PA CASSP Newsletter

**Pennsylvania Child and Adolescent Service System Program**

*A comprehensive system of care for children, adolescents and their families*

*Volume 22, Number 4* *December 2013*

# Integrating the Behavioral Health Screen in Primary Health Care

*by Linda Smith*

Recently, Tim, age 15, came to see me for a routine visit. His agenda form noted no patient or parental concerns. He is reportedly well-adjusted and was just in for a routine visit and to update vaccinations. I have seen him previously on many occasions and know him and his family very well. I thought I had done a great job before giving him guidance about his health. He consistently screened negative by my traditional history for academic, social or behavioral challenges. He had never noted concerns with depression, anxiety, substance abuse, bullying or suicidal risk. My bias was that he is the "easy" child; most of my interactions with him and his family were overshadowed by his younger brother's significant medical and developmental needs as a result of complex congenital heart disease necessitating multiple surgeries, developmental interventions and chronic disease management.

Before Tim entered the exam room, I was extremely surprised that the Youth Behavioral Risk Screen showed him to be at risk for Post-Traumatic Stress Disorder. Having this information significantly increased the value of our encounter and opened up dialogue about his years of stress and worry about his brother, as well as some heightened anxiety as his family plans to move into a new home where the boys will have separate bedrooms for the first time. I was able to start a focused discussion about his understandable and challenging lifelong worry and the availability of counselling resources to enhance his coping skills and increase his already amazing resiliency. As a primary care physician advocate, this patient-centered experience was incredibly enlightening and gratifying. It was also very well received by Tim and his grateful father.

Proactive universal screening for youth behavioral risk is so valuable. In our evolution as patient-centered medical homes, the Wright Centers for Primary Care struggle with effective integration of behavioral and mental health services so we can take our patient and community-centered care delivery and health promotion efforts to a higher level. We have had great success re-designing our team-based care delivery processes to be more strategic and to promote wellness and chronic disease management during every visit. As we build our comprehensive health home integration to promote the Institute of Healthcare Improvement's Triple Aim of better health, better healthcare and affordability, we honestly fear screening tools that open Pandora's Box and often highlight our deficiencies as medical providers. However, we are passionately committed to learn continuously with and from our patients and to back up our blind spots with intensified community partnerships.

Any screening tool vehicle with a ready-made roadmap to community resource agencies is welcomed at The Wright Centers. The Youth Behavior Risk Assessment was brought to us by Pennsylvania's Garrett Lee Smith Youth Suicide Prevention in Primary Care grant program through the Advocacy Alliance, a local mental health advocacy organization. The Youth Behavior Risk Assessment tool developed by this program is easy to use electronically and to integrate in our Electronic Medical Records (EMR) system. The program was immediately identified and embraced by our primary care physician leaders as a well-structured vehicle to improve our role as a medical home and to

*continued on page 7*

*December 2013*
*Volume 22, Number 4*



***Department of Public Welfare***
*Office of Mental Health and Substance Abuse Services*
*Bureau of Children's Behavioral Health Services*
*DGS Annex Complex*
*Beechmont Building, 2nd floor*
*P. O. Box 2675*
*Harrisburg, PA 17105*
*Telephone: (717) 772-7984*
*Fax: (717) 705-8268*
*E-mail: c-hbicksle@pa.gov*
*Website: www.dpw.state.pa.us*

**Subscription information:**
The *PA CASSP Newsletter* is distributed exclusively in electronic format and online. Subscribe to the CASSP News listserv to receive e-mail notification when a new edition is available at http://listserv.dpw.state.pa.us/cassp-newsletters.html. Access back issues since 2002 by clicking on the "2011" link. For issues before 2002, contact the editor. Please feel free to print, copy and distribute the newsletter freely.

# Integrating Physical and Behavioral Health

## OMHSAS Today and Tomorrow

*Guest editorial by Dennis Marion, OMHSAS Deputy Secretary*

OMHSAS is bringing people together in a series of forums throughout Pennsylvania to talk about needs, priorities and strategies to help guide behavioral health services for children and adults in the years ahead. We have held eight broad topic sessions to date. Four of the sessions were scheduled in connection with Consumer Support Program (CSP) regional meetings and the other forums were open to all stakeholders.

Over 400 individuals participated in these forums. These sessions featured open dialogue, audience response sessions, structured planning exercises and heartfelt discussion about our system of mental health services and supports for children and adults and older adults. Participants in the sessions contributed hundreds of personal observations about behavioral health care in Pennsylvania as it is now and how it can be in the future.

The following are samples of the youth-related recommendations heard during the forums. The system should:

- Increase the use of peer specialists working with transition age youth;
- Offer peer support for families involved in the children and youth service system and the juvenile justice system;
- Provide more support for individuals in transition from youth oriented to adult services; and involve youth in case conferences.

We also heard that CASSP still works.

An audience response system allowed us to poll the participants and generate immediate results that reflected the thinking of the varied stakeholders in attendance. We were pleased that the polling showed support for the long established OMHSAS Mission and Vision Statement and the related guiding principles. The core concepts and language have endured the test of time and still hold meaning in this era of change and innovation in our health care system.

## OMHSAS Guiding Principles

The mental health and substance abuse service system will provide quality services and supports that:

- Facilitate recovery for adults and resiliency for children;
- Are responsive to individuals' unique strengths and needs throughout their lives;
- Focus on prevention and early intervention;
- Recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation;
- Ensure individual human rights and eliminate discrimination and stigma;
- Are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family;
- Are developed, monitored and evaluated in partnership with consumers, families and advocates; and
- Represent collaboration with other agencies and service systems.

The OMHSAS guiding principles are used in concert with CASSP principles to set the direction for children's behavioral health services. As a result, behavioral health services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

Care management remains a key component of treatment approaches supported through our community-based

mental health service system. An important feature of our system is the increasing use of peers as part of the care team that works to support individuals. We are now seeing positive examples of applying this approach to concurrent physical and behavioral health needs.

During each forum we heard about the need for better coordination between physical health and behavioral health services across the whole health care system. OHMSAS is exploring service approaches to assure that our system is person and family centered in both design and practice—a system that values the role of the individuals in developing care plan in collaboration with doctors, therapists, peers, counselors, care managers and other sources of support. We now see similar approaches emerging in the physical health care system, most notably in the expanded use of person-centered medical homes.

Pennsylvania has served as a testing state for the Center for Health Care Strategies' "Rethinking Care Initiative" to integrate physical and behavioral health for Medicaid beneficiaries with serious mental illness. Regional efforts in Southeast and Southwest Pennsylvania brought together physical health managed care organizations (MCOs), behavioral health MCOs, county behavioral health offices, and participating providers to work together under a common integration framework. The framework features consumer engagement, establishment of a medical home that coordinates physical and behavioral health care, full and timely access to member information, aggressive follow-up after hospital discharges, close medication management, appropriate emergency department use for behavioral health treatment, and coordination with alcohol and substance abuse treatment providers.

## Looking ahead

Healthy Pennsylvania is Governor Tom Corbett's plan to increase access to quality, affordable health care for all Pennsylvanians. OMHSAS was engaged in stakeholder sessions related to the Pennsylvania Health System Innovation Plan that is part of the Governor's overall plan for the cmmonwealth. A key feature of the plan is the development of person centered medical homes to help meet the health and wellness needs of Pennsylvania residents.

The plan includes provisions for the further development of health care strategies that address in a more integrated approach both the physical and behavioral health needs of children and adults. As a result, individuals supported by OMHSAS resources will benefit in terms of overall wellness. As we move forward, we expect that physical health and behavioral health care systems in Pennsylvania will work in a more coordinated manner to better serve both youth and adults.

*Dennis Marion has been deputy secretary for the Office of Mental Health and Substance Abuse Services since 2012. Before that, he worked for Cumberland-Perry County.*

## Department of Public Welfare Convenes Health Care Workgroup

As part of the ongoing effort to improve the well-being of children in Pennsylvania's child welfare system, the Department of Public Welfare, through the Office of Children, Youth and Families, has convened a Health Care Workgroup to critically examine the issues surrounding the physical and behavioral health care needs of children in foster care. The Health Care Workgroup is driven by the mission to ensure that children in Pennsylvania's foster care system have access to comprehensive, quality health care through the development of interagency and cross systems policies and strategies, including the use of emerging technologies.

A Sponsor Team was convened in the spring of 2013 and met over the course of several months to identify priority issues and engage key stakeholders in joining a steering committee. The steering committee will advise and support the four workgroups which have been assembled to address the following priority topic areas: psychotropic medication, medical homes, trauma-informed care, and medical foster care.

The steering committee kicked-off its first official meeting September 11, 2013, and will continue to meet throughout the next year to support the workgroups in the development and implementation of strategies to improve the quality of health care for children in foster care. In addition, the Health Care workgroup includes representatives from OMHSAS as well as MH providers, family members and advocates.

For more information, contact Darlene Black at *dablack@pa.gov*, Natalie Perrine at *nperrin@pa.gov*, or Scott Talley at *stalley@pa.gov*.

# The Pennsylvania Physical Health-Behavioral Health Learning Community

*by Connell O'Brien*

In April 2009 the voices of the parents were clear, emphatic and painful to hear, but undeniable. A panel of parents had come together as part of the Pennsylvania Chapter of the American Academy of Pediatrics (PA-AAP) Medical Home Conference. The topic of the day was behavioral health and how pediatricians, mental health professionals, managed care companies and other stakeholders had collaborated to meet the needs of their patients with complex health care needs, in particular those with physical health and behavioral health care needs. The often emotional message to the health care providers, state leaders and managed care organizations was that we were failing. Dr. Renee Turchi, the director of the PA-AAP Medical Home project stood and moved to the front of the room, and I joined her there. That day Dr. Turchi thanked those parents for telling us what was important for Pennsylvania's health and mental health care system to hear. Then Dr. Turchi and I on behalf of our organizations said we would work together to begin to understand and to "fix" this problem.

In the months that followed the Pennsylvania Community Providers Association (PCPA), now the Rehabilitation and Community Providers Association, and the PA-AAP Medical Home Project formed a "mental health work group" and met regularly to survey community practitioners and providers and work to understand the barriers to collaboration, communication and coordination of the care for the children we were serving. We quickly discovered that there were many, many barriers between the children's primary health care and mental health systems. Training, regulations, funding, language, expectations, geography, and insurance had created a gap in children's care that needed to be filled. PCPA, with the help of the Office of Mental Health and Substance Abuse Services and the Mental Health Work Group convened a one-day Health Care Leadership Summit in December 2010. The leaders from government, health insurance, community foundations, hospitals, primary care medicine and behavioral health care came together to discuss what we now knew about what worked, what didn't and how we might improve care. At the end of the day, the number one recommendation was that the physical and behavioral health care providers and practitioners work to create a "Learning Community" to break down the "culture barriers," create relationships and models essential to the delivery of "integrated health care." Practice should drive the policy in Pennsylvania!

The Pennsylvania Physical Health-Behavioral Health Learning Community was formed three months later by the state's Academy of Pediatrics, Academy of Family Physicians, PCPA and representatives from OMHSAS. This group laid out a vision for the Learning Community: "to advance commonwealth wide efforts to improve the provider focused planning, policy development, communications, and practice enhancing collaboration and coordination of care between behavioral health providers and primary care providers serving Pennsylvania residents of all ages." By the end of 2011 most of the statewide organizations representing primary care physicians, advance practice nurses, community health centers and mental health organizations, psychiatrists and psychologists became part of this learning community and its shared vision.

Today an ever-growing number of primary care and mental health professionals and the statewide organizations that work on their behalf share practice models, research and their own experiences as they work to integrate community healthcare. Through the Learning Community these health care practitioners have access to a growing body of "how to" information on patient/consumer centered communication, collaboration and co-location of primary care and mental health care services. "Lunch Time Webinars" keep Learning Community members informed about promising integrated care practices while an on-line archive provides access to research and national publications on "integrated care solutions." Over the past year the learning community's statewide membership organizations have begun to coordinate practitioner training, conferences and meetings to reflect the vision and practice of integrated care. Member organizations routinely extend invitations and on-line access to their training across the entire Learning Community through the initiative's steering group and "Learning Community Infos" that go to our growing listserv. While long standing policy and practice barriers still need to be addressed, a growing number of primary care practices and mental health providers are now WORKING TOGETHER every day to better serve children and families.

*Connell O'Brien is the children's policy specialist at the Rehabilitation and Community Providers Association [RCPA] and project facilitator for the Pennsylvania Physical Health – Behavioral Health Learning Community. To participate in the Learning Community, contact cobrien@paproviders.org.*

# A Simple Solution: Behavioral Health Services in the Pediatrician's Office

*by Ken Nash, Abigail Schlesinger and Sheena Kelemen*

The pediatrician's office is often the go-to place to receive advice, diagnosis, and treatment for everything from immunizations to sniffy noses. Traditionally pediatricians have been encouraged to send all children with signs of behavioral health problems, like anxiety, to a specialized provider for diagnosis and treatment. To complicate matters, the identity of this unknown person or facility could only be determined by calling the 1-800 number on the back of an insurance card. Imagine what would happen if every child who wheezed had to go to an asthma specialist in order to receive an inhaler? There would be long wait lists, follow-up would plummet, and negative outcomes of asthma would skyrocket. (Sound familiar?).

With 1 in 5 children in the U.S. having a diagnosable mental health disorder, pediatricians have increasingly been called upon to identify and treat mental health concerns. Although well-educated, pediatricians do not have an overabundance of training in the always expanding field of mental health. In fact, one of the top requests of pediatricians is to have better access to behavioral health services, preferably in their practice. For this, a proposed simple solution: provide basic, evidenced-based behavioral health services in the pediatrician's office.

To address this issue, Western Psychiatric Institute and Clinic (WPIC), in partnership with Children's Hospital of Pittsburgh of UPMC and Children's Community Pediatrics (CCP), created a program that provides access to integrated behavioral health services in pediatric offices in western Pennsylvania. This initiative required senior leaders from three health care branches — pediatricians' offices, psychiatry, and a counseling center — to come together and develop a system in which children receive access to behavioral health and medical services under one roof—The CCP Behavioral Health Program.

Now, when a family comes to our pediatric offices, they are screened for behavioral health concerns and referred to an in-house therapist who works closely with the trained pediatrician in clarifying diagnoses and providing appropriate treatment or referral to a higher, more specialized level of care. Less than ten percent of youth seen are referred out, and in these cases it is for immediate safety issues or additional expertise.

The CCP Behavioral Health program began in 2008 with two masters-level licensed therapists serving three pediatric primary care offices. It has since grown to include ten licensed masters- and doctoral-level therapists embedded in 13 practices. Today, this program provides integrated care to the patients of more than 150 pediatricians, and provides 12,000 behavioral health services annually.

Placing the therapists in the pediatric office has had a great effect on the health care of children. Rates of showing up for therapist appointments at the pediatric offices are greater than 90 percent compared to the stand-alone community behavioral health clinic of 48-62 percent. The average child seen at the CCP Behavioral Health program is 2-3 years younger than those typically seen at a behavioral health only clinics, leading to early intervention as well as less hospitalization and medicalization for this population. Not only does this help the families financially, with convenience, and immediate access, but it also helps the system as a whole. By avoiding the constant referral to backed-up behavioral health clinics, it opens up (often scarce) high levels of care like psychiatry emergency rooms and hospital inpatient beds, so those in dire need or crisis can receive care faster and more efficiently.

The concept was simple, but the implementation was complex, requiring "buy-in" from the behavioral health providers, administrators, and medical offices. Success has been supported by an integrated medical record (so that the pediatricians, therapists, and psychiatrists can freely communicate). The program has continued to grow over the years and is financially sustainable with higher show rates, and improved reimbursement.

In order to continue the growth of the program and support the pediatric members of the team, the Stanton Farm Foundation provided funding for a four-part series on the diagnosis and treatment of mental health disorders. More than 100 pediatricians attended the two-hour lectures, which occurred in the evening, in addition to their daily responsibilities. In follow-up surveys a majority of attendees anticipated changing their practices. Follow-up chart reviews confirmed a significant increase in use of evidence- based interventions for depression and anxiety by pediatricians in the year following the series.

The CCP Behavioral Health Program has won the 2012 Hospital and Health System Association of Pennsylvania Achievement Award for Patient Care and Innovation, as well as the 2012 Fine Bronze Award of the Fine Foundation and Jewish Healthcare Foundation for Teamwork Excellence in Transitions of Care.

*Ken Nash, M.D., is associate professor of psychiatry and vice chair for clinical affairs in the Department of Psychiatry, and chief of clinical services for Western Psychiatric Institute and Clinic. He is also the co-administrator for the Youth and Family Training Institute. Abigail Schlesinger, M.D., is assistant professor of psychiatry for WPICc and medical director of Children's Hospital Community-Based Behavioral and Developmental Services. Sheena Kelemen is the project coordinator for the Office of Clinical Affairs at WPIC. She manages the medical staff credentialing and coordinates physician recruitment for the Department of Psychiatry.*

# Integrating Pediatric Health Care Services for Better Outcomes

*by Heather Hoeke, David Grabowski and Kelly Primus*

Josh, age 8, was referred for individual therapy by his pediatrician due to recurring stomach problems and sleep issues. The pediatrician had seen Josh in his office several times in a six- month period due to gastrointestinal problems that were affecting his ability to stay in school and participate in recreational activities. When he was referred, he was going to the school nurse every day. The family had gone to see a specialist in gastro-intestinal issues, and there were no physical problems. He was also having difficulty sleeping in his own room and needed a great deal of coaxing to fall asleep. He was tearful every night before bedtime as well as before going to school. His pediatrician referred him to Wesley Spectrum Services to explore the possibility that his physical symptoms were related to anxiety.

Josh and his family were eager to get these health problems under control so Josh could be a happier child. Over a four-month period, the therapist saw Josh weekly to discuss school anxiety as well as his worries about his father's job. The therapist worked with the parents on psychoeducation and bedtime routines. The therapist implemented cognitive behavioral therapy strategies, including relaxation, reframing, modeling, and coping skills to help Josh to overcome his anxiety. At the end of the treatment, Josh was no longer going to the school nurse and was engaging in all of his classes. His stomachaches were occurring less than once per week, and when they did occur, Josh reported that he was able to successfully manage the stomachache using deep breathing and visualization. Josh and his family avoided invasive and stressful gastrointestinal testing and found ways for Josh to recognize and manage symptoms of anxiety and stress independently.

Josh's story helps to explain why federal, state and other stakeholder initiatives are moving provider organizations towards accountable care and medical home models, which emphasize collaborative communication, improved patient access to services and a more holistic approach. Wesley Spectrum Services (WSS) is one such provider organization. WSS is a private, nonprofit service agency that provides a wide array of integrated education, behavioral health and family support services to meet the complex needs of at-risk children and families throughout Southwestern Pennsylvania. Our mission is to provide transformational support for children and families as they strive to become more independent, responsible, and caring members of the community.

Pediatric Alliance is the largest physician-owned group pediatric practice in Southwestern PA. Their board-certified pediatricians offer primary care to children and adolescents in ten different office locations. Pediatric Alliance is devoted to providing high-quality, comprehensive primary care to infants, children, and adolescents through clinical expertise, advocacy, education, collaboration, research, and information management.

Untreated behavioral health issues affect physical health and make it challenging for a child to form healthy relationships, obtain a quality education, secure and maintain employment, and function in society. Since January 2012, WSS has been working in collaboration with Pediatric Alliance to co-locate behavioral health care services in three of their pediatric offices. This partnership was developed as a result of existing professional relationships as well as a clear alignment of mission and values. Both organizations seek to increase the quality of life for children and families through wellness and prevention. The three clinicians from WSS who are assigned to the three pediatric offices provide individual and family therapy to children and adolescents who have been identified by their pediatrician as having current or emerging behavioral health needs during annual well-child visits, recurring problem visits, or parent requests. WSS recently began offering medication evaluations and medication checks through a certified registered nurse practitioner.

By collaborating with the pediatricians and continuing to discuss the impact of the co-location model, we have established services that offer families easier access to services and the comfort of knowing that there is communication between their physical health and behavioral health providers. With integrated care, we are able to capitalize on opportunities to share information about wellness and the impact that physical health symptoms have on behavioral health and vice versa. Since the inception of this co-location model, WSS has also been working with Allegheny HealthChoices, Inc. (AHCI), a local non-profit, to develop a plan for measuring outcomes for our co-location project. The plan includes measures in the following domains: participant/family member satisfaction; physician satisfaction; referrals, screening and assessment (timeliness and coordination with physicians); and services and discharge (frequency of visits, average length of stay, reason for discharge). The data collected provides both Wesley Spectrum and Pediatric Alliance with the opportunity to gauge success and identify areas for quality improvement.

To date, our outcomes have been positive regarding referrals, ease of access, show rate, and client satisfaction. Out of 394 referrals since January 2012, we have provided an assessment for 357 consumers. The average time from referral to first scheduled appointment with one of our therapists is 4.9 days which means that families are able to access services more quickly than typical outpatient services. Our data shows a 96 percent show rate for the assessment and 90 percent show rate for other scheduled appointments. This information correlates directly with client satisfaction outcomes. Clients have reported high, positive rating with overall services:

*continued on page 7*

*continued from page 1*

fill a gap in addressing adolescent mental health and behavioral and suicide risk assessment.

Integrating the Youth Behavior Risk Assessment tool into our EMR system has helped our clinical decision-making for youth ages 14-24. The tool has been very well received by both youth and their parents. Medical assistants determine if a youth is due for screening by reviewing the EMR's disease management/health maintenance alerts during pre-visit planning. The tool is explained and completed confidentially by youth in exam rooms on a tablet similar to an IPad before they see the doctor and other medical providers. Assessments are downloaded from a secure website funded by the grant project and into our EMR. This workflow allows time for medical assistants to quickly review results and alert providers to anything abnormal. High risk patients are referred to a partnering mental health agency. Referrals are tracked internally by our office and externally by the grantee. A crisis support management tool has been integrated into our EMR. All providers have been trained on the process of creating referrals and constructing crisis response plans for youth at high risk.

Our three-year participation in the Youth Suicide Prevention in Primary Care Program has allowed us to screen thousands of adolescents and young adults and has increased our awareness of the prevalence of behavioral risks, mental health issues and suicide risk within our practice. This experience has strengthened our community mental health partnerships and fine-tuned our care coordination efforts, especially for referral tracking. Having discovered how prevalent the risks are among our patients, two years ago we integrated on-site behavioral and mental health services and hired a social worker and psychiatric nurse practitioner. Recently, we proudly hired our first psychiatrist demonstrating our commitment to evolve full on-site behavioral and mental health services to enhance the quality, efficiency and effectiveness of our patient and community-centered care. Our on-site mental health providers are available for emergency consultations and coordinate care with emergency rooms, as well as with inpatient and outpatient mental health resource agencies. This whole experience has been incredibly rewarding for our patients, providers and our community, and we believe we are far more effective now than we were before.

*Linda Thomas-Hemak is board-certified in internal medicine and pediatrics, and is the president and CEO of The Wright Centers for Primary Care and Graduate Medical Education.*

## Staff Testimonials

"Working behavioral health screening into the workflow was cumbersome at first. It felt like another potentially "burdensome" change, and buy-in was challenging. Initially, we had only one computer capable of running the assessment tool, and youth had to sit in the hallway to complete it. Now, the program is recognized by everyone as a really good thing for our patients and community. We have iPad-like tablets to give youth more privacy. The program has helped us identify patients not only with suicidal risk, but also those with depression, anxiety, PTSD, eating disorders and abuse. The tool is very easy to download into our EMR, and the results are immediately available.

*- Patty Swierbinsk, medical assistant*

"As an internal medicine resident, I see many adolescent patients and recognize that there are many social, psychological, sexual and personal challenges. The behavioral risk screening tool helps detect early signs of risk in a well-structured, objective and scientific way. The format allows teens to answer all questions privately and with much less stigma. The results help the provider do meaningful and effective motivational interviewing, self-management support, crisis response planning, therapeutic interventions and referrals."

*- Dr. Cherif Abdelmalek*
*internal medicine resident*

*continued from page 6*

94 percent are satisfied with the convenience of location and 86 percent of families reported an increased likelihood to use services because of co-location. In addition, Pediatric Alliance physicians report more efficient coordination of care and ease of initiating treatment.

We have also administered the Strengths and Difficulties Questionnaire (SDQ) during assessment and at intervals throughout treatment to measure outcomes. This tool measures improvement in symptoms and the impact of treatment on consumers. Our initial findings are that clients experience a drop in overall stress scores and emotional distress during the course of treatment.

Our initial experience with co-location has been positive. We continue to work towards financial sustainability and further integration of physical and behavioral health services. Our next steps include conversations about ongoing changes in healthcare and gathering more data to demonstrate the positive impact that our collaboration has had on both WSS and Pediatric Alliance.

*Heather Hoeke, L.C.S.W. is clinical supervisor at Pediatric Alliance, David Grabowski, L.C.S.W. is director of outpatient services at Wesley Spectrum Services, and Kelly Primus, is director of quality and evaluation at Allegheny HealthChoices Incorporated.*

*PA CASSP Newsletter*

*published by*
***Pennsylvania Department of Public Welfare***
***Office of Mental Health and Substance Abuse Services***
***Bureau of Children's Behavioral Health Services***

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

# Behavioral Health Screening in a Pediatric Emergency Department

*by Warren D. Frankenberger*

When a young adolescent boy arrives at the emergency room with an asthma flare, you would expect rapid and efficient care. The care team assesses for immediate life threatening conditions, administers the prescribed treatment, and closely monitors the patient for signs of improvement or deterioration. In our emergency room, however, the mental health needs of the patient are also addressed along with the physical concerns that brought the patient to the emergency department. The importance of mental health and its interconnection with physical health is becoming an integral part of pediatric emergency care.

At the Children's Hospital of Philadelphia's emergency department, when a patient 14 years or older comes to the emergency room, the patient is given a laptop and headphones and asked to complete an online questionnaire. The questionnaire is a validated instruments that assesses for depression, suicidality, and high risk behaviors of the child or high risk in his or her environment. Of course, patients who are too sick or injured, or are developmentally delayed, are not administered this online questionnaire. The decision to administer the questionnaire beginning at the age of 14 is in part based on Pennsylvania state law, which allows a patient ages 14-18 to consent for outpatient mental health treatment.

After completing the questionnaire, the results are reviewed by the care team and appropriate follow-up is offered to the patient and family. Often a patient will have a complaint that is unrelated to a mental health or behavioral concern. The computerized behavioral health screen assists the care team by identifying red flags for acute mental health concerns, regardless of the initial reason for the emergency department visit. Social work and psychiatry staff assist the care team to evaluate the severity of a "positive" behavioral health screen and assist clinicians in developing the appropriate treatment plan. The treatment plan can include a range of possibilities, from outpatient counseling to inpatient psychiatric treatment.

Since we've been administering the screen, several patients have received inpatient psychiatric care, even though their initial chief complaint was physical in nature. The computerized behavioral health screen provides a comprehensive health assessment where clients' mental health is seen as just as important as their physical health.

When the behavioral health screen was first introduced, the nursing staff was educated not only on the process of administering, but also on the importance of mental health screening for all adolescents. Research continues to highlight the significance of teen mental health, the prevalence of teen depression, and the link between trauma and health. The pediatric emergency department may be the only point of entry into the health care system for a teenager. The behavioral health screen provides an opportunity to address a much needed and often neglected aspect of health.

The pediatric emergency department is a high-intensity, fast paced environment. While the time and energy to implement and monitor a computerized behavioral health screen has had challenges, the behavioral health screen is becoming the standard of care in the pediatric emergency department.

*Warren D. Frankenberger, M.S.N., R.N., C.C.N.S. is clinical nurse specialist at the Children's Hospital of Philadelphia in Philadelphia.*