Presentation Objectives:

1) Project LAUNCH Overview

2) Approaching the Integration Strategy

3) Discussion of Five Major Projects Undertaken
WHAT IS PROJECT LAUNCH?

Project LAUNCH seeks to promote the well-being and success of children, birth to 8 years of age, their families, and pregnant women through the delivery of a comprehensive, seamless system of services and supports.

The purpose is to help all children reach social, emotional, behavioral, physical and cognitive milestones and to thrive in school and in life.
PUBLIC AWARENESS

- Created *Healthy in All Ways* initiative with packets and posters to inform practitioners and the public about the importance of healthy social and emotional development in early childhood
- Produced Family Resource Key Rings and Pro-Tips Key Rings
- Supplied sandwich board sidewalk signs and posters to Family Support Centers to inform the public about the location of the centers

165 Organizations are represented on PA LAUNCH

SYSTEM CHANGE & SUSTAINABILITY

- Endorsed eight professionals via newly created state Endorsement® system
- Collaborated with CYF and 22 cross-agency partners to conduct a fishbowl exercise exploring benefits and barriers of reflective supervision
- Released an RFP for a grant supporting improved developmental screenings in pediatric practices
- Developed strong workforce development infrastructure featuring multiple ECMH opportunities

180 members

PA LAUNCH councils and work groups at the state and local level
**DIRECT SERVICES**

- Partnered with Allegheny County's coordinated referral line (the Link) to increase access to home visiting and other support services
- Supported NurturePA, text-based mentoring program for new mothers
- Maintained a partnership with Smart Beginnings to provide tiered EBP to AC families
- Supplied funding to partner agencies for Parent Café services

**WORKFORCE DEVELOPMENT**

- Provided 41 professionals higher education coursework aligned with Endorsement® framework
- Trained foster care agency staff to administer ASQ screenings
- Held a two-day training for providers of Be Strong Families Parent Cafés
- Organized a day-long training for home visiting providers on supporting moms with opioid dependency
- Presented at numerous state and local conferences to disseminate lessons learned

**4,485 Direct Services**

provided to young children and their families

**350+ Workforce Development**

community providers participated in a range of opportunities
Strategic Doing Across Five Prevention Goals:
* Integrate Behavioral Health in the Physical Health Setting
* Promote Quality Screening and Assessment
* Increase knowledge of infant and early childhood mental health across systems
* Strengthen Families
* Increase the quality and utilization of home visiting supports

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Behavioral Health/ Physical Health Integration

**Goal:** Enhance integration of physical health and behavioral health practices to improve access to care for children birth to 8 years, their families, and pregnant women.
INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.”

## Levels of Integration (SAMHSA)

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>KEY ELEMENT:</td>
<td>KEY ELEMENT:</td>
<td>KEY ELEMENT:</td>
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<tr>
<td>COMMUNICATION</td>
<td>PHYSICAL PROXIMITY</td>
<td>PRACTICE CHANGE</td>
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<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
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<tbody>
<tr>
<td>Minimal</td>
<td>Basic Collaboration at a</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with</td>
<td>Close Collaboration Approaching</td>
<td>Full Collaboration in a</td>
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<tr>
<td>Collaboration</td>
<td>Distance</td>
<td></td>
<td>Some System Integration</td>
<td>an Integrated Practice</td>
<td>Transformed/Merged Integrated</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Practice</td>
</tr>
</tbody>
</table>

Examples

Coordination
  Facilitated referral w/communication
  e-health or phone consultation

Co-location
  Outside clinician sees shared patients; delivers EBT

Collaboration/integration
  Embedded clinician; team-based care (PCP, nurse)

From David Kolko’s 9/21/16 presentation, “Integrated Pediatric Health Care: Services, Science, & Suggestions”
Assessing Integration in Practice

- Five major pediatric practice groups serving approximately 80% of the children in Allegheny County each completed the **Pediatric Provider Integrated Assessment**, a tool created by modifying and combining the Integrated Practice Assessment Tool (IPAT) and the Mental Health Readiness Inventory (MHRI). We also interviewed all of the FQHCs and FQHC-look-alikes who serve children.
Introduction to the PPIA

The LAUNCH Pediatric Provider Integration Assessment (PPIA) is intended to serve as an organizational self-assessment of the primary care practice’s level of integrated services and the extent to which office systems promote and support mental health practice. The PPIA was developed by a group of integration subject experts, providers and other stakeholders using modifications of the Integrated Provider Assessment Tool (IPAT) and the Mental Health Practice Readiness Inventory (MHPRI). Part 3 of the PPIA includes open-ended questions that sought to collect information specific to our Allegheny County providers – it may be helpful to amend this section to reflect the specific goals and interests of your practice.

Why perform a PPIA?

Each section of the PPIA has unique benefits:

IPAT© Potential Uses:

- Tailor product solutions to client need (Clients = health plans, states, practices, PCMH entity),
- to assess network readiness for integration,
- to establish baseline & monitor performance over time, or
- to assess the association between integration and selected clinical, cost, or utilization outcomes.

The Mental Health Practice Readiness Inventory can assist primary care clinicians and managers in assessing the strengths and needs of the practice and in setting its priorities. The inventory is organized in accordance with key elements in the chronic care model:

- community resources;
- health care financing;
- support for children and families;
- clinical information systems/delivery system redesign; and
- decision support for clinicians.
Findings:

All practices are eager to improve and enhance their behavioral health service offerings, and over the years, all practices either maintained or improved their level of integration.
Pediatric Provider Integrated Care Conference: Linking Behavioral and Physical Health to Enhance Care for Young Children (PPICC)

- Brought 89 multidisciplinary providers together in promoting a more comprehensive definition of health that includes a broad understanding of social and emotional development as an important element of overall wellness.
- Sponsored with PA-AAP and Community Care Behavioral Health
- Preceded by a provider survey to assess training needs
- Two training “tracks” – concurrent sessions – with a joint keynote, lunchtime panel of local integrated providers, and a resource fair
- Post-training evaluation
- Session materials available online
## PPICC Themes and Feedback

### Session Topics

- Social and behavioral factors related to risk level for poor health outcomes
- Models of integration
- Telephonic Psychiatric Consultation Service (TiPS) program at Children’s Hospital
- Engaging families
- Billing limitations
- Other challenges to integration (e.g., stigma, data sharing, and training)

### Participant Feedback

- Clarifying reimbursements for socio-emotional screenings and treatments from insurance and government agencies
- Examples of processes to incorporate screening results into the EHR
- Assisting providers in identifying the behavioral health services they need
- A shared consent form to facilitate cross-disciplinary care coordination

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Infant and Early Childhood Mental Health: Why it Matters for Your Field

May 9, 2019 | 8 AM-4 PM | Rodef Shalom | 4905 Fifth Ave, Pittsburgh, PA 15213

Save the date to join professionals across disciplines to explore the most critical topics related to infant and early childhood mental health (IECMH) at this FREE conference. Continuing Education Credits for a wide range of professionals will be available, including physicians, nurses, home visitors, early and primary educators, and many others. Breakout sessions will offer behavioral health clinicians, pediatricians, home visitors, early childhood educators, ECMH consultants, family members, child welfare workers and early intervention providers the opportunity to explore issues related to IECMH most relevant to their field. Keynote sessions will highlight the key themes within IECMH research that are critical for all of the systems that support families with young children.

For more information or to register, visit http://bit.ly/WhyIECMHMatters
Healthy in All Ways

Height  ✓
Weight ✓

Social Health □
Emotional Health □

A good check-up covers more than physical health. You can talk to a medical provider about your child’s behavior, moods, and feelings.

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Healthy in All Ways

How’s Teddy doing socially? Emotionally?
Healthy in All Ways

So often when we think about “healthy” infants and children, we think about their physical health, how well are they growing and are they generally sick or well. The materials in this booklet focus on another and equally important characteristic of health referred to as children’s “social-emotional health.” Just as children grow and develop physically, they grow and develop in social skills and emotional skills. They learn to understand and control their emotions. They form relationships with family and friends.

Parents, friends, caregivers and others play a key role in helping children grow into physically and mentally healthy adults. Read through the following pages to learn about how you can help young children become healthy in all ways.

**Promoting Social-Emotional Health**
provides three key factors to promote social and emotional health.

**Protective Factors**
explores key elements that strengthen families.

**Talk About Depression and Anxiety During Pregnancy and After Birth**
offers ways to identify and help women and families deal with post-partum depression.

**The Truth About ACEs**
examines the research on the link of Adverse Childhood Experiences and later adult health.
The PRIDE Program
promotes a community-wide approach to building positive racial
identity development in young African American children.

Age-Related Reactions to a Traumatic or Stressful Event
explains how children of may respond to life events in different ways based
upon their age and developmental abilities.

Mental Health and Young Children
provides data on common mental health problems and resources for
additional information.

Self-Health Tips for Parents & Caregivers
examines ways to develop a strong relationship with children and how
important it is for the adults to take care of themselves as well.

This booklet was produced through the funding of the PA Project LAUNCH grant which
seeks to promote the well-being and success of children, birth to 8 years of age, their
families, and pregnant women.

Thank you for caring.

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DEVELOPMENTAL SCREENING in the PEDIATRIC SETTING

Tips and Strategies for Preparation, Communication and Partnerships
## SCREENING TOOLS

<table>
<thead>
<tr>
<th>Depression</th>
<th>Tool</th>
<th>Full Name &amp; Link to Screen</th>
<th>Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHQ-9</td>
<td>Patient Health Questionnaire-9 (Screening for depression)</td>
<td>13+ years</td>
</tr>
<tr>
<td></td>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
<td>Perinatal women</td>
</tr>
<tr>
<td>Development</td>
<td>ASQ:SE</td>
<td>Ages and Stages Questionnaires Social-Emotional</td>
<td>6–60 months</td>
</tr>
<tr>
<td></td>
<td>PEDS</td>
<td>Parents’ Evaluation of Developmental Status</td>
<td>Birth–8 years</td>
</tr>
<tr>
<td>Autism</td>
<td>MCHAT</td>
<td>Modified Checklist for Autism in Toddlers</td>
<td>16–30 months</td>
</tr>
<tr>
<td>Psychosocial/Emotional</td>
<td>BITSEA</td>
<td>Brief Infant-Toddler Social and Emotional Assessment</td>
<td>12–36 months</td>
</tr>
<tr>
<td></td>
<td>ECSA</td>
<td>Early Childhood Screening Assessment</td>
<td>18–60 months</td>
</tr>
<tr>
<td></td>
<td>PSC</td>
<td>Pediatric Symptom Checklist (17- or 35-item tool)</td>
<td>4–16 years</td>
</tr>
<tr>
<td></td>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
<td>3–16 years</td>
</tr>
<tr>
<td>Risk Factor</td>
<td>SWYC</td>
<td>Survey of Well-being of Young Children</td>
<td>0–60 months</td>
</tr>
<tr>
<td></td>
<td>SEEK</td>
<td>Safe Environment for Every Child</td>
<td>0 – 5 years</td>
</tr>
<tr>
<td>Adolescent</td>
<td>CRAFFT</td>
<td>Car, Relax, Alone, Forget, Friends, Trouble; (Screening for substance abuse)</td>
<td>14 to 21 years</td>
</tr>
</tbody>
</table>
DURING THE SCREEN

Setting the Stage with the Family

Begin by reviewing the tools you will be using. Sometimes you might give the family their own copy and encourage them to take notes if they would like.

Use positive language when describing the tool and the intent of the screen.

Make sure the family understands that the information is confidential and they are not forced to answer a question if it makes them uncomfortable.

Be mindful of the family’s literacy level. Ask families how they would like the information to be presented. For example, you might say, "I have copies of the questionnaires so you can review them as we go along. Some people prefer me to read the questions out loud. What would work best for you?"

If you are using an interpreter, make sure you are looking at the family member to whom you are speaking, not at the interpreter, when you are addressing the family and/or child. It is recommended that you sit in a triangle formation with the interpreter seated to the side.
AFTER THE SCREEN

Coding the Visit

Appropriate coding and billing of services rendered to the child’s medical insurance provider can assist with reimbursement of time and supplies.

Below you will find a number of commonly used codes, along with the level of reimbursement outlined in Pennsylvania’s Office of Medical Assistance Fee Schedule (accurate as of August 2018). Reimbursement is always dependent on proper documentation.

CPT Codes
96110 - Developmental screening ($6.99)
- developmental milestone survey, speech and language delay screen; must include scoring and documentation with a standardized instrument

96127 - Brief emotional/behavioral assessment ($4.00)
- depression inventory, ADHD scale; must use a standardized instrument and include scoring and documentation
Patient Centered Medical Home (PCMH)

Quality improvement (QI) initiatives and activities are an important component of NCQA Patient Centered Medical Home (PCMH). One of the benefits of continuing to use the PPIA survey tool is that it can be used to assist in the application for and maintenance of certification for PCMH.

Below, questions from the PPIA are cross-linked to criteria for the PCMH application in a demonstration of the usefulness.

<table>
<thead>
<tr>
<th>Core or Elective</th>
<th>Competency</th>
<th>Criteria</th>
<th>PPIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>TC Competency B</td>
<td>TC 07 – Staff involvement in QI</td>
<td>Use of survey for QI</td>
</tr>
<tr>
<td>E</td>
<td>TC Competency B</td>
<td>TC 08 – Behavioral Health Care manager</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>KM Competency A</td>
<td>KM 02 – Comprehensive Health Assessment</td>
<td>PPIA promotes meeting E (behaviors affecting health), G (Social Determinants of Health) and H (developmental screening using a standardized tool)</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency A</td>
<td>KM 04 – Behavioral Health Screenings (must implement 2 or more)</td>
<td>Promotes D (pediatric behavioral health screening), F (ADHD), and G (postpartum depression)</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency A</td>
<td>KM 08 – Patient Materials</td>
<td>Aligns with patient materials matching demographics of patient population</td>
</tr>
<tr>
<td>C</td>
<td>KM Competency B</td>
<td>KM 10 – Language</td>
<td>Aligns with matching patient language preference</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency B</td>
<td>KM 11 – Population needs</td>
<td>Aligns</td>
</tr>
<tr>
<td>C</td>
<td>KM Competency B</td>
<td>KM 12 – Proactive Reminders</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>KM Competency F</td>
<td>KM 21 – Community Resource Needs</td>
<td>Promotes relationship with community resources</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency F</td>
<td>KM 25 – School/Intervention Agency Engagement</td>
<td>Aligns</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency F</td>
<td>KM 26 – Community Resource List</td>
<td>Promotes referral list</td>
</tr>
<tr>
<td>E</td>
<td>KM Competency F</td>
<td>KM 28 – Case conferences</td>
<td>Promotes involvement of others outside medical team</td>
</tr>
<tr>
<td>C</td>
<td>CM Competency A</td>
<td>CM 01 – Identifying patients for case management</td>
<td>Aligns with A (behavioral health conditions), D (social determinants of health), and E (referrals from outside organizations)</td>
</tr>
<tr>
<td>C</td>
<td>CM Competency A</td>
<td>CM 04 – Person centered care plans</td>
<td>Aligns</td>
</tr>
<tr>
<td>C</td>
<td>CC Competency B</td>
<td>CC 04 – Referral management</td>
<td>Promotes referrals and tracking</td>
</tr>
<tr>
<td>E</td>
<td>CC Competency B</td>
<td>CC 05 – Appropriate referrals</td>
<td>Protocols for appropriate referrals</td>
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<tr>
<td>E</td>
<td>CC Competency B</td>
<td>CC 09 – Behavioural health referral expectations</td>
<td>Coordinating information sharing and patient care expectations with behavioral health providers</td>
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<tr>
<td>E</td>
<td>CC Competency B</td>
<td>CC 10 – Behavioural health information</td>
<td>Integrate behavioral healthcare providers into practice</td>
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<tr>
<td>E</td>
<td>CC Competency B</td>
<td>CC 11 – Referral monitoring</td>
<td>aligns</td>
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<tr>
<td>E</td>
<td>CC Competency B</td>
<td>CC 20 – Care plan collaboration for practice transition</td>
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<tr>
<td>C</td>
<td>QI Competency A</td>
<td>QI 01 – Clinical Quality Measures</td>
<td>Need at least one measure in behavioral health</td>
</tr>
</tbody>
</table>
Education and the offer of fiscal support for sustainable models and add-ons that support integration:

• CHADIS

• Centering Parenting

• Triple P
Policy Recommendations:

<table>
<thead>
<tr>
<th>Type of Stakeholder</th>
<th>Number of key informants (there is overlap)</th>
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<tbody>
<tr>
<td>Parent/Family Member</td>
<td>2</td>
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<tr>
<td>Insurance Payer</td>
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<tr>
<td>Behavioral Health</td>
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<tr>
<td>Physical Health</td>
<td>3</td>
</tr>
<tr>
<td>Child Policy Expert/Advocate</td>
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<tr>
<td>Researcher/Subject Expert</td>
<td>3</td>
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<tr>
<td>Total</td>
<td>15</td>
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</table>

The Policy Recommendations deliverable was conceived to connect and collaborate with State partners and to advance the goals of Project LAUNCH’s BH/PH Integration Workgroup. The above table represents stakeholders (external to the local work group) who have reviewed, collaborated on and contributed to this document. One potential next step is to transfer the document to an advocacy-focused organization like the RCPA, who is willing to pursue the policy change efforts addressed in these recommendations.
Below are 7 recommendations put forth by the Allegheny County Project LAUNCH Behavioral Health/Physical Health Integration Work Group. Please note that these recommendations focus on strategic secondary prevention opportunities within the pediatric primary care setting, and are not meant to be a comprehensive account of potential improvements to Pennsylvania’s health care delivery system.

1. **Validated socioemotional health screenings in young children (0 to 10) with appropriate follow-up**

   First onset of mental and behavioral health conditions usually occurs in childhood or adolescence\(^1\). Typically, treatment does not start until much later\(^1\), yet only 1/8 children will ever receive treatment for their disorder\(^2\). Tragically, the leading causes of death in adolescents - accidents, homicide and suicide - are likely to be related to behavioral health issues\(^3\). Early identification and timely treatment could reduce severity-persistence of primary disorders and prevent or delay secondary disorders\(^1\). Screening children within the primary medical home and linking them to care at the time of their health visit is a strategy that has been associated with increased rates of treatment\(^3\). The **use of a validated socioemotional/psychosocial screen(s) in every well-child (e.g. EPSDT, yearly physical) primary care visit should be required across all age ranges. Validated socioemotional/psychosocial screen(s) should be the gold standard of care for all children, regardless of insurance provider.**
Questions?

Feel free to contact Kim Eckel, local coordinator: Kimberly.Eckel@alleghenycounty.us