
Future of Pediatrics
Pediatric Health Network
Children's National

Integrating Behavioral Health into Pediatric Primary Care Practice

Olivia Soutullo, PhD
Psychologist
Nikita Rodrigues, PhD
Psychologist

Disclosures

- The presenters have no relevant disclosures.

Objectives

1. Describe key components of behavioral health integration in pediatric primary care settings
2. Apply behavioral health tools and resources at the pediatric primary care provider and practice level

The State of Children's Mental Health

1 in 5 children have a diagnosable mental health condition[1]

3 out of 4 of those children will not receive support[2]

- Youth living in poverty/low SES households
- Youth experiencing trauma
- Youth in child welfare (50% with mental health condition) and juvenile justice[1]

- Youth in ethnic/racial minority groups
- Youth from immigrant families
- Those with public health insurance
- Those in the child welfare and juvenile justice systems[1]

1.National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* O'Connell, T. Boat, & K. E. Warner Eds. Washington, DC. The National Academic Press.
2.Martini R, Hilt R, Marx L, et al.; for the American Academy of Child and Adolescent Psychiatry. *Best principles for integration of child psychiatry into the pediatric health home.* pdf

71% of parents report that the pandemic took a toll on their child's mental health[1]

A third of high school students reported feeling unhappy and depressed much more than usual[2]

Hospitalizations for suicidal thoughts increased 57% from 2019 to 2020[3]

Suicidality is increasing alarmingly, especially for Black children under 12. It is the leading cause of death for Asian American youth and 2nd leading cause for youth nationally[4]

Mental health-related emergency department visits increased 24% for children ages 5-11 and 31% for children ages 12-17[5]

1. Lurie Children's Hospital. (2021, May 21). *Children's Mental Health Statistics covid-19 | Lurie Children's*.
2. Centers for Disease Control and Prevention. (2022, March 31). *New CDC data illuminate youth mental health threats during the COVID-19 pandemic*. Centers for Disease Control and Prevention.
3. Brewer, A. G., Doss, W., Sheehan, K. M., Davis, M. M., & Feinglass, J. M. (2022). Trends in suicidal ideation-related emergency department visits for youth in Illinois: 2016–2021. *Pediatrics*, *150*(6), e2022056793.
4. Meza, J. I., Patel, K., & Bath, E. (2022). Black youth suicide crisis: prevalence rates, review of risk and protective factors, and current evidence-based practices. *Focus*, *20*(2), 197-203.
5. Radhakrishnan, L. (2022). Pediatric emergency department visits associated with mental health conditions before and during the COVID-19 pandemic—United States, January 2019–January 2022. *MMWR. Morbidity and mortality weekly report*, *71*.

Call to Action from American Academic of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association

Increase	federal funding for mental health care access
Improve	telehealth access
Support	school-based mental health care
Integrate	mental health in primary care
Strengthen	efforts to reduce suicide risk
Address	challenges of acute care
Fund	community-based systems of care
Increase	access to trauma-informed care
Address	workforce challenges
Advance	mental health parity policy

AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health
https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

SAMHSA-HRSA Center for Integrated Health Solutions https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Models of Behavioral Health Integration

PCP identifies behavioral health concern

- **Coordinates care**: PCP provides referrals to community mental health providers; once family is connected, PCP may receive treatment summary and provide information to behavioral health clinician by phone/email

Sends patient to co-located care: PCP provides referral to behavioral health provider located within the medical home. No shared electronic medical records or further consultation. Patient receives full course of treatment.

Refers patient to integrated care provider: PCP provides referral to integrated behavioral health provider. Shares impression and family background in person or via shared medical record. Integrated behavioral health provider triages patient and bridges care as determined necessary. Disposition and follow up plan is shared with PCP.

Case Example

PCP identifies concern for anxiety when discussing recent increase in patient's asthma attacks

Coordinated Behavioral Health Care

Pros	Cons
- PCP has provided referrals and addressed family concern in some way - May work well for highly resourced and motivated families with the least amount of PCP burden	- Poor follow through for external referral - There will likely be disparities in who connects to care

Co-located Behavioral Health Care

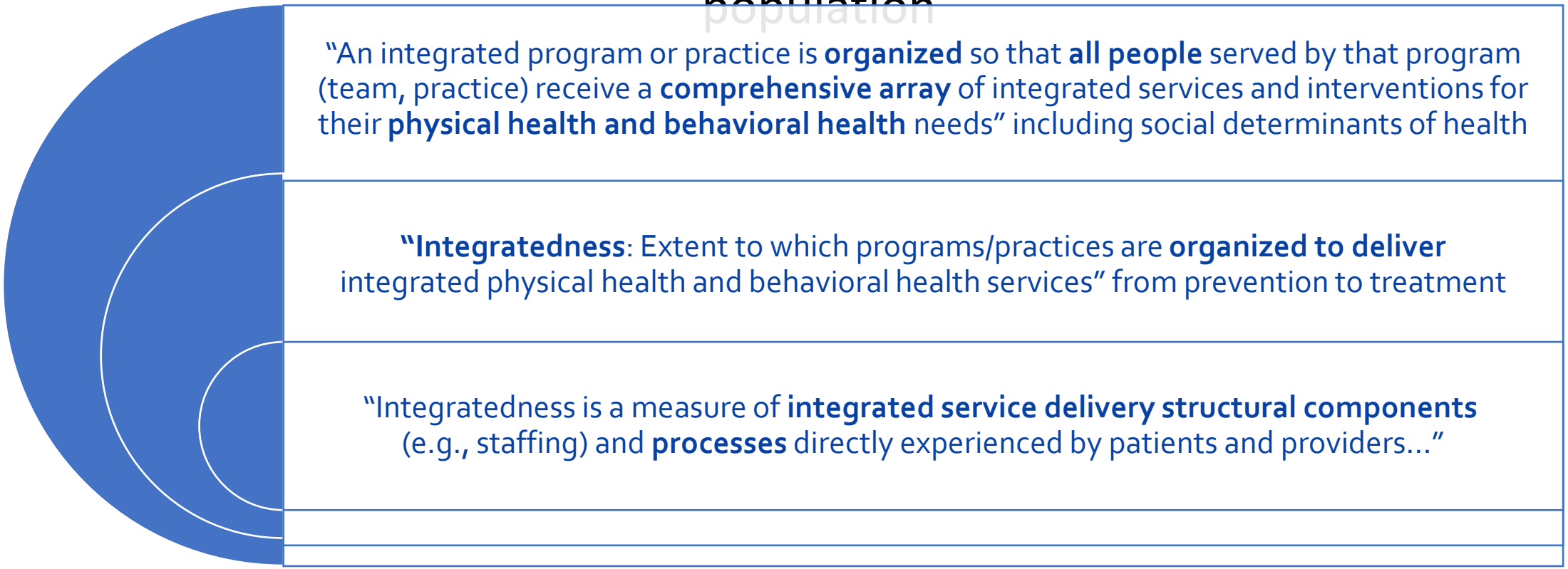
Pros	Cons
- PCP has provided referral and addressed family concern in some way - Family receives full course of treatment within the medical home	- PCP/BH coordination of care is limited - Co-located BH provider has limited capacity

Integrated Behavioral Health Care

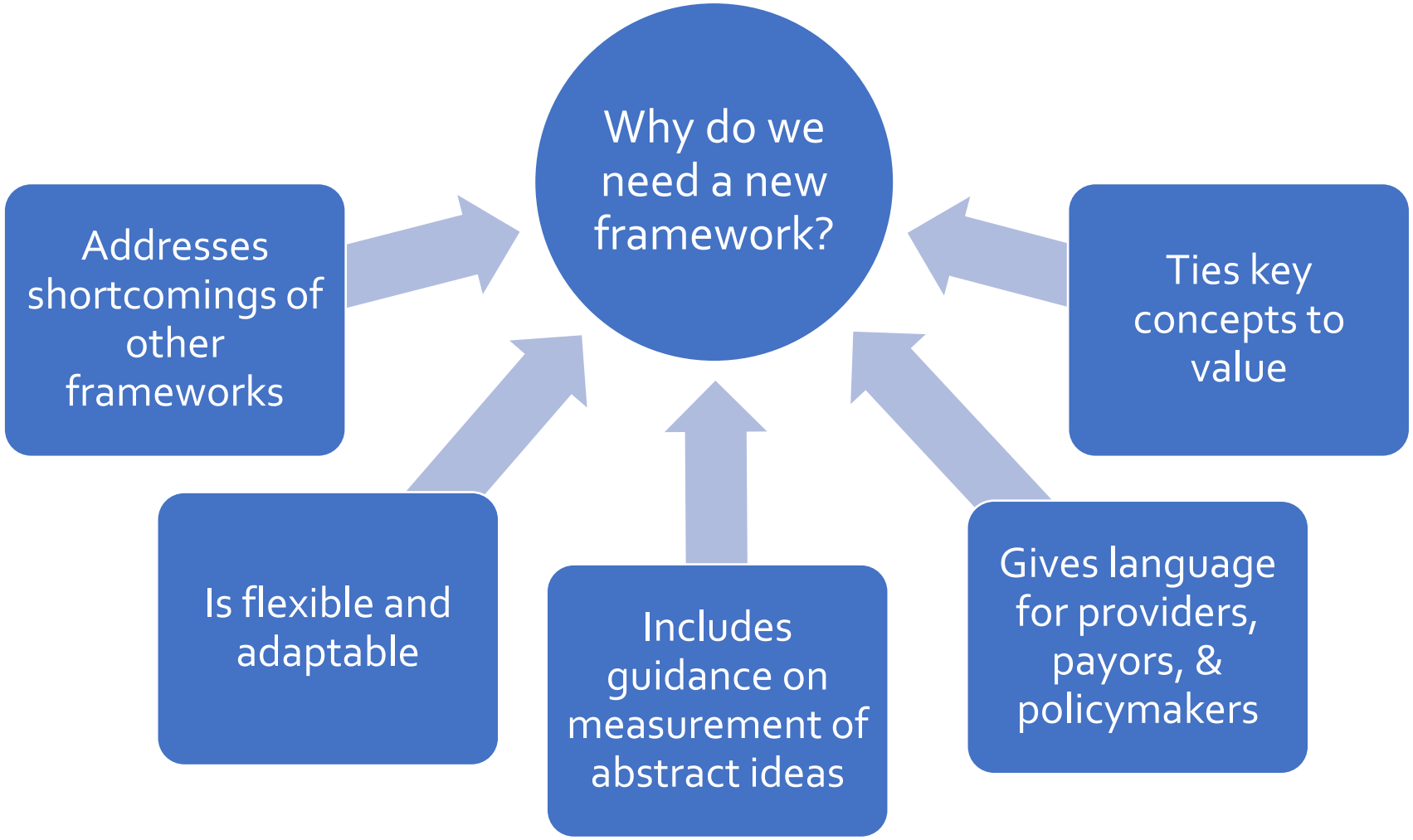
Pros	Cons
- PCP has provided referral and addressed family concern in some way - BH resources are rationally utilized for the benefit of the whole patient population - Holistic care is provided	- Family has to navigate multiple systems of care if further care/outside referrals are needed

Comprehensive Healthcare Integration Framework (National Council for Mental Wellbeing, 2022)

- Designed to be applicable to practices across sizes, resource levels, geography, population



Comprehensive Healthcare Integration Framework (National Council for Mental Wellbeing, 2022)



Comprehensive Healthcare Integration Framework

- Features 8 core domains of integration processes or services, each with its own subdomains
- Uses integration constructs (levels) as “benchmarks of progress” which build successively on each other to assess practice in 8 domains

Comprehensive Healthcare Integration Framework

Each construct is an "organized approach" created with "evidence-based or consensus-supported core service elements for integrated-ness that can be implemented flexibly"

Each construct has set of services, metrics that can show value

Providers and practices can use the framework to assess their own levels of integration, identify areas of strength and growth, and monitor progress

Table 2 – Alignment of Integration Constructs in the CHI Framework for all Ages and Populations

INTEGRATION CONSTRUCT	1- SCREENING AND ENHANCED REFERRAL	2- CARE MANAGEMENT AND CONSULTATION	3- COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT
Service scope	Interventions and practices	Program/team	Organization
People served	Individuals	1 + cohorts	2 + populations
Co-occurring issues addressed	At least one (prevention and/or treatment)	Several, according to design	All relevant
Measurement	Mainly screening and referral process measures	Process and some outcome measures	Comprehensive process and outcome measures
Value (health)	Improved health for individuals	Improved health and equity for cohort with complex needs	Improved population health and health equity
Value (cost)	Cost neutral or slightly higher	Reduced cost for high complexity cohorts	Reduced per capita cost
Payment	Enhanced FFS and quality incentives	1 + Care management payment	2 + Shared risk

Self-Assessing Behavioral Health Integratedness

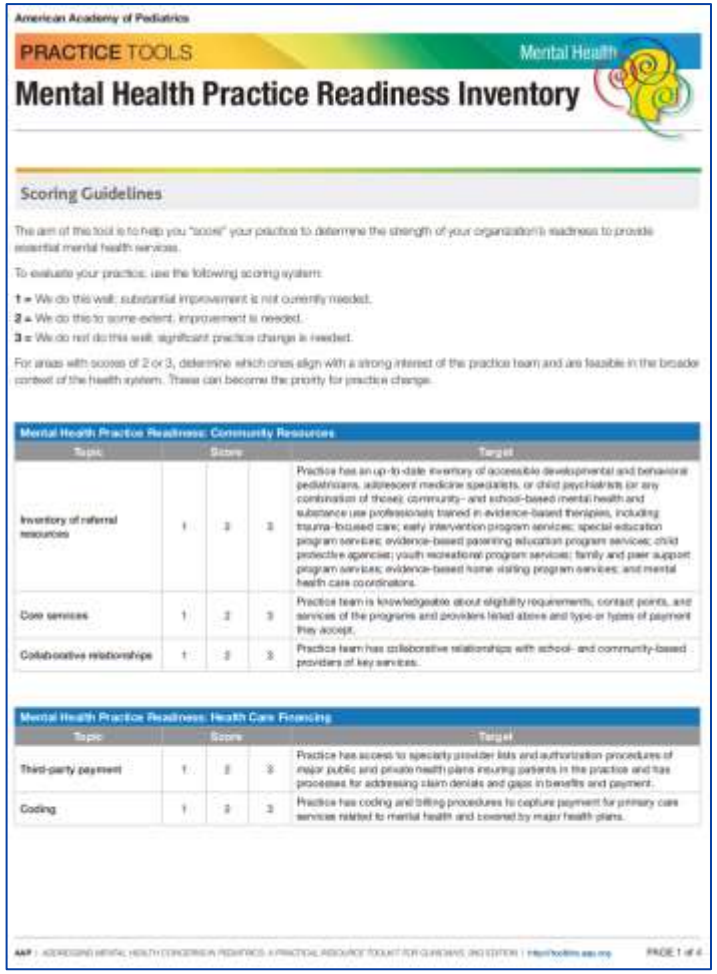
NATIONAL COUNCIL for Mental Wellbeing

Appendix 3:

The New Comprehensive Healthcare Integration Framework

NOTE: For BH settings, emphasis is on co-occurring PH, and for PH settings, emphasis is on co-occurring BH. Prioritized issues will vary based on age and other population variables.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	SUBDOMAINS	HISTORICAL PRACTICE	SCREENING AND ENHANCED REFERRAL	CARE MANAGEMENT AND CONSULTATION	COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT
1. Integrated Screening, referral to care and follow-up (f/u).	**1.1** Screening and follow-up for co-occurring behavioral health (MH, SUD, nicotine), PH conditions and preventive risk factors. **1.2** Facilitation of referrals and f/u.	Response to patient self-report of co-occurring behavioral health and/or PH complaints and/or chronic illness with f/u only when prompted. Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	Systematic screening for high prevalence BH and/or PH conditions and risk factors and proactive health/BH. Identify PCP and BH providers (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.	Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services. Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow-up and coordination re positive screens, with access to well-coordinated referrals to internal or external PH and/or BH service providers.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity and/or utilization and measuring the level of intensity of integrated care coordination. In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.



American Academy of Pediatrics

PRACTICE TOOLS — Mental Health

Mental Health Practice Readiness Inventory

Scoring Guidelines

The aim of this tool is to help you "score" your practice to determine the strength of your organization's readiness to provide essential mental health services.

To evaluate your practice, use the following scoring system:

1 = We do this well; substantial improvement is not currently needed.
2 = We do this to some extent; improvement is needed.
3 = We do not do this well; significant practice change is needed.

For areas with scores of 2 or 3, determine which ones align with a strong interest of the practice team and are feasible in the broader context of the health system. These can become the priority for practice change.

Mental Health Practice Readiness: Community Resources

Topic	Score			Target
Inventory of referral resources	1	2	3	Practice has an up-to-date inventory of accessible developmental and behavioral pediatricians, adolescent medicine specialists, or child psychiatrists (or any combination of those); community- and school-based mental health and substance use professionals trained in evidence-based therapies, including trauma-focused care; early intervention program services; special education program services; evidence-based parenting education program services; child protective agencies; youth recreational program services; family and peer support program services; evidence-based home visiting program services; and mental health care coordinators.
Core services	1	2	3	Practice team is knowledgeable about eligibility requirements, contact points, and services of the programs and providers listed above and types or types of payment they accept.
Collaborative relationships	1	2	3	Practice team has collaborative relationships with school- and community-based providers of key services.

Mental Health Practice Readiness: Health Care Financing

Topic	Score			Target
Third-party payment	1	2	3	Practice has access to specialty provider lists and authorization procedures of major public and private health plans insuring patients in the practice and has processes for addressing claim denials and gaps in benefits and payment.
Coding	1	2	3	Practice has coding and billing procedures to capture payment for primary care services related to mental health and covered by major health plans.

Case Example: Historical Practice Level Individual Provider

After many similar encounters, Dr. Z wants to enhance their behavioral health skills, so Dr. Z completes IBH self-assessments from the National Council website and AAP website.

Ares to improve include:

- BH screening (CHI Domain 1)
- Treating common BH conditions (CHI Domain 2)
- Self-management tools (CHI Domain 4)
- Community supports linkages (CHI Domain 7)

With new plans in place, Dr. Z goes back in time and sees the patient again…

Case Example: Screening and Enhanced Referral Level
Individual Provider

As part of routine care for all patients, Dr. Z now…

- Screens the 15-year-old female new patient for depression at the well visit using an evidence-based screener, the PHQ-9 Modified for Teens, after hearing about it at the PHN BHI Depression Webinar. The patient scores a 14 and denies the suicidality item, placing her in the moderate range for depressive symptoms, which is confirmed on interview (CHI Domain 1.1, Screening for BH Conditions).

- Dr. Z makes a referral to an outside behavioral health provider for therapy using an internal resource list developed by the practice using DCHealthCheck.net (CHI Domain 1.2, Facilitation of Referrals and Follow-Up).

Case Example: Screening and Enhanced Referral Level
Individual Provider

- Dr. Z reviews the VMAP depression care guide, linked on the PHN BHI Website that they learned about at the PHN BHI Depression Webinar, and follows the flowchart in session (CHI Domain 2.1, Screening/Prevention Protocols).

- Based on the flowchart, Dr. Z delivers a brief intervention on pleasant activity scheduling using the AAP Common Elements Approaches and Mental Health Strategies discussed in PHN BHI Office Hours (CHI Domain 2.2, Treatment Guidelines for Common Conditions).

- Dr. Z sees the patient again and learns she had a Zoloft prescription from her prior PCP but ran out a month ago. Dr. Z calls the Mental Health Access Program (VMAP/BHIPP/DC MAP) for a free telephone consultation with a psychiatrist for medication guidance (CHI Domain 2.3, Medication for Common Conditions).

Case Example: Screening and Enhanced Referral Level
Individual Provider

- At a follow-up visit, Dr. Z shares patient educational materials about depression including skills for healthy coping (resources coming to PHN BHI Website soon) (CHI Domain 4: Self-Management Support Tools).

- Finally, Dr. Z saw the family endorsed food insecurity challenges on a social determinants of health (SDOH) screener and uses FindHelp.org to share a list resources with the family in the follow-up visit (CHI Domain 7: Linkages with Community/Social Services).

Case Example: Care Management and Consultation Level
Practice with Integrated Behavioral Health Provider

- While the PCP titrates Zoloft, the IBH Provider checks in at visits and uses motivational interviewing to promote medication adherence. At integrated follow-up visits, IBH Provider reinforces behavioral activation skills and tracks response to intervention using screeners from the PHN BHI Website Resource Library (CHI Domain 5: Care Team).

- IBH Provider closes the loop with PCP after visits to discuss possible medication side effects mentioned in session and patient's increased motivation (CHI Domain 5: Sharing Information).

- IBH Provider uses Mental Health Technology Transfer Center (MHTTC) Network Pediatric Integrated Primary Care Guide to establish parameters for IBH practice and shares education with staff (CHI Domain 5: Integrated Care Team).

Case Example: Care Management and Consultation Level
Practice with Integrated Behavioral Health Provider

- At the practice level, Dr. Z's office regularly reviews depression screening and follow up measures in Arcadia so the practice can track population screening rates over time.

- Dr. Z's practice previously participated in the PHN Race Data Collection Initiative to reduce rate of patients who need racial data updated in the EHR, allowing for assessment of potential disparities in screening.

- Dr. Z's practice is participating in the PHN BHI QI Project to make systematic changes and increase the practice's overall behavioral health integrated-ness, which led to their hiring of the IBH Provider that the 15-year-old patient saw (CHI Domain 6.1: Quality Metrics for BH).

Takeaways

- Behavioral health is a key component of overall health and needs to be addressed in the primary care setting
- All providers can take action to improve how they address behavioral health in their own practice
- There are many resources to make this work accessible and successful
- Providers can use self-assessments to find the right level of "integrated-ness" for their own practice
- Providers can start small and work from where they are to achieve change and positive outcomes for their patients

Resources

- Full Comprehensive Healthcare Integration (CHI) Framework

- National Council website
- AAP Self-Assessment
- DCHealthCheck.net
- AAP Common Elements Approaches and Mental Health Strategies
- VMAP, BHIPP, and DC MAP
- FindHelp.org
- MHTTC Network Pediatric Integrated Primary Care Guide

- PHN Behavioral Health Initiative (BHI) Webinars
- PHN BHI Office Hours
- PHN BHI Website
- PHN BHI Resource Library
- Arcadia
- PHN Race Data Collection Initiative
- PHN BHI QI Project

PHN Behavioral Health Initiative

Behavioral Health Initiative (BHI) Purpose:

Develop a comprehensive strategy to address mental and behavioral health needs in our PHN regional practice network, recognizing there is *not* a one-size-fits-all solution

Education, Training, & Partnerships

Integrated Business Models & Care Management

Pediatric Health Network

Children's National

Opportunities for PHN Members to Participate

Training and Education:
Online Webinars, Office Hours,
& Provider Website

What: Free, virtual behavioral health webinars and office hours led by experts in child psychiatry & psychology

Who: Webinars and Office Hours are now open to all!

When: Once monthly on a Wednesday, 12-1pm

Next Office Hours:
June 5, July 10, August 14

Build Your Practice's
Integrated Behavioral Health Infrastructure

What: QI Project to improve your site's system of integrated behavioral health care, including free consultation with CNH and PHN integrated behavioral health experts

Who: A second pilot cohort of PHN sites who are participating in PHN Value-Based Care Contracts will be selected based on applications and availability

When: July 2024 – June 2025

Apply now through June 7

Thank you to the rest of our BHI Team!

- Lee Beers, MD, FAAP
- Jessica Chapman, DNP, RN
- Julia DeAngelo, MPH
- Charlotte Harper
- Perrine Heymann, PhD
- Faith Kelley, MD
- Elana Neshkes, MD
- Kelly Register-Brown, MD
- Amelia Roberts, BSN, RN
- Laura Willing, MD

Thank you!

For questions or comments, please contact:

Olivia Soutullo: osoutullo@childrensnational.org

Nikita Rodrigues: nrodrigues@childrensnational.org

BHI Website: Resources & Training Registration

QI Project Application

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