



Implementation of Behavioral Health Overlay Services in a Pediatric Medical Home: From Science to Service



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Abstract

Approximately 20% of children have a diagnosable mental health condition. Left untreated, children's emotional, behavioral problems and associated impairments are likely to lower their quality of life and reduce their opportunities. The burden to society is high in both human and fiscal terms. Early intervention and treatment leads to improved outcomes. In response to the need, a state funded children's medical agency embarked on a prevention intervention program by incorporating behavioral health overlay services in a medical home model. The impact of this program leads to future policy considerations.

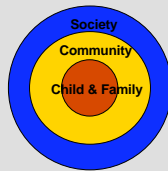
Introduction

Even though about 20% of the nation's children have a mental health concern, clinical judgment identifies fewer than 50% of children who have serious emotional and behavioral disturbances (Glascoe, 2000). Disorders that often appear first in childhood or adolescence are among those ranked highest in the World Health Organization's estimates of the global burden of disease. With the rate of increase among children and adolescent affected with mental health disorders, it will require a sustained preventive intervention to interrupt the imbalance between the economic burden and economic potential. Child and adolescent preventive interventions have the potential to reduce the economic burden of mental illness through the reduction of need for mental health and other related services; increasing the potential benefits of positive developmental outcomes, representing net societal savings (NIMH, 2004).

The public health system has not traditionally addressed mental health diagnoses. Children's Medical Services (CMS), a division within the Florida Department of Health, rose to the challenge and need of implementing an evidenced based practice of early identification and screening for developmental, behavioral, and emotional concerns in the pediatric medical home. This prevention intervention initiative focuses attention on the need for an early ongoing source of primary care for children that is "accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective" (AAP, 2002; p. 184). In the past decade, interest and activities in the interface between primary health care and mental health have increased markedly among the many stakeholders who care about positive outcomes for young children's mental health and well-being.

Primary health care providers are a natural point of contact for children and their families. (Rosman et al., 2005). AAP and HRSA leadership has shaped the medical home concept with the goal of improving access to services for children with special health care needs. Tenets of the ecological model (Bronfenbrenner, 1979) guided the integration of behavioral health overlay services within the medical home model based on community readiness.

Ecological Model



Adapted from Bronfenbrenner, 1979

Methodology

Due to prior provider resistance, relative to the complexity of navigating the mental health system, a convenience cohort (one of the largest pediatric primary care practices in the region) was identified for the initial pilot. The practice has 7,686 active clients of which 22% are receiving Medicaid. Stakeholder buy in was crucial as local pediatricians relied on surveillance and were concerned with the time, cost, and risk of implementing structured screening tools as they did not want to identify problems for which there was limited resources and follow up.

Behavioral health screenings in a medical home were facilitated by the use of the Pediatric Symptom Checklist (PSC).

This one page, multi-lingual screening tool has demonstrated high psychometric properties of validity (agreement with CBCL and CGAS) and reliability (Jellinek, Patel, Froehle, 2002). Due to current lack of established services addressing the 3-6 year old population and the crisis orientation of the adolescent population, the project focused on well visits for children 6-12 years of age and any child or adolescent with physician or parental concern.

The PSC was given to the caregiver at the time of sign in for a check up or with parental or physician concern. A licensed mental health provider was provided by CMS-BBR and was co-located in the medical home six hours a week, to score the PSC and follow up on "positive" screenings or direct referrals from physicians. In follow up with the family, a further strength and needs based assessment was developed by the licensed mental health provider; Bright Futures (Jellinek et al., 2002) anticipatory guidance materials were given; and referrals to appropriate providers were facilitated based on the funding source and individual need.



Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

For each item, please mark under the heading that describes your child:	Never	Sometimes	Often
1. Complains of aches and pains	1		
2. Sleeps restless at night	2		
3. Tires easily, has little energy	3		
4. Frequent stomach aches	4		
5. Has trouble with learning	5		
6. Gets nervous or upset	6		
7. Acts out (talks back or argues)	7		
8. Disruptive to others	8		
9. Clinginess	9		
10. Is afraid of new situations	10		
11. Fears new company	11		
12. Is socially shy	12		
13. Fails to respond	13		
14. Fails to finish conversations	14		
15. Does not respond to others	15		
16. Fights with other children	16		
17. Absent from school	17		
18. Schoolwork problems	18		
19. Is absent often or tardy	19		
20. Uses the computer when doing homework	20		
21. Has trouble sleeping	21		
22. Wakes up often	22		
23. Wants to be with you more than before	23		
24. Fights back at school	24		
25. Talks excessively at home	25		
26. Talks too fast	26		
27. Doesn't talk when he/she has to	27		
28. Acts strange when children hear or see him	28		
29. Does not follow rules	29		
30. Does not share feelings	30		
31. Does not understand other people's feelings	31		
32. Talks when he/she is not supposed to	32		
33. Talks when he/she is not supposed to	33		
34. Talks things that he or she is not supposed to	34		
35. Refuses to share	35		

Child's Name: _____ OFFICE USE: _____
 Date of Birth: _____ PSC: _____
 Today's Date: _____

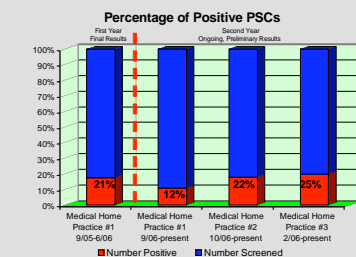
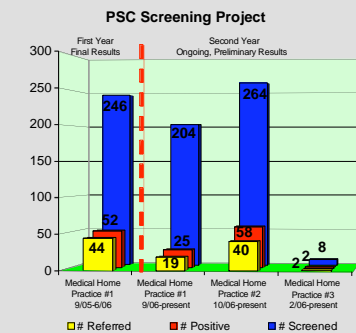
Results

Results are noted from both a quantitative and qualitative perspective. To date, results across implementation years among the various practices reflects a consistent trend toward the national average of 20% of affected children with mental health concerns.

As a result of the first year of implementation over 246 children were screened. Consistent with national statistics, 20% of the participants were further identified as having emotional, behavioral or learning concerns. The *qualitative evidence* is noted among the following:

- Results from the anticipatory guidance survey showed high satisfaction (90%) with regards to usefulness, understandability, and effectiveness of the material.
- Results from provider surveys showed high levels of satisfaction with regards to the program and screening tool. Providers surveyed stated that they would like to continue the program.
- Case studies with testimonials regarding the impact and positive changes experienced by families who participate in the project.

Charts



Discussion

Formal screening in a pediatric primary care medical home setting resulted in identifying approximately 20% of children with emotional, behavioral or learning concerns.

This finding matches the national average (Costello et al., 2004). Providers and participants agreed that a standardized screening tool was useful in identifying needs, easy to score, and helped to bridge difficult topics.



Guided by the Ecological Model (Bronfenbrenner, 1979), buy in and collective satisfaction enhanced the expansion into an additional practice while maintaining the first practice. Unsolicited funding was also received to expand the screenings to include mothers, infants and toddlers with the Edinburgh depression screen, Ages and Stages Developmental Questionnaire, and Ages and Stages Social Emotional. Preliminary results of the second tier of the project are pending. Longitudinal data is needed to continue to monitor the progress and functional outcomes of children that were identified.

Future consideration needs to be given to policy change rooted in practices valuing and incorporation of a structured screening mechanism. Ultimately these programmatic outcomes will likely impact policy driven changes to include ongoing early intervention screenings.

About CMS

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The mission of the Division of CMS Network & Related Programs is to champion excellence in the delivery of health care for children with special needs.

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CMS provides a comprehensive continuum of medical and supporting services to medically and financially eligible children and high-risk pregnant women. The continuum of care includes prevention and early intervention programs, primary care, medical and therapeutic specialty care and long-term care. Services are provided through an integrated statewide system that includes local, regional, and tertiary care facilities and providers.

CMS is a program of the Florida Department of Health (DOH) and is directed by the Deputy Secretary for CMS.

