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Toolkit for PCBH in Pediatric Primary Care

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Toolkit for PCBH in Pediatric Primary Care

Creator(s)

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Session #: PC 1

Toolkit for PCBH in Pediatric Primary Care

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CFHA 19th Annual Conference
October 19-21, 2017 • Houston, Texas

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2017

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Discuss a broad range of best practices in pediatric integrated care.
- Build and utilize a toolkit of integrated pediatric care resources for immediate implementation in medical settings.
- Identify common care pathways, brief interventions, and screening measures/assessment strategies for the most common issues in pediatric integrated care.

Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

Workshop Overview

- Brief Overview of Different Models of Pediatric PCBH
- Screening Tools and Assessment/Outcome Measures
- BREAK
- Brief Evidence-Based Interventions and Care Pathways
- Training for Pediatric PCBH/Characteristics of Effective BHCs in Pediatrics
- Questions and Answers/Discussion

Overview of Pediatric PCBH

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Pediatrics

Pediatrics is the specialty of medical science concerned with the **physical, mental, and social health of children from birth to young adulthood**. Pediatric care encompasses a broad spectrum of health services ranging from preventive health care to the diagnosis and treatment of acute and chronic diseases. (American Academy of Pediatrics)

Primary Care Behavioral Health (PCBH)

Primary Care Behavioral Health (PCBH) represents the contemporary and prospective vision of integrated healthcare.

PCBH epitomizes the systematic change within healthcare service delivery, which requires a multidisciplinary team-based approach.

Behavioral Health

An umbrella term for care that addresses:

- **behavioral problems impacting health**
- **developmental considerations**
- **stress and behavioral-linked physical symptoms**
- **mental health and substance use concerns**
- **patient activation and health behaviors**

PCBH is a model of integrated behavioral health services within primary care:

- which emphasizes a flexible generalist practice model (demonstrating on-demand, skill and practice for **all ages care**)
- **brief evidenced based interventions** and treatments (typically 15-30 minute visits)
- a **population based** clinical healthcare approach (population focused on whole clinic/community population health)
- focused on functionally based behavioral interventions (**addressing functional improvements and early identification**)
- working **collaboratively**, side-by-side with primary care clinicians as part of the primary healthcare team
- enhancing **preventative, acute, and chronic care** for a multidisciplinary, whole-person centered approach to healthcare delivery

PCBH - Pediatrics

- early identification with brief screening
- psychoeducation for caregivers and youth
- access to team based support for health care centers
- systems, school, and juvenile considerations
- improvement in psychosocial wellbeing
- child protective services and education
- skill training for youth and caregivers
- functional improvements

Implementing Clinical Innovations

JODI POLAHA, PH.D.

ASSOCIATE PROFESSOR

DEPARTMENT OF FAMILY MEDICINE

EAST TENNESSEE STATE UNIVERSITY

Munroe Meyer Institute for Genetics and Rehabilitation
University of Nebraska Medical Center

Genetics Clinics


Comfort INN

Nebraska


Rapid City
Sioux Falls
Omaha
Hastings
Lincoln
Kansas City
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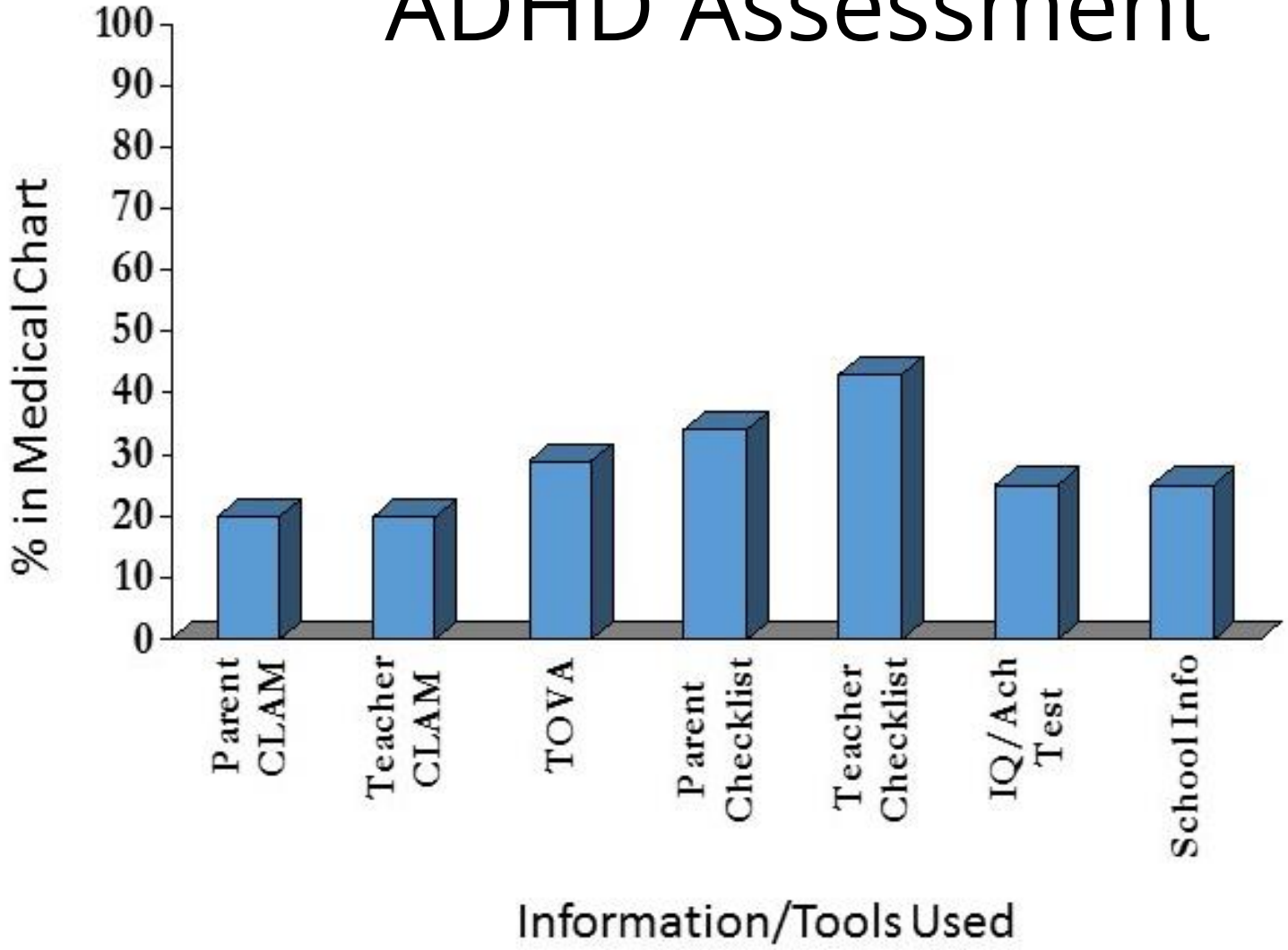
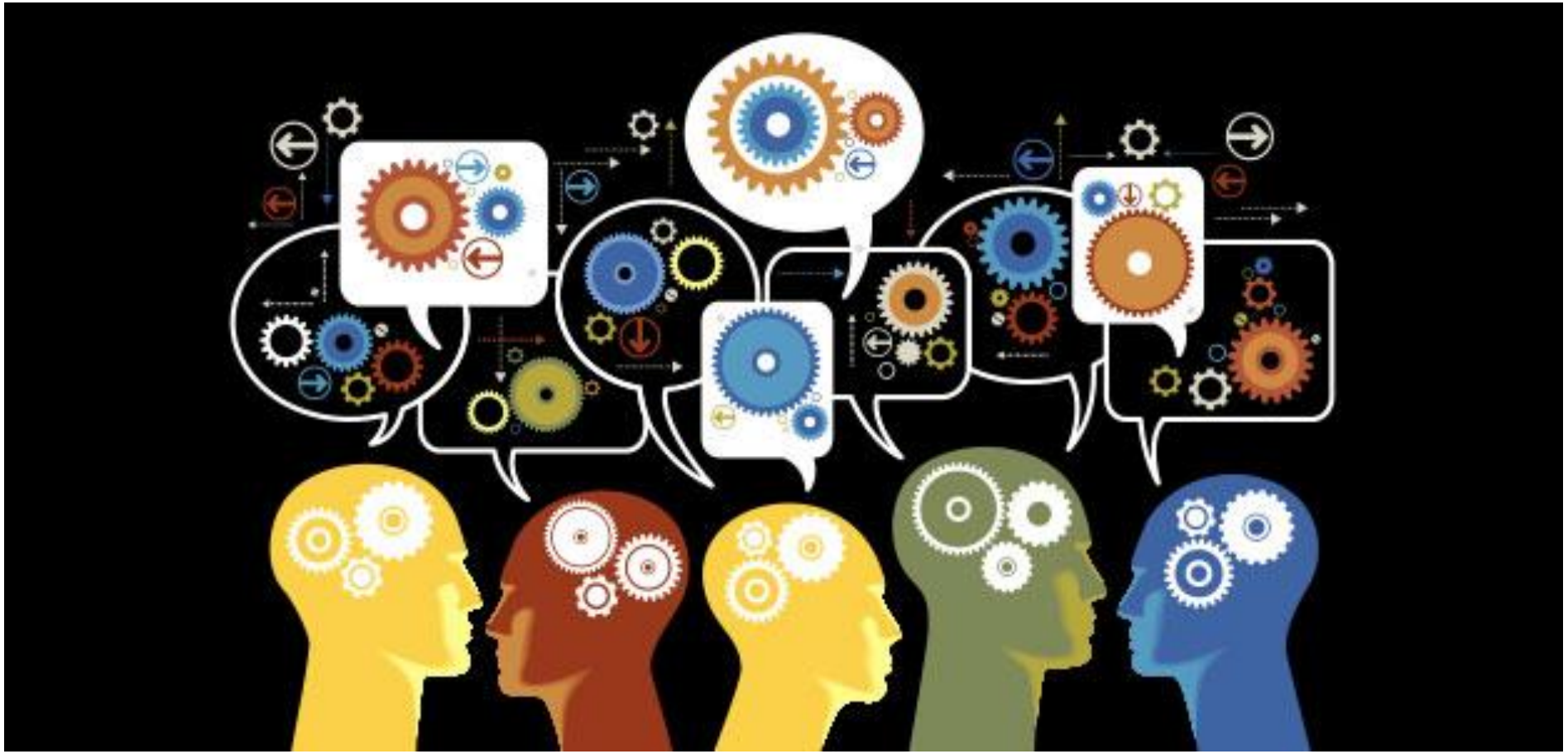
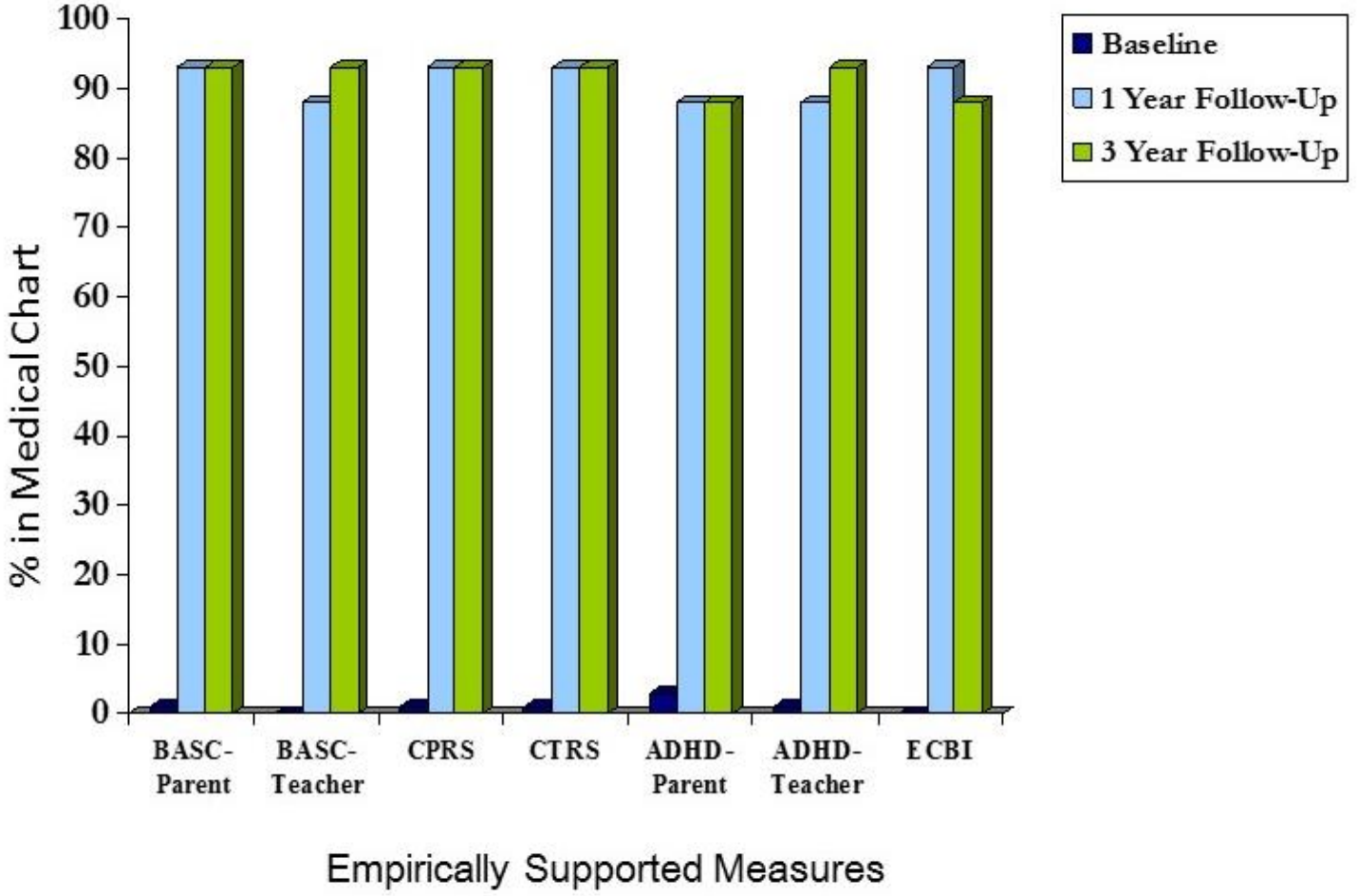
ADHD

ADHD Assessment





ADHD Assessment



PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

The Assessment of Attention-Deficit/Hyperactivity Disorder in Rural Primary Care: The Portability of the American Academy of Pediatrics Guidelines to the "Real World"

Jodi Polaha, Stephanie L. Cooper, Tawnya Meadows and Christopher J. Kratochvil

Pediatrics 2005;115;e120
DOI: 10.1542/peds.2004-1521


TEAMS
ETSU

Clinical Innovations are Challenging to Implement

- Top down initiatives not sufficient
- Readiness to participate differs across facilities
- Require the participation of multiple stakeholder groups
- Providers have limited availability for implementation activities
- Education alone rarely sufficient

Slide courtesy of Dr. JoAnn Kirchner

Facilitation

Process of interactive problem-solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.

Slide courtesy of Dr. JoAnn Kirchner

Champion Teams

Champion Teams: Essential Elements

- Small team paves the way for practice-wide uptake
- Champions choose projects relevant to their site
- Utilizes QI methods, other best-practice strategies
- Efficient, realistic process
- Synchronized with clinical operations
- Grant-supported architecture

Learning Healthcare System

Implementing Screeners in Pediatric Primary Care

JULIE AUSTEN, PH.D.
SARAH TRANE, PH.D.
MATTHEW TOLLIVER, PH.D.

What is a Screener?

A valid and reliable tool used to systematically detect the *potential* presence of a health concern.

It can be broad (exploring wide range of potential issues) or narrow (for a specific issue)
It should be relatively short and easy to administer
It should help inform an assessment (but it is not an assessment by itself)
Bonus points if it doubles as an outcome measure!

Screeners Are Our Labs

Why Screen in Pediatric Primary Care?

Universal Screening

1. Create a system of care that detects health issues that may be overlooked during well child check-ups.
2. To promote the idea of mental health as a part of whole-person health.
3. To promote value of behavioral health programming by accurately measuring need and demonstrating efficacy.

Individual Screening

1. Improve outcomes through accurate diagnosis and progress monitoring
2. Help patients learn to be aware of symptoms
3. Aid in good documentation

Types of Screeners

Developmental Screening

1. AAP/USPSTF recommendations, used in majority pediatrics clinics
2. Common examples include Ages and Stages
3. PSC-17
4. M-CHAT-R
5. PEDS

General health

1. Sheehan Disability Scale
2. Peds QOL (cost)
3. PROMIS measures

Types of Screeners Developmental

Developmental Screening:

The Bright Futures/**American Academy of Pediatrics** (**AAP**) Recommendations for Preventive **Pediatric** Health Care, also known as the "Periodicity Schedule," is a schedule of **screenings** and assessments recommended at each well-child visit from infancy through adolescence.

1. Ages and Stages (has fee)
2. M-CHAT-R
3. PEDS

Types of Screeners

<u>General health</u>: Focus on functional impact of behaviors/symptoms

1. Sheehan Disability Scale or Bullseye scale
2. Peds QOL (cost)
3. PROMIS measures

EXAMPLE:
How much have your problems interfered with your schoolwork?

0 1 2 3 4 5 6 7 8 9 10

Types of Screeners Emotional/Mood/Behavior

EMOTIONAL/BEHAVIOR SCREENING

Broad Spectrum/QI Measures:

PSC-17 (parent; PPSC, BPSC thru SWYC)
PHQ-9M(A) - ages 12+
CRAFFT - ages 12+
Vanderbilt (parent/teacher)
EPDS - Edinburgh Postpartum Depression Screen

Specific Depression/Anxiety/Mood

CES-DC (self)
RCADS (self/parent)
MDQ
SCARED (self/parent)
Spence (Self/parent)
(no good brief anxiety scr)

From Screeners to Outcome Measurement

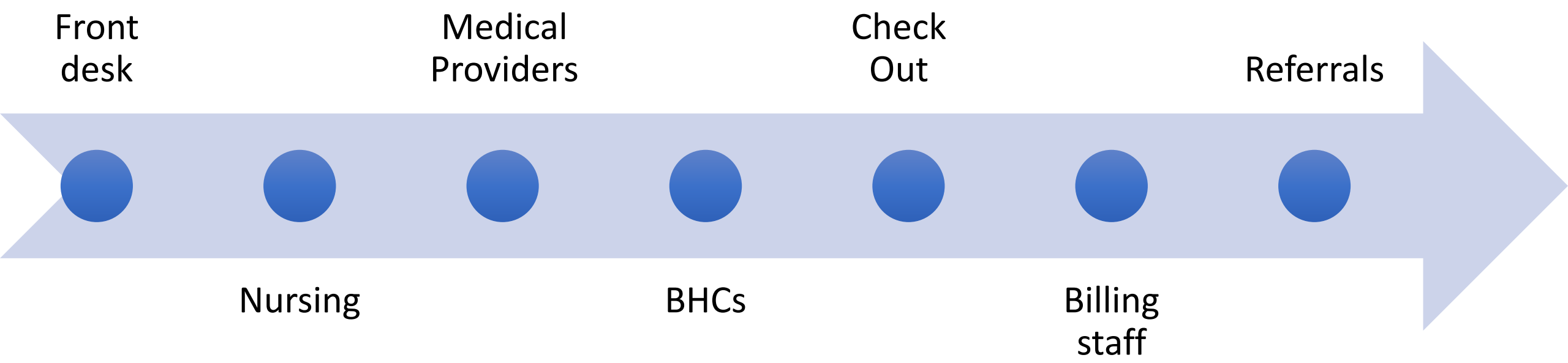
1. Assist PCPs in monitoring behavioral health issues over time (e.g., med response in ADHD using VPRS/VTRS Follow-up)

2. Documenting use of Quality Measures
    i. Improved QI
    ii. Increase revenue to the clinic

3. Measure impact of interventions and clinical outcomes

4. Promotes BHC service to administration with data

Who is Affected By Screener Flow



Billing for Screeners

Codes:

96110: Developmental Screening
- Ages and Stages
- M-CHAT-R
- PEDS

96127: Brief Emotional/Behavior Screening
- SCARED
- PHQ-9
- CRAFFT
- PSC-17
- Vanderbilt

Reimbursement:

Per screener

Long range view: PCMH requirements

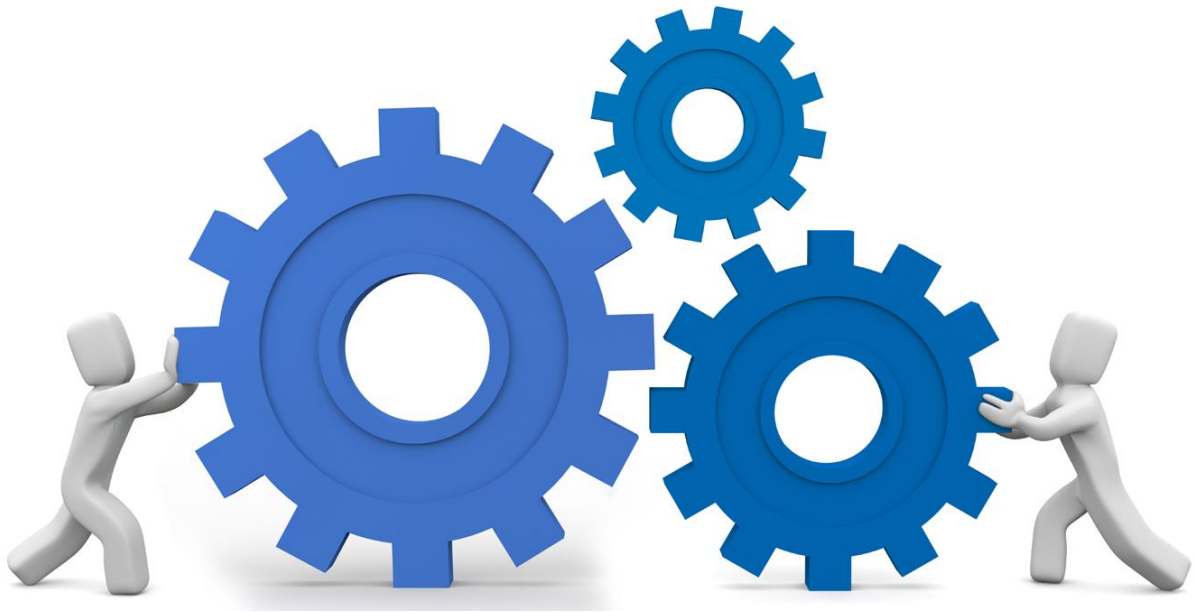
Mythbusters: Screeners Edition

Myth: Screeners create more paperwork and take too much PCP/Nursing Staff Time
Fact: They can be seamlessly integrated into check-in procedures. Screeners help promote proper clinic flow, allowing the BHC to get to the right place at the right time.

Myth: If a patient's score is elevated then we must do something about it.
Fact: It is true that something should happen when a screener is elevated. However, many events can occur, such as a BHC flag for follow-up, or if the situation is critical, then a clinic-wide policy should be in place to manage it.

Myth: If a screener is positive then I can move on to treatment.
Fact: Screeners are not assessments and cannot replace them. Sometimes we need to educate clinic staff about differential diagnoses and the need for further assessment

Myth: Any screener can be administered in many ways
Fact: Administration should be as similar to the instructions in the validation process as possible.



Translation to Real Practice

SCREENER IMPLEMENTATION EXAMPLE: THE PHQ-9

ETSU Pediatrics

DEPARTMENT *of* PEDIATRICS
Quillen College of Medicine
EAST TENNESSEE STATE UNIVERSITY

Residency training clinic (21 residents)
85% Medicaid
6 FTE attendings
Psychology/Social Work

SCREENER IMPLEMENTATION: 5 LESSONS LEARNED

1. **Form a small champion team (quality improvement team) that meets efficiently and as often as needed**

Champion Team Worksheet

Date: 3/21/17 **Attendance:** Tolliver, Jaishankar, Tuell, Garland, Shipley, Flack
Start: 12:15pm
End: 12:45pm

Overall Goal:
To implement the PHQ-9 at all well visits for children ages 13 and up.

Prior meeting action items:

1. Email to other pediatricians just to catch them up
2. Alice needs to add PHQ-9 to billing sheet. For now can write it in, but should be added soon.
3. Dr. Jai to call Paula regarding depression diagnosis – needs to be added to assessment not linked to screener. Follow-up plan documented with that.
4. Plan to launch this tomorrow.

Updates:
PHQ-9 was launched 2/15/17.
The team presented the document in #2.
PHQ-9 has been added to billing sheet.
Paula linked depression diagnosis to assessment.

Observations, Questions, Study:

1. Bridget pulled well-child checks since 2/15/17 = 59
   - 8 patients had scanned screener, but nothing documented in vitals tab.
2. Amy reported that from the nursing perspective the flow of scoring and documenting the PHQ-9 is going well. There are some concerns that at times teens may feel uncomfortable completing the screener if parents are watching. Should nurses give out the screener after rooming pt? Consesus is to stick with current plan for now.
3. Amy reported concerns from Dr. Heise that the PHQ-9 may result in too many false positives. Suggestion to use the Zung Depression Self-Rating Scale. As the PHQ-9 is recommended by the AAP and we could not find sensitivity/specificity info for the Zung, the group consensus was to stick with the PHQ-9.

Action Items:

1. Dr. Jai will find a time to train faculty in order to increase screening rate andn will send out Outlook invitation. Thursday in April will work best; possibly 4/6 at noon.
2. Matthew will see if Votaw auditorium is available, if it is, nursing staff and providers will be trained about PHQ-9 process at the same time. If not, they will be trained separately in break room.
3. Bridget will get Tracy to build a query that excludes follow-up appts from scanned screener data. She will also continue to report on number of well-child checks and how many screeners scanned and not put in vitals section.
4. Beth will follow-up about ability to specifically track billing for PHQ-9.

Representation From:

- EHR
- Medicine
- Nursing
- Behavioral Health
- Case Management
- Front Desk
- Billing

SCREENER IMPLEMENTATION: 5 LESSONS LEARNED

1. Form a small champion team that meets efficiently and as often as needed
2. **Get buy in early and throughout the process and consider how the screener will impact each member of the clinic**
   - cutoff score → BHC availability
   - nursing/physician/clinic flow
   - capturing quality data → attract grants, demonstrating need for BHC(s)

PREVALENCE OF ADOLESCENT DEPRESSION

- Past 30 days: 3%
- Past year: 8%
- Lifetime: 12%

Data from National Comorbidity Survey–Adolescent Supplement (NCS-A): 2001 to 2004 &
2011 National Survey on Drug Use and Health (NSDUH)

Forman-Hoffman, V., McClure, E., McKeeman, J., Wood, C. T., Middleton, J. C., Skinner, A. C., . . . Viswanathan, M. (2016). Screening for Major Depressive Disorder in Children and Adolescents: A Systematic Review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine, 164*(5), 342-349. doi:10.7326/M15-2259

U.S. PREVENTIVE SERVICES TASK FORCE

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

Prevalence of adolescent depression: Past year: 8% (National Comorbidity Survey–Adolescent Supplement (NCS-A): 2001 to 2004; 2011 National Survey on Drug Use and Health (NSDUH))

"The USPSTF concludes with moderate certainty that screening for MDD in adolescents aged 12-18 has a moderate net benefit"

Many depression screeners are not accurate. Concerns about overdiagnosis (Roseman, et al., 2016)

Two most studied screeners: PHQ-9A and the Beck Depression Inventory

Forman-Hoffman, V., McClure, E., McKeeman, J., Wood, C. T., Middleton, J. C., Skinner, A. C., . . . Viswanathan, M. (2016). Screening for Major Depressive Disorder in Children and Adolescents: A Systematic Review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine, 164*(5), 342-349. doi:10.7326/M15-2259

IDENTIFICATION AND TREATMENT

- **Historically, depression has been underdiagnosed in pediatric primary care**:
  - (Horwitz, Kelleher, & Boyce, 2002; Costello, Edelbrock, Costello, et al., 1988; Chang, Warner, & Weissman, 1998; Kramer & Garralda, 1998)

- **Treatment – Room for Improvement**:
  - Less than one-half of children and adolescents with MDD receive mental health treatment.
  - Those with more severe cases of depression were not more likely to receive treatment.

Forman-Hoffman, V., McClure, E., McKeeman, J., Wood, C. T., Middleton, J. C., Skinner, A. C., . . . Viswanathan, M. (2016). Screening for Major Depressive Disorder in Children and Adolescents: A Systematic Review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine, 164*(5), 342-349. doi:10.7326/M15-2259

BRIEF INTERVENTIONS CAN HELP

- Meta-analysis of 31 randomized controlled trials representing over 13,000 participants

- **Conclusion: integrated care was superior to care as usual when examining behavioral health outcomes for children and adolescents across a range of conditions (eg, depression, anxiety, behavioral concerns).**

Asarnow J, Rozenman M, Wiblin J, Zeltzer L. Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. *JAMA Pediatrics.* 2015;169(10):929-937 929p.

SCREENER IMPLEMENTATION: 5 LESSONS LEARNED

1. Form a small champion team that meets efficiently and as often as needed
2. Get buy in early and throughout the process and consider how the screener will impact each member of the clinic
3. **Thoroughly vet your screening instrument (consider psychometrics, length, scoring, acceptability, etc.)**

PHQ-9

- Sample: 442 youth aged 13-17.
- Compared PHQ-9 scores to a structured mental health interview (DISC-IV)
- Set cutoff at 11
- **Sensitivity**: 89.5% - the percentage of depressed teens who score clinically significant on the PHQ-9 (10.5% False Negative Rate)
- **Specificity**: 77.5% - the percentage of non-depressed teens who score negative on the PHQ-9 (22.5% False Positive Rate)

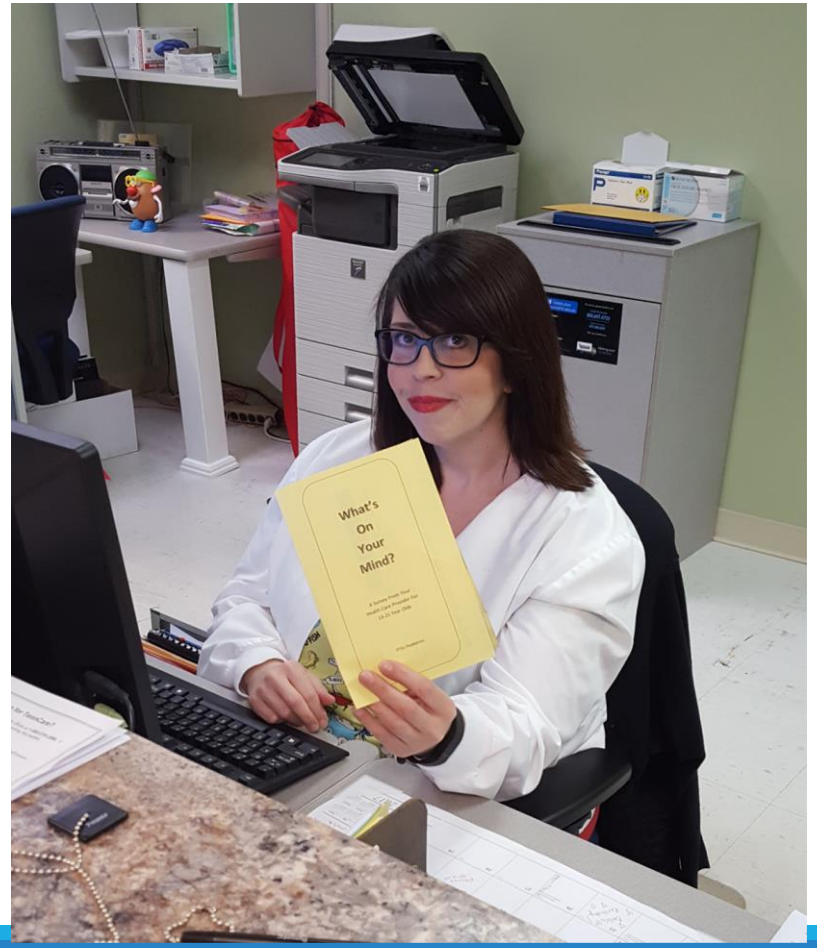
Richardson, L. P., McCauley, E., Grossman, D. C., McCarty, C. A., Richards, J., Russo, J. E., . . . Katon, W. (2010). Evaluation of the Patient Health Questionnaire-9 Item for Detecting Major Depression Among Adolescents. *Pediatrics, 126*(6), 1117-1123. doi:10.1542/peds.2010-0852

SCREENER IMPLEMENTATION: 5 LESSONS LEARNED

1. Form a small champion team that meets efficiently and as often as needed
2. Get buy in early and throughout the process and consider how the screener will impact each member of the clinic
3. Thoroughly vet your screening instrument (consider psychometrics, length, scoring, acceptability, etc.)
4. **Find an effective way to train clinic staff in the new protocol**

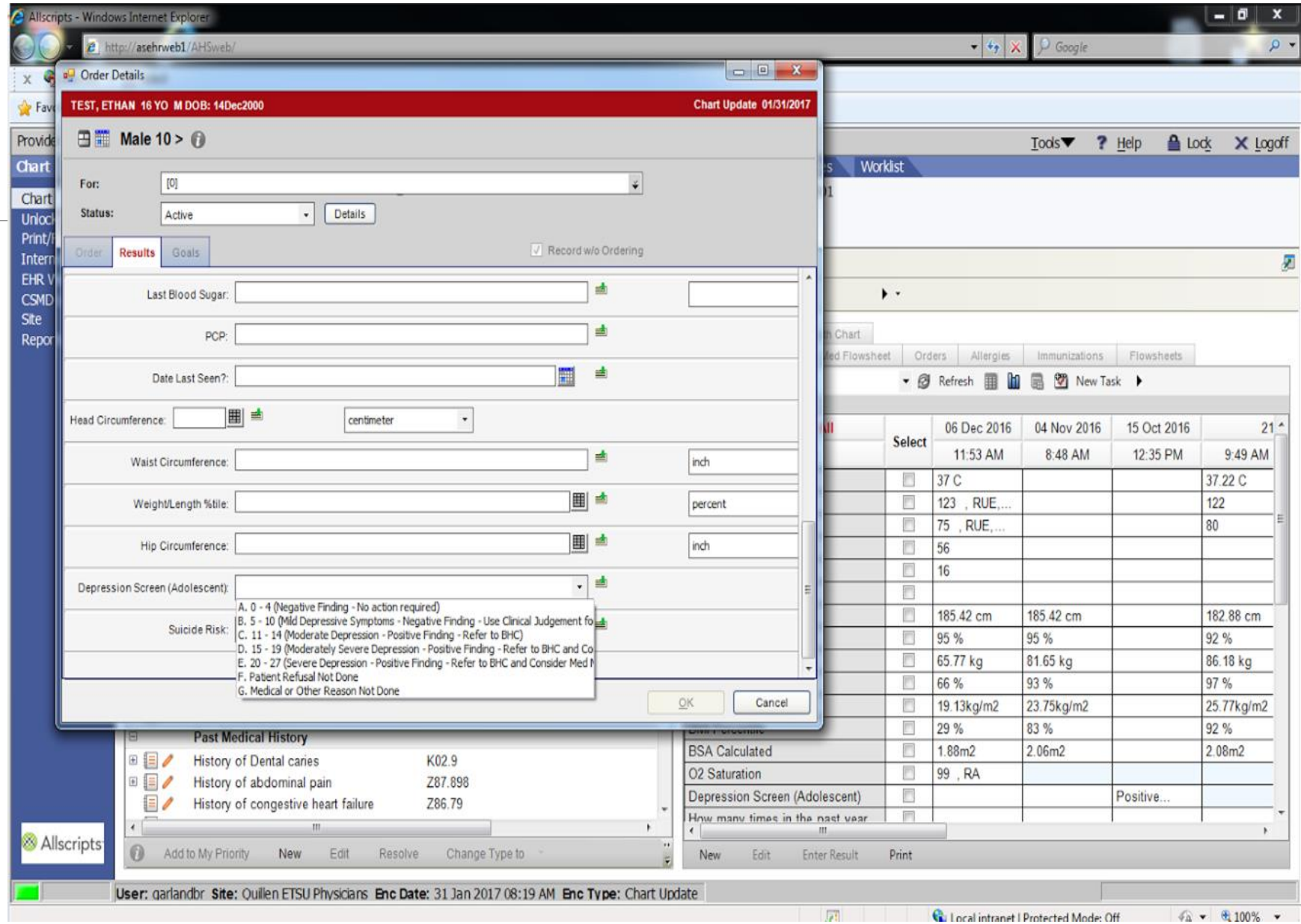
ADMINISTRATION : FRONT DESK STAFF

- The PHQ-9 will be given to patients 13 years and older at their annual WCC. The screener should be completed by the patient.



SCORING AND DOCUMENTATION OF DEPRESSION SCREEN: NURSE

- The nurse will score the PHQ-9 and will enter the appropriate score range in the Vitals panel under Depression Screen.



DOCUMENTATION OF SUICIDALITY: NURSE

- The nurse will also enter the corresponding answer to the Suicide Risk question. The suicide risk assessment should be marked “Positive” if Question 9 is marked as anything other than “not at all” OR if Question 12 is marked “yes”.

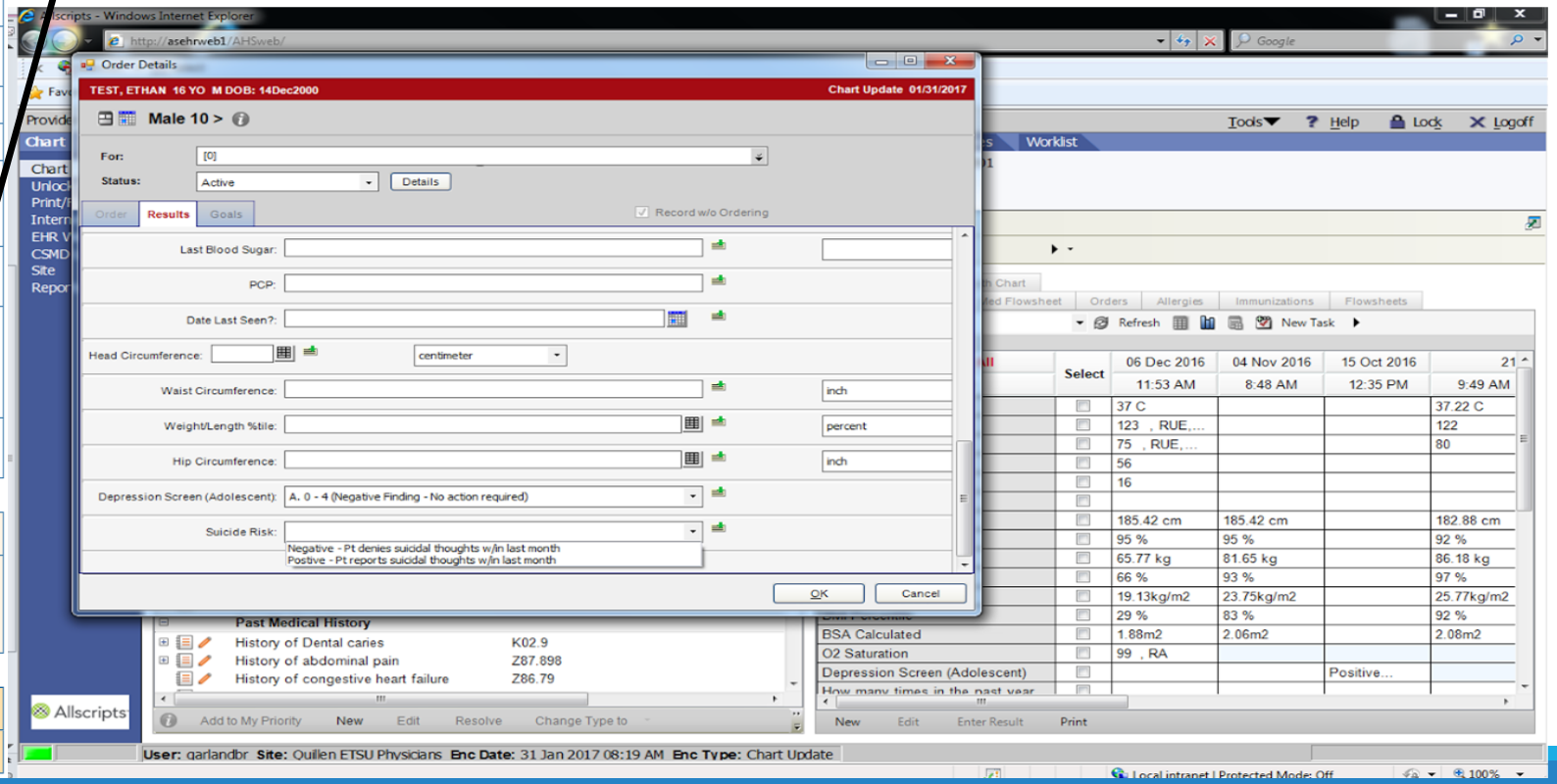
	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?			✓	
2. Little interest or pleasure in doing things?				✓
3. Trouble falling asleep, staying asleep, or sleeping too much?		✓		
4. Poor appetite, weight loss, or overeating?	✓			
5. Feeling tired, or having little energy?			✓	
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?			✓	
7. Trouble concentrating on things like school work, reading, or watching TV?		✓		
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?			✓	
9. Thoughts that you would be better off dead, or of hurting yourself in some way?		✓		

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☑ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☑ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☑ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☑ No



INTERPRETATION AND ACTION PLAN: PROVIDER

Score Ranges and Recommended Actions:

- 0-4 - **No action required**
- 5-10 – **Use Clinical Judgement**
- 11-14– **Refer to BHC**
- 15+ **Refer to BHC and Consider Med Management**
- **Regardless of the overall score, if the patient endorses suicidal ideation (via Questions 9, 12), refer to BHC and/or gather more information.**

Available Orders for BHC:

Behavioral Health Consultant – Warm Handoff

Order when BHC sees patient via warm handoff. This order does not route to worklist. Auto completes.

Behavioral Health Consultant – Phone Follow Up

Order when a phone follow up is needed by Behavior Health Team. Routes to BHC worklist.

Behavioral Health Referral – Outside Provider

Routes to Referral Worklist.

Behavioral Health Consultant – Scheduled Follow Up

Order when an appointment with BHC needs to be scheduled before the patient leaves. Routes to Check Out worklist.

ASSESSMENT AND BRIEF INTERVENTION: BHC

- BHCs can:
  - Assist in PHQ-9 interpretation with provider
  - Conduct clinical interview and made a diagnosis when applicable
  - Conduct suicide risk assessment when needed
  - Provide brief therapy
  - Help get patient referred/connected to longer term therapy when needed
  - Help reinforce your recommendations with patients and families

PRACTICE WITH DX AND INTERPRETATION

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?			✓	✓
2. Little interest or pleasure in doing things?				✓
3. Trouble falling asleep, staying asleep, or sleeping too much?		✓		
4. Poor appetite, weight loss, or overeating?	✓			
5. Feeling tired, or having little energy?			✓	
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?			✓	
7. Trouble concentrating on things like school work, reading, or watching TV?		✓		
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?			✓	
9. Thoughts that you would be better off dead, or of hurting yourself in some way?		✓		

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☑ Yes ☐ No

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12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☑ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☑ No

- Score?
- Diagnosis?
- Plan?

Less Involvement

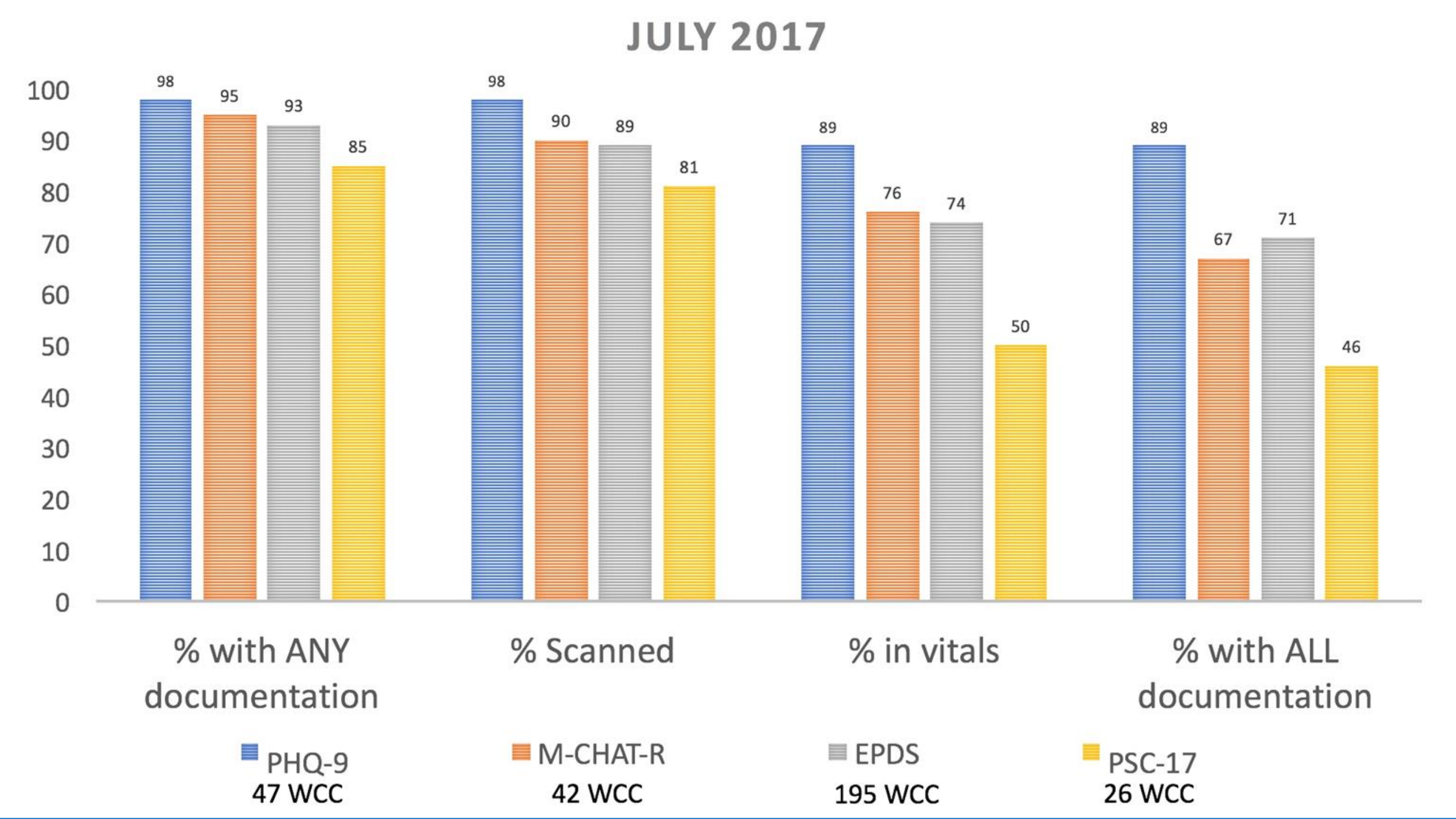
More Involvement

If <u>overall PHQ-9 score is 11+</u>
AND/OR <u>suicidality is endorsed via Question 9 or 12</u>
Then WARM HANDOFF TO BHC

- Use PHQ-9 along with your clinical interview to diagnose:
  - Major Depressive Disorder
  - Persistent Depressive Disorder
  - Unspecified Depressive Disorder
- Conduct suicide risk assessment as needed
- Provide brief counseling and prescribe medication when indicated

SCREENER IMPLEMENTATION: 5 LESSONS LEARNED

1. Form a small champion team that meets efficiently and as often as needed
2. Get buy in early and throughout the process and consider how the screener will impact each member of the clinic
3. Thoroughly vet your screening instrument (consider psychometrics, length, scoring, acceptability, etc.)
4. Find an effective way to train clinic staff in the new protocol
5. **Track relevant implementation metrics**


JULY 2017
100
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81
89
76
74
50
89
67
71
46
% with ANY documentation
% Scanned
% in vitals
% with ALL documentation
PHQ-9
47 WCC
M-CHAT-R
42 WCC
EPDS
195 WCC
PSC-17
26 WCC

BILLING AND REIMBURSEMENT

Timeframe: Feb 15 – March 31

	What we did	If we had billed for all screeners that we documented on	If we had screened and billed for all WCCs
# screeners billed	53	74	102
Projected Reimbursement	$236	$330 (+94)	$460 (+224)

Breakout Groups

1. Discussing Individual Screeners
2. Creating Champion Teams
3. Troubleshooting Implementation Efforts

Summary

BRINGING IT BACK TOGETHER

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Care Pathways and Evidence Based Interventions

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Nutrition and Exercise in Pediatric Primary Care

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The Why

Habits develop early and transmitted through family practices

- 16% of 1 y/o have a TV in their sleeping space[1]
- 33% of 10 m/o do not drink any water[2]
- For every 1 hr increase in TV, 3 y/o had increased intake of sweetened beverages, fast food, red & processed meat, and % energy from trans-fat[3]

Exposure to ~5,400 advertisements/yr for food/beverages[4]

~$1.6 billion/yr spent on marketing food products to children[5]

~20% ages 2 to 5 are overweight or obese[6]

Obese at age 6 have < 50% chance of being obese as adults, regardless of parental obesity status[7]

The Who:	Developmental Stage	Family Education	Interventions	Case Example
Infancy	-Parent learns feeding cues -Breastfeeding skills, if applicable -Transition to milk -Intro to solids	-Physical activity & time outside of devices such as bouncy seats -Screen time awareness -Sensory exploration with food -Introduction of solid foods	-Support groups -Lactation referrals -Verify understanding of growth chart -Planning family meals	Parents of 7 m/o say PCP told them to cut back on juice, but are worried about dehydration because baby doesn't like water.
Toddler	-Neophobia to foods -Preferences developing	-Focus on family foods -Modeling exploration -Establish rituals and routines -Encourage free play -Decoding food labels	-Plate A/Plate B -Addressing picky eating: Parent decides where, when, & what child eats. Child decides whether or not to eat & how much. -Discuss grazing and snacking habits	20 m/o refusing almost all solid foods and drinking substantial amount of formula, despite PCP advice to cut back.

The Who:	Developmental Stage	Family Education	Interventions	Case Example
Young Child	-Developing relationship to food -Increasing exposure to media	-Child autonomy and parental role -Cooking together -Balance of structured physical activities with free play	-Fun with Tastes! -Feeding the Whole Family, by Cynthia Lair -Parent coaching for nutrition language	Mom is making special dinners for her 5 y/o, because she refuses family meal. Eats mostly carbs and some fruits.
Older Child/ Teen	-More independence with food choices -Influence of peers -Body image	-Mindful eating -Goal setting for healthy habits -Identify physical activities of interest -Monitoring of screens/social media	-Mindful eating exercises -CBT as needed to address underlying MH needs -Address self-esteem -Sugar board	Overweight teen is now hiding food in her room because her parents are nagging her about food/eating

The What

BH visits aimed at behavioral & emotional aspects of eating, nutrition, and physical activity

Visit Elements:

- Education
- Provide resources
- Set goals
- Address psychological/emotional/family dynamics issues

Awareness of scope of practice issues and when to involve a nutritionist

- Enact recommendations by PCP by problem solving barriers, and generating ideas with the patient

The What:
Tips from the HALF Study (2009)[8]

- Parents are experts
- Empower parents to be models
- Realistic and actionable strategies
- Tailored and personalized information
- List of free activities
- Take time to explain the why
- Avoid obesity language

The When

Nutrition counseling part of every well visit

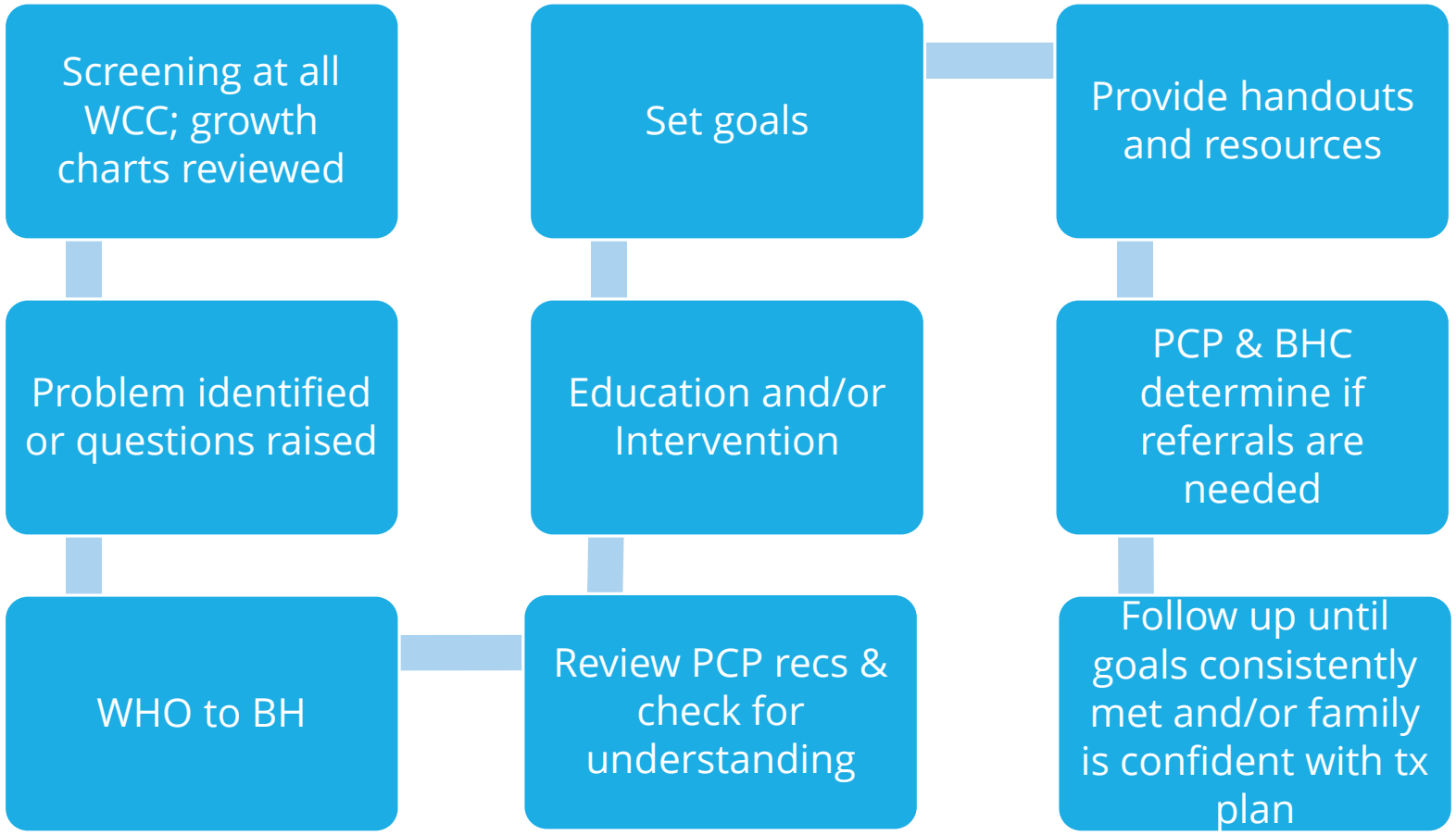
Conversation should be early and often

Utilize AAP interactive timelines to target discussion topics

Great way to introduce your BH services

Visits may be prompted by a family or PCP concern

The How


Screening at all WCC; growth charts reviewed
Problem identified or questions raised
WHO to BH
Review PCP recs & check for understanding
Education and/or Intervention
Set goals
Provide handouts and resources
PCP & BHC determine if referrals are needed
Follow up until goals consistently met and/or family is confident with tx plan

The How

Start with small, manageable goals

Mix up reduction goals with addition goals

Include child in goal setting

Ask families about culture and food practices; incorporate into your plan

Include parents &/or caregivers in plan and goals

Measure success by goal attainment, patient/family perception of improvement of health. Do not use weight as an indicator

Resources

Institute for Healthy Childhood Weight: Healthychildren.org

Evidence-based info/resources on sugar: http://sugarscience.ucsf.edu/

Grow Baby App

List of Apps supported by AAP focused on pediatric preventative health topics: https://www.aap.org/en-us/Pages/Get-the-AAP-Mobile-App.aspx

Guidelines for meal planning: www.myplate.gov

Interactive songs/games for kids: https://www.choosemyplate.gov/kids

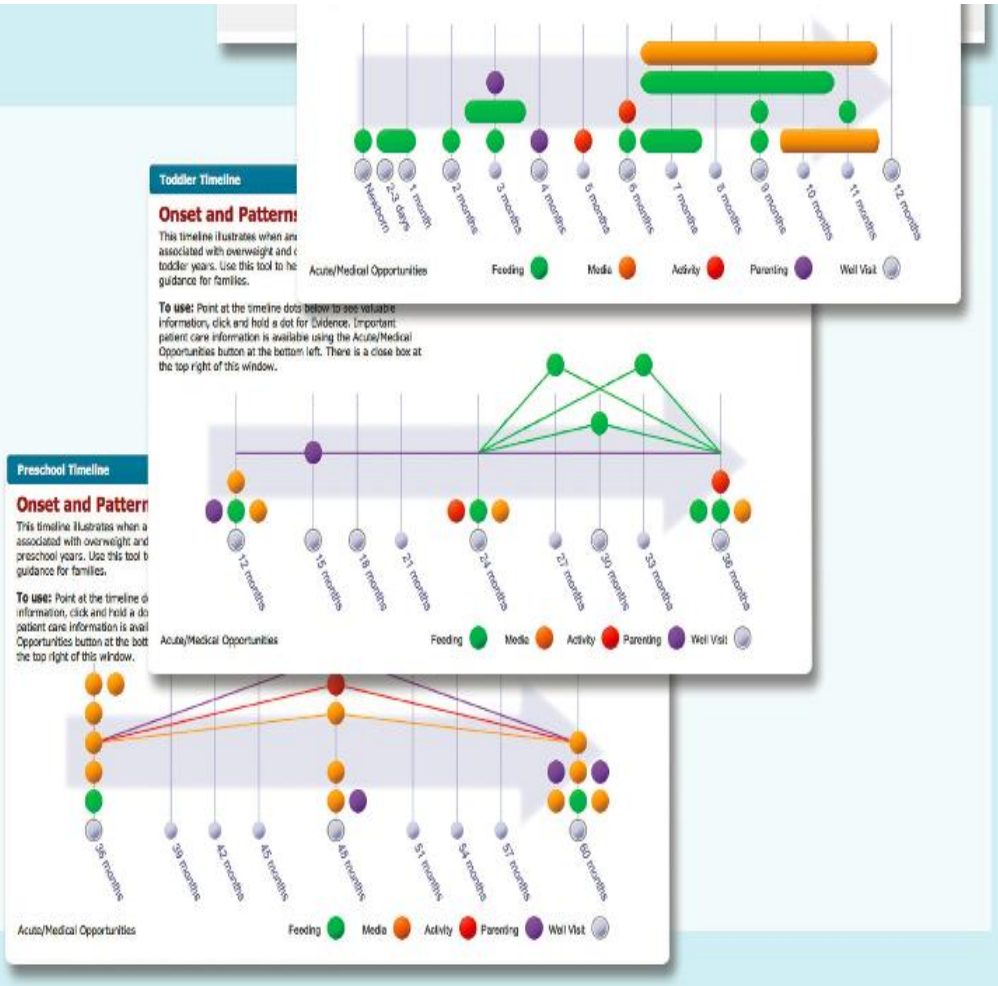
AAP HALF Implementation Guidelines: www.aap.org/HALFIG

HealthChildren.org Parent Resources

AAP Interactive Obesity Risk Timelines

Interactive Information

Three interactive *Onset of Risk Behaviors Timelines* exist. One for infants, toddlers and preschoolers to help clinicians prioritize what healthy active living topics to discuss during the 15 scheduled well visits from birth through age 5.



Sugar Demonstration Board

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Depression in Pediatric Primary Care

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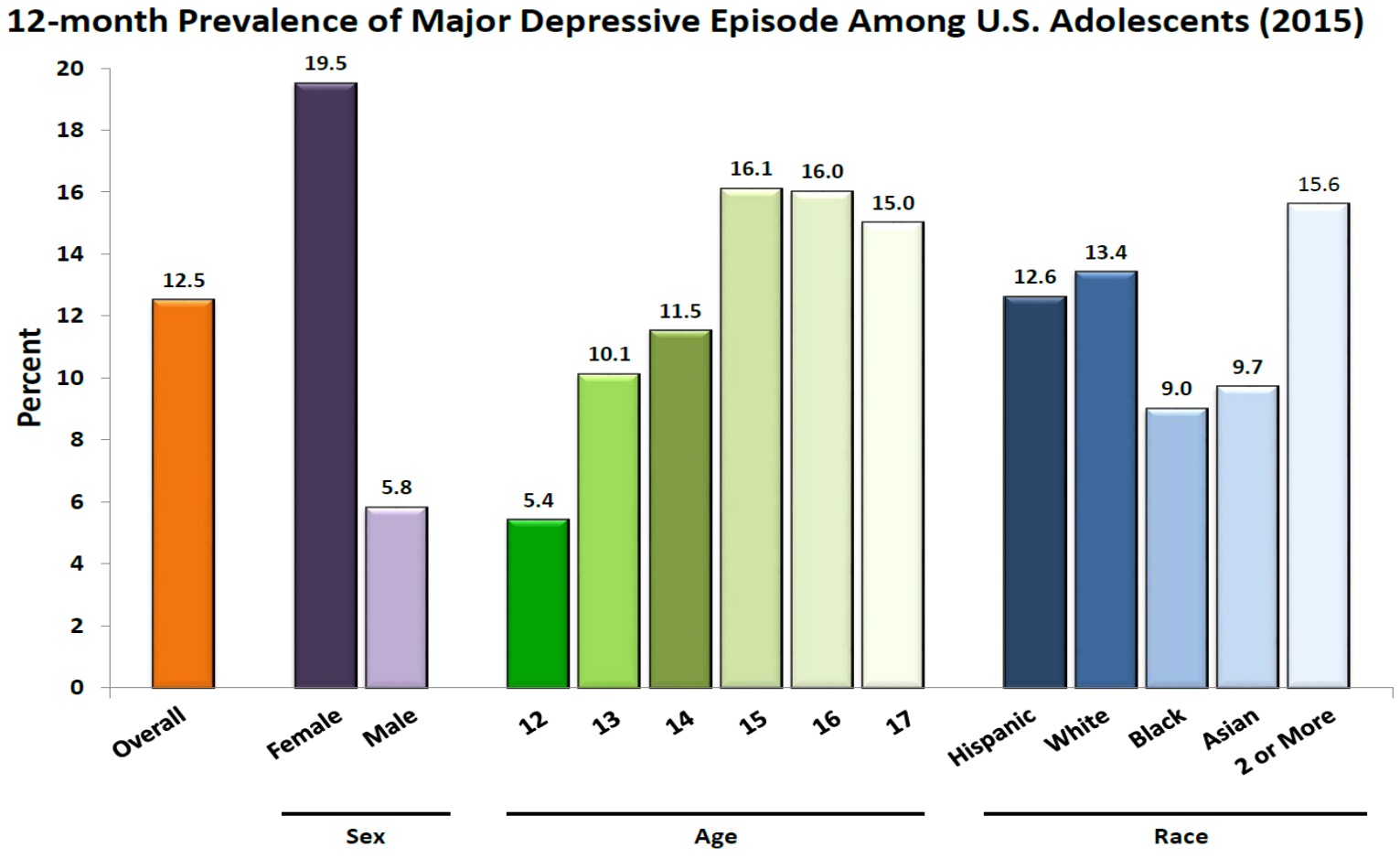
Depression



Data courtesy of SAMHSA

NIH National Institute of Mental Health

*NH/OPI = Native Hawaiian/Other Pacific Islander
**AI/AN = American Indian/Alaska Native

Depression: Care Pathway

Inclusion Criteria

Process for Identification

How to Connect Patient with BHC

Workflow Diagram

Inclusion into Pathway

Criteria to attend an IC appointment as part of standard evidence-based team healthcare:

- Patients or parents indicating concern for mood
  - 0-5 years old parents indicate depression concern on PCQ
  - 6-11 years old scoring 15+ on CES-DC
  - 12+ years old scoring 10+ on PhQ9
- New depression diagnosis
- Starting antidepressant medication or new antidepressant medication because the first was not adequately effective
- On antidepressant medication and have not seen PCP in over 12 months

Process for Identification

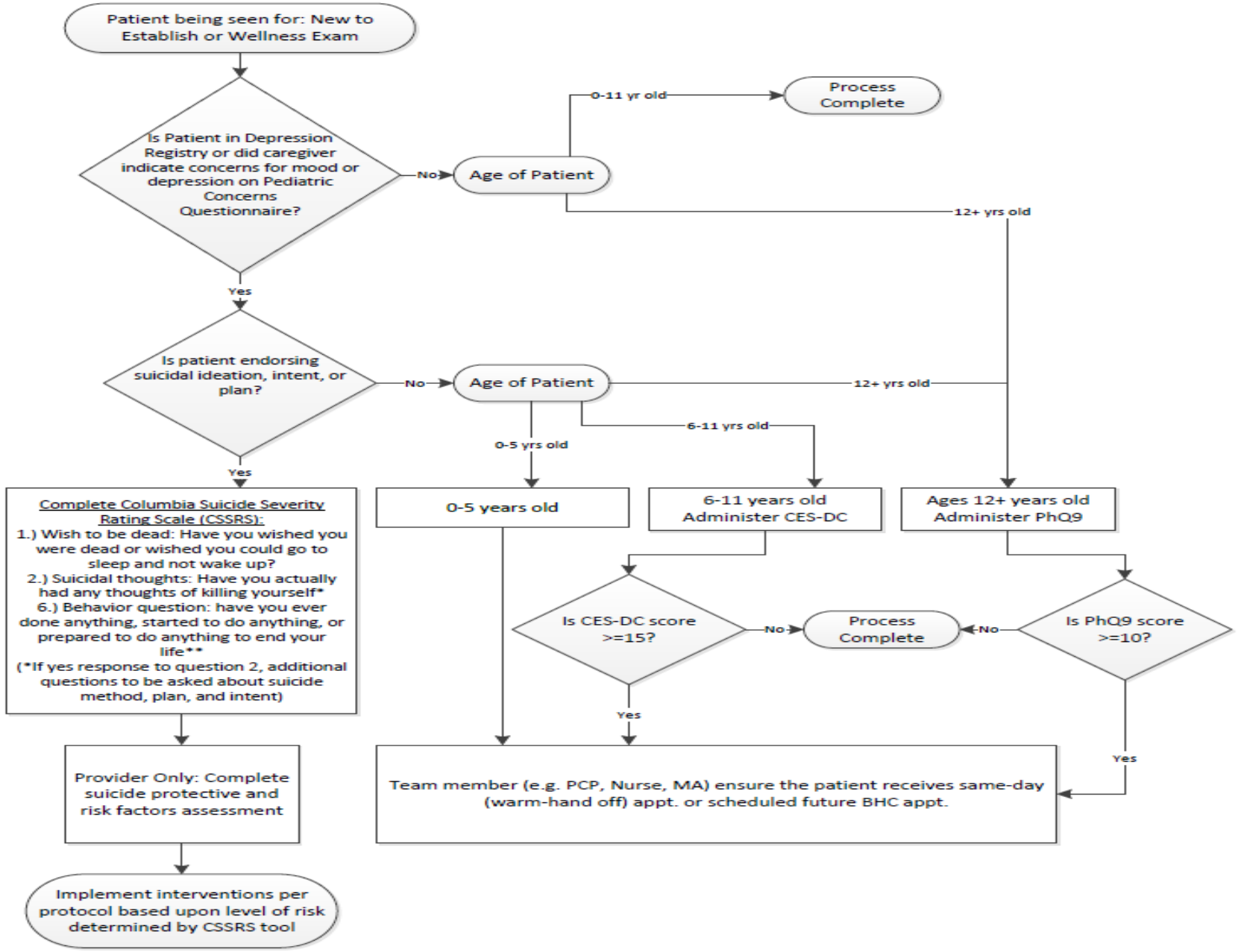
- Multiple methods to identify:
  - Morning huddle and review of PCP schedule
  - Identification by nurse/MA during screening
  - Identification by PCP during appointment
  - Patient or Caregiver identification
  - Parents of 0-5 yrs indicate concern on PCQ
  - 6-11 yrs scoring 15+ on CES-DC
  - 12+ yrs scoring 10+ on PHQ9

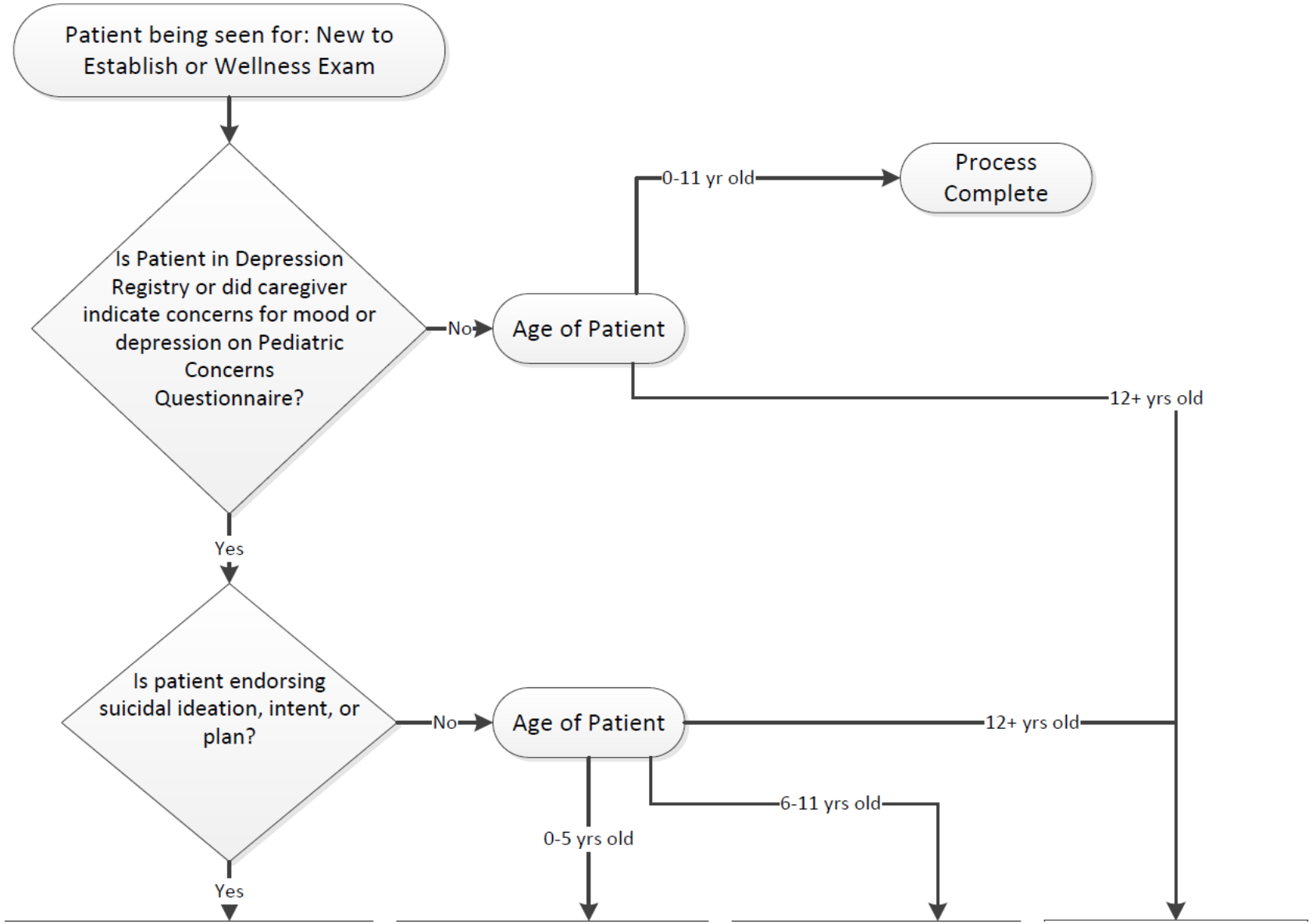
Connecting Patient with BHC

PCP/Nurse/MA ensure WHO and/or schedules future BHC appointment

Nurse/MA contact patient/guardian via phone or My Care messaging to encourage BHC appt

If patient/caregiver refuses to see BHC, the PCP/Nurse/MA may ask BHC to review EMR and document recommendations for care based on available data


Patient being seen for: New to Establish or Wellness Exam
Is Patient in Depression Registry or did caregiver indicate concerns for mood or depression on Pediatric Concerns Questionnaire?
No
Age of Patient
0-11 yr old
Process Complete
12+ yrs old
Yes
Is patient endorsing suicidal ideation, intent, or plan?
No
Age of Patient
12+ yrs old
0-5 yrs old
6-11 yrs old
Yes
Complete Columbia Suicide Severity Rating Scale (CSSRS):
1.) Wish to be dead: Have you wished you were dead or wished you could go to sleep and not wake up?
2.) Suicidal thoughts: Have you actually had any thoughts of killing yourself*
6.) Behavior question: have you ever done anything, started to do anything, or prepared to do anything to end your life**
(*If yes response to question 2, additional questions to be asked about suicide method, plan, and intent)
0-5 years old
6-11 years old Administer CES-DC
Ages 12+ years old Administer PhQ9
Is CES-DC score >=15?
No
Process Complete
No
Is PhQ9 score >=10?
Yes
Yes
Provider Only: Complete suicide protective and risk factors assessment
Team member (e.g. PCP, Nurse, MA) ensure the patient receives same-day (warm-hand off) appt. or scheduled future BHC appt.
Implement interventions per protocol based upon level of risk determined by CSSRS tool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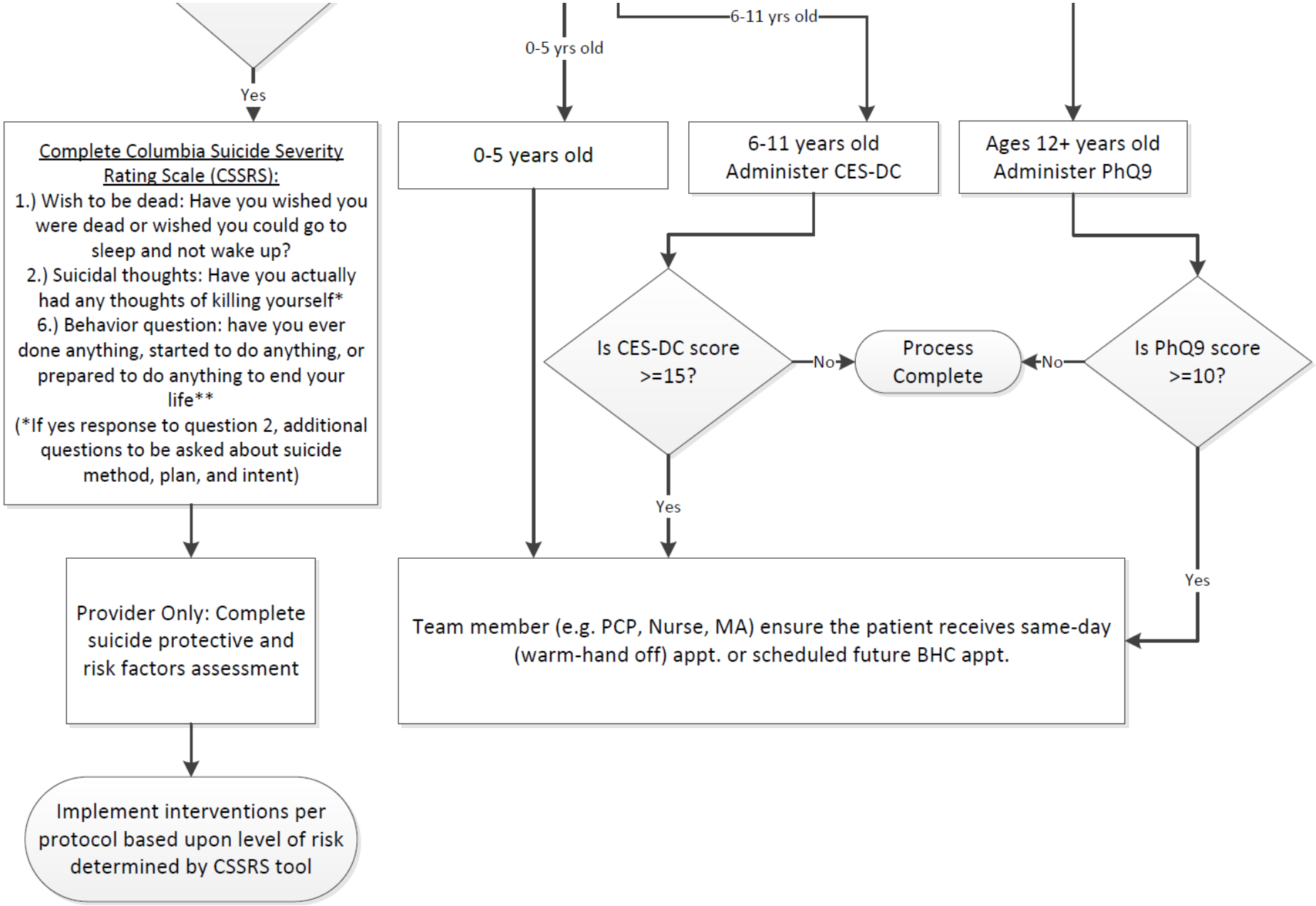
No
Age of Patient
12+ yrs old
6-11 yrs old
0-5 yrs old
Yes


Yes
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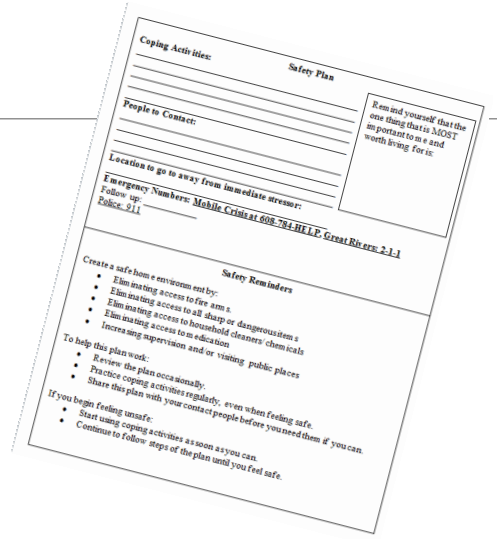
0-5 yrs old
6-11 yrs old
0-5 years old
6-11 years old
Administer CES-DC
Ages 12+ years old
Administer PhQ9
Is CES-DC score >=15?
No
Process Complete
No
Is PhQ9 score >=10?
Yes
Yes
Team member (e.g. PCP, Nurse, MA) ensure the patient receives same-day (warm-hand off) appt. or scheduled future BHC appt.

Suicide Risk Stratification	BH Consult	Interventions
<u>High Risk:</u> "Yes" to any of the following: -Suicidal intent (#4) -Specific plan (#5) -Suicidal bx (#6; < 3 mos)	Required	1. Safe immediate environment (Nursing staff) 2. Arrange for 1:1 (Nursing staff) 3. Develop appropriate action plan with clinic BHC or SW, if available, or on-call psychiatrist to discuss admission or appropriate next steps* i. If patient refuses admission, call Mobile Crisis ii. Follow local clinic protocol and state law for resource differences* 4. Provide 211/National Suicide Prevention Lifeline *Note: If admitted, have px escorted by 2 staff for safety
<u>Moderate Risk</u> "Yes" to any of the following: -Thoughts of killing self (#2) -Thinking about how (#3) -Suicide bx (#6; 3 mos to 1 yr)	Required	1. Work with BHC or SW, for further suicide risk assessment and next steps or Contact Assessment and Referral Team for urgent outpatient BH evaluation or Follow local clinic protocol and state law for resource differences 2. Provide 211/National Suicide Prevention Lifeline 3. Set follow-up appointment with PCP
<u>Low Risk</u> "Yes" to any of the following: -Wish to be dead (#1) -Suicide bx (#6; >1 yr)	PCP discretion	1. Provide 211/ National Suicide Prevention Lifeline 2. Work with BHC to set follow-up appointment with PCP and/or referral to Behavioral Health Department

BHC Evidence Informed Interventions


Safety Plan

Coping Activities:

People to Contact:

Location to go to away from immediate stressor:

Emergency Numbers: Mobile Crisis at 608-784-HELP, Great Rivers: 2-1-1

Follow up:
Police: 911

Remind yourself that the one thing that is MOST important to me and worth living for is:

Safety Reminders

Create a safe home environment by:
- Eliminating access to fire arms
- Eliminating access to all sharp or dangerous items
- Eliminating access to household cleaners/ chemicals
- Eliminating access to medication
- Increasing supervision and/or visiting public places

To help this plan work:
- Review the plan occasionally.
- Practice coping activities regularly, even when feeling safe.
- Share this plan with your contact people before you need them if you can.

If you begin feeling unsafe:
- Start using coping activities as soon as you can.
- Continue to follow steps of the plan until you feel safe.

- Warm Hand Off
  - Behavioral Activation
  - Assess and Manage Risk: Safety Planning
  - Psychoeducation
- BHC Appointment
  - Assessment of Depressive symptoms
  - Psychoeducation on depression developing understanding of relationship between thoughts, emotions, and behavior
  - Mood monitoring
  - Problem Solving
  - Cognitive Restructuring


Depression

What Is Depression?

Depressed mood varies from person to person and can look like:

Sad or cranky mood
Low energy
No longer wanting to do fun stuff
Avoids being social with friends or family
Loses weight or does not feel hungry
Problems with focus

Feeling hopeless
Low self esteem
Problems making choices
Body pain complaints (head or tummy aches)
Thoughts or actions to hurt or kill self (cutting, burning, scratching)

Factors that may impact depression:
- Family history
- Hormones or brain chemistry
- Having a life stressor (such as breakups, death, or being bullied)

Treatment

Following BHC Intervention

- BHC provides updates to PCP regarding interventions selected, plan, and offer recs to IPC team after patient contact

- BHC recommends referrals to other services as appropriate

Depression: Information for Clinic Staff

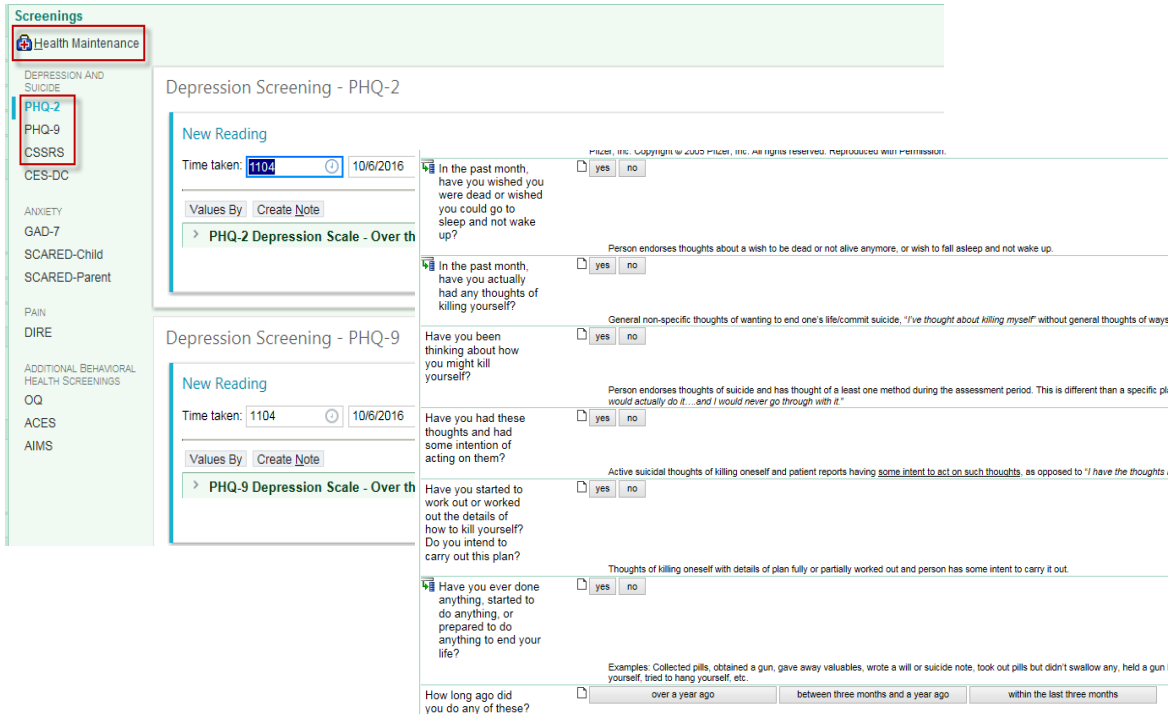
Workflow

EMR

Scripting

Handouts

What the BHC can do with more time



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Geisinger Caring

Sleep in Pediatric Primary Care

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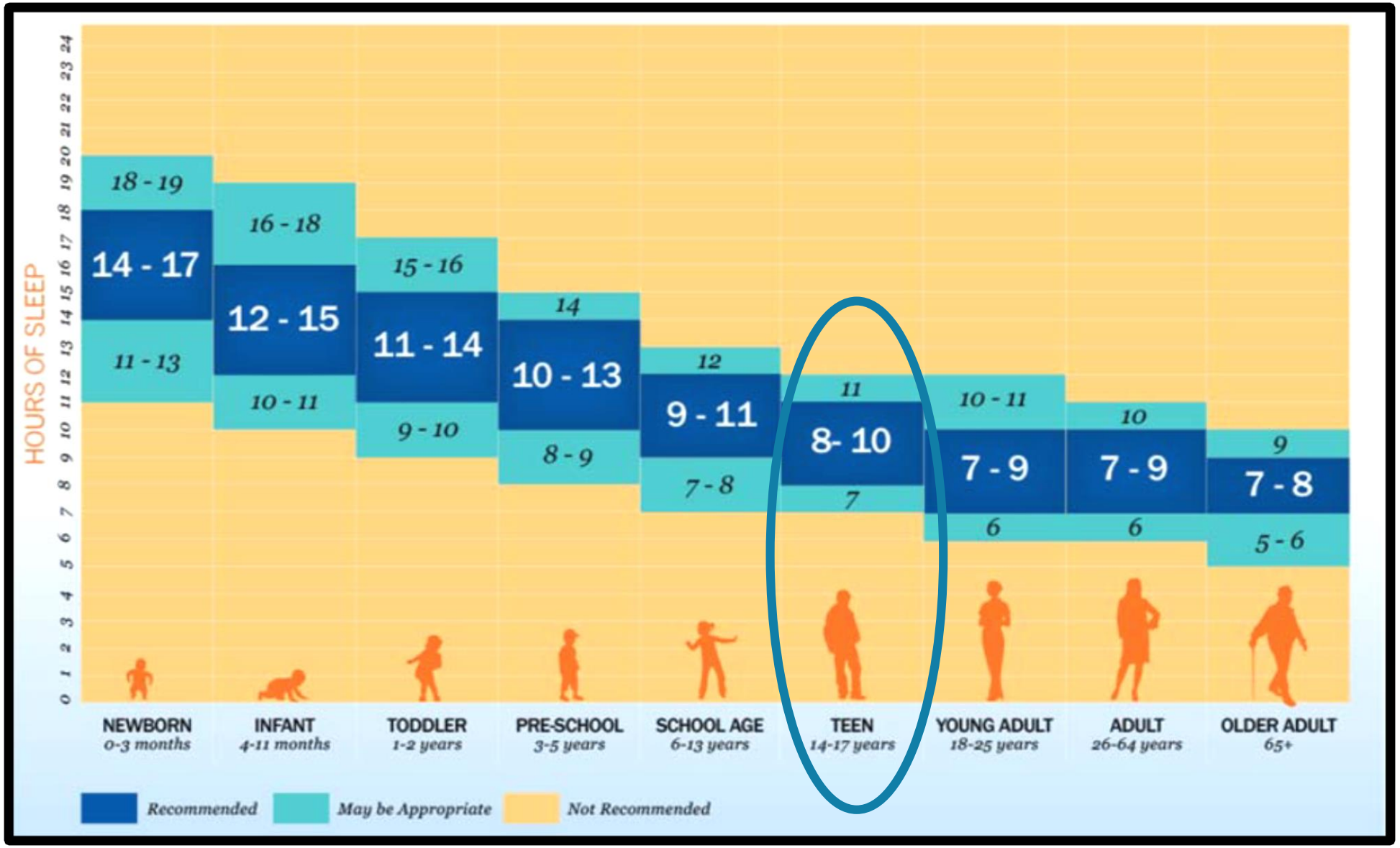
Assistant Professor, Temple University


HOURS OF SLEEP
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
NEWBORN
0-3 months
18 - 19
14 - 17
11 - 13
INFANT
4-11 months
16 - 18
12 - 15
10 - 11
TODDLER
1-2 years
15 - 16
11 - 14
9 - 10
PRE-SCHOOL
3-5 years
14
10 - 13
8 - 9
SCHOOL AGE
6-13 years
12
9 - 11
7 - 8
TEEN
14-17 years
11
8- 10
7
YOUNG ADULT
18-25 years
10 - 11
7 - 9
6
ADULT
26-64 years
10
7 - 9
6
OLDER ADULT
65+
9
7 - 8
5 - 6
Recommended
May be Appropriate
Not Recommended

How well are children actually sleeping?

69% experience 1+ sleep problems a few nights a week

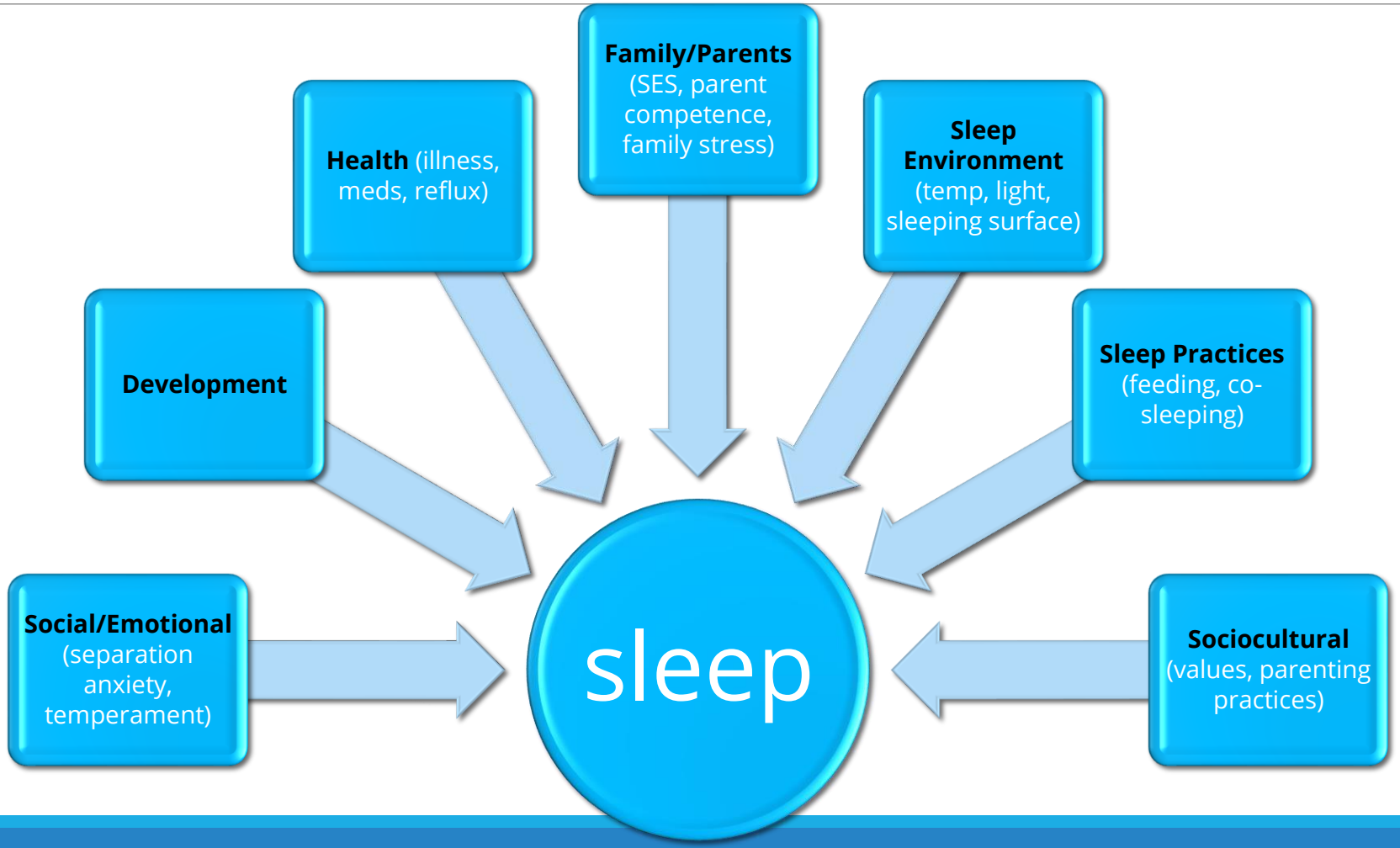
30% wake at least once a night

1 in 5 teens sleep 9+ hours on school nights. 45% sleep < 8 hours

Early elementary students miss 1-2 hours of sleep per night

Only 4% pediatric primary care patients have diagnosis

Factors Affecting Sleep



Why are children not sleeping?

Toddlers: 25-40%
- Bedtime resistance & nighttime awakenings

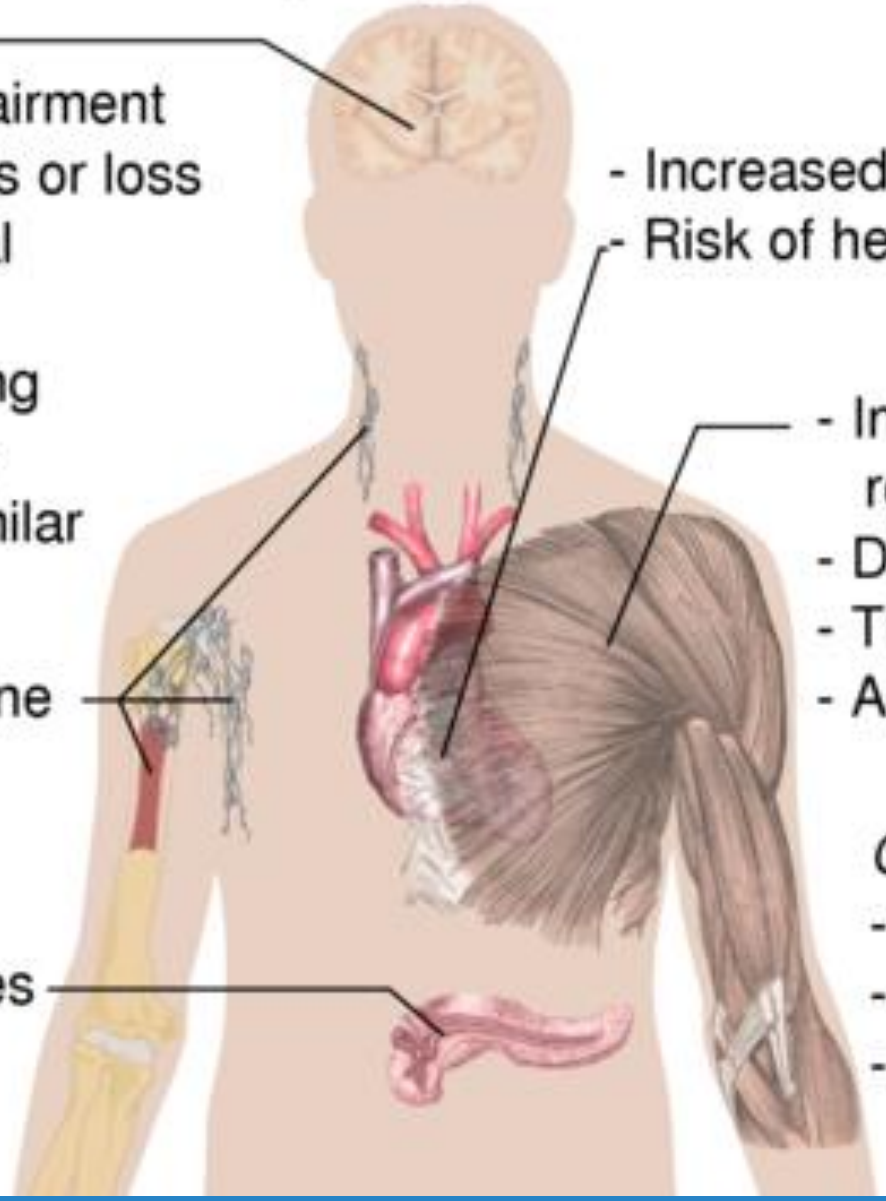
Preschoolers: 15-30%
- Nighttime fears, bedtime resistance, & night awakenings.
- Sleepwalking and Sleep Terrors

School age (6-12 years): 35%
- Bedtime resistance, anxiety, enuresis, & daytime sleepiness

Adolescents: at least 20%
- Sleep deprivation, poor sleep hygiene, & delayed sleep onset

Effects of

Sleep deprivation



- Irritability
- Cognitive impairment
- Memory lapses or loss
- Impaired moral judgement
- Severe yawning
- Hallucinations
- Symptoms similar to ADHD

- Impaired immune system

- Risk of diabetes Type 2

- Increased heart rate variability
- Risk of heart disease

- Increased reaction time
- Decreased accuracy
- Tremors
- Aches

Other:

- Growth suppression
- Risk of obesity
- Decreased temperature

Regular WCC Screening

- Snoring (pitch, quality, pauses, intensity, onset, frequency, duration)
- Sleep patterns (timing, restlessness, sleep positions, behavior during sleep, noisy arousals)
- Functioning while awake (development, school performance, personality, morning headaches, hyperactivity)
- Growth - Failure to thrive, obesity

Interview

Never ask:
- How many hours do you sleep
- Is your child getting enough sleep

Do ask:
- Bed time
- Time of sleep onset
- Total time awake during night wakings
- Wake time

Look for red flags

Red flags

Daytime sleepiness

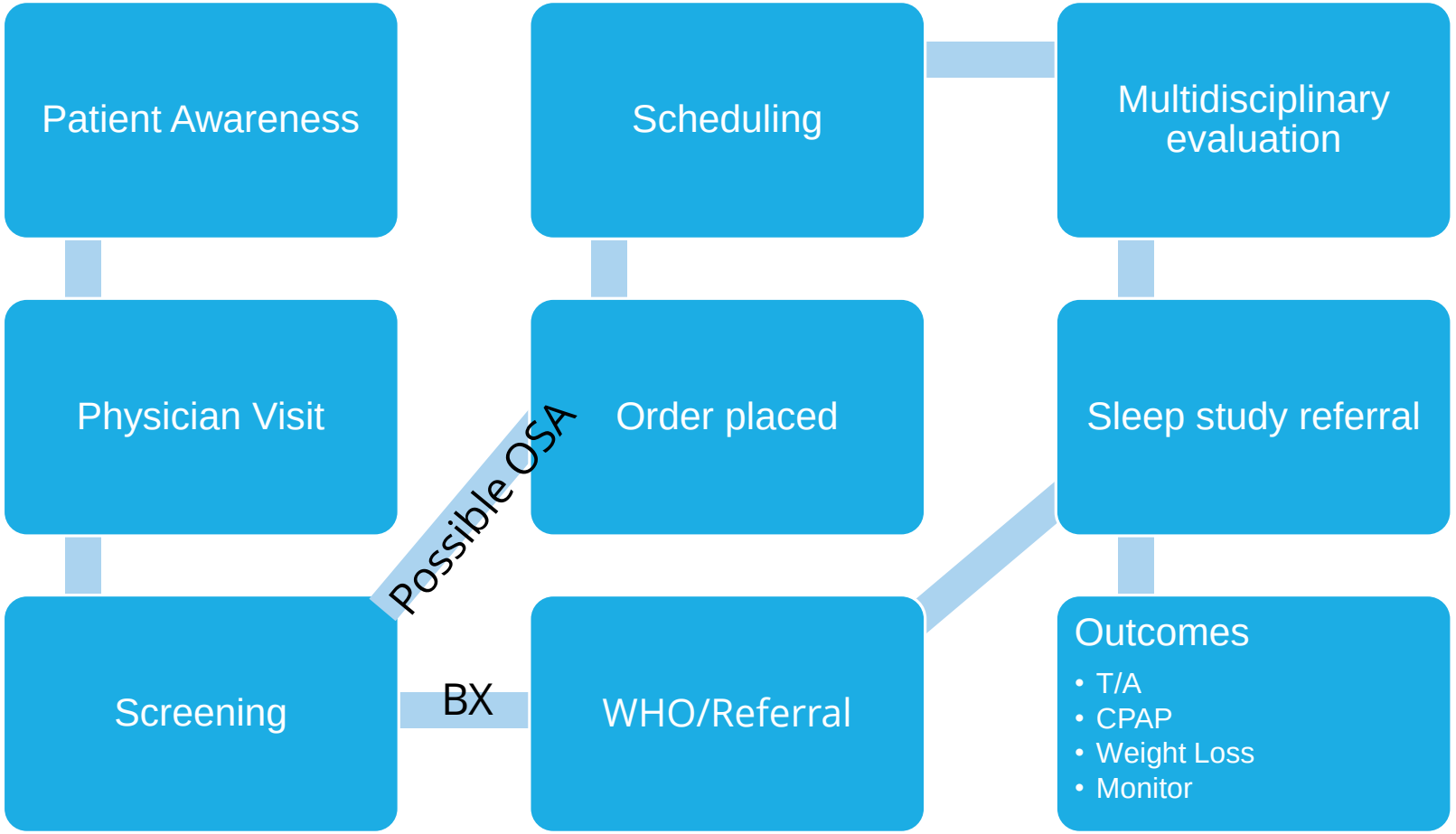
Difficulty waking in the morning

Falls asleep on short car trips

Sleeps more than 1 hour longer if allowed to wake spontaneously

Personality changes later in the day

Assess for snoring if yes to any of the above



Sleep Clinic Referral Process

BEARS

- Comprehensive screen for major sleep disorders
- Five major sleep domains
  - Age-appropriate “trigger questions” for use in the clinical interview
- Ages 2 to 18

	Toddler/preschool (2-5 years)	School-aged (6-12 years)	Adolescent (13-18 years)
Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does she still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day or take haps? (P) Do you feel tired a lot? (C)	Do you feel sleep a lot during the day? In school? While driving? (C)
Awakenings during the nightv	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night? Any sleepwalking or nightmares? (P) Do you wake up a lot at night? Have trouble getting back to sleep? (C)	Do you wake up a lot at night? Have trouble getting back to sleep? (C)
Regularity and duration of sleep	Does your child have a regular bedtime and wake time? What are they?	What time does your child go to bed and get up on school days? Weekends? Do you think he/she is getting enough sleep? (P)	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
Snoring	Does your child snore a lot or have difficult breathing at night?	Does your child have loud or nightly snoring or any breathing difficulties at night? (P)	Does your teenager snore loudly or nightly? (P)

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Answer considering how you have felt over the past week or so.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

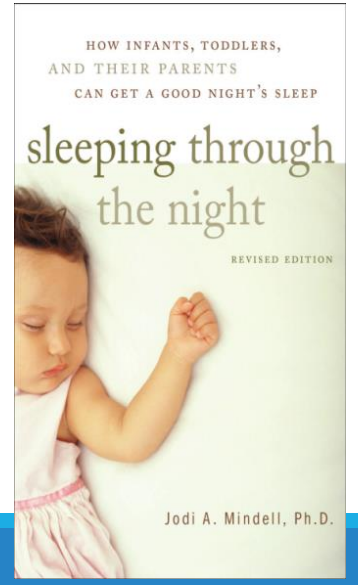
_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g. movie theater, meeting)
_____ As a passenger in a car for a hour without a break
_____ Lying down to rest in the afternoon when able
_____ Sitting and talking to someone
_____ Sitting quietly after lunch (without alcohol)
_____ In a car while stopped for a few minutes in traffic

Total Score_____

If you scored 10 or more please discuss this with your personal healthcare providor.

Role of the WHO: Prevention

- Put baby to bed drowsy but awake
- Keep a consistent schedule
- Remember that most babies do not need to be fed at night after 6 months of age
- Ensure an appropriate sleep environment
- Wake up and bright light exposure



Role of the WHO: Sleep Habits

75% of all sleep problems can be resolved with good sleep hygiene (Durand, 2008)

- Consistent Bedtime (<1 hour difference)
- Consistent waketime
- <30 minute bedtime routine
- Calming activities
- Snack but not a meal
- Limit or cut out caffeine (6 hours)
- Appropriate Environment
- Nap times/ages
- No watching TV in bed/No electronics for 1 hour

Role of the WHO: In Depth Assessment

(1) Bedroom Environment
- Familiar, non-stimulating, dark, quiet, comfortable temperature

(2) Bedtime Skills/Interactions
- Bedtime routine, independent sleep, nighttime awakenings

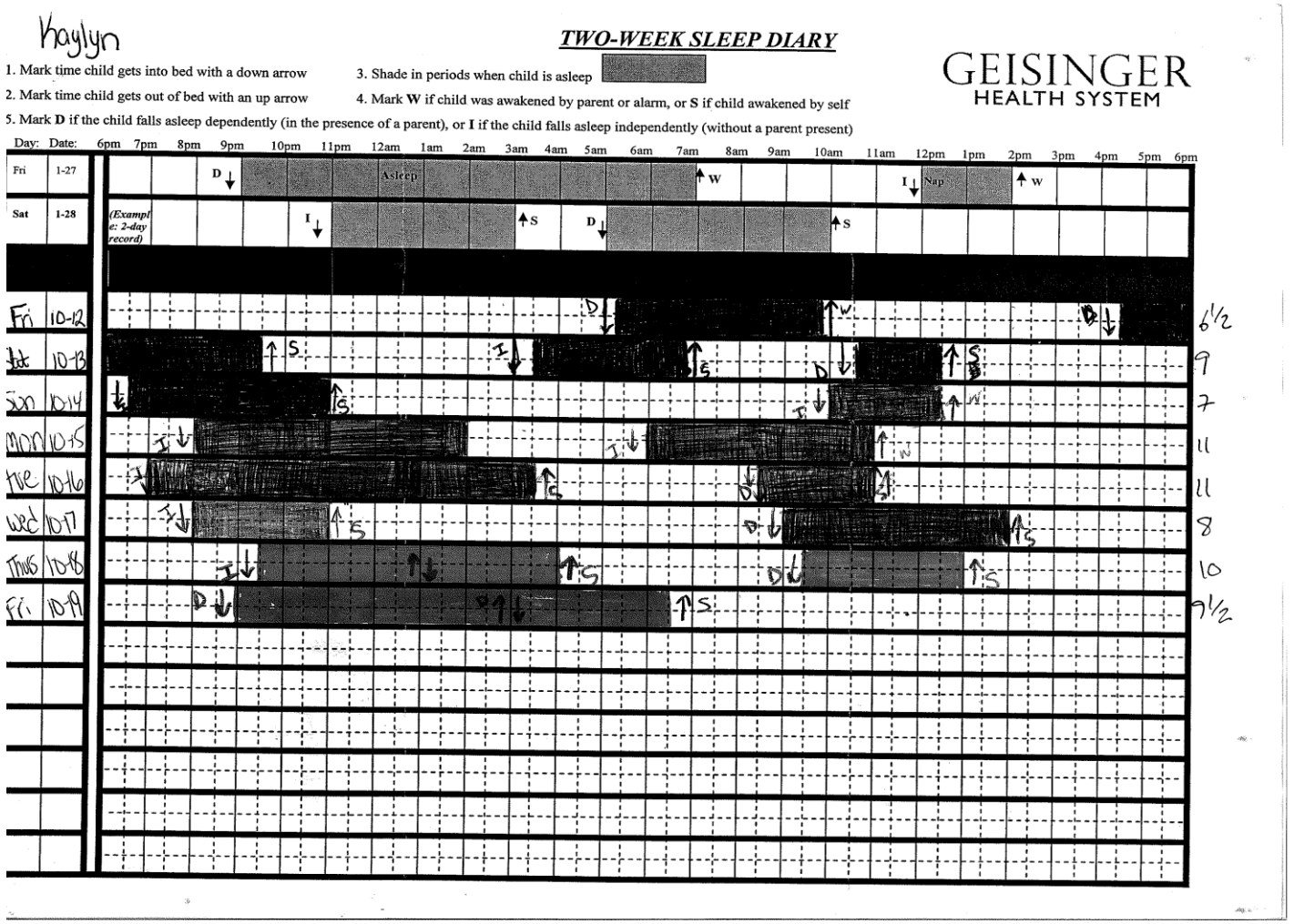
(3) Sleep-wake Schedule
- Bedtime, sleep-onset latency, wake time, sleep efficiency, naps

(4) Daytime Behavior/Skills
- Compliance, activity level, mastery of fears

(Kuhn 2007)

Sample Sleep Diary

3 yo



Kaylyn

TWO-WEEK SLEEP DIARY

GEISINGER HEALTH SYSTEM

1. Mark time child gets into bed with a down arrow
2. Mark time child gets out of bed with an up arrow
3. Shade in periods when child is asleep
4. Mark **W** if child was awakened by parent or alarm, or **S** if child awakened by self
5. Mark **D** if the child falls asleep dependently (in the presence of a parent), or **I** if the child falls asleep independently (without a parent present)

Day: Date: 6pm 7pm 8pm 9pm 10pm 11pm 12am 1am 2am 3am 4am 5am 6am 7am 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm

Fri 1-27 — Asleep — Nap

Sat 1-28 — (Example: 2-day record)

Fri 10-12 — 6½

Sat 10-13 — 9

Sun 10-14 — 7

Mon 10-15 — 11

Tue 10-16 — 11

Wed 10-17 — 8

Thurs 10-18 — 10

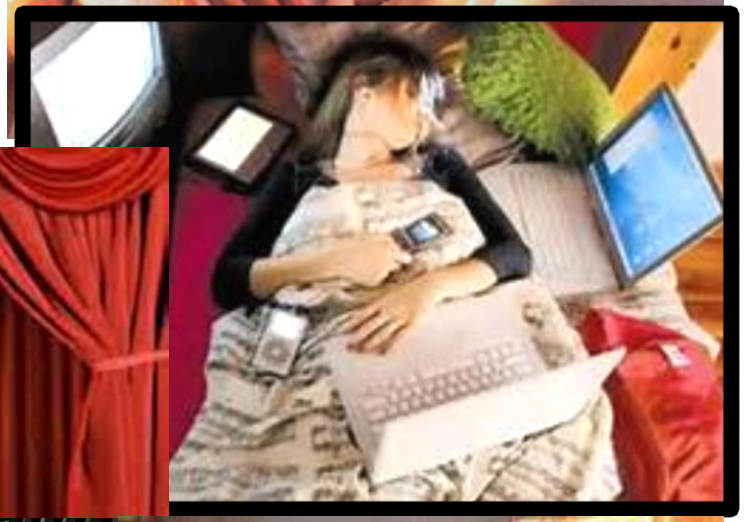
Fri 10-19 — 9½

Sample Behavior Log

BEHAVIOR LOG for Emma

Date	Time	Behavior at Bedtime	Your Response	Behavior During Awakenings	Your Response
3/19	9:15	Crying, throwing toys	Told her to stop, let her fall asleep on the couch		
3/20	9:30	Crying, screaming	Let her fall asleep in my lap		
3/20	12:30			Crying "Mommy!"	Let her come into our bed
3/21	9:15	Whining	Let her watch TV until she fell asleep in the TV room		

Role of the WHO: Intervention



Additional Resources

Mindell, J. A., & Owens, J. A. (2015). *A clinical guide to pediatric sleep: diagnosis and management of sleep problems*. Lippincott Williams & Wilkins.

Perlis, M. L., Aloia, M., & Kuhn, B. (Eds.). (2010). *Behavioral treatments for sleep disorders: a comprehensive primer of behavioral sleep medicine interventions*. Academic press.

Mindell, J. (2005). *Sleeping through the night: How toddlers and their parents can get a good night's sleep.* Amazon.

Owens, J., & Mindell, J. (2005). *Take charge of your child's sleep: The all-in-one resource for solving sleep problems in kids and teens.* Marlowe and Company.

Peterson, J., & Peterson, M. (2003). *Sleep fairy.* Behave'n Kids Press.

Training BHCs for Pediatric PCBH

LESLEY MANSON, PSY.D.

TAWNYA MEADOWS, PH.D.

Bottom Line Beginnings

Knowledge and development of:

- Child and adolescent development
- Family systems
- Psycho-social-behavioral-education matching developmental and health recommendations
- School and community systems and resources
- Pediatric primary health care schedules and needs
- Brief screening tools
- Legal, ethical, and professional practices
- Review pediatric competencies in practice

Competencies

- Attention-deficit/hyperactivity disorder
- Anxiety and depression
- Asthma
- Obesity
- Substance use
- Psychiatric and social emergencies
- Science
- Systems
- Professionalism
- Relationships
- Building resilience in all children
- Promoting healthy lifestyles
- Preventing or mitigating behavioral, developmental, mental health and substance use problems
- Identifying risk factors and emerging health problems in children and their families
- Partnering with families, schools, agencies, and mental health specialists to plan assessment and care
- Application and education
- Awareness of resources for children, adolescents, and families

Flexibility

- Be prepared for anything
  - WHOs
  - Tantrums
- Juggling multiple roles
- Prioritize timely tasks (mandated child abuse reports)

Office Set Up

Resource Library

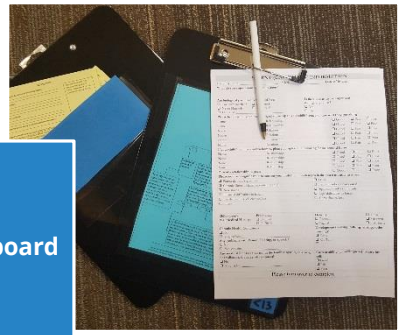
Behavior Passport

Shot Administration Distraction Kit

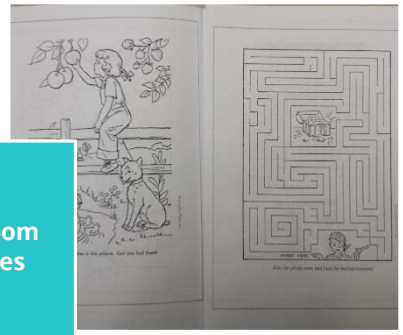
Pill Swallowing Kit

Rating Scales

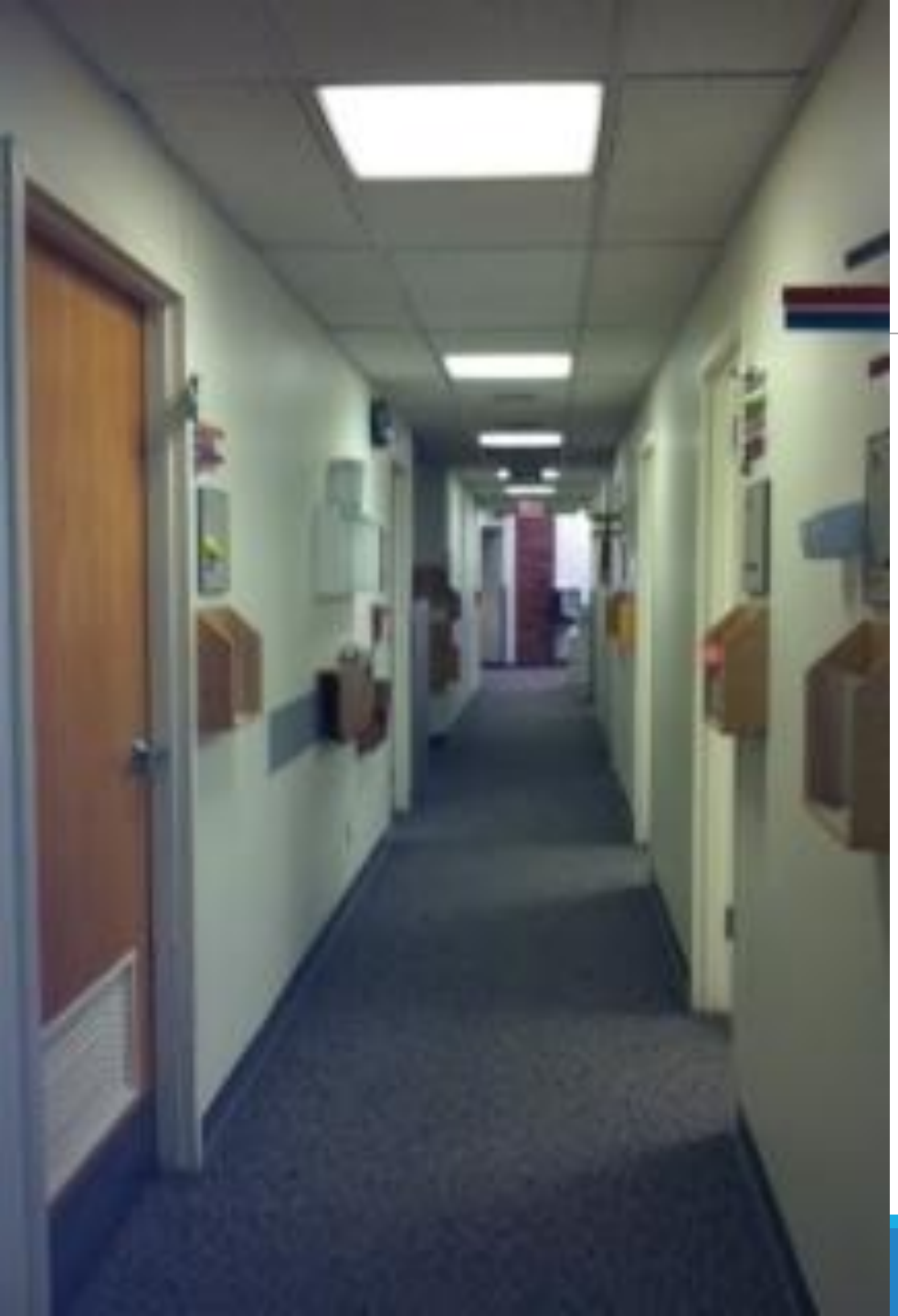
WHO Clipboard



Exam Room Activities



Waiting Room Bulletin Board



Training on “How to Use BHCs”

- Tailor talk to stakeholders (receptionists vs nurses vs providers)*
- Essential Components of Successful Referrals*
- Problem of the week*
- Brown bag lunches
- Verbal feedback on patients
- Location , Location, Location

Questions and Answers

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION