Systems of Care & Healthy Mental Development: Effective Strategies to Support CYSHCN in the Medical Home
Webinar Series
Episode 2

A webinar series brought to you by the National Resource Center for Patient/Family-Centered Medical Home

Thursday, June 30, 2022
12:00pm – 1:00pm CT
RECORDING

• This meeting will be recorded for educational purposes and shared with participants publicly via the medical home website.
HOUSEKEEPING

- All participants have been muted
- Live captioning is available
- Utilize Q&A box for questions for faculty throughout the presentation
ATTRIBUTION

National Resource Center for Patient/Family-Centered Medical Home

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DISCLOSURES

• Faculty have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this activity.
• Faculty do not intend to discuss an unapproved/investigative use of a commercial product/device in their presentations.
LAND ACKNOWLEDGEMENT

- We acknowledge the land in DuPage County, Illinois, in which the AAP Headquarters is located, is the original homelands of the Council of Three Fires—the Ojibwe, Odawa, and Potawatomi—and many other tribes that resided on or migrated through this land for generations, including the Illinois, Miami, Sauk, Fox, Kickapoo, and Ho-Chunk tribal nations. We can and should actively give voice to and solicit experience from Indigenous communities and all marginalized communities to inform our collective efforts to meaningfully, equitably, sustainably, and effectively address the needs of families from these diverse communities.
Dana Yarbrough
Associate Director, Partnership for People with Disabilities
Director, Center for Family Involvement
Virginia Commonwealth University

- Dana Yarbrough is the associate director of the Partnership for People with Disabilities, Virginia’s university center for excellence in developmental disabilities located at Virginia Commonwealth University. Among her many roles at VCU, Dana directs the Center for Family Involvement and youth transition related projects. Dana is also the mother of a young adult daughter who despite significant physical, intellectual and sensory disabilities owns her own dog boarding business.
SERIES’ LEARNING OBJECTIVES

At the end of the presentation, participants will be able to:

• Describe the systems of care providing behavioral and mental health needs for CYSHCN among pediatricians, allied health professionals, Title V programs and other partners.

• List key partners and collaborators within the behavioral and mental health systems of care at the practice, community, and state levels.
SERIES’ LEARNING OBJECTIVES (CONT)

- Discuss the role of the patient/family-centered medical home in supporting behavioral and mental health care for CYSHCN.
- Identify practical strategies for medical home and care coordination and integration of behavioral and mental health services for CYSHCN that can be implemented at the clinic, community, and systems levels.
Marian Earls, MD, MTS, FAAP
General Pediatrician
Developmental & Behavioral Pediatrics
Cone Health Medical Group, Pediatric Specialists

- Marian Earls is board-certified in both General Pediatrics and Developmental and Behavioral Pediatrics. Her career has focused on Medicaid and Early and Periodic Screening, Diagnostic and Treatment policy, and quality implementation in practice. Dr. Earls is the developmental and behavioral pediatrician of the NICU Developmental Follow-up Clinic for Cone Health System in Greensboro. She is a Clinical Professor of Pediatrics for the University of North Carolina Medical School.
Dr Rich Antonelli is a general pediatrician whose clinical work over nearly 4 decades has focused on providing care for children, youth, and young adults with special health care needs. As the Medical Director of Integrated Care at Boston Children’s Hospital, in the Department of Accountable Care and Clinical Integration, Dr Antonelli focuses on developing and implementing methodologies, tools, processes, and measures to facilitate and improve integration of care and care coordination—especially for children and youth with special health care needs and for adults with complex needs transitioning from pediatric to adult care.
Care Coordination and Care Integration are Essential

Richard Antonelli, MD, MS, FAAP
General Pediatrician
Medical Director, Integrated Care
Boston Children’s Hospital
Harvard Medical School
Medical Director, National Center Care Coordination Technical Assistance
Racial Disparities

- African American children with IDD are often diagnosed years after the onset of symptoms.
- Autistic people who are Black or Hispanic are twice as likely to report poor or fair mental and physical health as autistic people who are white.
- Black and Hispanic autistic people also experience higher rates of diabetes and other chronic medical conditions than white autistic people.
Five-Year Trends in US Children's Health and Well-being, 2016-2020

Lydie A. Lebrun-Harris, PhD, MPH; Reem M. Ghandour, DrPH, MPA; Michael D. Kogan, PhD; Michael D. Warren, MD, MPH

Figure 1. Trends in Selected Measures of Children's Health Conditions, Positive Health Behaviors, and Health Care Utilization, 2016-2020
**Integrated Care**

seamless provision of health care services, from the perspective of the patient and family, across entire care continuum. It results from coordinating the efforts of all providers, irrespective of institutional, departmental, or community-based organizational boundaries.

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**Care Coordination**

activities in “the space between”- visits, providers, hospital stays that co-create (with patient and family) and implement a plan of care.

MEASURE WHAT MATTERS: DOMAINS OF INTEGRATED CARE

Care Coordination

- Care Coordination Measurement Tool (CCMT)
- High Quality Handoffs: Clinician Reason for BCH Visit and Action Grid
- Inter-professional Education: Care Coordination Curriculum and Integrated Care Bootcamp

Person, Patient, Family, Caregiver Experience

- Pediatric Integrated Care Survey (PICS)

Provider Experience

- PCP Experience of Care Integration Survey

Utilization and Financial Outcomes

- Total Medical Expense (as relevant and available)
- Admissions, Readmissions, Emergency Department Utilization
**Pediatric Integrated Care Survey (PICS)**

- **Five Core Domains**
  - Access to Care
  - Communication with Care Team
  - Family Impact
  - Care Goal Creation/Planning
  - Team Functioning/Quality

- Validated assessment of the family’s experience of integration across the care team: medical, behavioral, social, educational, and family support
Children With Special Needs: Social Determinants of Health and Care Coordination

Aaron Pankewicz, DO, MPH¹, Renee K. Davis, MD, MPH², John Kim, MPH, CPH², Richard Antonelli, MD, MS³, Hannah Rosenberg, MSc³, Zekarias Berhane, PhD², and Renee M. Turchi, MD, MPH, FAAP²,⁵

Abstract
Care coordination (CC) facilitates access to resources/services for children/youth with special health care needs (CYSHCN). We conducted a cross-sectional analysis of the 2009-2010 National Survey of CYSHCN to examine socioeconomic factors related to report of receiving adequate CC services for CYSHCN. Descriptive statistics were used to describe sociodemographic characteristics of respondents and examine socioeconomic factors. Receiving adequate CC varied by socioeconomic variables including income (100% to 199% federal poverty line [FPL]; aOR [adjusted odds ratio] = 0.848; 95% CI [confidence interval] = 0.722-0.997; P < .05), insurance (uninsured; aOR = 0.446; 95% CI = 0.326-0.609; P < .0001), and marital status (never married; aOR = 0.79; 95% CI = 0.64-0.97; P < .05). More families reporting adequate CC had private insurance, non-Hispanic white ethnicity, income >400% federal poverty level, and 2-parent households. Findings suggest unmet needs in terms of adequate access or knowledge leading to insufficient provision of CC for families with the greatest needs. Further analysis identifying specific deficits and implementing strategies to address these disparities is warranted.
Discovering a New Standard for Treating Depressive Symptoms

Katherine Aumer, PhD, Michael A. Erickson, PhD, Richard Antonelli, MD, MS
Vol. 3 No. 6 | June 2022

Setting a New Standard for Behavioral Health Care Coordination

IHII’s engagement-focused care coordination model provides evidence to improve the current standards of care coordination for those suffering from depression. This study revealed that depressive symptoms can be reduced significantly in a diverse population when a care coordination model expands its standard of engagement with patients to at least seven contact attempts within

<table>
<thead>
<tr>
<th>Attempts</th>
<th>Worsening Symptoms</th>
<th>Education</th>
<th>Missed Appointments</th>
<th>ER Visit</th>
<th>Self-Harm</th>
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<td>1-3 (n = 110)</td>
<td>44.55</td>
<td>6.55</td>
<td>20.00</td>
<td>1.82</td>
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<td>4-6 (n = 47)</td>
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<td>19.15</td>
<td>6.38</td>
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<td>7-9 (n = 12)</td>
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<td>0.00</td>
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<td>≥10 (n = 39)</td>
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<td>2.56</td>
<td>3.13</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Source: The authors

Patient Health Questionnaire-9 (PHQ-9) Difference Scores for Patients, Grouped by Attempts Until Successful Contact

The median change in PHQ-9 scores for each group ranges from 4 to 7. This change would be equivalent to moving down one level of severity of depression (e.g., from moderate to mild).
National Resource

HRSA
Maternal & Child Health

Pediatric Mental Health Care Access Program Fact Sheet

PROGRAM PURPOSE
The Pediatric Mental Health Care Access (PMHCA) Program promotes behavioral health integration into pediatric primary care using telehealth. Statewide or

PROGRAM IMPACT
States will demonstrate increased access to pediatric mental health care resulting from telehealth efforts to achieve the following measures:
Five-Phase Replication of Behavioral Health Integration in Pediatric Primary Care

Step 1: Primary care Screening
- Attention and estimating or inattentiveness
- Primary care Guided self-management with follow-up
- Symptom persistence

Step 2: Primary care Focused assessment
- Mild to moderate ADHD, anxiety, and depression
- Serious and/or complex ADHD, anxiety, depression, and/or other specified severe and/or pervasive psychiatric disorder and/or medical or social condition

Step 3: Primary care Treatment
- Basic psychopharmacology and/or focused psychotherapy

Step 4: Specialty care Comprehensive assessment and/or treatment
- Diagnostic evaluation
- Advanced psychopharmacology
- Specialized psychotherapy

Phase 1
- 30-Day Fills per 1000 Patients per Year
- Percentage of Well Visits With BH Screening Documented, %

Phase 2

Phase 3

Phase 4

Phase 5

Walter, Vernacchio, et al
www.pediatrics.org/cgi/doi/10.1542/peds.2020-001073

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# MEDICAID CHILD CORE SET

## 2022 Core Set Measures

<table>
<thead>
<tr>
<th>Measure Name (NQF number, if endorsed)</th>
<th>Data Collection Method</th>
<th>Number of States Reporting for FFY 2020</th>
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<tr>
<td>Child Core Set</td>
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<tr>
<td>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) (#0108)</td>
<td>Administrative or EHR*</td>
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</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH) (#0576)</td>
<td>Administrative</td>
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<tr>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) (#2800)</td>
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<tr>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APM-CH) (#2801)</td>
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<td>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH) (#3488)</td>
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<td>Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUH-CH) (#3489)</td>
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<td>Not applicable (new to 2022 Core Set)</td>
</tr>
</tbody>
</table>

*ADD-CH is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Children Core Set reporting.

Integrated Care at Boston Children's Hospital

Integrated Care Program

Today's care teams are challenged to coordinate activities and recommendations across settings. Often, families must take the lead on these responsibilities. Along with adding substantial strain to families, these challenges often result in uncoordinated and inefficient care. Integrated care is the seamless provision of health services, from the perspective of the patient and family, across the entire care continuum and is essential to achieving the best health outcomes for every patient. Care coordination is the set of activities and functions that is necessary to create and implement a multidisciplinary plan of care in partnership with the patient and family.

The Integrated Care Program at Boston Children's Hospital creates and validates processes, tools, and measures that improve the integration of patient care across the healthcare continuum. Our goal is to improve care integration within and across settings and disciplines — especially for patients with complex and chronic conditions. We measure success by our impact on outcomes of quality and safety, patient and provider experience, and cost of care. In recognition of our work across the United States, our team is honored to be serving in its third year as the National Center for Care Coordination.
**Key Takeaways**

- Integration is **essential for achieving optimal value**— evidence
- Care Coordination is **necessary** but not **sufficient to achieve integration**
- Care Coordination is the set of activities which occurs in “the space between”
  - Visits, Providers, Hospital stays, Agency contacts
- Only way to succeed is to engage all stakeholders— including patients and families— as participants and partners
- Medical Home is a necessary, but not sufficient, component of high performing system
Children and Families FIRST!!!
REFERENCES

- AHRQ Care Coordination Atlas (McDonald Nov 2010, June 2014) and companion document Care Coordination Accountability Measures for Primary Care (McDonald Jan 2012).
- Care Coordination Curriculum and Care Mapping Tool User Guides: Antonelli, Browning, Hackett-Hunter, McAllister, Risko; Lind. Boston Children’s Hospital; funded thru Family Voices/MCHB HRSA grant. 2012. [Link](http://www.childrenshospital.org/care-coordination-curriculum)
- Continuity and Coordination of Care: a practice brief to support implementation of the WHO framework on integrated people-centered health services.Geneva:World Health Organization, 2018. Licence CC-BY-NC-SA 3.0 IGO.
Child and Family Mental Health

The Imperative for a Relational Health Approach and Promotion of Family Resilience

Marian F Earls, MD, MTS, FAAP
General Pediatrician
Developmental & Behavioral Pediatrics
Cone Health Medical Group, Pediatric Specialists
SPECTRUM OF PEDIATRIC MENTAL HEALTH DISORDERS, PROBLEMS, & CONCERNS

• 19% of children and adolescents in the U.S. have impaired MH functioning and do not meet criteria for a disorder
• 13% of school-aged, 10% of preschool children with normal functioning have parents with “concerns”
• 13 – 20% of children and adolescents experience a MH disorder in a given year
• Suicide is the second leading cause of death in 10-24 year olds
• Living in a home with a gun raises risk of youth suicide 4x
• Adults who had a childhood MH disorder — 6 x the odds of adverse adult outcomes (health, legal, financial, social)
• Adults who had impaired functioning in childhood — 3 x the odds of adverse adult outcomes
• 50% of adults in U.S. with MH disorders had symptoms by the age of 14 years
**Service Gaps & Workforce Issues**

- Of children/youth who have mental disorder
  - 20%-25% receive treatment
  - 40%-50% terminate services prematurely
- Chronically under-funded public mental health (MH) system focuses on individuals with severe impairment
- **Little support for prevention or services to children with emerging or mild/moderate conditions**
- Insufficient #s of child MH specialists
- Administrative barriers in insurance plans
- Many forces leading families to seek help for MH problems in primary care (eg, trust vs. stigma & unfamiliarity...)

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UNIQUE FEATURES OF MENTAL HEALTH IN PEDIATRICS

- Mental health competencies include promotion, prevention, management, and co-management
- The spectrum of mental health and behavioral problems presenting in pediatric patients extends from parents/youth with concerns, to a child/adolescent with functional issues but no diagnosis, to a child/adolescent with functional issues with a diagnosis
UNIQUE FEATURES OF MENTAL HEALTH IN PEDIATRICS (CONT)

• Severity of problems is predominantly from mild to moderate, but primary care practices still have to be prepared to recognize, and sometimes to treat or collaborate in the treatment of children with higher levels of severity

• The focus is on maximizing functioning of the child, reducing distress in the child and family, and prevention of adult morbidity

• There is a substantial long-term ROI (return on investment)
UNIQUENESS OF PEDIATRIC PRIMARY CARE

• Pediatric primary care clinicians have a **longitudinal, trusting relationship with parents and patients**
• Primary care providers are familiar with developmentally appropriate behavior, allowing them to distinguish between typical behaviors and concerning behaviors as children grow and age
• They are in a unique position to detect mental health issues in children at an early age or at an **early stage in the emergence of symptoms or dysfunction**
• Working in partnership with mental health practitioners to practice integrated care can improve care, enhance preventive services, lower costs, and strengthen the medical home
THE “BIG PICTURE”- ADDRESSING FACTORS THAT INFLUENCE HEALTHY SOCIAL-EMOTIONAL DEVELOPMENT

- Family/Environment Risks and Protective Factors
  - Social Drivers of Health
  - Caregiver mental health

- Healthy Social Emotional Development
  - Promotion
  - Prevention
  - Intervention

- CYSHCN – possible impacts of chronic condition on social and school experiences
CHILDHOOD ADVERSITY

Science reveals that the environment in which children develop – family, community, and culture – impacts brain development, health and genetics

• Childhood adversity – wide range of circumstances that pose a threat to health and well-being
  – Adverse Childhood Experiences (ACEs) – a subset of Childhood Adversities
  – Social disadvantage, including homelessness, discrimination, community violence, historical trauma, structural racism
  – **Trauma – one possible outcome of exposure to adversity**

• Toxic Stress – occurs when adversity is extreme, long-lasting and severe (such as chronic neglect, domestic violence, severe economic hardship, ACEs) without the buffer of a caring adult
POSITIVE CHILDHOOD EXPERIENCES (PCEs)

PCEs score included 7 items asking respondents to report how often or how much as a child they:

- (1) felt able to talk to their family about feelings;
- (2) felt their family stood by them during difficult times;
- (3) enjoyed participating in community traditions;
- (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled);
- (5) felt supported by friends;
- (6) had at least 2 nonparent adults who took genuine interest in them; and
- (7) felt safe and protected by an adult in their home.
“Study results demonstrate that PCEs show a dose-response association with adult mental and relational health, analogous to the cumulative effects of multiple ACEs. Findings suggest that PCEs may have lifelong consequences for mental and relational health despite co-occurring adversities such as ACEs.”

“Assessing and proactively promoting PCEs may reduce adult mental and relational health problems, even in the concurrent presence of ACEs.”

From Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample
The capacity to develop and sustain Safe, Stable, and Nurturing Relationships (SSNRs), which in turn prevent the extreme or prolonged activation of the body’s stress response systems (toxic stress)

Strengths-based approach, recognizes the evidence of the impact of Positive Childhood Experiences (PCEs)

Endorses a paradigm shift toward relational health because Safe, Stable, and Nurturing Relationships (SSNRs) not only buffer childhood adversity when it occurs but also promote the capacities needed to be resilient in the future

Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health. Andrew Garner, MD, PhD, FAAP; Michael Yogman, MD, FAAP Committee on Psychosocial Aspects of Child and Family Health., Section on Developmental and Behavioral Pediatrics, Council on Early Childhood.

AAP RECOMMENDATIONS FOR PEDIATRIC VISITS

  – Ask about parental strengths/protective factors at every well-visit
  – Routine Screenings – perinatal depression, development, adolescent depression, (suicidality), substance use
  – Psychosocial assessment (social-emotional, Social Drivers of Health, ACEs) at every well visit
• AAP ASHEW (Addressing Social Health and Early Childhood Wellness) Project
  – Family Strengths & Protective Factors, Perinatal Depression, Social Drivers of Health, and Social-Emotional Screening
• AAP Mental Health Competencies (2019)
  – Psychosocial assessment (social-emotional, SDoH, ACEs) at every well visit
  – Brief mental health update at acute and chronic visits
MENTAL HEALTH COMPETENCIES FOR PEDIATRICS: PRACTICE ENHANCEMENTS (AAP 2019)

- Collaborative and consultative relationships
- Practice team culture – embrace MH care as integral to pediatric practice; understanding impact of trauma on child well-being
- Systems – environment of respect, agency, confidentiality, safety, trauma & resilience–informed care; preparation for ID and management suicide risk and MH emergencies; registry, protocols, tracking for those with positive psychosocial assessments; standardized communication for co-management; coding and billing tools
- Regular data analysis for practice improvement
MENTAL HEALTH COMPETENCIES FOR PEDIATRICS: CLINICAL SKILLS (AAP 2019)

- **Promotion & primary prevention-healthy** lifestyles and stress management; routine, age-appropriate psychosocial history
- **Secondary Prevention** – identify and evaluate risk factors and emerging symptoms; appropriate tools for screening; referral to community resources
- **Assessment** – recognize MH emergencies/severe impairment needing urgent specialty care; interpret screening results for brief intervention and assessing need for full diagnostic evaluation; diagnose children and adolescents – ADHD, common anxiety disorders, depression and substance use
- **Treatment** – fundamental communication skills (common factors); common elements to initiate care; development of care plan with medical home team or in collaboration with MH specialist; proficiency in selecting, prescribing and monitoring medication appropriate for use in pediatric care; crisis plan; safety plan; warm handoffs and co-management
Primary Care Intervention

- Transdiagnostic Approaches
  - **Common Factors** communication skills
    - Components of interventions common to diverse therapies; coming from family therapy, cognitive therapy, motivational interviewing
    - See HELP mnemonic
  - **Common Elements**
    - Components of therapies that apply to a group of related conditions (such as anxiety, low mood, ADHD)
SKILLS TO ENGAGE THE CHILD AND FAMILY: THE “COMMON FACTORS” APPROACH

• HELP build a therapeutic alliance:
  – H = Hope
  – E = Empathy
  – L2 = Language, Loyalty
  – P3 = Permission, Partnership, Plan

RISK STRATIFICATION & DEVELOPING A REGISTRY

- Adding a registry layer based on presence of risk, in addition to presence of a chronic/complex *diagnosis*
- Identifying those children and families who have known risks for poor mental health outcomes (note – some may have both risk-conferring SDoH AND a complex diagnosis)
- Using a “flag” in the practice system to enhance population management (for proactive visit reminders and planning, scheduling for appropriate amount of time)
- Use of Z-codes that reflect SDoH, ACEs supports the complexity of the visit, as well as provides a source for population data and management
KEY PRINCIPLES

• Communication with families regarding the “why” of screening is essential
• Screening has an important role in promotion and prevention, as well as for intervention
• Engage families with screening as conversation, and as partners in care
• Engage the parent/caregiver as an expert on their child
• Utilize validated screening tools/questions
• Always have a conversation about results and incorporate primary care intervention
• Make effective referrals/linkages, prioritizing a warm handoff (Note the need to implement outreach to build collaborative relationships with community partners before beginning screening)
• “Close the loop”
COLLABORATION & CO-MANAGEMENT

• As pediatricians (both primary care and specialty) integrate mental health competencies into practice, collaboration and co-management are key elements.

• The pediatrician can have a range of relationships with mental health professionals (MHP), including having an integrated MHP as a member of the medical home team. Depending on resources and geographic location of a practice, these relationships may need to be primarily virtual.

• Spectrum of modalities for collaboration, and their relationships:
  — any number, or all, may be implemented in a practice
  — not mutually exclusive
  — not a linear process

• The integration of mental health competencies in practice is the underpinning of all the collaborative modalities.
Moving Toward Mental Health Integration in Primary Care: Collaboration & Co-management

Integration

Co-location

Consultation

Referral & feedback

Medical home team member, Practice employee (LCSW, LPC, LMFT, LPA, psychologist)

In-kind space for agency MHP, contractor, or practice employee (psychologist, psychiatrist, or licensed MHP)

NNCPAP (psychiatrist, licensed MHP, & care coordinator)

Telepsychiatry

Care Coordination an asset for all modalities

June 2016
INTEGRATED MH PROFESSIONAL IN PEDIATRIC PRACTICE

• Part of family-centered medical home team
• Partners during routine visits (eg, psychosocial history, screening, parenting education...)
  – Immediate triage/response to positive screen
  – Follow-up with secondary screens
• Involved routinely in visits for children with chronic/complex conditions
• Provides self-management counseling for patients with chronic medical conditions
• Accepts “warm” hand-offs”; and may see child and family for short term therapy
• Provides liaison with MH specialty system, schools, and agencies
• Monitors child’s/adolescent’s course
AAP MH Competencies

Policy Statement
Mental Health Competencies for Pediatric Practice, Jane Meschan Foy, Cori M. Green, Marian F. Earls and COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP, Pediatrics November 2019, 144 (5) e20192757; DOI: https://doi.org/10.1542/peds.2019-2757
https://pediatrics.aappublications.org/content/144/5/e20192757

Technical Report
Achieving the Pediatric Mental Health Competencies, Cori M. Green, Jane Meschan Foy, Marian F. Earls, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP, Pediatrics, Nov 2019, 144 (5) e20192758
https://pediatrics.aappublications.org/content/144/5/e20192758
AAP Mental Health Initiatives

• www.aap.org/mentalhealth

• Interactive Algorithm
  https://downloads.aap.org/AAP/PDF/Algorithm_Integration_of_Mental_Health_Care_Into_Pediatric_Practice.pdf

• Table of Tools:
KEY TAKEAWAYS

• CYSHCN - children who have, or are at increased risk for, chronic physical, developmental, and/or mental health/emotional conditions

• In pediatrics, integrated care is the application of mental health competencies to create team-based care, with primary care, specialists, and mental health clinicians working together to care for the whole child in the context of the family, school, and community

• The competencies are essential for both PCCs and specialists; collaboration and standardized communication are key
RESOURCES

• Advocacy – Child & Adolescent Healthy Mental Development

• Blueprint for Youth Suicide Prevention

• Child and Adolescent Mental and Behavioral Health Principles

• AAP Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic

• AAP Mental Health Initiatives: https://www.aap.org/en/patient-care/mental-health-initiatives/

• Child Psychiatry Access Programs. www.nncpap.org
THANK YOU!

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PARTICIPANT QUESTIONS
THANK YOU FOR YOUR PARTICIPATION!