Brief Intervention and Care Management for Pediatrics

Margaret Kirkegaard, MD
Lori Raney, MD
AGENDA

- DEVELOPMENTAL SCREENING RECOMMENDATIONS
- BEHAVIORAL HEALTH SCREENING RECOMMENDATIONS BY MASSHEALTH
- POSTPARTUM DEPRESSION SCREENING RECOMMENDATIONS
- QI LIFECYCLE
- ENGAGEMENT IN CARE MANAGEMENT AND BRIEF INTERVENTIONS

Related PCMH PRIME Elements:

C-1: Practice has at least one care manager qualified to identify and coordinate BH needs
D-2,6: Practice collects and regularly updates a comprehensive health assessment that includes developmental screening and post-partum depression screening where appropriate
Webinar 3
Clinical Decision Support for BH in the Primary Care Setting

Webinar 2 (Adult)
BH Screening Tools and Risk Assessments – Beyond the PHQ-9: Substance Abuse, Anxiety and Depression

Webinar 4
Financing BH Integration in a Changing Landscape: G-Codes and ACOs

Webinar 5
Medication Assisted Treatment

Webinar 6
Integrated Care Planning for Care Managers
CARE MANAGEMENT CYCLE

Screening

Referral for Treatment

Assessment/Diagnosis

Practice-Based Treatment

Care management and patient navigation
OBJECTIVE SCREENING TOOLS

✚ Developmental surveillance or monitoring recommended at every visit, milestones generally included in EMR

✚ Clinical judgement detects fewer than 30% of children with intellectual disability, learning disabilities, or developmental delay

✚ Clinical judgement identifies fewer than 50% of children with serious emotional and behavioral disturbances

✚ Objective developmental screening with validated tool recommended 9, 18, and 24/30 months

✚ Must be followed by diagnostic developmental evaluation

✚ Autism screening recommended at 18 and 24 months

✚ Yearly alcohol and drug use assessments recommended starting at age 11

PCMH PRIME Element D 1-5: The practice collects and regularly updates a comprehensive health assessment including:

• Behaviors affecting health and BH history of patient and family
• Developmental screening for children < age 3 using a standardized tool
• Depression, anxiety, SUD screening for adults and adolescents using a standardized tool
Multiple validated objective developmental screening tools. Examples include:

- Parents’ Evaluations of Developmental Status (PEDS)
- Ages and Stages Questionnaire (ASQ)
- Full list available through NECTAC: [http://www.nectac.org/~pdfs/pubs/screening.pdf](http://www.nectac.org/~pdfs/pubs/screening.pdf)

Autism Screening Tools:

- Modified Checklist for Autism in Toddlers (M-CHAT);
- Modified Checklist for Autism in Toddlers Revised with Follow-up (M-CHAT-R/F);
- Screening Tool for Autism in Toddlers and Young Children (STAT™)

Considerations in tool selection:

- Cost to purchase tool
- Availability in electronic or paper forms (integration in EMR)
- Language availability
- Acceptability to payers
- Age span
- Time to administer
- Parent vs provider completed
MassHealth requires all primary-care providers (PCPs) of MassHealth patients (from birth to 21 years) to offer standardized behavioral health screening as part of periodic and medically necessary interperiodic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens.

PCPs must choose a clinically appropriate behavioral health screening tool from a menu of approved standardized tools.
<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Full Name</th>
<th>Age Group</th>
<th>Answered By</th>
<th>Cost</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRAFFT</td>
<td>Car, Relax, Alone, Forget, Friends, Trouble</td>
<td>14 to 21 years</td>
<td>Youth</td>
<td>No</td>
<td><a href="http://www.ceasar-boston.org/clinicians/crafft.php">http://www.ceasar-boston.org/clinicians/crafft.php</a></td>
</tr>
</tbody>
</table>
There are several tools available for screening, each with pros and cons.

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</tr>
</thead>
<tbody>
<tr>
<td>PSC</td>
<td>Pediatric Symptom Checklist</td>
<td>4 thru 18 years</td>
<td>Parent</td>
<td>No</td>
<td><a href="http://www.massgeneral.org/psychiatry/services/psc_home.aspx">http://www.massgeneral.org/psychiatry/services/psc_home.aspx</a></td>
</tr>
<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
<td>3 thru 16 years</td>
<td>Parent</td>
<td>No</td>
<td><a href="http://www.sdqinfo.org/">http://www.sdqinfo.org/</a></td>
</tr>
<tr>
<td>SWYC/MA</td>
<td>Survey of Wellbeing of Young Children for Massachusetts for Postpartum Depression</td>
<td>2 to 4; 4 to 6; and 6 to 9 months</td>
<td>Parent</td>
<td>No</td>
<td><a href="http://www.mcpap.com/">http://www.mcpap.com/</a> <a href="https://www.mcpapformoms.org/Toolkits/PediatricProvider.aspx">https://www.mcpapformoms.org/Toolkits/PediatricProvider.aspx</a></td>
</tr>
</tbody>
</table>
Positive developmental screening requires more extended developmental assessment such as Batelle Developmental Inventory and Infant Toddler Developmental Assessment.

Children ages 0 to 3 years should be referred to Early Intervention (EI) for development of Individualized Family Service Plan and multi-modality intervention and therapy.

Children ages 3 to 21 should be referred to local education agency or school district.
Using MassHealth claims data, children with ≥300 days of eligibility in fiscal year (FY) 2009 were identified.

Of 355,490 eligible children, 46% had evidence of screening. Of those with screening modifiers, 12% were positive.

Of the children with positive BH screening, 43% had no BH history.

Screening for Behavioral Health Issues in Children Enrolled in Massachusetts Medicaid, Hacker KA, Penfold R, Arsenault L, Zhang F, Murphy M, Wissow L; Pediatrics, 2014; 133(1)
POSTPARTUM DEPRESSION SCREENING
POSTPARTUM DEPRESSION SCREENING

+ Estimated rates for depression among pregnant and postpartum women range from 5% to 25%. Rate in low-income mothers and pregnant/parenting teenagers may be 40% to 60%.

+ Peak incidence for major depression 6 weeks post-partum and 2 to 3 months post-partum for minor depression. There is another peak of depression 6 months post-partum.

+ USPSTF Grade B recommendation but does not specify periodicity of screening.

+ AAP recommends screening at 1-, 2-, 4-, and 6-month visits.

PCMH PRIME Element D-6: Practice collects and regularly updates a comprehensive health assessment including post-partum depression screening using a standardized tool.

Marian F. Earls, MD, THE COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH
POSTPARTUM DEPRESSION SCREENING

Tools:

- Edinburgh Postnatal Depression Scale most widely known, must be followed up by additional diagnostic tool
- Can also use 2-question screening, followed by a diagnostic tool if positive:
  - Over the past 2 weeks:
    - 1. Have you ever felt down, depressed, or hopeless?
    - 2. Have you felt little interest or pleasure in doing things?

- PHQ-2 or PHQ-9

Referral and supervision of connection to resources critical step if adult BH services are not offered through practice
QUALITY IMPROVEMENT LIFECYCLE: PLAN, DO, STUDY, ACT

1. PLAN:
   • Develop rationale for change
   • Determine billing and payment
   • Select leadership team
   • Select tool and develop workflow
   • Determine metrics

2. DO:
   • Pilot with subset of providers over planned pilot period

3. STUDY:
   • Track process metrics
   • Gather feedback

4. ACT:
   • Revise workflows
   • Repeat cycle
   • Write policy and procedure
   • Spread to all providers
   • Educate patients
   • Track metrics
**FULFILLING THE CARE MANAGER ROLE – IMPORTANT HIRE!**

Who are the BH CMs?

- Flexibility in qualification/training of care manager: Typically MSW, LCSW, MA, LPN, RN, CHW
- Variable clinical experience – leverage expertise in brief intervention skills, registry management

What makes a good BH CM?

- Organization
- Persistence - tenacity
- Creativity and flexibility
- Strong communication skills
- Enthusiasm for learning
- Strong patient advocate
- Willingness to be interrupted
- Ability to work in a team

**PCMH PRIME Element C 1:** Practice has at least one care manager qualified to identify and coordinate BH needs
CARE MANAGER TASKS FOR COLLABORATIVE CARE

Common BH Care Manager Functions:

- Facilitates patient/parent engagement
- Performs systematic initial and follow-up assessments
- Systematically tracks treatment response using registry including referral tracking
- Supports treatment plan with PCP
- Reviews challenging patients with the psychiatric consultant weekly (can be with PCP)

Note: PCMH PRIME Element C does not define the responsibilities of BH Care Manager. Practices are able to define priorities for the role and staff qualifications.
CONFIRM THE BEST TYPE OF TREATMENT FOR INDIVIDUAL PATIENTS

Stepped Care Approach

✚ Uses limited resources to their greatest effect on a population basis

✚ Different people require different levels of care

✚ Finding the right level of care often depends on monitoring outcomes

✚ Increases effectiveness and lowers costs overall

Primary Care + BH CM → Psychiatric consult (Face-to-face) → BH specialty short term tx → BH specialty long term tx → Psychiatric inpatient tx

Self-Management → Primary Care → Care management brief interventions
Brief Interventions can be done by BH care manager, PCP or a combination of both.

Selection of which Brief Intervention to use with a particular patient driven by clinical judgement and patient preference; Techniques can be used for wide range of diagnoses.

Techniques:
- Anticipatory guidance
- Brief therapeutic interventions
  - Diaphragmatic Breathing
  - Behavioral Activation
  - Problem Solving Therapy
  - Motivational Interviewing
  - Distress Tolerance Skills
  - Cognitive Behavioral Therapy (CBT)

Referral process

Measuring progress, registry management, case consultation.
CONFIDENTIALITY CONCERNS

+ Massachusetts

+ Minors (age 12+) may consent (without adult) to their own treatment for SUD, family planning services, or treatment for sexually transmitted diseases (including HIV or AIDS). M.G.L.A. c. 112 & 12E, c. 111 § 24E, and c. 111 § 117

+ A minor who is at least 16 years old may commit himself or herself for mental health treatment without parental consent. M.G.L.A. c. 123 § 10

+ In addition to the above categories, Massachusetts Courts have adopted the "mature minor rule." This means that if a doctor believes that the child is mature enough and able to give informed consent to medical care not described above; and it is in the best interests of the minor not to notify the child's parents, the doctor may accept the child's consent alone. Baird v. Attorney General, 371 Mass. 741, (1977)

+ PCPs and Care Managers continue to document their findings in the chart - use clinical judgement regarding how much detail to include
IMPLEMENTING BRIEF PSYCHOTHERAPEUTIC INTERVENTIONS

+ Include a patient engagement component. Skipping right to treatment doesn’t work
+ Be time efficient, running no more than 20-30 minutes a visit
+ Care managers can send the parents out of the room to collect additional information if needed (see slide on confidentiality)
+ Follow a structure-based approach. A modularized treatment with clear steps keeps the provider and patient on track despite the distractions in primary care
+ Minimize required clinical training. The treatment should be able to be administered by non-specialists who work in a health care team
+ Be relevant and applicable to the diverse patient populations found in primary care
+ While evidence-based practice is preferred, there are limited studies of interventions in pediatric practice. Pediatric care manager best practice is adapting the evidence based adult brief interventions to the pediatric population – described in the following slides

If an intervention occurs that meets criteria for a psychotherapy code (30, 60 minute etc.) or family therapy then bill it
"Anticipatory Guidance" is a common term in the field of general pediatrics. It refers to providing education to parents about what to expect, or anticipate, over the next few months or years with your child. Recommendations are specific to a child's age at the time of a visit.
BRIEF INTERVENTIONS - ANTICIPATORY GUIDANCE

- Educating parents regarding normal social and emotional development
- Training parents in basic behavior-modification principles; establishment of consistent expectations and structure, clear limit-setting, praise, and positive reinforcement
- Teaching strategies to enhance parent-child relationships
- Teaching strategies to improve family cohesion and address sibling conflicts
- Coaching parents on bullying issues
- Educating parents about the impacts of toxic stress and traumatic experiences
- Helping parents become effective advocates for their children with regard to addressing special education needs
**Anticipatory guidance for social-emotional development: Normal behaviours**

<table>
<thead>
<tr>
<th>Age</th>
<th>Behaviour</th>
<th>Behaviour</th>
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</thead>
<tbody>
<tr>
<td>6 months</td>
<td><strong>Separation anxiety (7,8):</strong></td>
<td><strong>Negative behaviours (24,26):</strong></td>
</tr>
<tr>
<td></td>
<td>• Calm him when he protests.</td>
<td>• To increase positive behaviours: Give immediate positive attention (eg,</td>
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<tr>
<td></td>
<td>• Transitional object (eg, a blanket) helps him feel calm.</td>
<td>specific praise &quot;Good sitting quietly in your chair&quot;, smile, hug).</td>
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<td></td>
<td>• Tell him where you are going, when you will return (follow through).</td>
<td>• Praise positive behaviours at least 3–4 times more often than you</td>
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<tr>
<td></td>
<td>• Leave with confidence, use a consistent caregiver.</td>
<td>identify misbehaviour. Children are not spoiled by praise.</td>
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<tr>
<td></td>
<td>• Hold him close upon return, until he signals readiness to move away.</td>
<td>• To decrease minor negative behaviour (eg, whining): Consistently ignore</td>
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<td></td>
<td>• Daycare: If he is very upset, integrate him gradually, with you</td>
<td>(ie, even negative attention is rewarding), know that it usually worsens at</td>
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<td></td>
<td>present, during part of the initial days.</td>
<td>first.</td>
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<td></td>
<td>• Stay with him during hospitalizations.</td>
<td>• As soon as misbehaviour stops, suggest appropriate behaviour, give</td>
</tr>
<tr>
<td>9 months</td>
<td><strong>Night wakings (10):</strong></td>
<td>immediate positive attention to the positive behaviour.</td>
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<tr>
<td></td>
<td>• Respond as you do at bedtime.</td>
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<tr>
<td></td>
<td>• Try moving bedtime earlier by a half hour or more.</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td><strong>Temper tantrums (8):</strong></td>
<td><strong>Negative behaviours (24,26):</strong></td>
</tr>
<tr>
<td></td>
<td>• Distract him (eg, alternate activity), remove him from that location.</td>
<td>• For recurring problems, use immediately:</td>
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<tr>
<td></td>
<td>• Try soothing him by holding and helping to label feelings.</td>
<td>• Logical consequence (eg, drawing on wall —crayons removed, helps clean).</td>
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<tr>
<td></td>
<td>• If unsuccessful, let him cry it out while you ignore the behaviour,</td>
<td>• Natural consequence (eg, dawdling before park — no time to go).</td>
</tr>
<tr>
<td></td>
<td>staying in the room with him.</td>
<td>• Stay calm.</td>
</tr>
<tr>
<td></td>
<td>• Once he will allow it, soothe him, help him verbalize feelings,</td>
<td>• A child’s feelings about himself are as important as obeying your</td>
</tr>
<tr>
<td></td>
<td>distract.</td>
<td>commands.</td>
</tr>
<tr>
<td>2 years</td>
<td><strong>Picky eating (23):</strong></td>
<td><strong>Aggression (26):</strong></td>
</tr>
<tr>
<td></td>
<td>• Do not coax.</td>
<td>• Time-out to calm down (ie, boring safe area, ignore him):</td>
</tr>
<tr>
<td></td>
<td>• Ignore it.</td>
<td>• Briefly explain (eg, &quot;No hitting/wrecking. You need a time-out to</td>
</tr>
<tr>
<td></td>
<td>• Serve the same variety of nutritious foods that you eat.</td>
<td>calm down&quot;).</td>
</tr>
<tr>
<td></td>
<td>• He is responsible for what and how much he eats.</td>
<td>• Lasts 3 min (three-year-old), 4 min (four-year-old), or 5 min (five</td>
</tr>
<tr>
<td></td>
<td>• He will grow up able to regulate food intake based on internal</td>
<td>or more years of age). It is not over until he has been calm for 2 min.</td>
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<tr>
<td></td>
<td>cues of hunger and satiety.</td>
<td>• After time-out: Praise his calming down, give him something else to do.</td>
</tr>
<tr>
<td></td>
<td>• Trust that when he is older, he will eat what you eat.</td>
<td>• Praise his first positive behaviour, encourage verbal expression of anger.</td>
</tr>
</tbody>
</table>

*Numbers in parenthesis indicate references*

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**Anticipatory guidance for cognitive and social-emotional development: Birth to five years. Cara Dosman, MD FRCPC FAAP and Debbie Andrews, MD FAAP FRCPC, Paediatr Child Health, 2012 Feb; 17(2): 75-80**
Providing stress management techniques: relaxation training such as diaphragmatic breathing and introduction to mindfulness-based stress reduction

- Sit or stand in a comfortable position with your back straight and your feet flat on the floor
- Place one hand on your chest and one on your stomach if you want
- Slowly inhale through your nose, counting slowly to 4
- Slowly exhale through the mouth, counting slowly to 6
- That’s it! Repeat several times.
**BRIEF PSYCHOTHERAPEUTIC INTERVENTIONS: BEHAVIORAL ACTIVATION**

- Behavioral Activation for depression
  - Set goals – social/physical are typically best mood boosters
  - Set follow-up to see if goal accomplished
  - Establish next goal

**Approach:**
Outside → In

Typically we think of acting from the “inside → out”
(e.g., we wait to feel motivated before completing tasks)

In Behavioral Activation, we ask people to act according to a plan or goal rather than a feeling or internal state.
Problem Solving Therapy – 7 steps

- Define a problem
- Select achievable goal
- Generate multiple solutions
- Pros and cons of each solution
- Select a feasible solution
- Implement solution
- Evaluate outcome
Motivational Interviewing

**DO (ACE)**

- **Honor Autonomy:** Allow the freedom not to change
  - "How ready are you to change?"

- **Collaborate**
  - "What do you think you’ll do?"

- **Elicit Motivation**
  - "What would you like to change about your drinking?"

**AVOID**

- **Making judgmental statements**
  - "You really need to stop drinking."

- **Push for commitment**
  - "If you delay getting sober, you could die."

- **Dictate**
  - "I would urge you to quit drinking."
DISTRESS TOLERANCE SKILLS - from Dialectical Behavioral Health

Self-Soothe With Senses
Find a pleasurable way to engage each of your five senses. Doing so will help you soothe your negative emotions

- Vision: Go for a walk somewhere nice and pay attention to the sights
- Hearing: Listen to something enjoyable such as music or nature
- Touch: Talk a warm bath or get a massage
- Taste: Have a small treat – it doesn’t have to be a full meal
- Smell: Find some flowers or spray a perfume or cologne you like

http://www.therapistaid.com/therapy-worksheet/dbt-distress-tolerance-skills/dbt/adolescents
Distress Tolerance Skills- from Dialectical Behavioral Health – Distraction

**Distraction (A.C.C.E.P.T.S.)**

*Negative feelings will usually pass, or at least lessen in intensity over time. It can be valuable to distract yourself until emotions subside. The acronym “A.C.C.E.P.T.S.” serves as a reminder of this idea.*

| A | Activities | Engage in activities that require thought and concentration. This could be a hobby, a project, work, or school. |
| C | Contributing | Focus on someone or something other than yourself. You can volunteer, do a good deed, or do anything else that will contribute to a cause or person. |
| C | Comparisons | Look at your situation in comparison to something worse. Remember a time you were in more pain, or when someone else was going through something difficult. |
| P | Pushing Away | Do away with negative thoughts by pushing them out of your mind. Imagine writing your problem on a piece of paper, crumpling it up, and throwing it away. Refuse to think about the situation until a better time. |
| T | Thoughts | When your emotions take over, try to focus on your thoughts. Count to 10, recite a poem in your head, or read a book. |
| S | Sensations | Find safe physical sensations to distract you from intense negative emotions. Wear a rubber band and snap it on your wrist, hold an ice cube in your hand, or eat something sour like a lime. |

http://www.therapistaid.com/therapy-worksheet/dbt-distress-tolerance-skills/dbt/adolescents
BRIEF PSYCHOTHERAPEUTIC INTERVENTIONS: CBT

- Utilizing cognitive-behavioral principles to help parents manage mild manifestations of generalized anxiety, social anxiety, and separation anxiety
- Utilizing the CBT triangle: Strong evidence base for CBT in adolescents in primary care
Frequent administration of validated measurement tools

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)
Tracking results on a registry allows Care Managers to quickly identify patients who are not progressing and take appropriate action.

**Observation: Recent screening value shows little improvement from initial**

**Possible CM actions:** Reconnect with patient for brief intervention, follow-up. Review case with PCP and psych consult. Change medication dosing, refer for therapy or other intervention.

**Observation: Patient has not been screened for a long time, no psych consult**

**Possible CM actions:** Reach out and reconnect with the patient, complete screening, discuss with psych consult as needed.

**Observation: Patient in remission**

**Possible CM actions:** Convey to PCP and psych consult with treatment plan. Continue to screen at defined intervals to prevent relapse.

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*Health Management Associates*
RESOURCES FOR PCPs

- Screening Tools
- Brief Interventions
- Self-help materials
- Parent resources too
- MASSBIRT
  http://www.masbirt.org/products
  - Videos demonstrating screening techniques
  - SBIRT Clinician’s Toolkit
  - Brief Treatment Manual
RESOURCES FOR PCPs: HANDOUTS

+ Useful Handouts
+ Need AAP Member login

https://patiented.solutions.aap.org/handouts.aspx

http://integratedcareforkids.org
REFERRAL TRANSITIONS

- Helping to prepare children and parents for therapy/child psychiatric referrals and educating them regarding what to expect

- Use available resources or refer to a trusted colleague if possible:
  - MCPAP: Telephone and Face-to-Face Psychiatric Consultation
    - www.mcpap.com

- Working with youth that may be transitioning from pediatrician to adult provider
Please evaluate this session by completing the survey found here:

https://www.surveymonkey.com/r/JBLKFDN