educate
chapter members
Primary care clinicians play a central role in the prevention, identification, and treatment of mental health problems in children. They can help promote children’s mental health (e.g., anticipatory guidance and parent education) and identify children who may be experiencing mental health issues (e.g., screening for developmental delays, and depression). They also play an essential role in the treatment of mental health problems. Approximately half the care for common mental health disorders is delivered in primary care settings. Moreover, primary care clinicians prescribe the majority of psychotropic medications for both children and adults.1

Given the prevalence of mental disorders in primary care settings and the ever-increasing shortage of mental health providers, particularly those who serve children, primary care clinicians are assuming more significant roles in children’s mental health. Pediatricians are challenged to place greater focus on the social, developmental, and behavioral needs of children—issues that are now considered a core element of pediatric care.2 Families who have questions or concerns about a mental health need in their child often first seek help from their primary care clinician. Primary care settings are where many families go regarding general health and other related concerns for their child, they are often perceived as less stigmatizing than mental health settings, and they can often best prevent, promote, and identify mental health issues (e.g., identification of developmental delays through well child visits).

In spite of the opportunities for addressing mental health issues in primary care settings, primary care clinicians are often ill equipped to assume extensive roles in the care of children’s mental health. Many primary care clinicians lack the time, training (e.g., interviewing, counseling, and diagnostic skills) and decision-making support (e.g., when to manage a mental health disorder vs when to refer) to provide care to children with mental health needs.2 Indeed, mental health problems are often undiagnosed, untreated, and under treated in primary care settings.1

When mental health conditions are identified, primary care clinicians may feel pressured by families or teachers to prescribe psychopharmacologic therapies. This phenomenon may be exacerbated in regions where pharmaceutical companies’ aggressive marketing to primary care physicians has substituted for legitimate continuing medical education (CME) about these therapies. Even formal CME activities may be overly influenced by pharmaceutical company interests.3

System barriers to integration between primary care and behavioral health care further compound these clinical barriers. These challenges include inadequate reimbursement for mental health services, rules and regulations that can limit the kinds of mental health services that primary care clinicians can provide, and poor integration of services between primary care clinicians and mental health professionals. Psychiatric specialty education provides insufficient training in primary care and the interactions and effects of coexisting medical disorders and psychiatric conditions.4 Furthermore, medical schools do not emphasize working as part of an interdisciplinary team—primary care clinicians and psychiatrists receive little training in collaborative practice arrangements.
What Does This Mean for American Academy of Pediatrics Chapters?
Given these issues, national reports and studies have called for better integration between primary care and behavioral health care in addressing children’s mental health needs. States and communities have begun developing initiatives to promote and foster better integration between these service delivery systems. In addition, models of integrated care are being developed in primary care practices across the country.

Chapters can play a significant role and service by educating their members on the prevention, early identification, and treatment of children’s mental health issues. Furthermore, chapters can help advance initiatives, strategies, and practice models to address better integration of primary and behavioral health care.

Chapter Strategies for Educating Chapter Members
Chapters may want to identify and consider a range of strategies for educating chapter members on the prevention, identification, and treatment of mental health problems in children. Key strategies include the following:

- Hold CME sessions on mental health prevention, early identification (eg, use of valid mental health screening tools), and diagnosis; psychiatric medications; and mental health case management. The American Academy of Pediatrics (AAP) Task Force on Mental Health has suggested guidelines for educational activities about psychopharmacology. (See the Tools and Resources in this section for: The Warning Signs Project Summary and a Glossary of Mental Health and Substance Abuse Terms.)

- Provide CME sessions on care integration; behavioral health management approaches; and reimbursement, coding, and other documentation issues.

- Provide guidance to members and their staff (eg, office managers) on how to appropriately code for mental health visits. (See the Tools and Resources in this section for the following related information: Commonly Reported Codes for Primary Care Clinicians and Mental Health Professionals, Coding for Primary Care Clinicians and Mental Health Professionals, and Developmental Screening/Testing: Coding Fact Sheet for Primary Care Clinicians).

- Use AAP resources such as the coding tips on attention-deficit/hyperactivity disorder in chapter newsletters.

- Develop a speaker’s bureau and write an article and/or other informational strategy on successful integrated practice models and collaborations between primary care and mental health professionals.

- Facilitate the sharing of effective models of integration with mental health professionals. For example, pediatric practices have had success with employing, co-locating with, and collaborating with social workers, psychologists, and nurse practitioners with specialized training to provide mental health services for children. Successful experiences could be shared at chapter meetings and through other dissemination mechanisms. (See Tools and Resources in this section for the following related information: Collaborative Models Sample Survey and Template Letter; Primary Care and Mental Health: Collaborative Projects; Health Plan Policies Fostering Co-location and Other Forms of Collaboration in the Care of Children With Mild to Moderate Mental Illness; and “Co-Location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models.”)
• Develop peer-mentoring programs to assist primary care clinicians with less experience in integrated practices.

• Convene collaborative, cross-disciplinary meetings between behavioral health and primary care clinicians to address gaps in services and promote treatment protocols and adherence to evidence-based practices. (See Tools and Resources in this section for the Evidence-based Child and Adolescent Psychosocial Interventions Matrix).

• Work with pediatric residency programs to ensure that children’s mental health is addressed in medical training. The overall mental health and social and emotional development of children is a major part of the future of pediatrics. Current and future medical residents need to be prepared to address the mental health needs of children. More information is available from the Association of Pediatric Program Directors, a national associated dedicated to promoting excellence in pediatric medical education to ensure the health and well-being of children, at http://www.appd.org.

References


Resources for Further Information

The AAP Division of Chapter and District Relations. Available at: http://www.aap.org/member/chapters/chapoverview.htm Accessed March 21, 2007


Bright Futures. Available at: http://brightfutures.aap.org/web/ Accessed March 21,
2007. Bright Futures, initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago and managed by the American Academy of Pediatrics, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community.


The Improving Mental Health in Primary Practice Through Access, Collaboration and Training (IMPACT) program is a grant from the federal Maternal and Child Health Bureau (MCHB) to the AAP to improve children's mental health by offering pediatricians and other primary care professionals the tools and support they need to provide community-based, collaborative care. Available at: http://www.aap.org/mentalhealth/mh1a.html Accessed March 28, 2007


Mental Health: The Cornerstone of Health contains mental health information related to US Department of Health and Human Services research, programs, policies, and media campaigns and highlights the latest research findings and policy efforts. Available at: http://mentalhealth.samhsa.gov/cornerstone/ Accessed March 28, 2007

strategies to educate chapter members
tools and resources

strategies for system change in children’s mental health: a chapter action kit

The Warning Signs Project Summary
Reprinted with permission from Peter Jensen MD, Center for the Advancement of Children’s Mental Health. This resource is an overview of a project developed by the Center for the Advancement of Children's Mental Health at Columbia University that is designed to provide clinicians, including pediatricians, with the skills and tools that are needed to recognize early signs of mental health problems in children.

Glossary of Mental Health and Substance Abuse Terms

Commonly Reported Codes for Primary Care Clinicians and Mental Health Professionals
This resource outlines common diagnosis codes that are used by primary care clinicians and mental health professionals for mental health problems in children and adolescents.

Coding for Primary Care Clinicians and Mental Health Professionals
This resource contains comprehensive listings of codes for services such as case management, office or other outpatient service codes, prolonged physician service codes, and mental health services codes.

Developmental Screening/Testing: Coding Fact Sheet for Primary Care Pediatricians
This resource provides guidance to primary care clinicians on developmental screening for children, and information on diagnostic codes that can be used for developmental testing (e.g., comprehensive developmental assessments).

Collaborative Models Survey Sample Letter and Template
This template and cover letter may be used by chapters to obtain information from mental health and substance use/abuse professionals regarding effective collaborative practices between primary care clinicians and mental health professionals.

Primary Care and Mental Health Collaborative Projects
This resource highlights examples from across the country of collaborative and co-location models between primary care clinicians and mental health professionals. It also lists the contact names, address, and phone numbers for more information.

Health Plan Policies Fostering Co-location and Other Forms of Collaboration in the Care of Children With Mild to Moderate Mental Illness
This tool is a checklist of policies to consider in support of co-location and collaboration between primary care clinicians and mental health professionals.
Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models


Reprinted with permission from Sage Publications. This article describes 3 North Carolina practice models in which mental health professionals are co-located with pediatric primary care clinicians, and outlines how advocacy efforts can impact the success of co-location models.

Evidence-based Child and Adolescent Psychosocial Interventions Matrix


Reprinted with permission from the State of Hawaii, Department of Health, Child and Adolescent Mental Health Division. This tool was developed to guide teams (eg, youth, family, educators, and mental health practitioners) in developing appropriate plans using psychosocial interventions.
the warning signs project summary

strategies for system change in children’s
mental health: a chapter action kit

Reliable studies have shown that about 75-80% of children and adolescents with mental health treatment needs fail to be identified and to receive treatment. Stigma and lack of awareness about mental health concerns contribute significantly to the problem.

In January 2001, US Surgeon General David Satcher issued the “Call to Action” report on children’s mental health which discussed the urgent need to identify children with mental health treatment needs and to find effective ways to communicate to the public that certain behaviors in children warrant professional attention.

In response to the call to action, the Center for the Advancement of Children’s Mental Health at Columbia University created The Warning Signs Project, with support from the National Institute of Mental Health and the Center for Mental Health Services. The project is designed to give frontline clinicians, including pediatricians, the skills and tools needed to recognize early symptoms of mental disorders. The project is modeled after the “Seven Warning Signs of Cancer” – created as part of the war on cancer in the 1970s.

In developing the warning signs, those leading the project used rigorous research, Diagnostic and Statistics Manual (DSM) criteria, and focus group input from diverse groups of families, physicians, school professionals and youth. The warning signs are designed to be easily communicated and understood by persons with diverse backgrounds, training, and education. Although these warning signs appear to be on the severe end of the spectrum, they were designed to differentiate between behaviors that may be a part of normal adolescence. While one adolescent may be exhibiting behaviors that are a part of normal development, others may exhibit behaviors or actions that suggest that there is a mental health concern.

The following are the 11 warning signs:

- Feeling very sad or withdrawn for more than 2 weeks
- Trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is being provided with the understanding that the authors are not engaged in rendering medical or other professional services. If medical advice or other expert assistance is required, the services of a competent professional should be sought.

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• Drastic changes in your behavior or personality

The project also included the development of a toolkit with a variety of resources, materials and training guidelines for various stakeholders, including physicians, teachers, parents, advocacy organizations, and the media. The following tools are available for pediatric practices:

• A sample poster (copy attached);
• A list of the 11 warning signs (copy attached);
• Fact sheets for each warning sign for parents and youth;
• Self-adhesive stickers for use in a medical chart to guide doctors in asking youth and families about the presence of the warning signs (copy attached);
• Sample scripts on how best to use the warning signs in clinical settings;
• Sample scripts and guidelines on how best to discuss the warning signs and issues related to making a mental health referral with youth and families; and
• Materials to educate and inform families about mental illnesses when a child is identified as needing treatment or a referral.

This project promises to help address the public health reality that far too many children and adolescents with mental health treatment needs fail to be identified. The tools developed for the warning signs project, when used in pediatric offices, will help to open the door to broader communication between youth and families and between families and the pediatric office staff about mental health related concerns.

Using the project tools communicates to youth and families that pediatricians are concerned with all aspects of a patient’s health and well-being, including their mental health. It also alerts youth and families that the circumstances listed in the warning signs warrant action and provides pediatricians with tools on how best to discuss the warning signs and mental health related issues with youth and families.

Pediatricians interested in learning more about the Warning Signs project and/or those interested in obtaining the tools developed for this project should contact:

Peter S. Jensen, MD, e-mail: psjensenmd@gmail.com,

or

c/o the Center for the Advancement of Children’s Mental Health
341 West 87th Street
Suite 4F
New York, NY 10024
ACTION Signs: Your Youngster’s Behavioral Health Thermometers

Wouldn’t it be great if a thermometer could tell you if your child was not feeling well emotionally?

Just as a thermometer measures if your child has a temperature, these action signs will tell you if your child has an emotional problem. The signs indicate when your child may be in need of professional evaluation.

If you think that your child may have any of the following warning signs, tell your family physician. Take action and help your child feel better!

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill him/herself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt him/her or others
- Not eating, throwing up, or using laxatives to make him/herself lose weight
- Intense worries or fears that get in the way of his/her daily activities
- Extreme difficulty in concentrating or staying still that puts him/her in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in his/her behavior or personality
Action Signs for Helping Kids in Your Setting

Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone...not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don’t wait. Talk with a helpful adult, such as your family, doctor, school nurse or counselor, or religious leader, if you have one.

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
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Sticker Example:

### Warning Signs for Mental Health

**Instructions:** Use this sticker as a reminder to ask the child about the following behaviors; follow-up on positive responses. Refer to the expanded information sheet.

- Feeling very sad or withdrawn; 2 weeks or more
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with racing heart or fast breathing
- Involved in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in danger or causes school failure
- Repeated use of drugs and alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality
The following is a list of key concepts and terms that are commonly used in the fields of mental health and substance abuse. Many of these terms have been defined by federal agencies, particularly the Substance Abuse and Mental Health Services Administration. This is not an exhaustive list, but it represents many of the concepts, services, and models of care that are used by mental health and substance abuse programs, services, and systems that serve children, adolescents, and their families.

Assessment
An assessment is a professional, comprehensive, and individualized review of child* and family needs that is conducted when services are first sought from a mental health professional (eg, psychiatrist, psychologist, or social worker). The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation, and behavior in the community. An assessment also evaluates the strengths and resources of the child and family. Any decisions about treatment and supports should be made by the family and mental health professional together.

Case management
Case management is a service that helps people arrange for appropriate services and supports (eg, health, mental health, educational, vocational, transportation, respite care, and recreational). Case managers typically organize and coordinate services and supports for children with mental health problems and their families. While numerous case management models exist, case management can involve assessment of child and family needs, development of service plans, contact with service providers on a child or family’s behalf, and work with the child and/or family to facilitate access to needed services.

Co-location
Co-location is one strategy for integrating primary and behavioral health care services to address issues of access, quality, and fragmented delivery systems in children’s mental health. Generally, this term refers to models whereby mental health professionals are co-located within primary care settings, or primary care clinicians are co-located within mental health programs, typically public programs. In cases where primary care settings co-locate mental health professionals, examples of models include large co-located multispecialty group practices (eg, behavioral care and primary care), community-governed nonprofit health centers, and traditional private primary care offices. In the latter, business arrangements may include an employee of a mental health agency who is “out-stationed” in the primary care office, a self-employed mental health professional who is renting or using space in the primary care office, or a mental health professional who is employed by the primary care practice. (See Resources for Further Information for information on co-location models in primary care settings.)

* For purposes of this Glossary, the term “child” is used to refer to children and adolescents from birth through 21 years of age.
**Consumer**

“Consumer” is the term used in the mental health system to describe a person who is a client or user of mental health services. This term embodies principles of self-determination, choice, and child/family-centered care—central to the recent movement toward “reform” or “transformation” of the public mental health system. Mental health consumers often convey these principles in the expression, “Nothing about us without us.”

**Crisis residential treatment services**

This term refers to short-term, 24-hour care provided in a nonhospital setting during a mental health crisis. For example, when a child becomes aggressive and uncontrollable, despite in-home supports, a parent can temporarily place the child in a crisis residential treatment service. This care is designed to avoid inpatient hospitalization, help stabilize the child, and determine the next appropriate step.

**Cultural competence**

Cultural competence refers to a set of congruent practice skills, attitudes, policies, and structures that come together in a system, in an agency, or among professionals and enable that system or those professionals to work effectively in cross-cultural situations. Cultural competency is the acceptance and respect for difference, continuing self-assessment regarding one’s own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources, and flexibility within service models to work toward better meeting the needs of diverse populations. These areas can be along the dimensions of race, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

**Culturally competent organizations**

Culturally competent organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally. The organizations have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve. They incorporate these components into policy-making, administration, practice, service delivery, and systematically involve consumers, key stakeholders, and communities.

**Day treatment**

Day treatment includes special education, counseling, parent training, vocational training, skill building, crisis intervention, and recreational therapy, lasting at least 4 hours a day. These programs work in conjunction with, and may be provided by, mental health, recreation, and education organizations.

**Diagnostic evaluation**

The goals of a diagnostic evaluation (general psychiatric evaluation) are (1) to establish a psychiatric diagnosis, (2) to collect data that are sufficient to permit a case formulation, and (3) to develop an initial treatment plan, with particular consideration of any immediate interventions that may be needed to ensure the patient’s safety, or, if the
evaluation is a reassessment of a patient in long-term treatment, to revise the plan of
treatment in accord with new perspectives gained from the evaluation.

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition**
(DSM-IV)
The DSM-IV is the official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when categorizing or describing mental health problems.

**Diagnostic and Statistical Manual for Primary Care (DSM-PC)**
Child and Adolescent Version
The DSM-PC Child and Adolescent Version provides a step-by-step guide for the primary care clinicians to help assess, diagnose, and refer mental health conditions. It includes symptom listings for simple, comprehensive diagnoses, mental/physical disorder differential diagnosis for psychosocial problems, enhanced communication between colleagues by DSM-IV compatibility, and easy-to-use charts, tables, and text.

**Dual diagnosis**
A person who has both an alcohol or drug problem and an emotional/psychiatric problem is said to have a dual diagnosis.

**Early intervention**
Early intervention is a process used to recognize mental, emotional, behavioral, and/or learning problems and to respond to factors that put individuals at risk of developing mental health problems before they become established and more difficult to treat. Early intervention can help children get better in less time and can prevent problems from developing or becoming worse. Early intervention processes use validated screening tools to identify children with or at risk for mental health problems; include consultation by trained professionals with parents, teachers and other caregivers; and work with children in their natural environments to provide needed supports and guidance.

**Early Intervention (EI) program**
The Early Intervention program was created as a result of the Individuals with Disabilities Education Act (IDEA), originally passed by Congress in 1986. States subsequently passed legislation to support and operationalize the system. There are two separate EI programs for young children who have or are at risk of having a disability or other special need that may affect their development, health, or education: the Infant-Toddler program covers children from birth through age two; the Preschool program covers children from three to five (or until the child enters kindergarten). Primary responsibility for each of these programs is assigned to a lead agency; these assignments vary from state to state.

Children participating in the Infant-Toddler Program are eligible for such services as a multi-disciplinary evaluation, service coordination, individualized family service plan (IFSP), and an array of assistive and supportive services. Agencies may render a charge for some of these services, though services cannot be denied because of a family’s inability to pay. Children participating in the Preschool Program are entitled to free and
appropriate special education service in the least restrictive environment through the local school system. Services may include a multi-disciplinary evaluation, individualized education program (IEP), and an array of assistive and supportive services.

**Emergency and crisis services**
Crisis intervention services are used in emergency situations to provide immediate intervention or care when children are, or are at high risk of becoming, a danger to themselves or others, or are experiencing acute psychotic episodes or other emergency events (eg, suicide). Such services are available 24 hours a day, 7 days a week, and provide screening, psychiatric evaluation, emergency intervention and treatment, stabilization services, and referral to community services and resources. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

**Evidence-based programs**
Evidence-based programs incorporate significant and relevant practices based on scientifically based research that obtains reliable and valid knowledge by (1) employing systematic, empirical methods that draw on observation or experiment; (2) involving rigorous data analyses that are adequate to test the stated hypotheses and justify the general conclusions drawn; (3) relying on measurements or observational methods that provide reliable and valid data across evaluators and observers, across multiple measurements and observations, and across studies by the same or different investigators.

**Evidence-based practices**
These are practices that research has shown to produce consistently good outcomes and applicable across varied populations.

**Family-centered care**
Family-centered care means that families have a primary decision-making role in the care and education of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. The term typically is used when describing mental health systems of care. Family-driven care includes the following:

- Choosing supports, services, and providers
- Promoting the inclusion of current, innovative treatments and therapies
- Setting goals
- Designing and implementing programs
- Supporting the youth/consumer to guide care as appropriate
- Monitoring outcomes
- Determining the effectiveness of all efforts to promote the mental health of children and youth

**Family self-help**
Self-help groups are based on the premise that people who share a condition have similar concerns, or have a family member with a condition also share common experiences and, therefore, can help each other by providing information, as well as practical and emotional support. Self-help groups are peer led and range from small,
informal groups to well-organized national networks. Family-run organizations may include drop-in centers and case management, employment, housing, crisis, and family support programs.

**Family support services**
Family support services refer to help designed to keep the family together, while coping with the mental health problems that affect them. These services may include consumer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

**Inpatient hospitalization**
This term refers to intensive mental health treatment that is provided in a hospital setting 24 hours a day. Inpatient hospitalization provides (1) short-term treatment in cases where a child is in crisis and may be a danger to self or others and (2) diagnosis and treatment when the patient cannot be evaluated or treated appropriately in an outpatient setting.

**Intake/Screening**
These services are designed to briefly assess the type and degree of a child’s mental health condition to determine whether services are needed and to link a child to the most appropriate and available service. Services may include interviews, psychological testing, physical examinations, including speech/hearing, and laboratory studies.

**Integrated care**
This term refers to a range of strategies and models to integrate primary and behavioral health care in to improve children’s access to mental health services and supports, reduce duplication and fragmentation of services, and improve the quality of care. These models can include, but are not limited to, the following:

- Initiatives to improve collaboration between independent, office-based primary care clinicians and mental health professionals (eg, referrals by primary care clinicians to mental health professionals);
- Embedding primary care clinicians within public mental health programs; comprehensive programs that offer primary and behavioral health care through one administrative entity;
- Co-location of behavioral health providers in primary care offices. (See Resources for Further Information for information on integrated care.)

**Linguistic competence**
Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a way that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence involves policy, structures, practices, procedures, and dedicated resources, including the following:

- Bilingual/bicultural or multilingual/multicultural staff
- Sign language interpretation services
TTY and other assistive technology devices
Print materials in easy-to-read, low-literacy, picture and symbol formats

Mental health
Mental health is the state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.

Mental health parity
Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments. The federal Mental Health Parity Act was passed in 1996 and established parity in lifetime benefit limits and annual limits. Many mental health advocates have recently substituted the term “equity” for parity.

Mental illness
Mental illness collectively refers to all mental disorders, defined as health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination) associated with distress and/or impaired functioning. Mental disorders feature abnormalities in cognition, emotion or mood, and the highest integrative aspects of human behavior, such as social interactions.

Mental health problems
This term refers to signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder.

Person-centered plan (PCP)
This term, or such similar terms as plan of care and plan of service, refers to a document that is developed through a process focused on and directed by the individual (consumer) and his or her family or advocate. It identifies the consumer’s desired outcomes and determines the supports and services needed to achieve the desired outcomes (Michigan Mental Health Code, 1995). In the case of child and adolescent consumers, the PCP is developed with input from the child, family, mental health professional(s), and representatives of involved agencies and schools. Many public mental health systems require development and documentation of such a plan and incorporate a review of the plan into periodic audits of service providers.

Residential treatment centers
Residential treatment centers provide services 24 hours a day for children with serious emotional disturbances who require constant supervision and care, and can usually serve more than 12 children at a time. Treatment may include individual, group, and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization. Residential treatment centers also are known as therapeutic group homes. The primary purpose of residential treatment is to improve overall functioning, including social and behavioral skills, so the individual can function adequately in the community, either at home or independently.
Respite care
Respite care is a service that provides a break for families who have a child with a serious emotional disturbance. Trained parents or counselors take care of the child for a brief period of time to give families relief from the strain of caring for the child. This type of care can be provided in the home or in another location. These services may be offered to families on a periodic or routine basis.

Screening
Screening is a process used to inform parents and professionals about the physical, cognitive, and emotional strengths and needs of a child. It is designed to determine whether children may be at-risk of having behavioral or emotional conditions that warrant further review and/or intervention. Mental health screening is designed to identify social and emotional development needs in children as early as possible to prevent potential mental health problems from developing or worsening. Screening is conducted by an adequately trained professional (e.g., health care provider, social worker, psychologist, or counselor) and uses objective, accurate, reliable, and validated instruments and methods. Screening does not result in definitive statements about a child’s problem nor does it draw a conclusion about a mental health disorder or diagnosis.

Serious emotional disturbances
Serious emotional disturbances are diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. Serious emotional disturbances may include depression, ADHD, anxiety, bipolar disorder, conduct disorder, eating disorders, or other conditions contributing to severe functional impairment.

System of Care
System of Care is an evidence-based approach to the care of children and adolescents with serious emotional disturbances and their families. It incorporates a broad array of services and supports that are organized into a coordinated network, integrate care planning and management across multiple levels, are culturally and linguistically competent, and build meaningful partnerships with families and youth at service delivery and policy levels. Guiding principles in a System of Care specify that services should be:

- Comprehensive, incorporating a broad array of services and supports
- Individualized
- Provided in the least restrictive, appropriate setting
- Coordinated both at the system and service delivery levels
- Involve families and youth as full partners
- Emphasize early identification and intervention

Treatment
Treatment is a type of service, support, or clinical intervention that is designed to address identified emotional, psychological, and social needs of a child and/or family. The term often refers to therapy and counseling that is repeated over a course of time, as determined by the child and/or family (depending on the age of the child) together with a service provider. Treatment includes, but is not limited to, hospitalization, partial hospitalization, outpatient services, evaluation, various psychotherapies, and medication monitoring.
Treatment plan
A treatment plan is a plan of care that is designed specially for each child and family, based on individual strengths and needs. Ideally, mental health professionals develop the plan with input from a child’s family. (See Person-centered plan.) The plan establishes goals and summarizes appropriate treatment and services to meet the special needs of the child and family.

Wrap-around services
Wrap-around services refer to a package of unique community services and natural supports that are flexible and tailored to meet the unique needs of children with serious emotional disturbances. Wrap-around services are based on a definable planning process and are designed for children and their families to achieve a positive set of outcomes in the home setting. Services are provided by multidisciplinary teams that may include case managers, psychiatrists, nurses, social workers, vocational specialists, substance abuse specialists, community workers, and family members or caregivers.

Resources for Further Information

Koyangi C, Carty L. Get it together: how to integrate physical and mental health care for people with serious mental disorders. Washington, DC: Bazelon Center for Mental Health Law; 2004


Abuse and Mental Health Service Administration, National Mental Health Information Center, Center for Mental Health Services. Available at: http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0005/default.asp Accessed April 3, 2007


commonly reported codes for primary care clinicians and mental health professionals

PROCEDURE CODES (CPT)

Physician Services:
- Office or other outpatient services: 99201-99215
- Office or other outpatient consultations: 99241-99245
- Prolonged physician services: 99354-99359
- Case management services: 99361-99362 & 99371-99373
- Central nervous system assessments/tests: 96110(screening); 96111(testing)

**Modifier 25:** Must be appended to the evaluation and management (E/M) code if 96110 or 96111 is reported at that same visit.

Non-physician Services:
- Health & behavior assessment/intervention: 96150-96155
- Education & training for patient self-management: 98960-98962

DIAGNOSIS CODES (ICD-9-CM)

Before a mental health condition is diagnosed, do not use “rule out” codes as the diagnosis. Use as many diagnosis codes that apply to document the patient’s complexity and report the patient’s symptoms and/or adverse environmental circumstances. Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses. Counseling diagnosis codes can be used when patient is present or when counseling the parent/guardian(s) when the patient is not physically present. The most correct coding accurately describes the condition requiring the service.

“V” codes are used to report circumstances other than a disease or injury and are recorded as “diagnoses” or “problems.” If appropriate, a numeric ICD-9-CM code should be reported before V codes are reported.

**NOTE:** ICD-9-CM codes in the 290-319 range are located in the “Mental Disorders” chapter of the nomenclature and, as such, payers’ claims adjudication systems may reject use of such codes when linked to E/M CPT codes.

**ABUSE**

- 303.00 Alcohol intoxication
- 305.00 Alcohol abuse; unspecified
- 305.20 Cannabis abuse; unspecified
- 305.70 Amphetamine abuse
- 305.90 Other, mixed, or unspecified drug abuse (drug/substance abuse/polysubstance abuse)
- 969.9 Psychotropic agents overdose (E855.9 accidental; E950.3 intentional)
- 989.89 Glue sniffing (E950.9 intentional)
- 995.51 Child abuse, emotional/psychological
- 995.52 Child maltreatment syndrome; child neglect (nutritional)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V15.41</td>
<td>Physical abuse, history of (child/physical/sexual abuse/rape)</td>
</tr>
<tr>
<td>V15.42</td>
<td>Emotional abuse, history of</td>
</tr>
<tr>
<td>V61.22</td>
<td>Counsel perpetrator parental child abuse</td>
</tr>
<tr>
<td>V61.11</td>
<td>Counsel victim spousal abuse</td>
</tr>
<tr>
<td>V61.41</td>
<td>Alcohol abuse, family history of</td>
</tr>
</tbody>
</table>

### ANXIETY

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.00</td>
<td>Anxiety state, unspecified</td>
</tr>
<tr>
<td>300.01</td>
<td>Panic disorder (panic attack)</td>
</tr>
<tr>
<td>300.20</td>
<td>Phobia, unspecified</td>
</tr>
<tr>
<td>300.23</td>
<td>Social phobia</td>
</tr>
<tr>
<td>307.59</td>
<td>Other and unspecified disorders of eating; loss of appetite of nonorganic origin (feeding disorder of infancy or early childhood)</td>
</tr>
<tr>
<td>307.6</td>
<td>Enuresis</td>
</tr>
<tr>
<td>307.7</td>
<td>Encopresis</td>
</tr>
<tr>
<td>308.0</td>
<td>Acute reaction to stress; predominant disturbance of emotions</td>
</tr>
<tr>
<td>309.21</td>
<td>Separation anxiety disorder</td>
</tr>
<tr>
<td>309.24</td>
<td>Adjustment reaction with anxious mood</td>
</tr>
<tr>
<td>309.3</td>
<td>Adjustment disorder with disturbance of conduct</td>
</tr>
<tr>
<td>309.81</td>
<td>Posttraumatic stress disorder</td>
</tr>
<tr>
<td>309.89</td>
<td>Adjustment disorder, other (homesickness)</td>
</tr>
<tr>
<td>780.59</td>
<td>Sleep disturbances; other</td>
</tr>
<tr>
<td>786.05</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>789.00</td>
<td>Abdominal pain; unspecified site</td>
</tr>
<tr>
<td>V15.49</td>
<td>Other personal history presenting hazards to health; psychological trauma (history of psychological trauma)</td>
</tr>
</tbody>
</table>

### DEPRESSION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.20</td>
<td>Major depressive disorder, single episode; unspecified</td>
</tr>
<tr>
<td>300.11</td>
<td>Conversion disorder (hysteria, conversion reaction)</td>
</tr>
<tr>
<td>300.4</td>
<td>Neurotic depression; anxiety depression, dysthmic disorder (depression with anxiety)</td>
</tr>
<tr>
<td>300.9</td>
<td>Self-mutilation (suicide attempt/risk)</td>
</tr>
<tr>
<td>309.0</td>
<td>Brief depressive reaction; adjustment disorder with depressed mood</td>
</tr>
<tr>
<td>V40.2</td>
<td>Mental and behavioral problems; depression</td>
</tr>
<tr>
<td>V62.82</td>
<td>Bereavement, uncomplicated</td>
</tr>
<tr>
<td>V62.89</td>
<td>Other psychological or physical stress, not elsewhere classified</td>
</tr>
<tr>
<td>V79.0</td>
<td>Special screening for depression</td>
</tr>
</tbody>
</table>

### EATING DISORDERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>307.1</td>
<td>Anorexia nervosa</td>
</tr>
<tr>
<td>307.50</td>
<td>Eating disorder, unspecified (atypical)</td>
</tr>
<tr>
<td>307.51</td>
<td>Bulimia nervosa</td>
</tr>
</tbody>
</table>

### LEARNING/DEVELOPMENTAL/ATTENTION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>299.80</td>
<td>Asperger syndrome</td>
</tr>
<tr>
<td>299.00</td>
<td>Autistic disorder, current or active</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>314.00</td>
<td>Attention deficit disorder, without mention of hyperactivity</td>
</tr>
<tr>
<td>314.01</td>
<td>Attention deficit disorder, with mention of hyperactivity</td>
</tr>
<tr>
<td>315.00</td>
<td>Reading disorder, unspecified</td>
</tr>
<tr>
<td>315.1</td>
<td>Mathematics disorder</td>
</tr>
<tr>
<td>315.2</td>
<td>Other specific learning difficulties (disorder of written expression)</td>
</tr>
<tr>
<td>315.32</td>
<td>Mixed receptive-expressive language disorder</td>
</tr>
<tr>
<td>315.39</td>
<td>Developmental speech or language disorder; other (developmental speech delay/articulation disorder)</td>
</tr>
<tr>
<td>315.4</td>
<td>Developmental coordination disorder (clumsiness syndrome)</td>
</tr>
<tr>
<td>315.9</td>
<td>Unspecified delay in development (learning disorder unspecified/NOS)</td>
</tr>
<tr>
<td>319</td>
<td>Mental retardation, unspecified</td>
</tr>
<tr>
<td>783.42</td>
<td>Late talking or late walking (delay in developmental milestones)</td>
</tr>
<tr>
<td>784.5</td>
<td>Other speech disturbance (speech articulation disorder/speech disturbance)</td>
</tr>
<tr>
<td>V40.0</td>
<td>Problems with learning</td>
</tr>
<tr>
<td>V40.1</td>
<td>Problems with communication (including speech)</td>
</tr>
<tr>
<td>V40.9</td>
<td>Unspecified mental or behavioral problem</td>
</tr>
<tr>
<td>V65.49</td>
<td>Other specified counseling</td>
</tr>
<tr>
<td>V79.3</td>
<td>Special screening for developmental delays in childhood</td>
</tr>
<tr>
<td>V79.9</td>
<td>Unspecified mental disorder and developmental handicap</td>
</tr>
</tbody>
</table>

**OTHER CONDITIONS/DISORDERS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>300.3</td>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>300.81</td>
<td>Somatization disorder</td>
</tr>
<tr>
<td>307.20</td>
<td>Tic disorder, unspecified</td>
</tr>
<tr>
<td>307.23</td>
<td>Tourette syndrome</td>
</tr>
<tr>
<td>307.3</td>
<td>Repetitive movements (head banging/spasmus nutans)</td>
</tr>
<tr>
<td>312.10</td>
<td>Temper tantrums</td>
</tr>
<tr>
<td>312.81</td>
<td>Conduct disorder, childhood onset type</td>
</tr>
<tr>
<td>312.82</td>
<td>Conduct disorder, adolescent onset type</td>
</tr>
<tr>
<td>313.81</td>
<td>Oppositional defiant disorder</td>
</tr>
</tbody>
</table>
NOTE: This resource contains comprehensive listings of codes that may not be utilized by your practice on a regular basis. We recommend that you identify the codes most relevant to your practice and include those on your encounter form/billing sheet.

**CPT (Procedure) Codes**

Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor* or a consultation code for the initial assessment:

**Office or Other Outpatient Service Codes**

99201/99202/99203/99204/99205: Use for new** patients only; require 3 of 3 key components or greater than 50% of the visit spent in counseling or coordinating care.

99212/99213/99214/99215: Use for established patients; require 2 of 3 key components or greater than 50% of the visit spent in counseling or coordinating care.

**Office or Other Outpatient Consultation Codes**

99241/99242/99243/99244/99245: Use for new or established patients; appropriate to report if another physician or other appropriate source (ie, school nurse, psychologist) requests an opinion regarding a patient. Require 3 of 3 key components or greater than 50% of the visit spent in counseling or coordinating care.

**NOTE:** Use of these codes requires the following:

a) Written or verbal request for consultation is documented in the patient chart.

b) Consultant’s opinion as well as any services ordered or rendered are documented in the patient chart.

c) Consultant’s opinion and any services that are performed are prepared in a written report, which is sent to the requesting physician or other appropriate source.

**Prolonged Physician Services Codes**

99354/99355: Use for outpatient face-to-face prolonged services.

99358/99359: Use for non-face-to-face prolonged services in any setting.

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Can only be reported in conjunction with codes that contain “typical times” as part of their descriptors (eg, 99201-99215, 99241-99245).
- Time spent does not have to be continuous.
- Codes are “add-on” codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201-99215).

*Time can be used as the key factor in determining a level of service when counseling and/or coordinating care constitute more than 50% of the encounter.

**A new patient is defined as one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years (Principles of CPT Coding (second edition), American Medical Association, 2001).
• If the physician spends at least 30 and no more than 74 minutes over the typical time associated with the reported E/M code, he/she can report 99354 (for face-to-face contact) or 99358 (for non-face-to-face contact). Codes 99355 (each additional 30 minutes of face-to-face prolonged service) and 99359 (each additional 30 minutes of non-face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
• Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.

Case Management Services Codes
99361/99362: Use to report a medical conference between the physician and an interdisciplinary team of health professionals to coordinate activities of patient care (patient not present).

99371/99372/99373: Use to report telephone calls made by the physician to patient/parent or for consultation or medical management or for coordinating medical management with other health care professionals.

Central Nervous System Assessments/Tests Codes
96110: Use to report limited developmental testing with interpretation and report (eg, Early Language Milestone Screen).
96111: Use to report extended developmental testing with interpretation and report (eg, Woodcock-Johnson Test).

NOTE: For mini-mental status examination performed by a physician, see evaluation and management codes.

Health and Behavior Assessment/Intervention Codes
96150/96151: Use to report health behavior assessment/re-assessment.
96152/96153/96154/96155: Use to report health behavior intervention (individual/group/family).

• Used to report services provided by non-physician providers. If physicians provide these services, report evaluation and management codes.
• Primary purpose is not psychiatric diagnosis but rather as a way for non-physician providers (eg, psychologists, social workers, nurses) to report behavioral assessments and/or interventions with patients who have medical (not psychiatric) illness.
• Health behavior assessment/intervention procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
• Describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient’s health status.
• These services do not represent preventive medicine counseling and risk factor reduction interventions.
• These services are offered to patients who present with established illness or symptoms, who are not diagnosed with mental illness, and may benefit from evaluations that focus on the biopsychosocial factors related to the patient’s physical health status.
• Focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.
• Focus of the intervention is to improve the patient’s health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.
• For patients who require psychiatric services as well as health behavior assessment/intervention on the same date of service, report the predominant service provided; do not report these codes in conjunction with psychiatric codes 90801-90899.
• Cannot be reported on the same date of service as evaluation and management codes.

Education and Training for Patient Self-Management Codes*

98960: Use to report education and training for patient self-management to an individual patient.
98961/98962: Use to report education and training for patient self-management to a group of patients.

• Used to report services provided by non-physician providers. If physicians provide these services, report evaluation and management codes or 99078.
• Used to report educational and training services prescribed by a physician and provided by a qualified, non-physician healthcare professional using a standardized curriculum for treatment of established illness(s)/disease(s) or to delay co-morbidity(s).
• Standardized curriculum must be used in order to report these codes but can be modified as necessary for the clinical needs, cultural norms, and health literacy of the patient(s).
• For health and behavior assessment/intervention that is not part of a standardized curriculum, see codes 96105-96155.
• Purpose is to teach the patient/caregiver how to effectively self-manage the patient’s illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient’s professional healthcare team.
• Education and training related to subsequent reinforcement or due to changes in the patient’s condition or treatment plan are reported in the same manner as the original education and training.
• The type of education and training provided for the patient’s clinical condition will be identified by the appropriate diagnosis code(s) reported.
• The qualifications of the non-physician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, non-physician healthcare professional society/association, or other appropriate source.

*The Education and Training for Patient Self-Management codes are new for 2006 and have an effective date of January 1, 2006. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that "the version of the medical data code sets specified in the implementation specifications must be the version that is valid at the time the health care is furnished." This means that HIPAA covered entities must start recognizing the new codes as of January 1, 2006. However, physicians should contact their carriers regarding coverage for the new codes.
ICD-9-CM (Diagnosis) Codes

- **Before a mental health condition is diagnosed**, do not use “rule out” codes as the diagnosis. Use as many diagnosis codes that apply to document the patient’s complexity and report the patient’s symptoms and/or adverse environmental circumstances.
- **Once a definitive diagnosis is established**, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses.
- Counseling diagnosis codes can be used when patient is present or when counseling the parent/guardian(s) when the patient is not physically present.
- “V” codes are used to deal with occasions when circumstances other than a disease or injury are recorded as “diagnoses” or “problems.” While some carriers may request supporting documentation for the reporting of V codes, others may not pay for them at all. In the latter case, a numeric ICD-9-CM code must be listed as the primary diagnosis.
- **NOTE**: ICD-9-CM codes in the 290-319 range are located in the “Mental Disorders” chapter of the nomenclature and, as such, payors’ claims adjudication systems may reject use of such codes when linked to E/M CPT codes.

**ABUSE**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>303.90</td>
<td>Alcohol dependence</td>
</tr>
<tr>
<td>303.00</td>
<td>Alcohol intoxication</td>
</tr>
<tr>
<td>304.6</td>
<td>Inhaling dependence/phencyclidine dependence</td>
</tr>
<tr>
<td>304.20</td>
<td>Cocaine dependence</td>
</tr>
<tr>
<td>304.30</td>
<td>Cannabis dependence</td>
</tr>
<tr>
<td>304.40</td>
<td>Amphetamine dependence</td>
</tr>
<tr>
<td>304.80</td>
<td>Polysubstance dependence</td>
</tr>
<tr>
<td>304.90</td>
<td>Drug dependence</td>
</tr>
<tr>
<td>305.00</td>
<td>Alcohol abuse; unspecified</td>
</tr>
<tr>
<td>305.20</td>
<td>Cannabis abuse; unspecified</td>
</tr>
<tr>
<td>305.30</td>
<td>Hallucinogen abuse; unspecified</td>
</tr>
<tr>
<td>305.60</td>
<td>Cocaine abuse; unspecified</td>
</tr>
<tr>
<td>305.70</td>
<td>Amphetamine abuse</td>
</tr>
<tr>
<td>305.90</td>
<td>Other, mixed, or unspecified drug abuse (drug/substance abuse/polysubstance abuse)</td>
</tr>
<tr>
<td>760.71</td>
<td>Noxious influences affecting fetus or newborn via placenta or breast milk; alcohol</td>
</tr>
<tr>
<td>760.72</td>
<td>Noxious influences affecting fetus or newborn via placenta or breast milk; narcotics</td>
</tr>
<tr>
<td>760.75</td>
<td>Noxious influences affecting fetus or newborn via placenta or breast milk; cocaine</td>
</tr>
<tr>
<td>969.9</td>
<td>Psychotropic agents overdose (E855.9 accidental; E950.3 intentional)</td>
</tr>
<tr>
<td>977.9</td>
<td>Drug overdose, unspecified (E858.9 accidental; E950.4 intentional)</td>
</tr>
<tr>
<td>989.89</td>
<td>Glue sniffing (E950.9 intentional)</td>
</tr>
<tr>
<td>995.51</td>
<td>Child abuse, emotional/psychological</td>
</tr>
<tr>
<td>995.52</td>
<td>Child maltreatment syndrome; child neglect (nutritional)</td>
</tr>
<tr>
<td>995.53</td>
<td>Child maltreatment syndrome; child sexual abuse</td>
</tr>
<tr>
<td>995.54</td>
<td>Child maltreatment syndrome; child physical abuse</td>
</tr>
<tr>
<td>V15.41</td>
<td>Physical abuse, history of (child/physical/sexual abuse/rape)</td>
</tr>
</tbody>
</table>
V15.42  Emotional abuse, history of
V61.22  Counsel perpetrator parental child abuse
V61.83  Counsel perpetrator sexual abuse
V61.12  Counsel perpetrator spousal abuse
V61.21  Counsel victim child abuse
V61.11  Counsel victim spousal abuse
V61.41  Alcohol abuse, family history of

ANXIETY
293.84  Organic anxiety syndrome
300.00  Anxiety state, unspecified
300.01  Panic disorder (panic attack)
300.02  Generalized anxiety disorder
300.09  Other neurotic disorders
300.20  Phobia, unspecified
300.21  Agoraphobia with panic attacks
300.22  Agoraphobia without mention of panic attacks
300.23  Social phobia
300.29  Other isolated or simple phobias
300.4  Neurotic depression; anxiety depression
300.5  Neurasthenia
300.7  Hypochondriasis
300.10  Hysterical reaction
306.4  Cyclical vomiting
306.1  Hyperventilation syndrome
307.54  Psychogenic vomiting
307.59  Other and unspecified disorders of eating; loss of appetite of non-organic origin (feeding disorder of infancy or early childhood)
307.6  Enuresis
307.7  Encopresis
307.80  Psychogenic pain, site unspecified
307.81  Tension headache
307.89  Other psychalgia
307.9  Other and unspecified special symptoms or syndromes, NEC; behavior activities
308.0  Acute reaction to stress; predominant disturbance of emotions
308.1  Acute reaction to stress; predominant disturbance of consciousness
308.2  Acute reaction to stress; predominant psychomotor disturbance
308.3  Other acute reactions to stress
308.4  Mixed disorders as a reaction to stress
308.9  Unspecified acute reaction to stress
309.21  Separation anxiety disorder
309.24  Adjustment reaction with anxious mood
309.28  Adjustment reaction with mixed emotional features; anxiety and depression
309.81  Posttraumatic stress disorder
698.4  Dermatitis factitia
780.59  Sleep disturbances; other
780.95  Other excessive crying of child, adolescent, or adult
780.99  Other general symptoms
786.01  Hyperventilation
786.05  Shortness of breath
787.01 Nausea with vomiting
787.02 Nausea alone
787.1 Heartburn
787.3 Flatulence, eructation, and gas pain
787.91 Diarrhea
787.99 Other symptoms involving digestive system
789.00 Abdominal pain; unspecified site
799.2 Nervousness
V15.49 Other personal history presenting hazards to health; psychological trauma
V40.2 Mental and behavioral problems; anxiety problem
V65.49 Other specified counseling; anxious variation
V69.5 Problems related to lifestyle; behavioral insomnia of childhood

DEPRESSION
296.20 Major depressive disorder, single episode; unspecified
296.21 Major depressive disorder, single episode; mild
296.22 Major depressive disorder, single episode; moderate
296.23 Major depressive disorder, single episode; severe, without mention of psychotic behavior
296.24 Major depressive disorder, single episode; severe, specified as with psychotic behavior
296.25 Major depressive disorder, single episode; in partial or unspecified remission
296.26 Major depressive disorder, single episode; in full remission
296.30 Major depressive disorder, recurrent episode; unspecified
296.31 Major depressive disorder, recurrent episode; mild
296.32 Major depressive disorder, recurrent episode; moderate
296.33 Major depressive disorder, recurrent episode; severe, without mention of psychotic behavior
296.34 Major depressive disorder, recurrent episode; severe, specified as with psychotic behavior
296.35 Major depressive disorder, recurrent episode; in partial or unspecified remission
296.36 Major depressive disorder, recurrent episode; in full remission
296.80 Manic-depressive psychosis, unspecified
298.0 Depressive type psychosis
300.11 Conversion disorder (hysteria, conversion reaction)
300.4 Neurotic depression; anxiety depression, dysthymic disorder (depression with anxiety)
300.5 Neurasthenia
300.9 Self-mutilation (suicide attempt/risk)
301.12 Chronic depressive personality disorder
307.59 Other and unspecified disorders of eating; loss of appetite of non-organic origin
307.6 Enuresis, non-organic
307.7 Encopresis, non-organic
307.80 Psychogenic pain, site unspecified
307.81 Tension headache
307.89 Other psychalgia
307.9 Other and unspecified special symptoms or syndromes, NEC; behavior activities
308.0  Acute reaction to stress; predominant disturbance of emotions
308.1  Acute reaction to stress; predominant disturbance of consciousness
308.2  Acute reaction to stress; predominant psychomotor disturbance
308.3  Other acute reactions to stress
308.4  Mixed disorders as a reaction to stress
308.9  Unspecified acute reaction to stress
309.0  Brief depressive reaction; adjustment disorder with depressed mood
309.1  Prolonged depressive reaction
309.21  Separation anxiety disorder; anaclitic depression
309.28  Reaction with mixed emotional features; anxiety and depression
311  Depressive disorder, not elsewhere classified
313.1  Misery and unhappiness disorder
780.59  Sleep disturbances; other
780.79  Other malaise and fatigue
780.95  Other excessive crying of child, adolescent, or adult
780.99  Other general symptoms
787.99  Other symptoms involving digestive system
789.00  Abdominal pain; unspecified site
V15.49  Other personal history presenting hazards to health; psychological trauma
V40.2  Mental and behavioral problems; depression
V62.82  Bereavement, uncomplicated
V62.84  Suicidal ideation
V62.89  Other psychological or physical stress, not elsewhere classified
V65.49  Other specified counseling; depression variation
V69.5  Problems related to lifestyle; behavioral insomnia of childhood
V79.0  Special screening for depression

EATING DISORDERS
307.1  Anorexia nervosa
307.50  Eating disorder, unspecified (atypical)
307.51  Bulimia nervosa
307.52  Pica
307.53  Rumination disorder
307.54  Psychogenic vomiting
307.59  Other and unspecified disorders of eating (feeding disorder of infancy or early childhood/infantile feeding disturbances of non-organic origin/loss of appetite of non-organic origin)

FAMILY/ENVIRONMENT
V60.0  Lack of housing
V60.1  Inadequate housing
V60.2  Inadequate material resources
V60.8  Other specified housing or economic circumstances
V61.10  Counsel marital/partner problem
V61.20  Counseling for parent-child problem, unspecified
V61.29  Parent-child problems; other (foster care)
V61.49  Health problems with family; other
V61.8  Health problems within family; other specified family circumstances (mental disorder of parent/substance abusing parent)
V61.9  Health problems within family; unspecified family circumstances
V62.0  Other psychosocial circumstances; unemployment
V62.3 Other psychosocial circumstances; educational circumstances (illiteracy of parent)
V62.4 Other psychosocial circumstances; social maladjustment (cultural deprivation/language barrier)
V62.5 Other psychosocial circumstances; legal circumstances
V62.81 Interpersonal problems, NEC
V62.89 Other psychological or physical stress, not elsewhere classified; other (domestic violence)
V65.2 Malingering

LEARNING/DEVELOPMENTAL
299.80 Asperger syndrome
299.00 Autistic disorder, current or active
307.0 Stuttering
307.46 Sleep arousal disorder (night terrors/sleepwalking)
307.9 Other and unspecified special symptoms or syndromes, NEC (masturbation, nail biting, thumb sucking)
309.0 Adjustment disorder with depressed mood (grief reaction)
309.22 Adjustment disorder, adolescent
309.3 Adjustment disorder with disturbance of conduct
309.3 Adjustment reaction; with predominant disturbance of conduct
309.89 Adjustment disorder, other (homesickness)
309.82 Adjustment disorder with physical symptoms
312.00 Undersocialized conduct disorder, aggressive type; unspecified
312.30 Impulse control disorder, unspecified
312.81 Conduct disorder, childhood onset type
312.82 Conduct disorder, adolescent onset type
312.9 Unspecified disturbance of conduct
313.22 Introverted/withdrawal disorder
313.81 Oppositional defiant disorder
313.83 Academic underachievement disorder
314.00 Attention deficit disorder, without mention of hyperactivity
314.01 Attention deficit disorder, with mention of hyperactivity
314.1 Hyperkinesis with developmental delay
314.2 Hyperkinetic conduct disorder
314.8 Other specified manifestations of hyperkinetic syndrome
314.9 Unspecified hyperkinetic syndrome
315.00 Reading disorder, unspecified
315.01 Alexia
315.02 Developmental dyslexia
315.09 Specific reading disorder; other (spelling difficulty)
315.1 Mathematics disorder
315.2 Other specific learning difficulties (disorder of written expression)
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.39 Developmental speech or language disorder; other (developmental speech delay/articulation development disorder)
315.4 Developmental coordination disorder (clumsiness syndrome)
315.5 Mixed developmental disorder
315.8 Other specified delay in development
315.9 Unspecified delay in development (learning disorder unspecified/NOS)
317 Mental retardation, mild, IQ 50-70
319 Mental retardation, unspecified
781.3 Lack of coordination (graphomotor disorder/dysgraphia)
783.40 Unspecified lack of or inadequate physiological development
783.41 Failure to thrive
783.42 Late talking or late walking (delay in developmental milestones
783.43 Short stature
784.5 Other speech disturbance (speech articulation disorder/speech disturbance)
784.61 Dyslexia
V11.9 Mental disorder, history of
V40.0 Problems with learning
V40.1 Problems with communication (including speech)
V40.3 Mental and behavioral problems; other behavioral problems
(hyperactive/impulsive behavior problem/inattention problem)
V40.9 Unspecified mental or behavioral problem
V62.89 Other psychological or physical stress NEC; other
V62.9 Unspecified psychosocial circumstance
V65.49 Other specified counseling
V69.1 Problems related to lifestyle; inappropriate diet and eating habits
V69.5 Problems related to lifestyle; behavioral insomnia of childhood
V71.02 Observation for suspected mental condition; childhood or adolescent antisocial behavior (negative emotional behavior problem/oppositional aggressive problem)
V71.09 Observation for suspected mental condition
V77.0 Special screening for thyroid disorders
V79.2 Special screening for mental retardation
V79.3 Special screening for developmental delays in childhood
V79.9 Unspecified mental disorder and developmental handicap
V80.0 Special screening for neurological condition
V82.5 Special screening for lead poisoning

OTHER CONDITIONS/DISORDERS
300.3 Obsessive-compulsive disorder
301.9 Personality disorder
302.70 Psychosexual dysfunction
302.6 Psychosexual identity disorder
299.90 Psychosis/schizophrenia of childhood
307.3 Repetitive movements (head banging/spasmus nutans)
302.9 Sexual deviation
313.21 Shyness disorder, childhood
300.81 Somatization disorder
312.10 Temper tantrums
307.21 Tic disorder, transient
307.20 Tic disorder, unspecified
307.23 Tourette syndrome
760.77 Noxious influences affecting fetus or newborn via placenta or breast milk; anticonvulsants
I. CODING
Developmental screening, surveillance, and assessment are often complemented by the use of special tests, which vary in length. This Coding Fact Sheet provides guidance on how pediatricians can appropriately report limited and extended developmental screening and testing services.

A. How To Report Developmental Testing

96110 Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report

The use of developmental screening instruments of a limited nature (eg, Developmental Screening Test II, Early Language Milestone Screen, PEDS, Ages and Stages, and Vanderbilt ADHD rating scales) is reported using CPT code 96110 (developmental testing; limited). Code 96110 is often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits. On the 2005 Medicare Fee Schedule (Resource-Based Relative Value Scale or RBRVS), the Centers for Medicare and Medicaid Services (CMS) published a total relative value unit (RVU) of 0.36 for 96110, which amounts to a Medicare payment of $13.64 (0.36 x $37.8975 {Medicare 2005 conversion factor} = $13.64). Because an office nurse or other trained non-physician personnel typically performs the service, this relative value reflects only the practice expense of the office staff and nurses, the cost of the materials, and professional liability -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code 96110 but the time and effort to perform the testing itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a limited screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both services should be reported and modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

96111 Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Extended developmental testing using standardized instruments (eg, Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition) are reported using CPT
code 96111. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (eg, an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code. In 2005, code 96111 has 3.83 total RVUs, which calculates to a Medicare payment of $145.15 (3.83 x $37.8975 (Medicare 2005 conversion factor) = $145.15).

When 96111 is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for 96110, if the E/M code is reported with 96111, modifier –25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be appended to the E/M code or modifier –59 (distinct procedural service) should be appended to the developmental testing code, showing that the services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of 96111 was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, starting January 1, 2005, physicians will report the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

B. When To Report Developmental Testing

96110
The frequency of reporting 96110 is dependent on the clinical situation. The AAP “Recommendations for Preventive Pediatric Health Care” schedule recommends developmental/behavioral assessment at each preventive medicine visit, and the AAP “Developmental Surveillance and Screening of Infants and Young Children” policy statement recommends that physicians use validated developmental screening tools to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening tests of a limited nature seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider’s judgement as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history, this is not a "test" as such, and is not separately reportable. Examples of validated limited screening tests along with clinical vignettes are provided below.

96111
Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code 96111 (developmental testing; extended). These tests are typically performed by physicians or psychologists and
require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code 96110, the frequency of reporting code 96111 is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code 96111 is reported only once the testing and its accompanying report are completed.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been “significantly low,” but who was clearly at risk for maintaining appropriate acquisition of new skills.

II. CLINICAL VIGNETTES

96110 Vignette #1
At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question “Do you have concerns about your child’s language skills?” The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her observations of the child’s language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

<table>
<thead>
<tr>
<th>CPT</th>
<th>ICD-9-CM</th>
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<tbody>
<tr>
<td>99392-25 Preventive medicine service; established patient, age 1-4 (appendged with modifier –25)</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>96110 Developmental testing; limited</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>315.31 Expressive language disorder</td>
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</tbody>
</table>

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the 99201-99215 series may be reported using a modifier –25, linked to the appropriate ICD-9-CM code(s) as appropriate (eg, 315.31, Expressive language disorder; 315.32, Mixed receptive-expressive language disorder; 315.39, Other developmental speech or language disorder).

96110 Vignette #2
At a five-year health maintenance visit, a father discusses his daughter’s difficulty “getting along with other little girls.” “Doctor, she wants friends, but she doesn’t know how to make — much less keep — a friend.” Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child’s physical exam consistently fell in the range of ‘normal for age’ in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger’s Syndrome...
and the father’s responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

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<tr>
<th>CPT</th>
<th>ICD-9-CM</th>
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<tbody>
<tr>
<td>99393-25 Preventive medicine service; established patient, age 5-11 (appended with modifier –25)</td>
<td>V20.2 Routine infant or child health check</td>
</tr>
<tr>
<td>96110   Developmental testing; limited</td>
<td>V20.2 Routine infant or child health check</td>
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**96111 Vignette #1**

An eight-year-old boy with impulsive, overly active behavior and previously assessed “average” intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

**CPT**

<table>
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<tr>
<th>CPT</th>
<th>ICD-9-CM</th>
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</thead>
<tbody>
<tr>
<td>96111   Developmental testing; extended</td>
<td>314.0x Attention deficit disorder</td>
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</table>

**96111 Vignette #2**

A 5 4/12 year old boy just beginning kindergarten whose mother’s responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays was seen for developmental testing. After greeting the parent and child and explaining to the child that he and the doctor would do some ‘non-school’ activities to see how he ‘used words to tell others about (his) good ideas’, the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Third Edition, and the Clinical Evaluation of Language Fundamentals-Fourth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive
Composite on the CELF-4. Both test scores were abnormal, indicating a mixed receptive–expressive disorder.

CPT
96111 Developmental testing; extended

ICD-9-CM
315.32 Mixed receptive expressive language disorder

III. DOCUMENTATION GUIDELINES

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (eg, a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress report of the visit itself. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

96110
PEDS (Parents’ Evaluation of Developmental Status)

This questionnaire is designed to identify any parent/primary caretaker’s concerns about a birth through eight-year child’s developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, “please list any concerns about your child’s learning, development and behavior” and a final “please list any other concerns.” The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the test.

ASQ (AGES AND STAGES Questionnaire)

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The ASQ also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any “Yes” responses should also be referred.

96111
In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child’s level of cooperation and observations of child’s behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child’s particular developmental or physical needs should be described, and specific notations should be made if any items offered resulted in a change in the child’s level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records). A brief
interpretation should be recorded and notation should be made for further evaluation or
treatment of the patient or family. A legible signature should also appear.

IV. SAMPLE TESTING TOOLS

96110
Ages and Stages Questionnaire-Second Edition (ASQ) and Ages and States
Questionnaire: Social-Emotional (ASQ:SE) (Brookes Publishing: Jane Squires, PhD and
Diane Bricker, PhD, et. al)

Australian Scale for Asperger’s Syndrome (ASAS) (Michelle Garnett, Master’s Clinical
Psychology and Anthony Atwood, PhD)

Behavior Assessment Scale for Children-Second Edition (BASC-II) (American Guidance
Service: Cecil Reynolds and Randy Kanphaus)

Behavioral Rating Inventory of Executive Functioning (BRIEF) (Psychological
Assessment Resources, Inc.: Gerald Gioia, PhD, Kimberly Espy, PhD, and Peter Isquith,
PhD)

Child Development Review (Behavior Science Systems, Inc.: Harold Ireton, PhD, et. al.)

Communication and Symbolic Scales Developmental Profile (CSBS DP) (Brookes
Publishing: Amy Wetherby, PhD, CCC-SLP, Barry M. Prizant, PhD, CCC-SLP)

Kaufman Brief Intelligence Test (American Guidance Service: Alan Kaufman and
Nadeen Kaufman)

Parents’ Evaluation of Developmental Status (PEDS) (Ellsworth and Vandermeer Press,
LLC: Frances Page Glascoe, PhD)

Pediatric Symptom Checklist: A Primary Care Screening Tool to Identify Psychosocial
Problems (PSC) (http:psc.partners.org: Michael Jellinek, MD, and J. Michael Murphy,
PhD)

Vanderbilt Rating Scales (Mark L. Wolraich, MD)

96111
Beery-Buktenica Developmental Test of Visual-Motor Integration-Fourth Edition, Revised
(VMI) (Modern Curriculum Press: Keith E. Beery, PhD)

Clinical Evaluation of Language Fundamentals-Fourth Edition (The Psychological
Corporation: Eleanor Semel, PhD, CCC-SLP, Elisabeth Wiig, PhD, CCC/SLP, Wayne A.
Secord, PhD, CCC-SLP)

(Psychological Corporation: Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD,
CCC-SLP, and Eleanor Semel, PhD, CCC-SLP)
Comprehensive Test of Nonverbal Intelligence (Pro-Ed: Donald Hammill, Nils Pearson, and J. Lee Wiederholt)

Developmental Test of Visual Perception-Second Edition (Pro-Ed: Donald Hammill, Nils Pearson, Judith Voress)


Test of Auditory-Perceptual Skills-Revised (Psychological and Educational Publications: Morrison Gardner)

Test of Language Competence-Expanded Edition (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Test of Nonverbal Intelligence-Third Edition (Pro-Ed Publishing: Linda Brown, Rita Sherbenou, Susan Johmsen)

Test of Problem Solving-Revised (LinguiSystems, Inc: Linda Zachman, Rosemary Huisingh, Mark Barrett, Jane Orman, Carolyn LoGiudice)

Test of Word Knowledge (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Woodcock-Johnson Test of Cognitive Abilities-Third Edition (Riverside Publishing: Richard W. Woodcock, PhD, Kevin S. McGrew, PhD, and Nancy Mather, PhD)
Date

Dear name of collaborative partner:

The name of the chapter is working to provide primary care clinicians with the tools and skills they need to identify, triage, refer, and/or manage behavioral health conditions. We believe that a critical component of effective behavioral health practice in primary care is collaboration with mental health and substance use/abuse professionals.

To this end, we need your help in defining effective collaboration between primary care clinicians and behavioral health professionals and in describing the role you envision for your own professional discipline in such a collaborative relationship. We thought the best approach would be to ask you what a successful collaborative model would look like and the types of barriers you often face.

We truly value your feedback and hope that you will take the time to complete and return the attached survey by date via e-mail or by mailing it to the following address:

Address

Thank you for your time and commitment. Please feel free to contact name of contact person at phone number or e-mail address if you have any questions.

Sincerely,
collaborative model survey template

strategies for system change in children's mental health: a chapter action kit

Name (optional):
Street Address (optional):
City: State: Zip Code:
Work Phone (optional): Alternate Phone (optional):

<table>
<thead>
<tr>
<th>Your discipline/primary area of practice (Check all that apply.)</th>
<th>Medical professionals with whom you currently collaborate</th>
<th>Medical professionals with whom you would ideally collaborate</th>
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</thead>
<tbody>
<tr>
<td>Nurse Practitioner With Behavioral Health Expertise</td>
<td>General Pediatrician(s)</td>
<td>General Pediatrician(s)</td>
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<td>Psychopharmacologist</td>
<td>Developmental-Behavioral Pediatrician(s)</td>
<td>Developmental-Behavioral Pediatrician(s)</td>
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<td>Other Pediatric Subspecialist(s) (please specify):</td>
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<td>School Social Worker</td>
<td>Family Physician(s)</td>
<td>Family Physician(s)</td>
</tr>
<tr>
<td>Child and Adolescent Psychiatrist</td>
<td>Neurologist(s)</td>
<td>Neurologist(s)</td>
</tr>
<tr>
<td>Child and Adolescent Clinical Psychologist</td>
<td>Nurse Practitioner(s)</td>
<td>Nurse Practitioner(s)</td>
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<tr>
<td>Master’s-level Psychologist</td>
<td>Physician Assistant(s)</td>
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<td>Licensed Counselor</td>
<td>Nurse(s)</td>
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<td>Licensed Clinical Social Worker</td>
<td>Adult Psychiatrist(s)</td>
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<td>Marriage and Family Therapist</td>
<td>Child and Adolescent Psychiatrist(s)</td>
<td>Child &amp; Adolescent Psychiatrist(s)</td>
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<td>Other Pediatric Health Care Providers (please specify):</td>
<td>Other Pediatric Health Care Providers (please specify):</td>
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<tr>
<td>Other Pediatric Behavioral Health Care Provider (please specify):</td>
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<tr>
<td>Community Nonprofit Organization</td>
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<td>Faith-based Organization</td>
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<td>Federal or State Agency</td>
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<td>Private Practice</td>
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<tr>
<td>Other setting (please specify):</td>
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</tbody>
</table>
What would you like collaborating medical professionals to know about your professional discipline or area of practice?

List the top 3 barriers to communication and collaboration with medical professionals:

1. 
2. 
3. 

List your suggestions for breaking through each of these barriers to increase communication and collaboration with medical professionals:

1. 
2. 
3. 

What are some common terms that are used in your field or practice that are often misunderstood?

Describe any collaborative models you believe to be successful. (Please provide a link if a description of this model is available via the Internet.)

Other suggestions to promote collaboration between medical professionals and behavioral health professionals:
Please note that the list of projects that follow was compiled from a number of sources, including American Academy of Pediatrics (AAP) chapter presidents, vice presidents, executive directors, Pediatrics for the 21st Century symposium presenters, AAP mental health e-mail list participants, AAP Task Force on Mental Health members, AAP Council on Community Pediatrics Rural Health Special Interest Group members, Bright Futures members, and others. The list is not exhaustive.

As this Chapter Action Kit is also available electronically, it will be updated as information changes and/or is provided to us. If you are aware of any collaborative projects that you would like us to consider including in this list, please e-mail us at mentalhealth@aap.org.

**ALABAMA**

**Mental Health Project**

*Statewide - AL*

**Description:** The chapter’s Mental Health Project has evolved into a very active, multidisciplinary, statewide effort to increase the number of children screened and referred for mental health services. Within a short period of time, the Mental Health Project Advisory Committee was formed, and developed a questionnaire to survey primary care clinicians on their attitudes regarding the availability of mental health services for children. The committee also planned and implemented a series of educational dinner meetings that were being held at 4 different regions across the state. The sessions consist of 1-hour presentations by child and adolescent psychiatrists and 1 hour of roundtable discussion between pediatricians and mental health professionals. Attendance at these continuing medical education (CME) dinners has been very good, with more than 250 people attending the first 2 meetings. As a result of the project, many resource tools have been developed, including 4 regional mental health directories and standardized referral/follow-up forms to improve communication between pediatricians and child/adolescent psychiatrists.

**Web Address:** [www.alchapaap.org](http://www.alchapaap.org)

**Contact Name:** Linda Lee, Chapter Executive Director

**Contact Address:** 19 S Jackson St  
Montgomery AL 36104

**Contact E-mail:** llee@aap.net

**Contact Phone:** 334/954-2543
ARIZONA

Indian Health Service Telehealth Program
Flagstaff, AZ

Description:
- Active clinical telehealth experience in Indian Health Service (IHS) and Tribal facilities across the country
- Leading clinical applications are radiology, dermatology, psychiatry, retinal screening, and cardiology
- Experience with over 30 different types of clinical telehealth
- Emerging capability in home telehealth, chronic illness care, telepharmacy, rehabilitative services, eICU®, and other services
- Focuses on business modeling, infrastructure development, and collaborations
- Innovative uses of new media for distance learning and training

The tools of telehealth care can improve access to care and chronic illness care management for patients, families, and communities. Innovation in clinical service delivery also offers opportunities for enhancements in quality and cost efficiency.

Web Address: www.telehealth.ihs.gov
Contact Name: Mark Carroll MD
Contact Address: 1215 N Beaver St, Suite 201
Flagstaff, AZ 86001
Contact E-mail: Mark.Carroll@ihs.gov
Contact Phone: 928/214-3920

Tuba City Indian Medical Center
Tuba City, AZ

Description: In 2000, a pediatrician member of the Medical Staff and Information Technology Department at the Tuba City Indian Medical Center became interested in telemedicine applications in our remote setting in northeast Arizona. The Arizona Telemedicine program through the University of Arizona (U of A) had been established several years earlier and was interested in expanding its network into rural areas.

Because of staff shortages in mental health that disproportionately affected children and adolescents with emotional and behavioral concerns, we worked toward establishing a Telemedicine link with the U of A Department of Child and Adolescent Psychiatry. Our links were set up at both of our local high schools (a public high school and a former Bureau of Indian Affairs high school that is now a charter school but continues to offer boarding to students who come from even more remote settings). In a unique manner, the schools are tele-connected with the hospital via a wireless radio system. The hospital employs a DS3 connection with the Arizona Telemedicine network.

The local high schools were eager to participate in the proposed telemedicine program. After meetings with Parent Advisory groups, counselors, and school administrators, a
A consent form was developed and a standard protocol for student referral was established. Collaborative agreements between the schools and the hospital already existed because of a thriving School-based Health Program sponsored by the Pediatrics, Family Medicine, and Midwifery Departments.

We have been providing in-school telemedicine mental health services on a continual basis for the last 4 school years. The primary provider from University of Arizona is a PhD psychologist, and the Adolescent and Child Psychiatry division director acts as a liaison for more difficult cases or those requiring medication management problems. The Director of Adolescent Health Services oversees all students who do require medication with selective serotonin reuptake inhibitors, but these tend to be the minority of patients seen. We currently provide a total of 6 hours of telepsychiatry per week, a number that is often insufficient to meet need/demand and are exploring other options. The psychologist primarily engages the students in cognitive behavioral therapy. She sees the entire gamut of diagnoses. Our largest area of fallout is student’s who are in need of urgent care. These students get referred to the emergency department at our hospital and are handled by the members of our Mental Health Department at the Tuba City Indian Medical Center.

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CALIFORNIA

Fresno Healthy Steps Pediatrics: Child Development Training
Fresno, CA

Description: Healthy Steps (http://www.healthysteps.org/) is an innovative, evidence-based approach to primary health care for young children that support mothers and fathers in their role as nurturers of the emotional, behavioral, and intellectual growth of their children. Healthy Steps adds a new member to the primary care faculty team, the Healthy Steps Specialist (HSS), an expert in child development. Healthy Steps services to families include enhanced well child care, home visits, a child development telephone information line, developmental and psychosocial screening, written informational materials, parent groups, linkages to community resources, and literacy promotion through Reach Out and Read. We have shown a 26% reduction in severe and harsh punishment with toddlers, a 24% increase in breastfeeding, a 50% increase in reading to babies, and a 34% decrease in premature water and solid food feeding of babies.

Fresno Healthy Steps not only provides services to children from birth to 5 years of age and their families, but also effective training for primary care residents. The HSS teaches residents normal child development through structured experiential and didactic sessions. At the core of the Healthy Steps training the HSS precepts residents with their patients, including both office well child examinations with the focus on normal child
development, as well as joint home visits with high-risk children. Using the *Ages & Stages Questionnaires Child Monitoring System* ([http://www.agesandstages.com/](http://www.agesandstages.com/)), residents provide the highest quality developmental screening while improving their child development skills. Residents have shown significant improvement in practice behaviors and knowledge as measured by a beginning- and end- of-year survey and rate Healthy Steps as #1 among all the developmental and behavioral training experiences.

**Web Address:** [http://www.fresno.ucsf.edu/pediatrics/program_info.htm](http://www.fresno.ucsf.edu/pediatrics/program_info.htm)

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**The Children’s Clinic (TCC), Serving Children and Their Families**  
*Long Beach, CA*

**Description:** The Children’s Clinic (TCC), Serving Children and Their Families, is continuing work to incorporate mental health services into its scope of practice. Community needs assessments and surveys of our patients indicated this is a service that is sorely needed by the population the clinic serves. The Children’s Clinic hired 3 master’s-level social workers to assist in screening for mental illness and referring to community providers; however, there are several barriers that patients face in accessing mental health services, including stigma, lack of insurance, language/cultural barriers, insufficient funding, limited number of mental health professionals with long waiting lists, and lack of communication between health care and mental health professionals. The Children’s Clinic held a meeting with several local mental health professionals to explore these issues and develop collaborative relationships. Memorandums of understanding were developed to facilitate mental health referrals. One agency, Pacific Clinics, volunteered to co-locate therapists on-site at TCC to provide mental health counseling to pediatric patients at a place that is familiar to them and is without stigma. The referral relationships and co-located services allowed patients to access appropriate mental health services. The Children’s Clinic Social Services Manager is participating in various work groups, councils, and coalitions that focus on mental health to ensure that TCC is aware of the local issues in mental health care and to advocate for the needs of TCC’s patient population. This has resulted in a relationship with Los Angeles County Department of Mental Health, which eventually will allow TCC access to county funding streams for the provision of mental health services.
COLORADO

Project CLIMB (Consultation Liaison in Mental Health and Behavior)
Child Health Clinic and The Children’s Hospital
Denver, Colorado

Project CLIMB infuses comprehensive mental health services into a high-volume inner-city primary care residency training clinic and enhances the capacity of primary care clinicians to identify and treat common mental health concerns in children. The intervention involves co-location of mental health clinicians – child psychiatrist (1), child psychologist (1), and trainees including psychiatry fellows, postdoctoral fellows in childhood anxiety and in infant mental health, psychology interns, and psychology graduate students - in the primary care training clinic. CLIMB clinicians are present daily during continuity care clinics and provide on-site services to pediatric providers, children, and their families.

The program includes the following components:

- Healthy Steps for Young Children implementation to enhance developmental services in pediatric primary care settings; delivered during well-child visit.
- Developmental, socio-emotional and postpartum depression screening at well-child checks using validated tools (e.g., Ages and Stages Questionnaire; Edinburgh)
- Resident training using multimedia toolkit, didactics in clinic, noon conference and other venues, and case collaboration.
- Precepting residents and clinical trainees during their continuity care clinics in order to provide consultation and intervention as needed; consultation available from child psychiatry fellows and a psychology intern.
- Direct services for children and their families: psychopharmacology clinics, postpartum depression groups, psycho-educational groups for parents and children, clinic-based individual treatment, liaison to outside mental health services, and outpatient treatment.
- An evaluation component to assess impact of our intervention on family satisfaction and improvement in pediatric resident’s attitude, knowledge, skill, and proficiency in providing basic developmental and mental health services.
• Systems building and integration through consultation, collaboration, and outreach with state and local agencies/partners invested in providing comprehensive care to pediatric populations.

This project is funded by Rose Community Foundation, HealthONE Foundation, and the American Academy of Child and Adolescent Psychiatry.

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**FLORIDA**

**Duval County Community Clinics**
*Jacksonville, FL*

**Description:** This model consists of a pediatric psychiatrist who works in collaboration with pediatricians and pediatric residents in the Duval County Health Department community clinics. The collaboration began in July 2003 with the hiring of a pediatric psychiatrist by the Duval County Health Department and the University of Florida Department of Pediatrics. The purpose of the collaboration is to train pediatricians and pediatric residents in the diagnosis and treatment of behavioral and mental health problems. The pediatric psychiatrist initially spent half a day, every 2 weeks, in 7 community clinics. The collaboration involves the psychiatrist and the pediatrician or resident seeing patients together and discussing diagnosis and treatment. Previously seen patients also might be discussed, as well as any other questions the pediatrician might have relating to mental health problems. The pediatricians were educated about the diagnostic criteria for mental health disorders in childhood and the appropriate interventions for these disorders, including the use of psychotropic medications. The success of this model has been dependent on the pediatricians’ interests in expanding their practices to include mental health problems. After 2 years, the pediatric psychiatrist continues to work in collaboration in 4 of the 7 community clinics and is available for consultation for all pediatricians within this health system. There has been a documented increase in mental health diagnoses in each of the community clinics since implementation of this model. Future plans include an expansion of the training of pediatric residents in mental health, and elaboration of the collaborative model.

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Illinois

Social/Emotional Screening and Referral
*Multiple Cities throughout IL*

**Description:** This project aims to improve the delivery and financing of preventive health and developmental services for children from birth to 3 years of age. The project goals will be reached by offering educational programs, including office-based presentations for primary care clinicians, allied health care professionals, and their office staff. It aims to increase medical professionals’ knowledge of social and emotional development, including the use of screening tools to recognize the early signs of delay and facilitate discussion with families and caregivers on social/emotional health and how this can impact the child’s long-term development. It is also a desire to increase providers’ awareness of community referral resources. By helping to provide health care professionals with a range of strategies they can implement to most effectively provide comprehensive, developmentally oriented health care. The program provides an overview of social/emotional development and teaches how to incorporate screening and referral procedures, for social, emotional and developmental growth into the practice setting. Resource binders are distributed to each practice, along with ideas for how to disseminate the binder’s contents appropriately and efficiently. The content is offered at basic to intermediate levels, in an attempt to reach the knowledge of all staff/faculty of the clinic/practice.

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Children’s Hospital of Illinois at OSF Saint Francis Medical Center
*Peoria, IL*

**Description:** This project addresses the unmet mental health needs of children in central Illinois through the development of a coordinated system of care, which incorporates:

- Routine screening for behavioral/mental health problems into general pediatric practices
- Increased training on the diagnosis and treatment of depression to pediatric primary care clinicians (pediatricians and nurse practitioners)
• Primary care-linked case coordination and educational services for patients and families
• Increased collaborative associations between mental health professionals and pediatricians

The initial focus is on the identification of depression in children and adolescents and piloting academic detail training of the pediatricians and nurse practitioner in a medical school-based primary care practice. Individual case coordination, parent/family education, and psychiatric backup to the pediatric primary care clinicians will be provided by a centralized resource center called Resource Link™, which is supported by community collaborative efforts. The project is funded by a 3-year grant from the Illinois Children’s Healthcare Foundation. The program will secure other funding for long-term sustainability by the third year. Provided the project is successful, the model will expand with regard to the number of patients served, encompassing a more broad age range. Over time, it is probable that the project will expand to address a more broad range of mental health issues. It is anticipated that a 3-year analysis of program and client outcomes will demonstrate the effectiveness of an interdisciplinary, interagency team working collaboratively to reduce the significant community burden from childhood depression.

_Treating Child and Adolescent Depression in Primary Care_

Through this project, the Illinois AAP Chapter and Children’s Hospital of Illinois at OSF Saint Francis Medical Center developed a 90-minute office-based training that covers the screening, diagnosis, and treatment of depression in children and adolescents. The training content is tailored to meet the specific needs of the primary care physician practice. However, in general the following topics are covered:

• Prevalence of depression among children and adolescents
• *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* diagnostic criteria for depression and differentiating depressive symptoms in adults from those in children and adolescents
• Instructions for incorporating depression screening into the primary care practice by utilizing the Center for Epidemiological Studies Depression Scale for Children.
• A review of evidence-based treatments for depression
• An overview of common medications for treating depression in children and adolescents. This includes a discussion of the Food and Drug Administration’s (FDA’s) black box warning and call for close monitoring
• Question-and-answer session during which practice staff may ask questions about specific medications, disorders, or patients

The training is presented onsite at the primary care practice and it is recommended that as many practice staff as possible attend, including physicians, nurse practitioners, nurses, and office staff. This enables the practice to discuss specific staff roles with regard to the screening and treatment of depression. The format is modular so that it can be completed all at once or broken into 3 half-hour modules. At the conclusion of the training, the practice receives a manual that includes current research articles focusing on child and adolescent depression, case vignettes, informational handouts for parents, a guide for billing for depression screening, a list of Web sites for more information about child and adolescent mental health and tools such as a consent to release health and mental health-related information, the CES-DC screening for depression, and a progress
report form to assist with communication between the counseling provider and the physician.

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**IOWA**

**Healthy Mental Development Health Provider Education Initiative**
*Statewide - IA*

**Description:** There are 4 modules (4 hours) for physicians, nurse practitioners, physician assistants, and nurses that include

- Healthy Mental Development of Young Children in Iowa
- Clinical Implementation of Surveillance for Development; Social, Emotional and Behavioral Health; and Family Risk Factors
- Clinical Implementation of Screening in 4 Domains: Development; Social, Emotional and Behavioral Development; PDD/Autism, and Parental Risk Factors
- Developing Community Partnerships for Referral and Systems Development

For department supervisors, nurse and/or office managers, coders and billing personnel there is one module (1 hour) that includes Office Implementation of the Guidelines.

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**KENTUCKY**

**Prevention and Awareness of Teen Hardships and Suicide**
*Statewide - KY*

**Description:** The Prevention and Awareness of Teen Hardships and Suicide (P.A.T.H.S.) grant has been successfully completed. Kentucky Pediatric Society conducted 5 P.A.T.H.S. events in Northern Kentucky, Barren River, Purchase District, and Lake Cumberland. More than 150 child health providers attended the statewide trainings. Nearly 70% report, as a result of this training, that they will apply the knowledge gained in current work situations and share their handouts and other information with colleagues. In addition, more than 80% of participants rated the workshops and programs or presentations; the organizations include the Kentucky School Counselors Association, the Kentucky School Nurses Association, Jefferson
County Public Schools, and representatives from the Kentucky Telehealth Network. In an effort to provide ongoing education to child health providers about the prevention of teen suicide in Kentucky, selected materials created for the P.A.T.H.S. program will be posted on the Kentucky Pediatric Society Web site.

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MAINE

Kennebec Pediatrics: From Infancy to Independence  
Augusta, ME

Description: Children with behavioral and/or learning problems have special needs that require additional help and support. Parents, teachers and care providers have to work through many challenges to help children with special needs achieve success. This program model enables families of children with disruptive behavior disorders to access services and care coordination through the primary care clinicians.

Kennebec Pediatrics Cares Program (KP Cares) provides outreach to families to help them consistently follow through on their treatment plans in school and home settings, reduce crises, and improve school performance and social functioning. KP Cares enhances continuity and quality of care for children with behavior disorders by:

• Creating a primary care team to provide supportive services to the child's family and school  
• Adding the family perspective directly to team deliberations  
• Coordinating more effectively with the child's therapeutic behavioral health support  
• Creating a database that contains key information on patients for the team's ongoing work with the child and family and for evaluation of the program

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MARYLAND

D-TECKT
Baltimore, MD

Description: The D-TECKT (Developmental Troubleshooter’s Eclectic Checklist for Kids and Teens) is a template developed by the Maryland Chapter AAP Committee on Emotional Health. The D-TECKT is designed to assist pediatric clinicians in systematically considering what underlying conditions may be contributing to behavior problems in children and adolescents. The D-TECKT is a checklist that is divided into Intrinsic Factors (biomedical, normal development, temperament, and child psychopathology) and Extrinsic Factors (situational, parenting difficulty, communication problems, family dynamics issues, and parental psychopathology). By referring to the checklist, the clinician can develop a differential diagnosis of what issues are contributing to the presenting behavior problem. The clinician can then develop primary care intervention strategies that directly address the underlying problems. The D-TECKT was published in the August 2005 issue of Contemporary Pediatrics. A working copy of the checklist also can be provided for evaluation. The D-TECKT has been presented at pediatric grand rounds at several medical centers in Baltimore, and has been integrated into the behavioral pediatrics rotation at University of Maryland.

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Mental Health Training for Pediatric Residents
Baltimore, MD

Description: An experiential mental health curriculum is being developed for residents in the Johns Hopkins pediatric residency-training program. Residents will work closely with several licensed mental health professionals in 2 settings: the Harriet Lane Clinic (an urban primary care resident continuity clinic) and a community child and adolescent mental health center. The 2-week experience will occur during the 4-week required community and advocacy rotation in the PL-3 year. The content and format of the 2-week experience is guided by a baseline Web-based needs assessment. The objectives for the experience fall within the 6 core competencies of residency training and include the following:

- To recognize and manage common mental health problems and emergencies in patients and families
• To recognize the impact of psychiatric dysfunction and psychosocial distress on youth and families
• To understand the complex system of care for children and families with mental health problems and become familiar with community-based resources
• To communicate effectively with mental health professionals to facilitate effective referral for the diagnosis and treatment of mental health problems in children and adolescents

The curriculum will include didactic, small group, and one-on-one teaching with participating faculty and staff in the Harriet Lane Clinic and the community mental health center.

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MASSACHUSETTS

Cambridge Health Alliance - Healthy Tomorrows
Cambridge, MA

Description: In 2004, the Cambridge Health Alliance (CHA) began the Healthy Tomorrows project in its pediatric clinics. This collaborative model of practice includes mental health screening using the Pediatric Symptom Checklist (PSC) and co-location of a clinical social worker (LICSW), supervised by a child psychiatrist. To date, more than 2,000 children have been screened and 180 previously unrecognized children have been identified as needing mental health support. Key elements for success include a collaborative management team that represents psychiatry and pediatrics, planning and monitoring the model, adequate reimbursement, and buy-in from practitioners. Funding from the Healthy Tomorrows Partnership for Children helped catalyze the project and provided start-up funding for the LICSW. The multifaceted evaluation examined impediments to progress, changes in the number of identified children, the relationship of PSC score to demographic variables, provider satisfaction, and cost–effectiveness. Key findings include an 80% increase in identification and referral of children with mental health issues and a significant relationship between PSC score and insurance status. The project also has proven to be cost efficient, with the LICSW salary covered by revenue. The numerous benefits of this model include increased access, improved referral processes, and increased provider satisfaction. The model also increased awareness of mental health issues in pediatric practice, decreased stigma for families, and improved communication between pediatrics and psychiatry. We are spreading the model to a second site because it has proven highly sustainable. Additionally, we are incorporating the PSC into the electronic medical record, which will allow spread throughout CHA’s 11 pediatric sites.

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The Massachusetts Child Psychiatry Access Project (MCPAP)
Statewide - MA

The Massachusetts Child Psychiatry Access Project (MCPAP) is aimed at assisting pediatric primary care clinicians to effectively respond to mental health concerns in primary care. Statewide, 6 mental health teams have been developed. Each team includes child psychiatrists, therapists, and a care coordinator, and is led by child psychiatry divisions of academic medical centers, including Baystate Medical Center, Massachusetts General Hospital, McLean Hospital, University of Massachusetts Medical Center, North Shore Medical Center, New England Medical Center, and the Children’s Hospital of Boston. The goal of each team is to have all the pediatric and family physician primary care clinicians in their area who see children or adolescents enrolled in the project. Once enrolled and oriented to the project, primary care clinicians may have access to a number of services for their patients, including telephone consultation, psychiatric/diagnostic evaluation, care coordination to assist in finding available mental health providers, brief psychotherapy, and local educational programming. Funding comes from the Department of Mental Health. The program is open to all children and adolescents regardless of insurance status. Design and administration is under the leadership of Dr. John H. Straus at the Massachusetts Behavioral Health Partnership which is the state Medicaid behavioral health managed care vendor. Child psychiatrists Barry Sarvet and Joe Gold are the program medical directors.

As of the end of August 2007, the MCPAP project has successfully formed teams in all 6 regions of the state, providing mental health support for 92% of the 1.5 million children and adolescents in the population. Satisfaction surveys of PCPs report that, because of MCPAP, they are now able to meet the psychiatric needs of children and adolescents in their practices.

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MINNESOTA

CentraCare Integrative Behavioral HealthCare Initiative
St Cloud, MN

Description:
CentraCare Health System in partnership with BlueCross BlueShield of Minnesota and the Medica Health Foundation has launched an initiative that will integrate behavioral health services and primary care in all of the primary care clinics throughout the health system, including pediatrics, family medicine, obstetrics and gynecology, and internal medicine. The initiative calls for mental health screening at all well visits across the age span, incorporating the use of electronic tablets and Web-based electronic platforms for screening. Each clinic will have a licensed mental health professional to conduct crisis mental health assessments and provide patient education, case management, and consultation on-site. In addition, child and adolescent psychiatrists and adult psychiatrists will provide scheduled consultations to primary care clinicians, and weekly emergency psychiatric appointments will be available for patients who are seen by the primary care clinic-based mental health professional or who are currently being treated by the primary care clinician. Treatment and management protocols are being developed for depression, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), eating disorders, and substance abuse, which will guide the primary care physician in the ongoing management of the condition, such as how often to follow up, what to do at the follow-up appointments, and how to appropriately monitor for safety and treatment effectiveness.

BlueCross BlueShield has agreed to pay for mental health screening, the clinic-based mental health crisis assessments, and physician–to-physician consultation. CentraCare and BlueCross BlueShield have committed to evaluating outcomes and cost over the next 3 years. Other health plans are being approached to support the integrative model as well. The state of Minnesota has passed legislation that calls for psychiatrists to primary care physician consultation to be reimbursed for Medicaid patients. Efforts are underway in the state to expand this reimbursement for all health plans as well.

The CentraCare Integrative Behavioral HealthCare Initiative is a model that has evolved from 3 specific efforts by St Cloud Hospital and CentraCare Clinics to improve access to children's mental health care and the quality of the mental health care received. These past efforts have included co-location of child and adolescent psychiatry and primary care pediatrics with ongoing open access for informal consultation; a school-based integrative care model and outreach effort that has involved a school-based mental health professional conducting crisis triage mental health assessments and referring high-acuity students to emergency child psychiatric appointments; and, finally, multiple community and professional education efforts to provide opportunities to increase awareness and practical clinical understanding of diagnosis, treatment, and management of common children's mental health problems. These initial efforts have shown that children attending school and receiving care in the areas with access to these services had a reduced utilization of high-cost inpatient adolescent psychiatric hospitalizations and, ultimately, had access to care much faster.

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NEW YORK

Comprehensive Family Care Center
Bronx, NY

Description: In a federally qualified community health center in the Bronx, two programs have been implemented to address the mental health and well being of families and young children: a screening and consultation program and a Healthy Steps for Young Children program.

The first program, implemented in March 2005, consists of the co-location of an infant/toddler psychologist (24 hours weekly) within a pediatric practice to address the social-emotional and developmental needs of children from birth to 3 years of age via screening, consultation, and direct service. The model was implemented with funds provided by the New York City Department of Health and Mental Hygiene, through a city council initiative, and is a collaborative between the Children’s Hospital at Montefiore and the Children’s Evaluation and Rehabilitation Center of the Albert Einstein College of Medicine.

The program has been remarkably successful, as more than 1,600 infants and toddlers have been screened using the Ages and Stages Questionnaires: Social-Emotional (ASQ:SE). Seventeen percent of these children received a score at or above the clinical cutoff. In addition, 9% of children had concerns mentioned on a subclinical ASQ:SE, and an additional 17% were referred by a pediatric provider. Of the total children indicated, 33% were seen for an extended evaluation and/or ongoing therapy, and 26% were referred to another service, such as Early Intervention. Additionally, education regarding infant brain development within a relationship context, postpartum depression, and attachment theory has been delivered to 14 attending physicians, 60 pediatric residents, and 25 fourth-year medical students.

The program is undergoing evaluation, including a process evaluation, a clinical qualitative review, and a quantitative analysis of screener scores across time related to intervention. Chi-square tests revealed that the ASQ:SE may be a particularly sensitive tool for the early identification of language delays/learning problems and regulatory issues in children aged 6 to 36 months, and of behavior problems in general in older toddlers (ages 24-36 months).

Key factors to our success have been the focus on prevention and early detection and the cooperation and support of all providers, including nursing staff. The program will be sustained and expanded pending renewal of funding, and has helped to generate funding for a newly established Healthy Steps program at the practice.

Healthy Steps for Young Children has been implemented at CFCC since September 2006, with two Healthy Steps Specialists (a doctoral level psychologist and a licensed social worker with postgraduate training in infant-parent psychotherapy) caring for more than 100 first-time parents. Healthy Steps families receive home visits and co-managed office visits, children are screened for social emotional, cognitive, language, and motor development (including a specific screening for autism), and parents are screened for mental health problems, domestic violence, parental stress, attachment to their infant,
and harsh disciplinary measures, and families are invited to participate in support groups. 2nd-year residents receive training by the Healthy Steps Specialists during their Developmental Behavioral Pediatrics rotation. There is a control group located at another clinic, and an extensive research component to this program.

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New York City Metropolitan Pediatric Clinics – Integrated Mental Health Primary Care Program
New York City, NY

Description: The Integrated Mental Health-Primary Care Program (IMP) is a unique collaboration between the Columbia University Departments of Pediatrics and Pediatric Psychiatry and the Ambulatory Care Network at Morgan Stanley Children’s Hospital of New York Presbyterian. Since 2002, psychiatrists and psychologists have practiced in 5 community-based general pediatric clinics in a Hispanic community in Northern Manhattan, working collaboratively with primary care clinicians. This novel treatment system offers psychiatric evaluation and short-term treatment services in the medical home setting. Seventy-two percent of IMP staff are Latino and Spanish speaking, with all staff trained in cultural sensitivity. Patients are seen on site, immediately, reducing parental anxiety, reducing the need for emergency department/crisis service/outside referrals, and simultaneously contributing to pediatrician education, based on patients the pediatrician has referred. Communication between mental health staff and pediatricians is immediate and brief, tailored to busy pediatric clinical schedules. Pediatricians have access to an electronic medical record to track psychiatric treatment. A 2004 survey of IMP-served primary care practices revealed that 86% of primary care physicians reported improved access to psychiatric services, with 88% reporting referring to IMP, and 91% reporting that the referral was helpful. Ninety percent of physicians said patients reported being satisfied or very satisfied with the IMP referral, and 95% of primary care clinicians reported being satisfied or very satisfied with the IMP program. A wide variety of diagnoses have been treated, with 40% of children having ADHD. The program is supported by Medicaid revenues to the hospital clinic and will be sustained.

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Starlight Pediatrics, Monroe County Health Department  
(dedicated to the health of children and adolescents in foster care)  
Monroe County, NY

Description: Starlight Pediatrics is a primary care pediatric practice located at the health department, and serves as the medical home for children and teens in foster care. In addition to all routine and acute pediatric services, Starlight Pediatrics serves as the health care coordinator for this population. Customers include children and teens, their foster and birth parents, caseworkers, legal professionals, courts, and other health providers. Because the office is under county management, there are minimal communication barriers among health and casework staff. Systems to share information with casework, legal, and mental health professionals have matured over time. Through collaboration with several mental health agencies, Starlight Pediatrics is able to provide contextual evaluations in either the foster home and/or child care setting for children up to age 6 years, as well as intake mental health evaluations through a single mental health site for older children and adolescents.

Starlight Pediatrics, in collaboration with the behavioral health program at the University of Rochester, is embarking on routine mental health screening of all children older than 7 years at admission to foster care. In addition, Starlight Pediatrics will re-screen children who remain in foster care every 6 months. The collaboration with the University of Rochester benefits patients of Starlight Pediatrics through timelier access to mental health services. The feasibility, acceptance, and impact of periodic mental health screening of this high-risk population in the medical home setting will be evaluated.

A developmental pediatrician from the local University performs some on-site developmental evaluations. Starlight also is involved as a clinical site for nurse practitioner and resident education.

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NORTH CAROLINA

Aegis Winston East Pediatrics  
Winston-Salem, NC

Description: Our model of co-located care was developed with the “out-stationing” of a mental health provider into an urban pediatric practice with a high volume of Medicaid-enrolled patients. The mental health professional was an employee of the local community mental health center and provided consultations, therapy, and case

5-65
management to the practice. This structural arrangement allowed the pediatricians easy
access to psychiatry consultations through the mental health agency. The mental health
agency was responsible for all billing and record keeping. The model was implemented
with funding from the Duke Endowment. The community mental health center
reimbursed the grant with patient fee collections. Monthly reports with expenses and
collectibles suggested that the model was self-sustaining. Benefits of the model included
increased comfort by medical providers to address their patients’ mental health issues,
convenience to the patient and family, immediacy of services, decreased stigma and
increased comfort for patients seen for mental health services in their pediatrician’s
office, increased follow-through by patients for recommended mental health services,
and regular communication between the MH provider and primary care clinicians.
Difficulties with the model included significant paperwork required by the mental health
system to open a case on a child with Medicaid. Satisfaction with services was rated
high by the pediatricians (5/5). Keys to success included “buy-in” by the medical
providers and a committed practice manager.

This model has the potential to be replicated and sustained elsewhere by community
mental health agencies, if the population served is insured and if reimbursements are
sufficient to cover expenses. The model at Aegis Winston East Pediatrics was
transitioned to a new configuration after state mental health reforms resulted in failure
of the mental health agency; since January 2006, Wake Forest University Health Sciences
(WFUHS), the regional academic medical center, has employed the co-located mental
health professional. Paper work was simplified. Satisfaction of pediatricians remains
high, and, as of February 2007, reimbursements are approaching a level consistent with
sustainability. A WFUHS psychiatrist funded by a grant provides on-site consultation
during a half-day session every other week and periodic “lunch-and-learn” sessions for
the pediatricians.

Web Address:
http://www.bqsm.edu/Aegis/pages/locphys/winstoneast/weastpeds.htm
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Guilford Child Health, Inc.
Greensboro, NC

Description: Guilford Child Health, Inc (GCH), was established in 1997 to provide
primary and specialty health care services for underserved children. Motivated by the
goal of providing the highest quality, comprehensive, family-centered pediatric care
available, all staff members at GCH believe in caring for the “whole” child. By providing
health care services for a child’s medical, social, and emotional needs, GCH works to
ensure that each child is developmentally prepared at home, at school, and in the
community.
Guilford Child Health serves as a pilot for Mental Integration in Primary Care. This pilot involves the use of a mental health collaborative team—4 licensed clinical social workers, 2 developmental and behavioral pediatricians, 1 co-located child psychologist, 1 contracted child and adolescent psychiatrist, and primary care clinicians GCH provides child and adolescent psychotherapy. The psychiatrist sees referrals but also has case-review sessions with the primary care clinician regarding the care of the primary care clinician’s patients. In addition, psychiatric evaluation and counseling is offered on site. Screening and treatment of maternal depression is also provided. Through a team approach, there is collaboration and treatment coordination for both primary and mental health care. The Developmental and Behavioral, Mental Health Team of providers meets weekly to review referrals and coordinate services.

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**Sustaining Psychosocial Screening in Everyday Practice Flow**

*Durham, NC*

**Description:** The Healthy Development Collaborative used breakthrough series methodology to engage families and health care providers to improve developmental outcomes of children birth to age 5 through improved office systems in the following areas: (1) eliciting parents' experiences communicating with their child’s health care provider regarding family issues (eg, depression) and (2) identifying and referring children at risk of poor developmental outcomes through routine structured psychosocial screening.

At the end of the 12-month collaborative, the following key factors were identified as important to successful implementation: (1) a desire in the practice team to make real changes in the way health care is provided to children and families; (2) determining which issues the practice wishes to focus on, which screens best fit the practice’s needs, and identifying a screening schedule; and (3) collecting data that enable practices to measure the impact of changes and adjust efforts accordingly.

Supplemental funding supported measurement and learning session participation. However, practices completed all data collection without additional resources. An evaluation with a control group was completed; analysis is forthcoming. A lack of regular, systematic screening for family psychosocial problems was identified through chart audits and parent feedback at project start-up. Using the breakthrough series collaborative model, participating practices worked toward implementing and sustaining psychosocial screening in everyday practice flow. Preliminary findings show 60% of families received psychosocial screening. Participating practices indicated through exit interview plans to sustain changes past their participation in the collaborative. One practice indicated that “the collaborative provided the motivation to implement psychosocial screening.” A proposal has been submitted to replicate this model.
NC Chapter AAP/NC Pediatric Society  
**Raleigh, NC**

**Description:** The North Carolina Chapter engages in a statewide initiative known as ICARE. This is an acronym for integrated, collaborative, accessible, responsive, evidence-based—a model that we are using to integrate mental health and primary care, which includes training events and resource networking among a variety of organizations. The Web site lists multiple training opportunities of which the North Carolina Chapter is a contributor and supporter. ICARE has grant support from private philanthropy and pharmaceutical companies and is housed in a private nonprofit foundation affiliated with state government.

In addition, the North Carolina Chapter is connected to the southeastern North Carolina’s Southern Regional Area Health Education Center’s Evidence-Based Practices Center, located at [www.ncebpcenter.org](http://www.ncebpcenter.org). This site is dedicated to support evidence-based mental health practices, treatments, and interventions. The site includes information on the following modalities: assertive community treatment, supported employment, family psycho-education, wellness (illness) management and recovery, and integrated dual disorder treatment.

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**OHIO**

**Healthy Connections for Families – Family Care Center**  
**Toledo, OH**

**Description:** Since 1997, Healthy Connections has been providing mental health services to children through pediatric Services in St Vincent Mercy Family Care Center and the Medical University of Ohio. By using a collaborative approach, primary care clinicians receive training and resources to identify and refer children with behavioral health problems to the mental health professionals located within the same facility. Providing all of the services within the medical home facilitates access and utilization for the families. A case manager is available to support the family, reduce barriers to
service, and facilitate communication among physicians, families, and behavioral health care providers. Families have a strong rapport with their primary care clinician and are open to behavioral health treatment connected to their primary health care, reducing the stigma of mental health. Healthy Connections has used grants to implement this model of integration, such as Mercy Children’s Hospital Foundation, Ohio Hospital Association Foundation for Healthy Communities, Healthy Tomorrows Partnership for Children, and Administration for Children & Families (ACF) Integrated Mental Health Services. Outcomes are measured through length of time from referral to first appointment; show rates, patient satisfaction, and the Ohio Outcomes System. Among the benefits of this model are a collaborative and cohesive approach to mental health care for families, an increase in access and use of mental health services, and higher satisfaction. Healthy Connections will continue to submit grants at the local, state, and federal level and obtain state certification to expand services to other pediatric services.

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SOUTH CAROLINA

Beaufort Pediatrics, PA
Beaufort, SC

Description: Beaufort Pediatrics is an 8-provider single-specialty practice located on the coast of South Carolina. The practice handles approximately 60% Medicaid patients, and sees large numbers of Caucasian, African American and Hispanic Patients. Because of a lack of mental health professionals in the community, the practice has hired its own mental health professional to provide on-site counseling. Providing mental health services within the pediatric office is well accepted by patients, many of whom would feel stigmatized going to a mental health center. This arrangement also facilitates consultation between the pediatric staff and the mental health professional, including the use of a joint medical record. Beaufort Pediatrics has rural health clinic status, which enables the practice to receive a more favorable reimbursement rate from Medicaid for those clients. The practice provides free office space and allows the mental health professional to keep 100% of his collections to make his practice financially feasible.

Over the past 15 years, Beaufort Pediatrics has developed a comprehensive screening program to identify those families most at risk for poor mental health and developmental outcomes early in the child's life. The practice now screens for maternal depression, family substance abuse, domestic violence, socioeconomic distress, community connectedness, and developmental status, using a variety of instruments. The practice uses a professional social worker to help refer those families identified as at risk on screening to home-based parenting support and other services within the community. Beaufort Pediatrics believes that, to be successful, satisfactory mental health services must include a preventive and screening component.
SOUTH DAKOTA

Caring for the Whole Child Program
Statewide - SD

Description: Through its Caring for the Whole Child program, the South Dakota Chapter intends to make developing emotionally healthy children a top priority for the state. The Children’s Mental Health Awareness Initiative Advisory Group was established and the group along with input from the South Dakota Voices Coalition for Children, prepared the document, *Children’s Mental Health Awareness, Multi-Year Plan for South Dakota*. The document outlines the following 2 goals:

- Increase community understanding of strategies and resources to help develop emotionally healthy children
- Increase community recognition of
  - Efficacy of early detection, intervention, and treatment of mental illness
  - Emotional and developmental precursors of mental illness in children
  - Where to go for help

In each goal, health care providers are considered 1 of the 4 target audiences. The chapter president plans to visit every pediatric practice in the state and include those interested family practitioners to inform them about the 2 goals. The intent is to survey them about their understanding of community strategies and resources available related to detection, intervention, and treatment of children’s mental health illnesses. The project includes education by providing 2 valuable AAP resources—*Bright Futures in Practice, Mental Health Volume I and II* and *The Classification of Child and Adolescent Mental Diagnosis in Primary Care (DSM-PC Child and Adolescent version)*.

Texas

Hogg Foundation for Mental Health: Integrated Health Care Initiative Grant Program
Houston/El Paso, TX
**Description:** In April 2006, the Hogg Foundation for Mental Health, an administrative unit of The University of Texas at Austin, launched its Integrated Health Care Initiative grant program. The 5-grantee organizations will receive more than $2.6 million over 3 years to promote the effective identification and treatment of mental health problems in primary care settings.

The grantees treat mental health problems in different age groups. Three of the 5 organizations provide treatment for children. One focuses exclusively on ADHD, and the other 2 treat a variety of mild to moderate disorders.

The 5 organizations funded through this initiative adopt the collaborative care model and address the implementation barriers they encounter. Adapted from Wagner’s Chronic Care Model, collaborative care is an integrated health care approach in which primary care and mental health professionals’ partner to manage the treatment of persons with mental health problems in the primary care or pediatric setting. Two decades of research have demonstrated that the collaborative care model improves primary care patients’ mental health outcomes with a minimal investment of resources.

For more than 65 years, the Hogg Foundation has accomplished its mandate through grant making to mental health services, research, policy, and public education projects in the state of Texas.

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**Texas Adolescent Mental Health in Primary Care Initiative**  
*San Antonio/Longview/El Paso/Gonzales, TX*

**Description:** The purpose of the Texas Adolescent Mental Health in Primary Care Initiative (TAMHPCI) is to improve the health of adolescents in the state of Texas by engaging private and public partnerships and creating sustainable system changes. This collaborative project involves 8 academic health centers, 6 professional organizations/associations, 2 patient advocacy organizations, and 3 state governmental agencies. This initiative is aligned with the goals of the President's New Freedom Commission on Mental Health, the Institute of Medicine, the Substance Abuse and Mental Health Service's Federal Action Agenda, and the fundamental transformation of the Nation's mental health system. The TAMHPCI implementation sites include the Brooke Army Medical Center (a pediatric military clinic), the Community Health Center of South Central Texas, Inc (a Federally Qualified Health Center [FQHC]), the Longview Wellness Center (a FQHC look-a-like), the Texas Tech University Health Sciences Center (TTUHSC) Fabens Clinic (a border school-based clinic), and the TTUHSC Family Practice Center (an academic family practice clinic). Unlike other projects that
have examined either 1 or 2 disorders, the TAMHPCI includes a broad spectrum of psychosocial health, suicide ideation, depression, ADHD, and at-risk drinking, that present among adolescents in primary care settings, using a standardized protocol, while allowing for some variation across local delivery systems to achieve generalizability to real-world clinical settings.

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UNIFORMED SERVICES WEST

Military Youth Coping With Separation: When Family Members Deploy
San Antonio, TX, and multiple military bases nationally and internationally

Description: The teen support video, Youth Coping with Separation: When Family Members Deploy, has been finished and is being distributed. The Department of Defense has considered rapid deployment of the video through its online distribution channels. This would be an initial wave of release that hopefully will peak interest in the subject and provide a tangible resource to youth, families, and youth serving professionals as we continue to work on a more comprehensive distribution plan that will include the ability to make hard-copy packages of the DVD program (video, facilitator guide, interactive military youth stress management plan, and other resources) available through outlets such as Military One Source. The next phase of the teen support project will focus on development of an interactive multimedia form of the currently available military youth stress-management plan and an enhancement to the video that includes parent- and youth-serving professional video perspectives. The other exciting news is that the new Mr. Po and Friends is also nearing its final stages of development. The script has been modified and the story will now be animated rather than a puppet show for the elementary-age demographic. A sneak preview of the new Mr. Po and Friends animated video is available at http://www.rexraygun.com/freelance/decypher/scene1.htm. The new target for completion of the elementary product is May 2007. The possibility of using the teen and elementary video programs as a basis for the Youth component of the Battlemind Program being developed by the Army is being pursued. Battlemind is a psycho-educational program that helps soldiers and their families anticipate, understand, healthfully cope with, and find resources to address the stresses that are associated with the various stages of deployment.

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UTAH

University Health Care Neurobehavior Healthy Outcomes Medical Excellence Program
Salt Lake City, UT

Description: The Neurobehavior Healthy Outcomes Medical Excellence (HOME) Program is a University of Utah-based, co-located specialty clinic. It began in July 2000 as part of the Medicaid Redesign Project with the Utah State Department of Health, sponsored by the Robert Wood Johnson Foundation Center for Health Care Strategies. The program receives the blended Medicaid medical and mental health funding streams to provide comprehensive health care to individuals with developmental disabilities. The interdisciplinary focus of this program is to provide care in an integrated, collaborative, cost-effective manner to a generally underserved population who often receive fragmented specialty care. Our clinicians have training and experience in working with the complex medical and mental health concerns often presented by patients with traumatic brain injury, epilepsy, genetic syndromes, birth trauma, autism spectrum disorders, and mental retardation.

Services are provided by 2 triple-board physicians (in Pediatrics, Adult Psychiatry, and Child and Adolescent Psychiatry), a Child and Adolescent psychiatrist, a family practice physician, 2 advance practice nurses, 4 clinical social workers, 2 clinic case managers, 4 state-employed case managers, a behavior specialist, a billing/coding specialist, 2 medical assistants, and administrative support staff. Services include the following:

- Primary and preventive medical care
- Psychiatric care
- Coordination of care with university-affiliated specialty care, such as neurology, genetics, physical medicine and rehabilitation, orthopedics, and pulmonology
- Case management and triage of crises
- Individual and family psychotherapy and group psychotherapy
- Functional behavior analysis and supports
- Autism Diagnostic Testing
- Dietitian/Nutritional counseling
- School accommodations advocacy
- Home visits to assess habilitative needs
- Electronic medical records
- Coordination of insurance benefits
- State disability services advocacy
- Community outreach
- Research
- Education and training for residents in psychiatry, family practice, dentistry, social work, and psychology, and nurse practitioner and physician assistant students
- Telemedicine
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VERMONT

Hagan and Rinehart Pediatricians, PLLC
Burlington, VT
Description:
Our small primary care practice of 2 pediatricians, 2 pediatric nurse practitioners, and an excellent support staff employs 2 innovations to enhance our behavioral health care:

- Case management services for children and youth with special health care needs
  - Medical home model of care coordination with care plans, family-centered team collaboratives, and an extensive community resource network
- Collaborative practice with clinical psychologists
  - Clinical psychologist and post-doctoral fellow are on site part-time to see patients on referral, collaborate with pediatric staff on shared cases, and provide behavioral telephone callback for families

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Upper Valley Pediatrics
Bradford, VT
Description: What began as a Community Access To Child Health grant to a solo pediatrician in 1994 has resulted in a practice with 1 pediatrician, 5 part-time nurse practitioners, and 7 full- and part-time mental health therapists and social workers. The nurse practitioners help with the "nuts and bolts" pediatrics (ie, well child checks and acute episodic illnesses). This allows the pediatrician time to concentrate on children with the behavioral, emotional, and learning problems. The licensed clinical social workers and mental health counselors help to deliver direct psychotherapeutic services to patients at the practice site. These personnel are able to be credentialed by third-party insurers, and the practice has been able to obtain reimbursement such that the practice has actually profited financially. Upper Valley Pediatrics is a practice much better able to respond to patients' "new morbidities," and the extensive use of mental health professionals has allowed us to be financially successful as well. We feel that our collaborative, co-location model is superior because of the following:

5-74
• Collaboration between physician and therapist, especially in managing children on psychotropic medication
• Better continuity and quality of psychotherapy than at Community Mental Health Center, where the therapists are generally entry-level employees who leave as soon as they gain credentials and experience
• Less stigma receiving mental health services at pediatric office
• Lower costs to state Medicaid, as we are reimbursed at a lower rate than services delivered at Community Mental Health Center

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WASHINGTON

High Point Medical Center, Puget Sound Neighborhood Health Centers
Seattle, WA

Description: Behavioral health integration was achieved by hiring a behavioral health specialist (BHS) and training primary care physicians, nurses, and other appropriate staff in a community health center to provide integrated care. Training included scope of BHS practice, referral sources, assessment, engagement, negotiation of collaborative care, and triage. This model led to an 80% adherence to the treatment plan. Key factors to success include champions on the clinical team, a children’s integrated preventive model in place, limited wait time for a behavioral health appointment, the convenience and cohesion of on-site care that minimizes obstacles to change and provides a less-fragmented experience for patients, and collaboration between professionals that provides better patient support and facilitates a consistent message from all providers. This allows patients to focus on step-by-step problem solving and achieve small changes on a regular basis, which leads to the maintenance of change over time. Benefits include substantial increases in the goals of assessment of mental health problems and promotion of healthy mental development for children and families at the clinic. A on-site BHS creates an additional resource on the provider team for mental health concerns. Providers are better able to focus on non-mental health medical and dental concerns. The BHS builds immediate relationships with patients so they are not necessarily required to go outside the clinic to address mental health issues. This increases the likelihood that patients will follow through with attending therapy meetings. The clinic is already sustaining the model and the Kids Get Care program has plans to replicate it.

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WISCONSIN

Office Management of Pediatric Mental Health: Promoting Resiliency in Trying Times
Sheboygan, WI

Description: This comprehensive, 1.5-day CME course, sponsored by the AAP Wisconsin Chapter, an array of experts who gave didactic presentations as well as a case study workshop, all applying directly to pediatric primary care practices. Topics covered:

- Learning Disabilities—Practical Aspects of Screening and Helping Families With LD Children
- Depression: Overview of Trends, Diagnosis, and Treatment Options
- Practical Management of Outpatients With Eating Disorders
- Brief Office-based Interventions for Behavioral Problems and Conflict
- Maximizing Reimbursement for Provision of Mental Health Care
- Assessment and Treatment Planning on Aggressive, Bipolar, Oppositional, and Conduct Disorders
- Use of Screening Tools for Behavioral and Mental Health Disorders
- Case Studies Panel
- Autism: WI Prevalence Data and Current Thoughts on Medication Management
- Balancing a Professional Career: Minimizing Burnout for Ourselves and Our Staff

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MULTIPLE SITES

Federal Program to Promote Models of Integrated Health Care
New York, Montana, Tennessee, Massachusetts, and Ohio

Description: On the basis of its recognition of the importance of mental health to children’s overall health and well-being, the limited access that young people have to mental health services relative to primary care services, and its documentation of the paucity of models that address these issues, the Maternal and Child Health Bureau has supported the 2-phase initiative, “Integrated Health and Behavioral Health Care for Children, Adolescents, and Their Families,” since 2000. It has competitively awarded 23 two-year planning grants across 3 cohorts and, thus far, 6 three-year implementation grants to health care organizations to develop community-responsive model systems of care that integrate physical and mental health care and substance abuse services.
Models are required to address such dimensions as governance, multidisciplinary staff configuration and interactions, financing, legal and regulatory issues, managed care environment, education and training, information systems, medical records and community involvement, and sustainability. The 6 implementation sites are in New York (2 sites), Montana, Tennessee, Massachusetts, and Ohio, and include an urban ambulatory care center; 11 family medicine practices affiliated with a not-for-profit county-wide health care system; and a health care system that provides services in a family practice, a pediatric practice, and a community health center. Each site serves patients with a mix of private and public health insurance and screens patients using standardized forms that were developed for use in primary care settings. In general, behavioral health clinicians meet identified families in the primary care site and perform further assessment. A national evaluation has been conducted, showing promising results.

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health plan policies fostering co-location and other forms of collaboration in the care of children with mild to moderate mental illness

strategies for system change in children’s mental health: a chapter action kit

Authorization/Access

- Patient can access outpatient mental health services without referral authorization.
- Primary care clinician can refer/authorize outpatient mental health services for their patients.
- Authorization of psychiatric care, when required, can be readily obtained via phone/fax/Internet.
- A generous number of outpatient visits is allowed (eg, up to 26 per year).
- A sufficient number of outpatient visits without a specific diagnosis is allowed (eg, 6 visits).
- Primary care clinician has access to list and contact information for credentialed (empanelled) mental health professionals.
- Mental health professional lists include notations of their qualifications for the care of children and adolescents.
- Plan surveys prescription claims for multiple providers of psychopharmacology.
- Insurer clarifies coding specifications (see matrix from North Carolina, page).

Payment

- Pediatricians are identified as appropriate primary care clinicians for mental health services in all plans.
- Primary care clinicians are paid for delivering outpatient mental health services.
- A mental health professional employed by a primary care clinician can be reimbursed for services using the primary care physician clinician code; this is termed “incident to.”
- A mental health professional employed by a clinician can bill in his own name.
- Independently credentialed mental health professionals can bill medical insurers directly (eg, they are not required to be employed by or bill through a mental health management entity).
- Primary care clinicians are paid for mental health case management services (non–face-to-face elements of care/follow-up, such as family or teacher conferences, telephone consultations, etc).
- Independent mental health professionals are paid for mental health case management.
- Mental health professionals employed by a primary care clinician are paid for mental health case management.
- Psychiatrists are reimbursed for specific patient’s consultation with primary care clinician or non-medical mental health professionals (eg, with patient not present).
The primary care clinician is reimbursed for consultation with a mental health professional. Co-payment rates are the same as those for physical health care. Public insurance payment rates at least equal to Medicare. Primary care clinicians can bill under mental health diagnostic codes. Primary care clinicians with specialty training in mental/behavior health are recognized as specialists. Primary care clinicians are reimbursed for mental health screening. Primary care clinicians are reimbursed for initial visit(s), prior to determining diagnosis. Mental health benefits include a certain number of mental health visits authorized by the primary care clinician (eg, unmanaged by the mental health management entity).

Communication

- Performance standards stipulate that mental health professionals communicate with primary care clinicians.
- Process is in place through which a primary care clinician referral expedites a patient’s intake for outpatient mental health services.
- Mental health professionals are given incentives to collaborate with primary care clinicians.
- Primary care clinicians have access to a directory of the plan’s mental health professionals who have pediatric expertise and experience.
- A “case manager” is designated who will ensure continuation and coordination of care.
- The plan has communication standards for mental health professionals; specifically, routine request for child/parent consent to exchange information with primary care clinician; routine written or verbal update to primary care clinician, especially in relation to medications.
- Primary care clinicians are notified regarding mental health visit to the emergency department, mental health hospitalization, and residential placement, and discharge plans for each.
Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models

Jane Williams, PhD
Steven E. Shore, MSW
Jane Meschan Foy, MD

Summary: The pressing need for identification and treatment of behavioral health disorders in primary care has renewed interest in the concept of co-located models of care. The purpose of this article is to describe three North Carolina practice models in which mental health professionals are co-located with pediatric primary care providers. Each of the models was sustainable, partly due to systemic changes brought about by advocacy efforts. In addition to providing practical guidance for possible replication in primary care, this article reflects on how advocacy efforts can impact the success of co-location models. Clin Pediatr. 2006;45:537-543

Introduction

North Carolina pediatricians have experienced many barriers to serving children with mental health (MH) disorders. In an effort to address these problems, the North Carolina (NC) Chapter of the American Academy of Pediatrics (AAP) formed a task force consisting of community and academic pediatricians and representatives of MH provider and advocacy organizations to articulate their mutual concerns with the leaders of NC’s Medicaid program.

Outcomes of that process included a number of changes in NC’s Medicaid policy: direct enrollment of independent MH providers into Medicaid; up to 26 unmanaged MH visits annually per child (6 without a diagnosis), billable by either the primary care provider (PCP) or a MH professional authorized by either the PCP or the area’s public MH authority; and changes in “incident to” rules to permit a PCP to bill for the services of employed MH professionals. An increase in overall Medicaid rates, currently indexed to 95% of Medicare, and 12-month continuous enrollment of children after eligibility determination were also achieved during this period as a result of parallel efforts by other advocates.

These Medicaid changes were intended not only to give greater choice of MH providers for children enrolled in Medicaid, but also to increase collaboration between PCPs and MH providers in the care of mutual patients. Of particular interest to the North Carolina AAP task force was fostering co-location of PCPs with MH professionals. Co-located practices have been found to decrease the use of general health care services by “overserviced and underserved” patients (i.e., chil-
dren with unidentified and untreated MH morbidities and high utilization of medical services for somatic complaints); for these children, a co-location model has resulted in improved outcomes and reduced costs.4-6 When an MH professional is available, the PCP is less reluctant to explore psychosocial issues that might result in a MH referral; families experience less stigma associated with seeking MH care; communication between providers is enhanced; and cross-fertilization of skills and knowledge between disciplines is increased.7

There is a variety of structural and organizational models for co-located care: the PCP may hire staff to provide MH services on site or may provide space in which an independent MH practitioner or an employee of another organization provides MH services on site.8 Co-location models have been viable in large healthcare maintenance organizations and often provide a wide range of medical and MH specialty services. However, in small private primary care practices, co-location has been more fragile due to financial and structural barriers. Grant funds have often been used to support the initial development of co-location arrangements. Unfortunately, the end of the external funding period has often resulted in termination of the model, even though healthcare providers and families have been satisfied with the additional services.8

In reviewing models in North Carolina, the authors found a long-standing pediatric practice in which a co-located group of MH providers has sustained itself through reimbursements from private insurers; however, they have not served the approximately 50% of Medicaid-enrolled children in the practice because, for many years, only public clinics could provide MH services to Medicaid beneficiaries.

The recent changes in North Carolina Medicaid offer the opportunity for co-located practices to serve a mix of Medicaid and privately insured children. This article describes three NC co-location models that serve both privately insured and Medicaid-enrolled children.

Methods

Descriptions of the three models were obtained by a standardized interview with physicians, MH providers, and business managers in each of the practices. Each description focuses on operational arrangements, clinical responsibilities, and professional acceptance and satisfaction.

Model 1: Employee of Community MH Center Out-Stationed in a Private Pediatric Practice

Operational Arrangements

The first model was the “out-stationing” of a MH provider employed by a community MH center into an urban pediatric practice owned by a hospital network (Table 1). The model was initiated with grant support from the Duke Endowment and was a collaboration of the Northwest Area Health Education Center, medical center pediatric faculty, and the community MH center.

Expenses for the co-location model included salary for the MH provider and a laptop computer. Office space was provided “in-kind” by the practice. Office staff time was required for some administrative tasks; however, this cost was offset by decreasing time demands on one nurse who previously made all MH referrals.

All billing for services in this model was completed by the community MH center. Initially, grant funds covered the MH provider’s salary and benefits, malpractice insurance, and administrative overhead. As the project progressed, billing was initiated to determine sustainability of the MH provider. MH services were offered only to patients enrolled in the pediatric practice.

Billed services provided enough revenue to pay the salary and benefits for the MH professional based on the hours spent in the co-location model and Medicaid reimbursement indexed to 95% of Medicare. The remainder of salary was generated through the MH provider’s working in the community mental health center and another co-located clinic. At this point, the model was sustainable.

Clinical Responsibilities

Responsibilities of the medical providers included time for initial meetings concerning implementation of the project, completion of satisfaction surveys, and any written input concerning needed changes in MH services. Ongoing clinical responsibilities involved informal consultations and/or formal referrals to the MH provider. Medical providers read and signed all notes made by the MH professional in the patient’s medical record. The office manager assisted with interviews for the prospective MH provider and coordinated clinical and office staff activities. Office staff registered patients and assisted with scheduling.

The model employed a licensed clinical social worker, as the pediatric practice required a MH provider with both treatment skills and knowledge of social resources in the community. Services offered included informal
Co-location of Mental Health Professionals

Consultations between the physician and MH provider, diagnostic interviews, individual and family therapy, and case management. Case management involved referral to other community programs as well as frequent school contacts for children with attention deficit hyperactivity disorder (ADHD) and/or learning disabilities. In addition to making notes in the medical record, the licensed clinical social worker (LCSW) maintained a separate MH record on any child who had paperwork completed for an open case with the community MH center.

Medication consults with psychiatrists were provided directly through the community MH center and facilitated by the co-located MH provider. Patients with medication needs were directly scheduled for the psychiatrist at the MH center without having an additional intake interview.

Outcome Findings

Based on information gained in the interviews, advantages of the model included convenience to the patient and family, immediacy of services, easy access to psychiatry consultations, a perceived increase in follow-through by patients for recommended MH services, a perceived increase in comfort for patients seen for MH services in the pediatric practice rather than being referred to other sources, and regular communication between the MH provider and pediatricians concerning shared patients.

### Table 1

<table>
<thead>
<tr>
<th>Model No.</th>
<th>Practice Size</th>
<th>No. of FTE Physicians, PAs, and NPs</th>
<th>Practice Payer Mix</th>
<th>Type of MH Provider</th>
<th>Weekly Time in Practice</th>
<th>Primary Activities in Practice (% time in each activity)</th>
<th>Most Frequent Diagnoses</th>
<th>Salary Range</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>5,000</td>
<td>4</td>
<td>Medicaid = 72%</td>
<td>LCSW</td>
<td>2 days</td>
<td>Therapy (44%) Consultation/assessment (35%) Case management (21%)</td>
<td>ADHD (49%) Depression/Anxiety (30%) Behavior D/O (10%) Adjustment D/O (6%) Other (5%)</td>
<td>$32,000–$45,000</td>
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<td></td>
<td></td>
<td></td>
<td>Private insurance/PPO/HMO = 23%</td>
<td></td>
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<td></td>
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<td>Self-pay = 5%</td>
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<tr>
<td>2</td>
<td>14,600</td>
<td>7</td>
<td>Medicaid = 50%</td>
<td>LPA</td>
<td>5 days</td>
<td>Testing (67%) Therapy (19%) Consultation/assessment (14%)</td>
<td>ADHD</td>
<td>$45,000</td>
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<td></td>
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<td>Private insurance/PPO/HMO = 30%</td>
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</tr>
<tr>
<td></td>
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<td>Self-pay = 10%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Contracts = 10%</td>
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<tr>
<td>3</td>
<td>20,000</td>
<td>7.5</td>
<td>Medicaid = 64%</td>
<td>LCSW, PhD, MA, Psychiatrist</td>
<td>2–4 days (Physician = 1 day/week)</td>
<td>Therapy (40%) Psychological evaluation (30%) Parent consultation (20%) Physician/professional consultation (10%)</td>
<td>ADHD (32%) ODD (28%) Anxiety/depression (24%) LD (8%) OCD (4%) PDD (4%)</td>
<td>$40,000–$80,000</td>
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<td></td>
<td></td>
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<td>Private Insurance/PPO/HMO = 5%</td>
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<td></td>
</tr>
</tbody>
</table>

FTE = full-time employee; PA = physician assistant; NP = nurse practitioner; MH = mental health; PPO = preferred provider organization; HMO = health maintenance organization; LCSW = licensed clinical social worker; LPA = licensed psychological associate; ADHD = attention deficit hyperactivity disorder; D/O = disorder; LD = learning disability; ODD = oppositional defiant disorder; PDD = pervasive developmental disorder.
Difficulties with the model included the large amount of paperwork required by the MH center to open a case on a child with Medicaid. This decreased the likelihood of opening a case with the resulting loss of potential reimbursement, as well as the MH provider’s productivity. Initially, patients were offered same-day appointments for both medical and MH services, but this compounded the waiting time and resulted in patient dissatisfaction. The practice decided to split visits unless a crisis was involved, and this problem was resolved. Last, the practice lacked high-speed Internet access, which would have enabled the MH provider to have quick and easy access to the community MH center’s database.

Satisfaction was high for the medical providers, who rated the MH service 5/5 on confidential ratings during the first year. Pediatricians perceived that quality of care improved due to assessment and feedback by the MH provider, as this information assisted them in addressing more of their patients’ psychological issues. When comorbidities were ruled out and a diagnosis was confirmed by the MH provider, comfort increased in prescribing medication.

The MH provider perceived there was more “buy in” by the patient for MH services when a physician referral was made. Collaboration and enhanced dialogue between medical and MH providers were thought to improve patient care.

**Model 2: MH Provider Employed by a Pediatric Practice**

Operational Arrangements

The second model involved the employment of a MH provider by a private pediatric practice. The pediatric practice assumed all responsibility for the expenses and reimbursement for this model (Table 1).

Expenses included salary for the MH provider plus benefits, malpractice insurance, office space and a testing room, and administrative costs related to billing and scheduling of patients.

The model was supported by contracts with the school district for testing services and reimbursement for MH services by Medicaid, insurance, preferred provider organizations (PPOs), and health maintenance organizations (HMOs). All billing was completed by the business manager for the pediatric practice. Medicaid charges were billed “incident to” the physician (i.e., billed in the physician’s name in accordance with NC Medicaid rules that allow physicians to bill for MH services provided on site under their direct supervision if the MH provider is employed by the physician or by the same entity that employs the physician). The MH provider did not enroll on the behavioral health panels of some private insurance plans because of poor reimbursement. Parents whose children were covered by these plans were required to pay for MH services, and frequently a payment plan was worked out. MH services were open to both patients and nonpatients of the pediatric practice.

Billed services provided enough revenue to pay the salary, benefits, and administrative costs for the MH professional. Because the model had been so successful, a second MH provider, focused more on therapy services, was employed.

**Clinical Responsibilities**

Responsibilities of the medical providers involved informal consultations and/or formal referrals to the MH provider. Office staff sent out a packet of forms to prospective patients requesting information about background history, present problems, and demographics. The packet was to be completed and returned before the patient was scheduled for an appointment. Scheduling was handled by both the MH provider and staff: the MH provider determined slots available for testing or therapy and reviewed the intake packet, and the office staff called the parent with an appointment. A chart, separate from the medical record, was created for each patient and kept by the MH provider in a secured area.

The clinic employed a licensed psychological associate (master’s level degree in psychology) because of the need for psychological and psychoeducational assessment as well as psychotherapy. Services offered include informal consultations between the physician and MH provider, testing, diagnostic interviews, and individual and family therapy. Utilization was high as intake appointments were typically booked for a month in advance.

Medication consultations with psychiatrists were provided by phone conversation with private providers or referrals to a nearby medical school. These consultations and referrals were initiated by either a medical or MH provider.

**Outcome Findings**

Based on information gained in the interviews, advantages of the model included increased access to MH care in the community; shared educational information between physicians and MH providers; increased specialization of medical practitioners as physicians with an
Co-location of Mental Health Professionals

interest in a specific disorder, such as ADHD, could see the majority of these patients, while other providers could focus on other medical or behavioral health problems; perceived improvement in making behavioral health diagnoses; and increased revenue for the practice.

Difficulties with the model included an initial lack of clinical space and the amount of time required for billing. This issue was resolved when the practice moved into a new building, in which the MH provider was allocated an office and testing room in the new clinic. Learning the right questions to ask insurance companies about billing for MH codes was initially time consuming and required persistence by the business manager. Over time, the practice put more responsibility onto families for checking on MH benefits in their insurance policies before making appointments.

Satisfaction by medical providers was focused on increased efficiency and improved diagnostic and treatment processes. For all new cases, the MH provider reviewed the referral packet, obtained information from the school, and conducted a diagnostic interview and/or testing with the child/family. Many of these children/families needed no further evaluation or treatment by the medical providers. If the child needed to see the medical provider, the MH professional’s history was available for the physician to use for diagnostic and treatment purposes. This allowed the medical provider to go into more depth concerning specific symptoms, such as ADHD, and decide on the most appropriate medication. Physicians reported more comfort in writing prescriptions and were more likely to use phone consultations with psychiatrists instead of sending the patient some distance for a referral to a tertiary care setting.

The MH provider perceived that patients were more comfortable, open, and motivated due to trust in the pediatric setting. Compared to traditional MH settings, the MH provider felt that co-location allowed for more flexibility in daily practice and more comfort in setting limits with patients who consistently missed their appointments. The MH provider also was relieved not to have responsibility for billing and other administrative tasks.

Model 3: Co-location of an Independent MH Practice with a Pediatric Practice

Operational Arrangements

The third model was the placement of a self-employed doctoral psychologist in a rural pediatric practice (Table 1). High demand for MH services resulted in the addition of another psychologist, clinical social worker, and psychological associate. A separate corporation for the MH practice was established. The pediatric and MH practices were on the same floor in a building with a common hallway, and the patient reception windows were in close proximity. Each practice had its own practice manager and receptionist, handled its own administrative functions, and had its own private offices. Each practice maintained separate records for patients.

Expenses for the co-location model included salaries and benefits for the MH providers benefits, MH malpractice insurance, office rental and associated expenses, and all administrative costs. All expenses were the responsibility of the MH practice.

The MH professionals were directly enrolled as Medicaid providers and were credentialed by insurance companies, PPOs, and HMOs. In addition, the MH practice had contracts with local schools and other community agencies to provide testing and other services needed by their respective constituencies. All billing for MH services was completed by the MH practice. Both patients and nonpatients of the pediatric practice were seen in the MH practice.

The MH providers spent from 2 to 4 days per week in the practice, and the MH practice was sustainable based on revenues generated and expenses.

Clinical Responsibilities

Ongoing responsibilities of the medical providers involved informal consultations and formal referrals to the MH providers.

The MH receptionist scheduled, called to remind patients of their appointments, and registered patients. Services offered by the MH providers included informal consultations between the medical and MH professionals, diagnostic interviews, psychological and psychoeducational testing, individual and family therapy, parenting, and school consultations.

The MH practice contracted with a psychiatrist to spend 1 day per week in the practice for medication consultations and referrals.

Outcome Findings

Based on information gained in the interviews, advantages of the model included increased communication between medical and MH providers due to immediate access and convenience; shared education between the two sets of providers on a variety of pediatric and mental health
Discussion

Across all three models of co-location, enhanced communication between medical and MH providers was consistently perceived as improving quality of care for patients, increasing comfort in diagnosis and treatment of behavioral health disorders by physicians, and providing educational opportunities between disciplines.

Satisfaction with each of the models was reported by both pediatricians and MH professionals. Pediatricians perceived themselves to be more efficient in their practice, especially when psychosocial issues and comorbidities had been addressed by the MH provider. In one practice, staff efficiency was increased as the MH provider took care of MH referrals that had previously been handled by a practice nurse. In all of the models, convenience for both the patients and the providers was stressed. Several providers perceived decreased stigma and increased follow-through with MH services.

Compared with services provided in traditional community MH centers, the out-stationing of a MH provider by a community MH agency (Model 1), provided more convenience for patients, less stigma, and better communication with primary care physicians. This model offered the advantages of psychiatric supervision from permanent staff of the MH center and the opportunity to share the out-stationed MH provider across multiple pediatric practices. As in other models, sustainability was dependent on the MH provider’s billing for an adequate volume of services; however, its sustainability was potentially enhanced by its capacity to target and shift resources to practices where need is greatest.

In all of the models, a committed practice manager was perceived to be essential to success. In addition, physicians’ beliefs concerning the need for MH services in the medical setting and commitment to working with a co-located MH professional were critical. Flexibility on the part of both MH and medical providers was needed to enhance effectiveness and efficiency. All models required adequate and appropriate space for the MH provider.

All three models demonstrated sustainability at the time of this report. In two of the models, sustainability was enhanced by contracting with schools and other community groups to provide child/family MH services and/or testing and by providing services to both patients and non-patients of the practice. The pediatric practice that employed a MH provider cited coding skills and administrators’ persistence in pursuing reimbursement as critical to sustainability.

Generalizability

Although the three models described in this article were all sustainable in NC, the question of generalizability arises because of variability from state to state in respect to Medicaid policies and reimbursement. Since all three models serve a high percentage of patients with Medicaid, NC’s Medicaid reimbursement rates, indexed at 95% of Medicare, play a critical role in sustainability. If a state’s rates are less than this, a MH provider would have to provide proportionately more billable service in order to sustain any of the models.

Model 1, the out-stationing of an MH provider employed by a community MH agency, has the potential for replicability in most Medicaid policy environments,
provided the employer’s administrative requirements and paperwork do not create daunting inefficiencies or the inflexibility to respond to the practice’s needs. There must be sufficient patient referrals and billable services to support both the salary and administrative costs of the MH professional.

Model 2, the employment of an MH provider by a pediatric practice, depends on Medicaid policies that either (1) allow physicians to bill MH diagnostic codes on behalf of MH professionals in their employ or (2) allow MH professionals employed by physicians to directly enroll and bill as Medicaid providers and/or participate as providers in MH carve-outs of Medicaid managed care plans. This model is not replicable in areas where Medicaid allows only public MH providers to bill Medicaid.

Model 3, independent MH practitioner(s) co-located with a pediatric practice, depends on policies that allow MH professionals to directly enroll as Medicaid providers or to participate as providers in MH carve-outs of Medicaid managed care plans. Medicaid reimbursement rates that are substantially less for independent MH providers than for public MH providers would threaten the viability and stability of this and any model built independently enrolled Medicaid providers.

Limitations of the Study

Although responses to the questionnaire by professionals in the three models offer insight into the formation and operation of co-located practices, many empirical questions remain concerning outcome findings. It is suggested that access to MH care is increased by co-location but whether the quality of both medical and mental health is improved is unknown. Future studies need to measure both of these variables as well as their interactions. In addition, measurement of patient satisfaction with co-located care is critical, as well as whether patients are more likely to utilize and follow through with physician referrals for co-located MH care.

Conclusions

With the increased need for identification, diagnosis, and treatment of MH disorders in primary health-care settings, co-location of MH providers in primary care practices is a concept whose time has come. This article has outlined the experience of implementing three co-location models, described their business structure and level of provider satisfaction, and developed practical guidance drawn from these findings. Although these guidelines are instructive, it is essential to consider the uniqueness of the patient population served, characteristics of providers, and practice parameters when a model is instituted.9

In addition, the article documents the importance of advocacy efforts by pediatricians and MH providers. In this case, systemic changes resulting from advocacy efforts made sustainability of new co-location models achievable.

Acknowledgments

The authors would like to acknowledge the assistance given by the three practices: Aegis Winston East Pediatrics (Winston-Salem, NC), Washington Pediatrics (Washington, NC), and Sylva Clinical and Sylva Pediatrics (Sylva, NC). Contacts for further information at each of the practices include: Model 1—Carrie S. King (phone: 336-725-0514), Model 2—Dr. Debbie Ainsworth (phone: 252-946-4134), and Model 3—Dr. Jerry Coffey (phone: 828-586-5555).

REFERENCES

Evidence-Based Child and Adolescent Psychosocial Interventions

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html).

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1 - BEST SUPPORT</th>
<th>Level 2 - GOOD SUPPORT</th>
<th>Level 3 - MODERATE SUPPORT</th>
<th>Level 4 - MINIMAL SUPPORT</th>
<th>Level 5 - KNOWN RISKS</th>
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<tbody>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT); Exposure</td>
<td>CBT with Parents; CBT with Medication; CBT for Child and Parent; Educational Support; Modeling</td>
<td>None</td>
<td>Eye Movement Desensitization and Reprocessing (EMDR), Play Therapy, Psychodynamic Therapy</td>
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<td>Attention and Hyperactivity Behaviors</td>
<td>Behavior Therapy with Medication; Parent Training</td>
<td>Behavior Therapy</td>
<td>None</td>
<td>Biofeedback; Play Therapy, Individual or Group (Supportive) Therapy, Social Skills Training; “Parents are Teacher,” Parent Effectiveness Training, Self-Control Training</td>
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<td>Autistic Spectrum Disorders</td>
<td>None</td>
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<td>Applied Behavior Analysis; Functional Communication Training; Caregiver Psychoeducational Program</td>
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<td>Bipolar Disorder</td>
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<td>Behavioral Problem Solving, Family Therapy, Self-Control Training, Self-Modeling, Play Therapy</td>
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<td>Disruptive and Oppositional Behaviors</td>
<td>Parent Training</td>
<td>Anger Control; Assertiveness Training; CBT; Problem Solving Skills Training, Rational Emotive Therapy, AC-SIT, PATHS and FAST Track Programs</td>
<td>Social Relations Training; Project Achieve</td>
<td>Client-Centered Therapy, Communication Skills, Goal Setting, Human Relations Therapy, Relationship Therapy, Relaxation, Stress Inoculation, Supportive Attention</td>
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<td>Eating Disorders</td>
<td>CBT* (bulimia only)</td>
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<td>Multisystemic Therapy**</td>
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<td>Group Therapy**</td>
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<td>Schizophrenia</td>
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* Based on findings with adults only; ** if delinquency and willful misconduct are present. § Also consider medication alone or combined treatment for hyperactivity, or combined treatment for depression or hyperactivity, academics (reading), and family interaction. *** under re-review as possible level 5 intervention; use with caution.

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ebs027 - psychosocial interventions - 1 Jul 07