SC CHIPRA Grant

Behavioral Health Initiatives

CHIPRA Quality Demonstration Grant
Kristine Hobbs, LMSW
Lynn Martin, LMSW
Integration - a balancing act...
Lessons Being Learned

- Let the practices set their own priorities with the goal of moving each practice toward integration
- ALL kids are ‘their’ kids
- Find and use your mental health champions
- Help connect grant activities to what they are already doing
- Frame mental health in the context of physical health
- Pay them for what they do
- Provide guided outreach to community resources
- Keep the message “front and center” in both big and small ways

QTIP - Hobbs
CHIPRA Core Measures:

**Category A** – Experiment with, and evaluate the use of, new measures for quality in children’s health care

**EHRs/HIT:**

**Category B** – Promote the use of Health Information Technology (HIT) for the delivery of care for children

**Medical Home/Behavioral Health:**

**Category C** – Evaluate provider-based models which improve the delivery of children’s health care services
Demographics...

- Business Models:
  - FQHCs, RHCs, academic practices, privately owned, or hospital owned
- Sizes:
  - From 1 doc to 18 docs; some have NPs
- EMR systems:
  - 11 different EMR systems; 2 still using paper charts
- Medicaid Populations:
  - Range from 43 to 98%
- Communities:
  - Rural, suburban, and urban (for SC)
- Desire for integration:
  - Attitudes ranged from “I don’t do mental health.”... “I have to do mental health”
- Grant interests
  - May have been more interested in other parts of grant rather than integration or vice versa
Learning Collaborative
- Semi-annual sessions attended by QI team
- Quality measures presented, expert speakers, PCMH and behavioral health concepts, information sharing, etc.

On-Site Visits
- QTIP team technical assistance site visits
- Peer reviewer participation
- Academic detailing
- Mental Health education and community resource meetings
- Quality Improvement coaching

Pediatric Practices
- 18 practices selected
- Each practice identified a QI team lead: practitioner, nurse and office manager

Plan-Do-Study-Act cycles
- Practices document quality improvement work

Maintenance of Certification
- Physicians can earn Part IV MOC credit on QI work

Planning & Steering Committee
- Active committee; meets quarterly
From the grant:

“Behavioral health is fully integrated into our demonstration grant as Category C which specifically focuses on the integration of behavioral health care within the medical home...”

Pediatric Visits

*Pediatrics*, 2006...24% of pediatric primary care visits involve behavioral, emotional or developmental concerns

Suicide

3rd leading cause of death - 10-14 yr olds & 15-24 yr olds
1. **South Carolina Child Suicides**

For South Carolina children ages 10 to 14, suicide is the second leading cause of injury deaths. For South Carolina children ages 15 to 17, suicide is the third leading cause of injury deaths.

Data Source: SC Department of Health and Environmental Control
<table>
<thead>
<tr>
<th>Tasks from the Grant</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refine Family Involvement</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Identify current mental health integration w/in QTIP practices</td>
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<tr>
<td>Environmental scan of mental health services</td>
<td></td>
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<td></td>
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<tr>
<td>Assess current utilization of validated mental health screening tools</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Identify mental health screening tools w/ quality measures</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Begin recruitment of MH providers</td>
<td></td>
<td></td>
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<tr>
<td>Explore telemedicine options with DMH</td>
<td></td>
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<tr>
<td>Integration of MH models w/in practices - Incorporate developmental and mental health screenings into practice models - Provide assistance - Work with community supports, other state agencies</td>
<td></td>
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<tr>
<td>Research &amp; Identify a certification program</td>
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</tr>
<tr>
<td>Initiate Training/ Certificate Program in Primary Care behavioral health w/ MH providers</td>
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<td></td>
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<tr>
<td>NCQA tasks, additional QI measures</td>
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<tr>
<td>Review family involvement - Assess degree of family involvement - Incorporate recs made by P&amp;S and QTIP practices</td>
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<td></td>
</tr>
<tr>
<td>Refine integrated mental health practice model - Incorporation of prevention strategies and screening such as maternal depression, substance abuse, community connectedness to address prevention services. - Incorporation of treatment services with QTIP practices</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>“Boots on the Ground” – TA visits with medical director; specific site visits without medical director, community visits with providers, site specific problem solving</td>
<td></td>
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</tr>
</tbody>
</table>

QTIP - Hobbs
Start where the practice is
Provide consistent contact and messaging
Provide tangible and desired resources
Visit community providers together
Summary from 1st Site Visits...

Needs:
- Effective screening,
- More service providers,
- Easier access to services, and
- Billing issues resolved

Strengths:
- Some have added additional services in-house,
- Some have expanded your capacity to provide limited services,
- dedicated, creative practitioners.

Challenges:
- Limited capacity of caregivers, resources, specialist, knowledge of resources, Financial issues.
5 Categories – Framework for Grant Activities

- Community Resources
- Health Care Financing
- Support for Children and Families
- Clinical Information Systems/Delivery Systems Redesign
- Decision Support for Clinicians
2012, 2013, & 2014 QTIP Averages and Total Possible Points AAP Mental Health Practice Readiness Inventory

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Total Possible</th>
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</thead>
<tbody>
<tr>
<td>QTIP Average 2012</td>
<td>6.7</td>
<td>6.5</td>
<td>6.9</td>
<td>9</td>
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<tr>
<td>QTIP Average 2013</td>
<td>4.8</td>
<td>4.1</td>
<td>4.9</td>
<td>6</td>
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<tr>
<td>QTIP Average 2014</td>
<td>25.4</td>
<td>24.3</td>
<td>27.7</td>
<td>36</td>
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<tr>
<td>Clinical Info/Systems Redesign</td>
<td>17.3</td>
<td>18.4</td>
<td>20.1</td>
<td>30</td>
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<tr>
<td>Decision Support for Clinicians</td>
<td>9.8</td>
<td>9.8</td>
<td>11.6</td>
<td>15</td>
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</tbody>
</table>
5 Categories – Framework for Grant Activities

- Community Resources
- Health Care Financing
- Support for Children and Families
- Clinical Information Systems/Delivery Systems Redesign
- Decision Support for Clinicians
<table>
<thead>
<tr>
<th></th>
<th>DMH</th>
<th>Family Groups</th>
<th>Others</th>
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</thead>
<tbody>
<tr>
<td>AnMed Health Children's</td>
<td></td>
<td>Family Connection July '12</td>
<td>Marshall I Pickens, May '12</td>
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<tr>
<td>Healthcare Center</td>
<td></td>
<td></td>
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<tr>
<td>Barnwell Pediatrics PA</td>
<td>Polly Best DMH July '12</td>
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<tr>
<td>Beaufort Pediatrics</td>
<td>Coastal Empire DMH May '13</td>
<td>NAMI - Feb '12</td>
<td>Beaufort Alliance - Fall '11; First Steps March '12</td>
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<tr>
<td>BJCHS</td>
<td>Coastal Empire DMH May '13</td>
<td></td>
<td>Beaufort Alliance - Fall '11</td>
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<tr>
<td>Carolina Pediatrics (Cheraw)</td>
<td></td>
<td></td>
<td>First Steps Mar '12 (not present)</td>
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<tr>
<td>Carolina Pediatrics (Columbia)</td>
<td>Columbia DMH March'12;</td>
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<tr>
<td></td>
<td>Lex DMH Psychiatrist May '13</td>
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<tr>
<td>Center for Pediatric Medicine</td>
<td>Piedmont DMH Sept '12;</td>
<td></td>
<td>Marshall I Pickens, May '12</td>
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<td></td>
<td>Greenville DMH Mar '13</td>
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<tr>
<td>CHOC</td>
<td>Lexington DMH 10/11;</td>
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<td></td>
<td>Columbia DMH March '12;</td>
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<td></td>
<td>Lex DMH April '13;</td>
<td></td>
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<td></td>
<td>Lex DMH Psychiatrist May '13</td>
<td>PASOs Jan '13;</td>
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<td>PASOs Health Fair May '13</td>
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<tr>
<td>Eastern Carolina Pediatric</td>
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<td>First Steps Mar '12</td>
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<td>Associates</td>
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<td>Little River Medical Center</td>
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<td>NAMI - Oct '12</td>
<td>DMH - TTI Grant Oppt.</td>
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<td>MUSC Pediatric Primary Care</td>
<td>Charleston DMH Fall '11;</td>
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<td>Berkeley Jan '12</td>
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<td>PPAC</td>
<td>Lexington DMH 10/11;</td>
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<td>DMH - TTI Grant Oppt.</td>
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<td>NAMI - June '12</td>
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<td>PPLC</td>
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<td>Rock Hill Pediatric Associates</td>
<td>Catawba DMH Feb '12</td>
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<td>Cabarrus County Integration Fall '11;</td>
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<td>DHHS Prior Auth Dec '12</td>
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<td>Sandhills Pediatrics</td>
<td>Lexington DMH 10/11;</td>
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<td>Three Rivers July '12;</td>
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<td></td>
<td>Columbia DMH March '12;</td>
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<td>DHHS - credentialing Oct '12</td>
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<td>Kershaw DMH Aug '12;</td>
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<td></td>
<td>Lex DMH April '13;</td>
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<td></td>
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<tr>
<td></td>
<td>Lex DMH Psychiatrist May '13</td>
<td>Family Connection Aug '12</td>
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<tr>
<td>Stono Pediatrics</td>
<td>Charleston DMH Fall '11</td>
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<tr>
<td>Sumter Pediatrics</td>
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<tr>
<td>The Children's Center of</td>
<td></td>
<td></td>
<td>DMH - TTI Grant Oppt.;</td>
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<tr>
<td>Carolina Health Centers</td>
<td></td>
<td></td>
<td>Home visiting &amp; ECCS</td>
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<tr>
<td>Totals</td>
<td>11 Practices/ 10 DMH Centers</td>
<td>6 Practices/ 3 Family Groups</td>
<td>11 Practices/ 11 Other Opportunities</td>
</tr>
</tbody>
</table>
PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: ____________ ( ) Initial ( ) Follow-up

Referring Physician Name: ____________________________

Address: ____________________________

City: ____________ State: ____________ Zip: ____________

Patient’s Name: ____________________________ DOB: ____________

Parent’s Name: ____________________________ Address: ____________________________ Phone: ____________________________

Date(s) Patient Seen: ____________________________ Reason(s) for Referral: ____________________________

Any Specific Questions or Requests: ____________________________

__________________________ ____________________________
Referring Physician’s Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of this form to remain in the patient’s record, complete a form after initial assessment, continue additional forms periodically during treatment (as indicated) and when treatment is terminated, and mail or fax completed forms to the provider listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your cooperation.

Consultant’s Report

Date(s) Patient Seen: ____________________________

☐ Patient did not make appointment

☐ Patient made an appointment but did not keep appointment.

Initial Diagnoses:

1. ____________________________

2. ____________________________

3. ____________________________

Recommendations: ____________________________

Medications Prescribed: ____________________________

Follow-up Arranged or Provided by Consultant: ____________________________

Other Care Needed: ____________________________

☐ Further diagnostic testing

☐ Medication management by POC

☐ Individual therapy

☐ Group therapy

☐ Family therapy

☐ Lab tests

☐ Follow-up recommended

☐ Medication management

☐ Return visit: ____________________________

☐ Other: ____________________________

Name (type or print): ____________________________

Signature: ____________________________

Fax to: ____________________________

Add disclaimer statement per your invitation here: ____________________________

American Academy of Pediatrics

Dedicated to the health of all children

doi: 10.1542/peds.2010-0788Q

Stono Pediatrics
P.O. Box 2209
Charleston, SC 29401

PRIMARY CARE FEEDBACK FORM

Mental Health update

Date: ____________ ( ) Initial ( ) Follow-up

DOB: ____________ Phone: ____________________________

Patient’s Name: ____________________________ Parent’s Name: ____________________________

Address: ____________________________

Reason(s) for Referral: ____________________________

Specific Questions/Requests: ____________________________

Consultant’s Report

Date(s) Patient Seen: ____________________________

Initial Diagnoses:

1. ____________________________

2. ____________________________

3. ____________________________

Recommendations: ____________________________

Medications prescribed: ____________________________

4. ____________________________

5. ____________________________

Name: ____________________________

Signature: ____________________________

Fax to 843-795-5889

Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient and may contain confidential and/or legally privileged information. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message. Any unauthorized review, use, disclosure, or distribution is prohibited. Thank you.
“We obtained more information in that one hour than multiple phone calls could have accomplished!”

“I had no idea of the scope of services provided by our area mental health center. Nor was I aware of the variety of settings in which these services can be provided. We also got some great advice on streamlining the referral process.”

“I thought the county mental health had one set of criteria, when we visited I learned they don’t want simple cases they want more complex ones. This has changed the way I refer.”
In a follow up email, Sumter Pediatrics Practice Staff reported,

“Things have been wonderful!!!! Our MH facilities have really stepped up!!! Only thing is we are still having a little trouble with feedback being sent automatically but we can get it if we call and request. It just takes a while. Thank you for all of your help and for meeting with us to help them see our side and us see theirs. Its made a huge difference!”
AAP’s Mental Health
Practice Readiness Inventory

5 Categories – Framework for Grant Activities

 ula Community Resources
 ula Health Care Financing
 ula Support for Children and Families
 ula Clinical Information Systems/Delivery Systems Redesign
 ula Decision Support for Clinicians

QTIP - Hobbs
Health Care Financing

- Billing and coding for screening
- Authorization Processes for different Medicaid Providers
- Linking referral staff with HMO staff
- Lists of MCO providers
- Outreaching to providers on list using AAP Toolkit Letters
DHHS is working on the policies around authorizations

MCOs have different authorization policies

System of Care Grant

CMS/SAMSHA bulletin published May 7, 2013 – Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Concerns
AAP’s Mental Health
Practice Readiness Inventory

5 Categories – Framework for Grant Activities

✿ Community Resources
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✿ Support for Children and Families
✿ Clinical Information Systems/Delivery Systems Redesign
✿ Decision Support for Clinicians
Support for Children and Families

Did you know?

CAUTION
50% of all LIFE-TIME mental health disorders START BY AGE 14!!!

31% of our nation’s youth suffer from serious mental illness

80% of mentally ill youth are NOT identified — NO HELP

Suicide is the third leading cause of death for youths 10-24 yrs old.

Screening Tools help your doctor identify if your child is AT RISK

Screening Tools can help your pediatrician identify Postpartum Depression in New Mothers

YOU ARE NOT ALONE!

Beaufort Peds’ Bulletin Boards...
Support for Children and Families

Rock Hill Peds - Group ADHD visits
Support for Children and Families

Referral Assistance/Care Coordination
- 10 have Parent Partners though QTIP and Family Connection partnership
- 2 of you have Community Health Workers

BJHCHS
- NAMI of Beaufort leading to Family Classes at their location

Carolina Peds of Cheraw
- Connected to their First Steps
- Connected a child with grief camp after the parent died
5 Categories – Framework for Grant Activities

- Community Resources
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## SC QTIP Recommended Routine Screening Protocol

<table>
<thead>
<tr>
<th>Babies and Preschoolers</th>
<th>Elementary School</th>
<th>Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Screening ALL:</strong></td>
<td><strong>All:</strong></td>
<td><strong>All:</strong></td>
</tr>
<tr>
<td>ASQ-3 or PEDS MCHAT</td>
<td>PSC – parent report</td>
<td>PSC-Y 11+</td>
</tr>
<tr>
<td><strong>Psychosocial/Environmental Risk Factors - ALL</strong></td>
<td>If indicated:</td>
<td>If indicated or desired:</td>
</tr>
<tr>
<td>Edinburgh Post-Partum depression screen for moms SEEK-PSQ</td>
<td>SCARED – 8+ Vanderbilt</td>
<td>Modified PHQ-9 CRAFFT SCARED Vanderbilt</td>
</tr>
</tbody>
</table>
100% of practices using one or more routine screens
100% doing routine developmental screening using standard instrument

Self-Report of Routine Use of QTIP Recommended Screens as of July 2014

- Peds or ASQ
- MCHAT
- Edinburgh
- PSC
- PSC-Y
- CRAFFT
- PHQ-9
- SEEK

QTIP - Hobbs
## Carolina Pediatrics Screening Protocol

<table>
<thead>
<tr>
<th>Screenings:</th>
<th>Ages:</th>
<th>Given:</th>
<th>Yearly Office Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRAFFT</td>
<td>11-18 years of age</td>
<td>At Well Checks or if Parent/Child expresses a concern (mental, social, etc)</td>
<td>Yearly Well Exams</td>
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<tr>
<td>PSC-Y</td>
<td>11-18 years of age</td>
<td>At Well Checks or if Parent/Child expresses a concern (mental, social, etc)</td>
<td>Yearly Well Exams</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Only if above screenings “flag” for PHQ-9</td>
<td>Yearly Well Exams</td>
<td></td>
</tr>
<tr>
<td>SCARED</td>
<td>Only if above screening “flag” for SCARED</td>
<td>Yearly Well Exams</td>
<td></td>
</tr>
<tr>
<td>Postpartum</td>
<td>At 2 weeks and 2 months</td>
<td>Given to mother at 2 week well exam for newborn and 2 month well exam.</td>
<td>HIPAA for consent to share with OB/GYN</td>
</tr>
<tr>
<td>PEDS</td>
<td>9, 18, 24 Months (unless a screening is missed during that time).</td>
<td>At well checks: see Ages column. 3 screenings can be given by the age of 36 months.</td>
<td>Yearly Well Exams</td>
</tr>
<tr>
<td>Ages and Stages</td>
<td>If PEDS screening is positive</td>
<td>Yearly Well Exams</td>
<td></td>
</tr>
</tbody>
</table>
MUSC

- Increased postpartum screening from 2% to 60%
- Put 4 questions into the EMR template
Another state employee shared with Kristine her delight with Carolina Peds Columbia...

“When I took my 16 yr old for his physical, they asked him to fill out mental health screens - on his OWN clipboard; this is something they never did with my 22 year old.”
AAP’s Mental Health Practice Readiness Inventory

5 Categories – Framework for Grant Activities

❖ Community Resources
❖ Health Care Financing
❖ Support for Children and Families
❖ Clinical Information Systems/Delivery Systems Redesign
❖ Decision Support for Clinicians
Primary care clinicians are accustomed to a certain level of diagnostic uncertainty. Children presenting with fever are typically triaged based on the child’s clinical appearance—the very toxic-appearing child may require further diagnostic assessment and admission to the hospital for observation and presumptive treatment; the child with clinical findings suggesting a specific diagnosis may be treated as an outpatient, returning for further attention if recovery does not progress as expected; the child with mild symptoms may simply require parental reassurance, symptomatic care, and monitoring. Clearly, in many instances the clinician can relieve parental distress and decrease the child’s discomfort without knowing exactly what is causing the child’s symptoms.

Similarly, in the absence of an emergent need, clinicians presented with a child’s mental health problem can often take steps to address parents’ distress and children’s symptoms without knowing the specific diagnosis. They may offer parenting strategies to cope with common behavioral problems. They may offer advice about lifestyle issues affecting mental health, such as sleep, exercise, sunlight, diet, and one-on-one time for the parent and child. They can employ effective family-centered techniques known as common factors, so-called because they are common factors in a number of evidence-based interventions. These can be represented by the mnemonic HELP.

H Hope
Increase the family’s hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family.

E Empathy
Communicate empathy by listening attentively.

L Language
Use the child or family’s own language to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.

Loyalty
Communicate loyalty to the family by expressing your support and your commitment to help.

P Permission
Ask the family’s permission for you to ask more in-depth questions or make suggestions for further evaluation or management.

Partnership
Partner with the child and family to identify any barriers or resistance to addressing the problem, find strategies to bypass or overcome barriers, and find agreement on achievable steps aligned with the family’s motivation.

Plan
Establish a plan (or incremental first step) through which the child and family will take some action(s), work toward greater readiness to take action, or monitor the problem, then follow up with you, based on the child and family’s preferences and sense of urgency. The plan might include, for example, gathering information from other sources such as the child’s school, making lifestyle changes, applying parenting strategies or self-management techniques, reviewing educational resources about the problem or condition, initiating specific treatment, seeking referral for further assessment or treatment, or returning for further family
Decision Support for Clinicians

Primary Care Principles for Child Mental Health

Whole Document:
Download PDF

Individual Sections:
Introduction
DSHS services guide
General care advice
WA Mental Health Resources
PSC-17
Evidence Based Tx Overview
ADHD
Anxiety
Autism
Bipolar
Depression
Eating Disorder
Disruptive Behavior and Aggression
Sleep Hygiene

http://palforkids.org/resources/

Kim Conant used this as the outline for Pal Peds resource manual...
One of our pediatricians has participated.

“...Designed to provide additional expertise to the practicing clinician in South Carolina in ADHD and learning disorders as well as many behavioral disorders....”

Mental Health Initiatives
American Academy of Pediatrics
Mental Health Leadership Work Group

Resident Curriculum Pilot Project

Call for Participants!

The American Academy of Pediatrics’ Mental Health Leadership Work Group is calling for 10 to 15 continuity clinic preceptors to pilot a new mental health residency curriculum. The curriculum has 2 short modules, one introducing an evidence-based approach to engaging patients and families in managing mental health concerns, and one focused on recognizing and managing mild to moderate anxiety. Participation requires attendance to a 1-day training workshop at the AAP headquarters in
Anita Khetpal, MD is a Child Psychiatrist with QTIP in 2014!
## Consistent Contacts & Messaging
### At Learning Collaborative Sessions

<table>
<thead>
<tr>
<th>Date</th>
<th>Presentation Content</th>
<th>Surveys and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2011</td>
<td>ADHD</td>
<td></td>
</tr>
<tr>
<td>July 2011</td>
<td>Holy Cow! Mental Health: It’s not all it’s cracked up to be...yet!</td>
<td>All practices choose top 3 priorities from list of 21 options...</td>
</tr>
<tr>
<td>Jan 2012</td>
<td>...MNOPs of Behavioral Health...</td>
<td>AAP’s MHPRI; NAMI resources</td>
</tr>
<tr>
<td>July 2012</td>
<td>“Think, Think, Think. Keeping mental health on the agenda.”</td>
<td></td>
</tr>
<tr>
<td>Jan 2013</td>
<td>General mental health focus- Screening, AAP Toolkit, office processes, family involvement...</td>
<td>AAP’s MHPRI; AAP MH Toolkits; Level of Integration Measure; AAP Pamphlets</td>
</tr>
<tr>
<td>July 2013</td>
<td>“Focus on Mental Health” Adolescent health focus</td>
<td>Homegrown questionnaires about screening and resources; AAP Book on Adolescent Health</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>Toxic stress factors and medical home interventions</td>
<td>AAP’s MHPRI; homegrown survey about grant</td>
</tr>
<tr>
<td>July 2014</td>
<td>TBA – In Process</td>
<td></td>
</tr>
<tr>
<td>Jan 2015</td>
<td>Celebration Time! Oh! Yeah!</td>
<td>AAP MHPRI</td>
</tr>
</tbody>
</table>

QTIP - Hobbs
## Consistent Contacts & Messaging

### On-Site Technical Assistance Visits

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics Explored; Resources Shared....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring 2011</td>
<td>General Grant Questionnaire; Federation of Family Posters</td>
</tr>
<tr>
<td>Fall 2011</td>
<td>ACE study; school-based resources; authorization ‘cheat’ sheet; LIPS providers; MH Handouts; Fed of Family Referral Packets</td>
</tr>
<tr>
<td>Spring 2012</td>
<td>AAP’s MHPRI – AAP suggestions</td>
</tr>
<tr>
<td>Fall 2012</td>
<td>Review original questionnaire; clinical resources; AAP’s MHPRI results – AAP suggestions</td>
</tr>
<tr>
<td>Spring 2013</td>
<td>Implementation of screening protocols; billing; processes</td>
</tr>
<tr>
<td>Fall 2013</td>
<td>Visits are becoming more site specific</td>
</tr>
<tr>
<td>Spring 2014</td>
<td>Visits continue to be more site specific – 9 practices have asked for specific visit outside of TA visit to focus on mental health</td>
</tr>
<tr>
<td>Fall 2014</td>
<td></td>
</tr>
</tbody>
</table>

All practices are visited at least twice yearly. Some request additional visits.

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Other Grant Related Interventions

Just to name a few:

- CHADIS Pilot
- UMASS Certificate Programs in Primary Care Behavioral Health & Integrated Care Management
- Academic Detailing – ADHD, Anti-psychotics
- Community Visits – with recommendations for feedback loops
- Mental Health Specific Site Visits
- Liaison with community serving providers
- Liaison with Family Advocacy Groups
- AAP Mental Health Toolkits
- Emails to specific providers about training/grant opportunities
- Training to office staff on MH
- Psychiatric Consultant (new)
- Training opportunities for providers and staff

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State Level Initiatives Running Parallel

Just to name a few:

- Jan 2011 – physician rate reduction due to SCDHHS budget deficit
- Summer 2010 – Licensed Independent Practitioners enrolled
- April 2012 – BH carved into MCOs
- SC DMH - funding and criteria for services moving target
- PCMH – NCQA 2013– statewide incentives
- Statewide initiatives - obesity; SBIRT; System of Care...

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### Top 6 of 21 Options Practices Chose in July 2011

- Finding ways to access child psychiatry
- Work with community providers to facilitate accessing local resources
- Identify a list of resources for specific needs in your community
- Learn more about billing and coding for mental health services
- Identify appropriate and time effective assessment and screening tools
- Information about funding/billing options for co-located staff

### Most Useful/important/helpful thing we have done to facilitate integration:

- **Tangible resources**
- **Screening protocol**
- **Reimbursement** mechanisms in place for screenings
- **Constant** discussion and reinforcement

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### What Practices Wanted in 2011

#### What Practices Appreciate in 2014

<table>
<thead>
<tr>
<th>Top 6 of 21 Options Practices Chose in July 2011</th>
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<td>5. Identify appropriate and time effective assessment and screening tools</td>
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<td>6. Information about funding/billing options for co-located staff</td>
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Plans for 2014

Practices say they will:

▷ Monitor screening
▷ Continue screening
▷ Resource linkages for needs identified on screens

Practices Want MH Coordinator to Work:

▷ More billing and funding
▷ More specialists
▷ Better access
▷ Continued Liaison and advocacy between practices and others
A Few Challenges

- Continued systems changes
- Limited resources
- Multi-layered authorization processes
- Payment mechanisms to support the work being done
- Buy-in
- Many models needed to meet skills, business structure, local resource base
- Payment for integration is not in place
- Differing levels of comfort and skill of practitioners
Next Steps

- More of the Same
- Training Opportunities for Providers
- Access to Specialists and Crisis Response
- Reimbursement Strategies for Integration
- Continued advocacy and liaison work
Lessons Being Learned

- Let the practices set their own priorities with the goal of moving each practice toward integration
- ALL kids are ‘their’ kids
- Find and use your mental health champions
- Help connect grant activities to what they are already doing
- Frame mental health in the context of physical health
- Pay them for what they do
- Provide guided outreach to community resources
- Keep the message “front and center” in both big and small ways

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"We delight in the beauty of the butterfly, but rarely admit the changes it has gone through to achieve that beauty."

— Maya Angelou
Contact Information

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