sees patient

Based on results, discussion with parent and possible call to case manager

**Possible secondary screening**

Results may indicate referral is needed

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**Office Flow**

- Patient arrives for well visit

- Front desk staff gives PSC and/or Y-PSC in waiting room

- Nurse or Ink scores initial screening and places in chart prior to exam.

- Patient completes secondary measures in waiting room prior to leaving

- Use provided flow chart to decide secondary screening measures of importance

- Patient gives forms back to front desk staff prior to leaving

- Fax forms to Hub for scoring and interpretation

- Hub will call to discuss results

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**Considerations for Implementation**

- Set a goal
- Choose a screening tool
- Assess your work flow, including EMR if applicable
- Identify roles for team members
- Set up a plan for tracking
- Get to know community providers

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**How to Identify & Intervene with Children’s Mental/Behavioral Health Issues**
GREEN: Universal Surveillance & Screening

- Surveillance
- Screening
  - SWYC: children ages 2 months – 5 years
  - PSC-35: parents of youth ages 6 years & up
  - Y-PSC: youth ages 11 year and up

YELLOW: Pediatricians’ Care Coordination

- Practice staff attempts to get child some help for lower order issues, including:
  - Based on initial screening, decide if secondary screening is necessary
  - Refer to:
    - PerformCare – County-specific community resource referral to family support organizations, parenting groups, etc.
    - Early Intervention or Help Me Grow
    - Central Intake – social, housing, food support for family
    - Head Start/other educational resource for child AND/OR
  - Consider contacting the PPC Hub for consult

RED: Consultation & Referral

- Patient scores positive on screening, pediatrician concern, family in crisis, psychiatric emergency
- Call DCP&P if there is a concern about child safety issues: 1-877-NJ ABUSE
- PerformCare
  - Mobile response & stabilization unit
- For those enrolled, call the PPC Regional Hub, currently available in 11 counties, expanding statewide this year

Circumstances Requiring Immediate MH Specialty care

Psychiatric emergencies, regardless of diagnosis:
- Suicidal or homicidal intent
- Psychosis
- Drug overdose
- Dangerous or destructive, out-of-control behavior
- Panic attack
- Abuse / neglect
Circumstances Requiring MH Specialty Care

- Severe impairment in functioning, regardless of diagnosis
- Not responsive to primary care interventions, regardless of diagnosis
- Multiple MH / SA problems
- Substance use in high-risk situations (e.g., driving, baby-sitting)
- MH or SA problem complicating medical condition and/or adherence to treatment
- Symptoms preceded by trauma

Circumstances Requiring MH Specialty Care (cont.)

- Age less than 5 yrs. w/ signs of social-emotional problems
- Problem you are not comfortable treating
- Family is not comfortable with you treating
- Symptoms suggest panic disorder or OCD
- Disorder other than ADHD, anxiety, depression, substance use and abuse
- Psychopharmacologic intervention (need psychosocial intervention)
- Psychopharmacologic interventions other than ADHD meds and SSRIs (need psychiatric consultation)

Primary Care Approach to Psychopharmacologic Prescribing

Pediatric involvement in psychopharmacology:

- ADHD – many/most doctors willing to do this
- Anxiety & Depression

AAP Task Force on Mental Health collaboration with Johns Hopkins to create primary care guidance (Riddle et al.):

4 classes of medications meet criteria for effectiveness, dosing, and monitoring safety in primary care:

- stimulants
- alpha-2 adrenergic agents
- serotonin and norepinephrine reuptake inhibitors (SNRIs)
- selective serotonin reuptake inhibitors (SSRIs)

Providing Care While Awaiting Specialty Care (or readiness for referral)

- Find agreement on goals and steps to reduce stress
- Find agreement on healthy activities (e.g., exercise, time outdoors, limits on media, balanced and consistent diet, sleep [!!!], one-on-one time with parents, reinforcement of strengths, open communication, pro-social peers)
- Educate family; de-mystify the condition; support them in monitoring for worsening of symptoms or emergencies
- Initiate care (even if planning referral) using “common factors” and/or “common elements” of evidence-based Rx
- Monitor progress (e.g., telephone, e-communication, return visit)
- Provide assistance with referral
Clinical Skills Needed for Making Effective Referrals

- Triage for level of urgency
- Engage child and family
- Reinforce child and family strengths, your optimism and commitment
- Identify barriers
- Reach agreement on next steps (may involve return to 1st care)

Referral Systems – The Pediatric Psychiatry Collaborative “Hubs”

Currently 4 Hubs in New Jersey:
- Meridian @ Jersey Shore
- Meridian @ St. Peter’s
- Cooper @ Camden
- Cooper @ Pennsville

Social Worker helps arrange services, including evaluation for urgent cases

Assessment and Evaluation occur at no cost to family (sliding scale for services – after initial consult)

Purpose of the Hub

- To aid the pediatrician with patient care via care coordination and medication consultation
  - The Hub will only perform face-to-face patient consults for urgent (but non-emergency) cases
- To increase screening for mental/behavioral health issues in primary care to facilitate quicker entry into treatment

Collaborative Hub Procedure – Pediatrician Role

- Screen patients universally - use Survey of Wellbeing of Young Children (SWYC), and Pediatric Symptom Checklist (PSC-35 and Y-PSC)
- For positive screening result, or if concerns, either:
  - Call the Hub for consultation with a CAP regarding diagnostic care, medication recommendations
  - Simply fax referral to Hub, providing some background info, current clinical picture, and reason for referral (make sure family is aware and in favor of your referral to Hub)
- You will receive, depending on referral:
  - Continued consultation support and communication from CAP and/or psychologist and/or social worker
  - Diagnostic opinion by CAP/ & care coordination by Hub staff
Collaborative Hub Procedure – Hub Role

- Hub may call you upon receipt of referral form and ask you/your staff additional questions
- Hub staff psychologist/ LCSW will contact family and discuss current concerns and suggestions for treatment
- Family is given a list of referrals for therapy services to address current mental health concerns
  - These referrals are researched and contacted first by staff psychologists/ LCSWs; most often accept patient insurances
- Hub staff will follow-up with you on initial outcome
- Hub will follow-up with family 3 and 9 months later

The PPC Hubs’ First Two Years

Participation:
- 223 primary care providers across 11 counties
- 34,494 patients screened for MH issues
- 1,746 MH consultation services provided

- Most (77.8%) reported that, as a result of the PPC, their patients had either “somewhat” or “a great deal” more access to psychiatric care compared to before.
- Most (78.6%) reported that, as a result of the program, they are able to provide more effective referrals to their patients.

Children’s System of Care (CSOC)

Committed to providing services based on the needs of the child and family in a family-centered, community-based environment (wrap-around model).

Serves children and adolescents:
- in need of behavioral and mental health services
- in need of substance abuse services up to age 21
- with intellectual and developmental disabilities up to age 21

PerformCare

- Single point of entry for all children, youth and young adults entering the New Jersey Children’s System of Care.
- Goal is to help families and caregivers create a more stable and healing environment for children, address barriers to well-being, and maximize youth and family strengths.
- Families should call if their child’s behavior has changed from normal or if they are overwhelmed by challenges at home or in the community.

1-877-652-7624 ; TTY: 1-866-896-6975
Available 24 hours a day, 7 days a week
Central Intake

- New, statewide network of Central Intake Hubs for all counties
- Primary focus – to facilitate linkages from pregnancy to age five
- Provides pregnant women, families, and providers w/easy access to resource info & referrals to local community services that promote child and family wellness.
- Range of services include – prenatal care, infant/child health, family planning, nutrition/WIC, home visiting, Head Start, child care services, preschool programs, Family Success Centers, early intervention, special child health services, domestic violence support, financial needs/public assistance, substance use/addiction treatment, etc.

Different #s, by county; handout available

What Do You Say?

Communicating with Families about Mental Health Issues

Ways to Evaluate & Support Relationships

- Ensure the mental health of parent and child are addressed at each visit
- Use open-ended questions as well as screens
- Adapt Bright Futures Guidelines
- Use screening protocols
- Have other staff to engage in education
- Connect families with resources (child care, parenting groups, etc.)
- Link into Patient Centered Medical Home (PCMH) and Quality Improvement (QI) efforts

BATHE: A Useful Mnemonic for Eliciting the Psychosocial Context

B Background
A Affect
T Trouble
H Handling
E Empathy

The Basics of Creating a Safe Environment

**Ask Open-Ended Questions**
- Ask questions that can’t be answered yes/no
- Use patient’s own words
- Utilize a tone that invites openness

**Pay Attention to Non-Verbal Communication**
- Put patient at ease
- Your body language
- Facial expressions
- Use eye contact
- Convey respect
- Interview in a private setting
- Pay attention to patient’s body language

The Basics of Creating a Safe Environment (cont’d)

**Convey Care and Empathy**
- Acknowledge their feelings
- Use language that is non-judgmental
- Consider things through the family’s lens
- Find agreement on goals and steps to reduce stress

Skills to Engage Child and Family: The “Common Factors” Approach: H.E.L.P.

H.E.L.P. build a therapeutic alliance:
- HOPE
- EMPATHY
- LANGUAGE and LOYALTY
- PERMISSION, PARTNERSHIP and PLAN

AAP Mental Health Toolkit
Applications of Common Factors Methods

- Addressing undifferentiated problems
- Rolling with resistance
- Managing conflict
- Preparing for referral
- Managing non-adherence
- Closing a visit supportively

Case Example of Common Factors in Action: REGINA

Regina, age 17, was seen for a normal summer camp physical. On your way out the door her mother remarks that Regina isn’t sleeping well and wants to know is she should be concerned. Regina gets angry with her mother for bringing it up.

Common Factors in Action for Regina

- Reinforce the strengths of Regina and her family
- Discuss ways that Regina thinks she could reduce her stress.
- Help Regina and her mother identify healthy activities to relax, relieve stress, improve sleep quality, and spend time with pro-social peers.
- Educate Regina and her family on worsening symptoms, warning signs, or emergencies.
- Monitor progress with phone check in, email, or follow-up visit.

Case Example of Common Factors in Action: LUIS

Luis, age 4, was referred by his childcare provider for fighting. His father explains that he has been kicked out of two previous daycares for the same thing. His father seems critical and periodically gives Luis orders in an angry tone of voice to sit still and behave.
Common Factors in Action for Luis

- Reinforce the strengths of Luis and his family.
- Administer standardized screening for behavior and follow-up screens for ADHD if indicated.
- Find agreement on steps to reduce conflict and improve the parent-child relationship.
- Find agreement on steps to increase healthy activities, limit media, and improve sleep quality.
- Model use of praise and encourage one-on-one time and rewards for good behavior.
- Make a referral to a behavioral specialist if the family agrees.
- Monitor referral and progress with a follow-up visit.

Community Care of North Carolina (CCNC Pediatrics)

Motivational Interviewing

- Empathetic, patient-focused directive counseling style
- Seeks to create conditions for positive behavioral change
- Well-suited for brief clinical encounters
- Evidence-based (>200 clinical trials, both adults and adolescents)

Two Assumptions:

1. Motivation: due to interpersonal interaction (not just innate character trait)
   - Confrontation leads to resistance
   - Empathy and understanding lead to change

2. Ambivalence to change: normal and natural
   - Competing positive and negative feelings
   - Decision balance: pros and cons

The Spirit of M.I.
Motivational Interviewing - Roles

1. Counselor/ Health care provider: Facilitator
2. Client/ Patient: Presents arguments for change

Counselor:
- Listens for ambivalence in patient’s own words
- Reflects back negative and positive aspects of behavior AND of changing behavior
- Supports client self-efficacy:
  - Points out strengths
  - Points out previous successes
  - Acknowledges difficulties of making behavioral change
  - Avoids resistance by avoiding lecturing and arguing with patient

It is CRITICAL to engage clients in treatment plan (especially adolescents!!!)

Giving Information and Advice

- Ask for permission
- Qualify honoring autonomy
  - “Of course, while I can only suggest, you’re ultimately the one to decide…”
- Ask – Provide – Ask
  - “….what do you think of that? Do you think that would work for you? Why? Why not?”
- For suggestions, offer several, not one (otherwise it looks like the “right” answer)

Remember

- Stress physiology is often driving “problem behavior”
- Make sure you/ someone on health care team is exploring stress reduction techniques with client
- When stress is managed in a more healthy, pro-social way, need for problem behavior diminishes
Tips for Communicating Results

- Attend to parent concerns
- Clear communication
- Communicate concerns within the context of specific strengths
- Delineate clear action steps
- Provide ongoing support
- AAP has 6 video vignettes on how to talk to parents about some common mental health concerns: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/introduction.aspx

Mental Health Care Coordination

Models, Processes & Tools for Practice Implementation

A Medical Home . . .

- Is an approach and process to providing care
- Is not a building
- Is a partnership with the child, family and practice care staff
- Emphasizes the primary care practice as the “home” where the family and child:
  - feel recognized and supported
  - find a centralized base for medical care
  - find connection to other medical and non-medical community resources

General Activities of the Medical Home

- Anticipatory Guidance – prevention and developmental promotion
- Identification of Risk Factors – physical, mental, social
- Understanding Family Strengths and Protective Factors
- Helping families Set Goals and Priorities for self-management
- Management/Referral to medical & community resources
- Ensuring Follow-up – was the patient able to follow recommendations, complete referrals?
- Planning for Future Encounters ahead of time (instead of reacting to problems as they are presented)
Challenges to Providing Medical Home Care

- TIME, TIME, TIME (and reimbursement)
- Adequate parent-professional partnerships
- Communication
- Coordination
- Medical staff turnover
- Awareness of community resources and programs

Benefits to the Practice

- Increased professional satisfaction
- Improved coordination of care
- Efficient use of limited resources
- Streamlined office procedures
- Compensation for the additional care provided

AAP Care Coordination Policy Statement

**Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems**

Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee

Lead Authors: Renee M. Turchi, MD, MPH, FAAP & Richard C. Antonelli, MD, MS, FAAP

*Pediatrics*, May 2014

What is Pediatric Care Coordination?

“A patient and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families”

-Antonelli, McAllister & Popp
Shared Care Plans . . . Background

“Every patient can benefit from a care plan (or medical summary) that includes all pertinent current and historic, medical, and social aspects of a child and family’s needs. It also includes key interventions, each partner in care, and contact information. A provider and family may decide together to also create an action plan, which lists imminent next health care steps while detailing who is responsible for each referral, test, evaluation or other follow up.”

From www.medicalhomeinfo.org

Shared Care Plans

- Developed collaboratively with child and family, incorporates child and family goals
- Effective way to support self-advocacy and self-determination
- Types of care plans
  - Medical summary/transition summary
  - Emergency care plan
  - Working care plan or action plan
  - Individual Health Care Plan for educational setting

Tools for Fostering Family Centered Care & Teamwork

- Care Plans
- Staff Meetings
- Huddles
- Resources Nights
- Contracts for Parent Partners
- Advertisements
- Newsletters
- Family Faculty & Advisory Councils
- Community Liaison
Caregivers and Care Plans

Families MUST be involved:
- Families receive copy of care plan at end of visit
- Access via patient portal
- PCP completes care plan and give to parent for review and discussion at the visit
- Families can sign care plan
- Not all practices provide completed care plan to the family

Key Elements in Shared Care Plans

- Name, DOB
- Parents/Guardians
- Primary Diagnosis
- Secondary diagnosis(es)
- Original Date of Plan, Updated last
- Main concerns/goals:
  - Current plans/actions
  - Person(s) responsible
  - Date to be completed
- Signatures

Co-management

- Established referral relationship
- Knowing when and how to refer
- Warm hand off to both therapist and psychiatrist
- A partnership among primary care and MH professional(s) (e.g., psychiatrist, therapist, school-based personnel, agencies, patient/family)
- Standardized exchange of information with both therapist and psychiatrist (see joint AAP-AACAP resource)
- Shared record if integrated or co-located
- Shared care plan

Inter-visit Activities

- Screening (youth, parent, teacher)
- Functional assessment
- Diary
- Reading
- Behavioral “homework” assignment
- Stress / conflict reduction
Case Success Story

- Patient with PTSD and epilepsy – 8 year old
- Previously hospitalized twice in three months for seizures
- Care plan written and shared with family that included agreement to seek therapy for PTSD in an effort to reduce the risk for more seizures
- Three month regular follow-up – family encouraged and also asked for sharing of the care plan for the neurology specialist

Improving Care Coordination in your Practice

- Assess current protocols
- Assign new roles in office
- Identify system supports
  - Consider creating a Quality Improvement team
  - Develop system for follow-up
- Schedule re-visit(s) as needed to check-in

Making it Work in Your Practice

Clinical Tools, Payment/ Coding, and Community Resources
“Feelings Need Check-Ups Too”

- AAP resource and toolkit on crisis-related mental health problems
- Case study approach
- Demo of various screening tools
- Info on parental reassurance and bereavement support

AAP Policy Statement:

- “Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies”
  [http://pediatrics.aappublications.org/content/138/3/e20161570](http://pediatrics.aappublications.org/content/138/3/e20161570)

National Center for Medical Home Implementation (NCMHI) (AAP)

- Pediatric Care Coordination Webinar Series 2015:
  - Access here: [https://medicalhomeinfo.aap.org/tools-resources/Pages/Webinars.aspx](https://medicalhomeinfo.aap.org/tools-resources/Pages/Webinars.aspx)
  - Building Your Medical Home: Coordinated Care

Coding & Payment - Overview

A variety of codes can now be used for your mental/behavioral health care services in your practice, including:

- codes for screening to identify issues
- codes for communication about treatment and referral options
- codes for consultations with other providers and specialists

Consultation E/M (99241-99245)*

The 3 R’s:

- REQUEST for consultation is made and documented in the chart.
- Consulting clinician RENDERS an opinion or advice back to the requesting source.
- Consulting clinician provides a written REPORT back to the requesting source.

Source of request examples: school personnel, another colleague in the same practice, a therapist, a nurse practitioner, an attorney

*NOTE: A parent/legal guardian or patient is not an acceptable source

*3 key components—history, physical examination, and medical decision-making—must be performed and documented.
Prolonged Services

If the clinician spends at least 30 minutes more than the time typical for a particular visit, the clinician may additionally report prolonged service codes:

- **99354–99355** Outpatient face-to-face prolonged services; 30 to 74 minutes/more than 74 minutes
  - Time must be spent on the same day as the visit, but does not need to be continuous.
- **99358–99359** Non-face-to-face prolonged services in any setting; 30 to 74 minutes/more than 74 minutes
  - No longer needs to be provided on the same date as the underlying face-to-face service and does not need to be continuous, but must be on the same calendar date.

Prolonged Services (cont’d)

- The face-to-face prolonged service codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided (e.g., office or other outpatient service codes).
- Documentation is essential.
- If the patient is on a capitated plan, the clinician may request authorization to bill the family directly for these non-covered services.
- If coding based on time, then prolonged services only begins when you have exceeded 30 minutes beyond the typical time in the highest code in the code set (e.g., 99215, 99245, 99223).

Patient not Present

Parent or legal guardian presents to discuss mental health issue, patient is not present. **How do you code?**

- You can report an office-based E/M service.
- Note this is a face-to-face service.
- Typically counseling or coordination of care will dominate, therefore report on time.
- CPT guidelines state “time spent with patient and/or family”
- Note some Medicaid plans do not allow this (per Medicare rules).

Care Plan Oversight (non face-to-face services)

Recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement

**Examples:**

- Reviewing reports or lab results
- Assessing progress in therapy (e.g., speech/language, OT, PT, MH)
- Receiving or making contacts with other providers or schools by telephone or in writing
- Communicating with family members
Care Plan Oversight (non face-to-face services) (cont'd)

Codes:

- **99339** (15–29 minutes per month)
- **99340** (30 minutes or more per month)

Log can be attached to billing sheet

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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

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Codes for Developmental Screening/ Mental/Behavioral Health Screening

- **96110** – Used for conducting developmental screenings including M-CHAT, ASQ, SWYC
- **96127** – NEW CODE for conducting a brief emotional/behavioral screening, including PSC, Y-PSC, and PHQ-9

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Comments on Coding for Mental Behavioral Health Screenings

- First, determine if you are fee-for-service on Medicaid HMO plans or are you capitated.
  - If you are fee-for-service on all Medicaid plans then bill the Medicaid HMO; they will pay you.
  - If you are capitated then in addition to the bill you submit to the Medicaid HMO’s you need to separately bill the mental health component (96110 or 96127) to Molina Medicaid which is the state agency that processes Medicaid billing.
- When you use the SWYC or M-CHAT the CPT code is 96110 and that can be used with the z00.129 well child ICD 10 code
- When you use the PSC or PSC-Y then you can use the 96127 CPT code with the z13.89 ICD 10 code
Additional State Resources – Mental Health

- Mental Health Cares Hotline:
  - 1-866-202-4357
- PerformCare:
  - 1-877-652-7624
- Statewide Parent Advocacy Network (SPAN):
  - 973-642-8100
- National Alliance on Mental Illness NJ (NAMI NJ):
  - 732-940-0991

Additional State Resources – Basic Needs

- 211 (Available 24/7)
- NJ Help – www.njhelps.org
  - Gives consumers a “one-stop” shopping resource for wide range of programs, info & services provided by the Dept. of Human Services and its partners
- NJ Housing Resource Center – 1-877-428-8844
- End Hunger NJ – www.endhungernj.org

Putting It All Together

- Primary prevention – referrals to PerformCare, Central Intake, and parenting resources, anticipatory guidance about social-emotional health and positive parenting
- Secondary prevention – including surveillance and universal standardized screening
- Referral to PerformCare, the PPC Hubs
- Care Coordination – it’s a chronic disease process
- Tools for anticipatory guidance, screening, referral, and care coordination
- Community resources

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