



Wayne County Pediatric Integrated Health Care Concept Paper

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Executive Summary

To plan for the integration of behavioral and physical health care in Wayne County, the Detroit-Wayne County Community Mental Health Agency and its CONNECTIONS system of care partners convened a Pediatric Integrated Health Care (PIHC) work group to identify best practices and make recommendations for implementing integrated care services for children and youth. Impetus for the PIHC workgroup came from the implementation of the Affordable Care Act and an understanding of the unique environmental risks Wayne County children and youth face that shape their health status. The PIHC workgroup's overall goal was:

To develop a model of integrated health care that is uniquely fashioned to fit the developmental, socio-emotional and health care needs of all children in Wayne County.

They also identified five objectives that would lead to achievement of this larger goal.

- *Pediatric Integrated Health Care Services are provided for children/youth.*
- *Children with behavioral health care needs will be identified through appropriate screening.*
- *Everyone is informed about, and trained on pediatric integrated health care models.*
- *Services and outcomes are documented and monitored.*
- *Services are financed and sustainable.*

To prepare for developing their plan, the PIHC workgroup conducted exhaustive reviews of the available literature on best practices in integrated health care models, conducted site visits to functioning integrated models, and interviewed the executive directors of integrated health programs in Michigan and other states. The PIHC service model they describe in this concept paper is based on the 4 quadrant model developed by the National Council for Community Behavioral Health. It is modified to reflect the developmental stages of childhood and adolescence, and the health care settings available to children and youth.

The PIHC workgroup identified developmentally appropriate screening tools, and protocols along with describing the most appropriate settings for the use of these screening instruments. Training and workforce development strategies and recommendations for educating both consumers and professionals about PIHC models are presented by the PIHC workgroup in this concept paper. The PIHC workgroup also researched and makes recommendations on best practices in program service delivery and outcomes monitoring. Without adequate financing integrated care models cannot be established or sustained, hence the PIHC workgroup reviewed current funding barriers and offers best practice recommendations to facilitate the financing of integrated health models for Wayne County children and youth.

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FORWARD

The Detroit Wayne County Systems of Care CONNECTIONS and the Detroit-Wayne County Community Mental Health Agency (DWCCMHA) are dedicated to working together to improve access to health care for children and adolescents in Detroit and Wayne County. The work of the CONNECTIONS System of Care follows that of the DWCCMHA and the Wayne County Health Authority focusing on adults. The Wayne County Pediatric Integrated Health Care Concept Paper was developed with active engagement of key stakeholders in primary care, specialty programs, mental health, substance abuse, developmental disabilities, state officials, consumers, family members, youth advocates, parent partners, and parent support partners.

This reports and the products it contains represents hundreds of hours of time donated by caring and dedicated professionals from the Detroit Wayne County area. We would like to thank all of the individuals and organizations who contributed time and effort to this project. A complete roster of the pediatric integrated health care work group participants and concept paper reviewers is included in Appendix A.

As the work group transitions from the planning phase to implementation we hope to expand the number of participants and generate an ever greater commitment to the health and welfare of our community.



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RATIONALE

As the debate over health care coverage continues on the national level, communities are assessing approaches to expand health care coverage and integrated behavioral and physical health care service delivery methods. Many states and communities have made health care policy changes affecting health care outcomes for their citizens; others are just starting to explore needed policy, financing and service delivery mechanism changes. Integrating the provision of behavioral health services in a physical health primary care setting and/or physical health services in a behavioral health setting, is the emerging model for communities to improve health and wellness outcomes. Integrated care approaches are being driven in part by the Patient Protection and Affordable Care Act of 2010 (ACA) which emphasizes integrated care approaches. As a result, integrated health care is no longer a concept, but a way of doing business.

In planning for what integrated health care will look like in their communities, policy makers, health care professionals and other stakeholders must bear in mind the special developmental needs of children which often cannot be met by policies and procedures developed solely to address adult's needs. Further, due to the comparatively rapid development which takes place from birth to 20 years of age, approaches for subsets of children are necessary to address the unique characteristics of each developmental stage. In serving children and youth the foremost consideration is the developmental stage of the child as different stages require different approaches and services. The Wayne County Pediatric Integrated Health Care (PIHC) model is designed for children/youth in the following developmental stages.

Infants & Toddlers: birth – age 3

Preschoolers: age 4 - 5

School-Age Children: age 6 - 12

Adolescents: age 13 - 17

Young Adult: age 18 - 20

Children and youth may also be involved in other children/youth services systems: education, child welfare, juvenile justice, substance abuse, mental health, and developmental disabilities. Children and youth have specialized responses to amplified high risk environments. These risks and responses are listed below:

Social/Emotional/Trauma Risks: all forms of abuse/neglect; attachment issues; bullying; lack of social supports; negative social environment; absent parent; incarcerated parent; substance abusing parent; mentally ill parent; teen parent, domestic violence, foster care placement, and community violence

Developmental Responses: speech; language; learning; fetal alcohol spectrum; Autism Spectrum; ADHD

Health Responses: obesity; eating disorders; diabetes; asthma; use of alcohol, tobacco and other drugs, serious emotional disturbance, depression and other mental disorders, suicide, STIs and/or teen pregnancy

Pediatric integrated health care is defined as “any service delivery model where coordinated primary health and behavioral health are provided to the same consumers at the same site” as described in the National Council for Community Behavioral Health (NCCBH) Four Quadrant Clinical Integration Model. The comprehensive Pediatric Integrated Health Care plan developed by the Wayne County Pediatric Integrated Health Care Workgroup builds upon the NCCCBH model. See Appendix A for a list of workgroup members and report reviewers. The Pediatric Integrated Health Care plan is divided into five distinct objectives with corresponding recommendations:

1. Everyone (Pediatricians, behavioral health specialists, administrators, school personnel, parents and children) will be informed of and trained on the Pediatric Integrated Health Care model (Training and Workforce Development)
2. Children with behavioral health care needs will be detected (Screening)
3. Pediatric Integrated Health Services are provided (Service Delivery)
4. Services and outcomes are documented and monitored (Evaluation, Information Technology)
5. Services are financed (Financial)

Pediatric Integrated Health Care Workgroup Goals

The need for a Pediatric Integrated Health Care model in Wayne County is clear. Many children who make it to a doctor’s office are either not identified as having behavioral health needs, because there is no model for screening, or if identified, most patients are told to contact a local mental health service provider. Without assistance or a warm hand-off parents/caregivers are less likely to follow through on referrals and children/youth do not receive needed early intervention services. A survey of 220 Wayne County consumers of physical, behavioral, substance abuse, and developmental disability services and 194 Wayne County providers of these services was conducted in the summer and fall 2011 by the Cross Systems Coordination Subcommittee of the Wayne County Community Planning Council. A majority of consumers report the biggest barrier to service access was not having anyone to help them access services (88 percent). Providers acknowledged the level of integration and collaboration with providers from other systems was not as good as it could be with between one-quarter and one-third reporting their level of collaboration was “basic at a distance,” meaning they only periodically engage with other systems. Two-thirds also stated they think collaboration and integration is an area that needs further development in their organization (2012).

Recognizing that many Wayne County children and youth live in environments that put them at higher risk of physical and behavioral health disorders; the Wayne County Pediatric Integrated Health Care Workgroup is pursuing the following overarching goal.

To develop a model of integrated health care that is uniquely fashioned to fit the developmental, socio-emotional and health care needs of all children in Wayne County.

Where one lives affects their health status. Environmental, social and economic factors, along with health care access all have an effect on an individual’s health. For example, individuals living in a community with parks, where it is safe to be out-of-doors are more physically active, reaping the physical and psychological benefits exercise yields. The Robert Wood Johnson

Foundation and the University of Wisconsin Population Health Institute are collaborating to assess the overall health of counties in every state in the nation. Table 1 below depicts the 2011 ranking for Wayne County in contrast to Michigan's other 81 counties.

Table1: Wayne County's Rank among Michigan's 82 Counties

<i>Health Factors</i>	<i>Rank</i>
<i>Health Behaviors:</i> tobacco use, diet, exercise, alcohol use, unsafe sex practices	79 th
<i>Clinical Care:</i> access to care and quality of care	74 th
<i>Social & Economic Factors:</i> education, employment, income, family and social supports, community safety	82 nd
<i>Physical Environment:</i> quality of environment, built environment	74 th
<i>Health Outcomes</i>	
<i>Mortality:</i> premature death	80 th
<i>Morbidity:</i> poor health status, low birth weight, more poor physical health days, more poor mental health days	82 nd

Additional information on risk factors in Wayne County comes from the Michigan League for Human Services and Michigan's Children *Kids Count-Michigan* project funded by the Annie E. Casey Foundation. According to *Kids Count-Michigan* (2011) in Wayne County:

- 13.6% of live births were to teen mothers
- 18.1% of live births were repeat teen mothers
- 5.5% of births with late or no prenatal care
- 10.4% of births were qualified as low birth weight babies
- 52.5% of children in Wayne County are covered by Medicaid
- 10.3 children die per 1,000 live births
- 80.8 teens die per 100,000 teens in the County
- 10.3 children per every 1,000 children age 0-17 are confirmed abused/neglected
- 6.9 per every 1,000 children age 0-17 are placed in foster care

These statistics show that Wayne County children are at high risk for a number of physical and behavioral health problems. These risk factors, in conjunction with the fragmented nature of the current behavioral and physical health delivery systems make it clear Wayne County children will benefit from integrated health care approaches.

The Relationship between Children's Health Issues and Adult Health Status

The guiding belief of the Wayne County Pediatric Integrated Health Care Workgroup is that children with physical and behavioral health needs who go unrecognized and untreated will likely become adults with more expensive and extensive physical and behavioral health needs. A study by United Health's® Center for Health Reform and Modernization (2010) reports that, "more than 50 percent of Americans could have diabetes or pre-diabetes by 2020 at a cost of 3.35 trillion dollars over the next decade if trends continue." According to the same study, about 27 million people are affected by a current diabetes diagnosis and another estimated 67 million people have known or unknown pre-diabetes conditions. The estimated annual health cost for an individual with diabetes is \$11,700 compared to an estimated cost of \$4,400 for an individual who does not have diabetes.

Experts predict that one out of three children born in the year 2000 will develop diabetes in their lifetime. Being overweight or obese is one of the primary risk factors for developing diabetes. As of 2007, the percentage of overweight and obese children in Michigan was 30.6 percent (National Conference of State Legislatures, 2012). Obese children are not only at risk of becoming obese adults and developing diabetes, they are at higher risk for heart disease, high blood pressure, hyperlipidemia (too much cholesterol in the blood), sleep apnea and breathing problems, bone conditions, gastro-intestinal diseases, early puberty and psychological problems such as depression (Bellows and Roach, 2009).

Depression, another leading health problem for adults, costs an estimated \$83 billion each year due to lost productivity and increased medical expenses. Adult depression has been linked not only to childhood depression, but child trauma and stress as well (Leahy, 2010). The Surgeon General's report emphasized that childhood depression "may leave behind psychological scars that increase vulnerability throughout early life". According to a study connecting childhood obesity and depression, these conditions have shared symptoms such as sleep problems, sedentary behavior and dis-regulated food intake which appears to be related to shared pathophysiological mechanisms (Reeves et al., 2008).

Childhood trauma has also been linked to the development of adult depression. According to the Office of Trauma Services, up to 70 percent of women treated in a psychiatric setting have histories of sexual or physical abuse, or both, women molested as children are four times more at risk for Major Depression as those with no such history. Adults who had experienced multiple types of abuse and violence in childhood compared to those who had not, had a two-to-four fold increase in smoking, poor self-rated health, 50+ sexual partners, sexually transmitted disease, a high rate of physical inactivity, and severe obesity (Whitfield, undated).

The probable long-term effects of childhood obesity and trauma/stress on future adult illnesses like diabetes and depression carry a high financial cost. Not to mention the impacts on quality of life across the lifespan. Integrated behavioral and physical health interventions that prevent these conditions are worth the effort.

Current Service Delivery Approaches

Increasing behavioral and emotional problems are occurring at younger ages. A recent family survey conducted for the National Alliance for Mental Illness (NAMI) found that 63 percent of families reported their child first exhibited behavioral or emotional problems at seven years of age or younger. At these ages the most common point of contact for families with children experiencing these problems is their pediatrician or primary care physician, yet only 34 percent of families in the NAMI survey said their primary care doctors were "knowledgeable" about mental illness. Another 17 percent said their primary care doctor was "somewhat knowledgeable," with 59 percent reporting their primary care doctors was "not knowledgeable" about mental health treatment. A slightly higher percentage (64 percent) state their primary care doctors were not knowledgeable about local resources and supports for families (2011).

An issue paper published by the National Institute for Health Care Management Foundation (NIHCM) describes the shortcomings of the current fragmentation between behavioral health and physical health care system.

One in five children and adolescents in the U.S. experiences mental health problems, and up to one-half of all lifetime cases of mental illness begin by age fourteen. Seventy-five percent of children with diagnosed mental health disorders are now seen in the primary care setting, making the management of mental health issues a growing part of pediatric practices. Pediatricians are well positioned to detect problems in a child's social and emotional development due to their consistent presence in a child's life, (however) pediatricians are increasingly relied upon not only to detect problems, but also to provide the full spectrum of mental health services without the tools and resources to do so effectively (NIHCM Foundation, 2009).

It is also clear that the current Primary Care Provider (PCP) system, where children are likely to make their first and most consistent contact with a health professional, is not currently successful in impacting these childhood issues. How many children who have been abused, or traumatized, or stressed walk in and out of their doctor's office without anyone noticing their condition? How many children are identified as obese, their parents given information on resources and then never receive any follow through support or intervention? There is a high probability that having a Behavioral Health Specialist (BHS) on the pediatric team to help with the screening, intervention, and resource follow-up will have a positive impact in these scenarios. The current fragmented approach is depicted in Figure 1 on the following page.

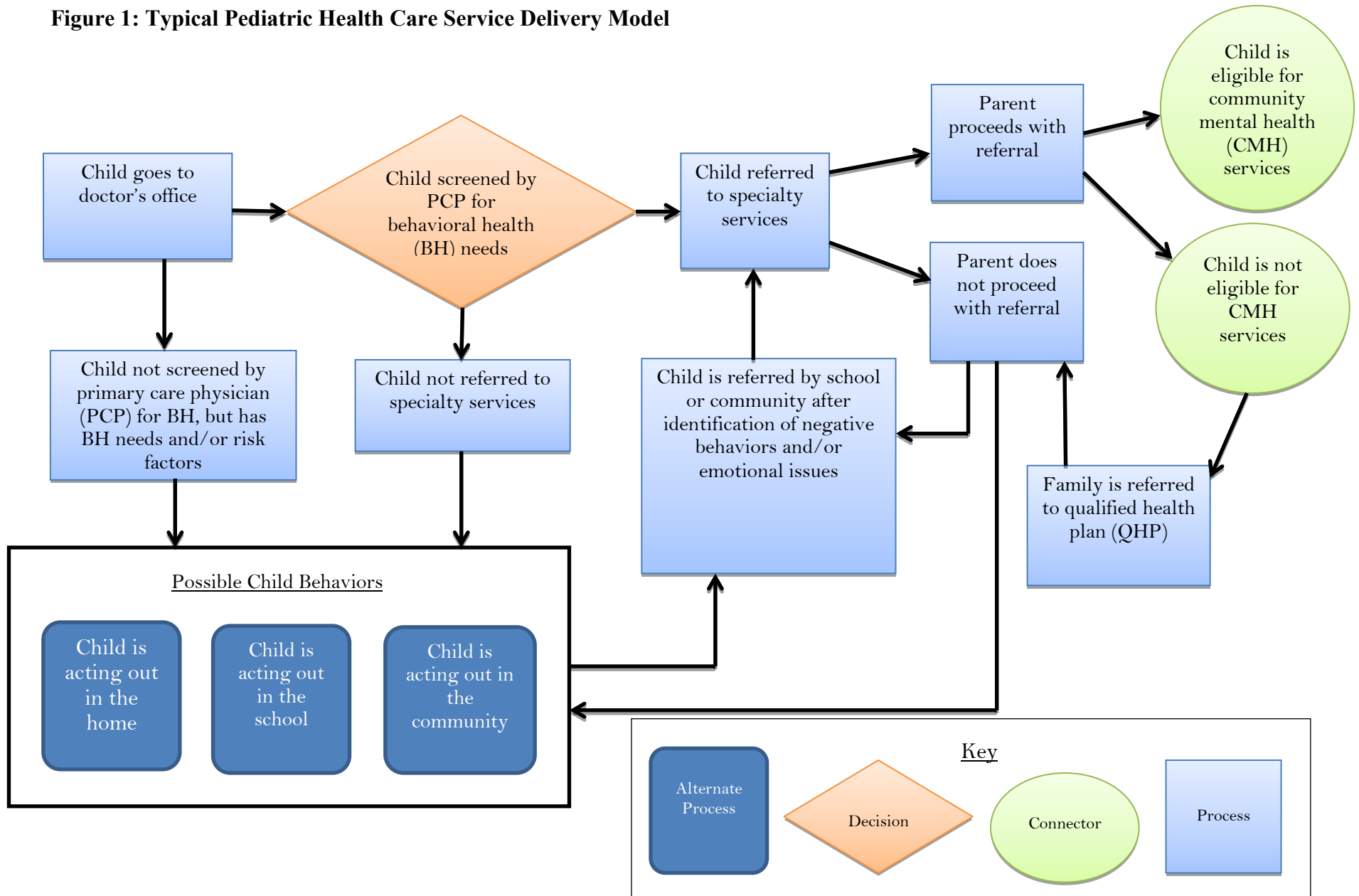
The Wayne County Perceptions of Collaboration Survey conducted by the Detroit-Wayne County Community Mental Health Agency (DWCCMHA) Community Planning Council's Cross System Coordination Subcommittee also asked providers about whether they regularly coordinate services at discharge and admission. There were 188 providers responding to the question about coordinating with the hospital at admission for children/youth under age 18, of these 16 percent coordinate all the time, 15.4 percent regularly, 18.1 percent sometimes, and 17.6 percent never coordinate at admission. In responding to the question about coordinating at hospital discharge for children and youth under age 18 (n=168) 16 percent of providers coordinate all the time, 15.4 percent regularly, 18.1 percent sometimes, and 17.6 percent never. The most frequent response to these two questions by providers of physical, behavioral, developmental disabilities, or substance abuse services was not applicable at admission (33 percent) and at discharge (36.3 percent) (2012).

Integrated Health Care and Children's Health Issues

Obesity and infant mortality/morbidity are two health issues Governor Snyder identified as top Michigan priorities. Recommendations from statewide summits held on both these issues in 2011 included integrating and coordinating health services. Additional children's health issues include: asthma, dental health, sexually transmitted infections, substance use, teen pregnancy, and low birth weight.

A pediatric integrated health care model can provide assistance to medical providers to address the top children's health issues in a fast paced medical environment where unique intervention opportunities are present, but marginally utilized. Missed opportunities to provide comprehensive health education is not a purposeful one on the part of medical providers, but rather an outcome of insurance mandates and health professional shortages. It can be difficult

Figure 1: Typical Pediatric Health Care Service Delivery Model



for a busy health care professional to pinpoint an intervention for a child who shows risk factors for alcohol or tobacco use when s/he is seeing the doctor for a kidney infection which is, and should be, the number one priority. Behavioral Health Specialists (BHS) are uniquely positioned to join the medical team and at least double the detection, intervention, and follow-up rate for the provision of behavioral health services.

Table 2 illustrates the likely difference between a pediatric medical office visit with and without an integrated approach for a new patient who needs a school physical. The patient is a 16 year old female with a kidney infection and reports she smokes, occasionally consumes alcohol and is obese.

Table 2: Medical Office Visit With and Without Integration

Medical Practice without Pediatric Integrated Health Care (best case scenario below)	Medical Practice with Pediatric Integrated Health Care
<ol style="list-style-type: none"> 1. Doctor provides a physical examination including blood work. 2. Doctor provides treatment for kidney infection. 3. Doctor speaks to patient about importance of normal BMI and provides dietary guidelines. 4. Doctor provides handout on dangers of drinking alcohol. 5. Doctor speaks to patient on dangers of smoking and provides smoking cessation kit. 6. Doctor recommends patient schedule a follow-up appointment if kidney infection medication is not effective. 	<ol style="list-style-type: none"> 1. Doctor provides a physical examination including blood work. 2. Doctor provides treatment for kidney infection 3. Doctor provides PHQ-Adolescent screening 4. Doctor provides CRAFFT® substance use screening. 5. Doctor speaks to patient about the importance of normal BMI, dangers of smoking and smoking cessation kit. 6. Doctor refers patient to behavioral health specialist (BHS). 7. BHS reviews screenings and provides comprehensive assessment. 8. BHS psycho-educates teenager and parent on obesity and creates a patient centered eating plan, provides parent with locations of local healthy food stores and/or programs to assist with healthy food options and/or assists parent in locating a nutritionist. 9. BHS assess patient's substance use, psycho-educates on the effects of drinking and facilitates patients plan for abstaining during stressful times. 10. BHS psycho-educates on the dangers of smoking, assists patient with the smoking cessation kit and provides resources for support. 11. BHS schedules an appointment in 4 weeks to follow-up on patient's plans and make additional referrals if necessary. 12. BHS documents patient's plan in the patient's medical record.

FOUNDATIONAL INTEGRATION APPROACHES

Several approaches to integrated/coordinated services delivery are in use that can serve as a foundation for a fully integrated model of pediatric health care. Table 3 presents the commonalities relative to integrated care in these foundational modalities discussed below including the ACA's promotion of Accountable Care Organizations (ACO), systems of care and patient centered medical homes.

Health Reform and Systems of Care

With the passage of the ACA, the estimated number of children insured by the State Children's Health Insurance Program (SCHIP) will increase by approximately 6.5 million children by 2019 (CBO, 2011). In Michigan the SCHIP program is called MI-CHILD, the Center for Health Care Research and Transformation at the University of Michigan projects the percentage of Michigan's under age 65 population covered by Medicaid and MI-CHILD will increase from 16 percent in 2009, to 20 percent in 2014 and to 22 percent by 2019 (Ogundimu & Udow-Phillips, 2010). The ACA also encourages states to coordinate and integrate primary care and specialty services to improve outcomes, reduce the cost of care, and improve the quality of services. The ACA specifically encourages the use of integrated behavioral health and primary care models and the creation of ACOs to accomplish these objectives.

The ACO model delivers a full continuum of care for its clients and aligns clinical and financial incentives within a single entity. ACOs must coordinate care for all beneficiaries assigned to it, use evidence-based medical practices, and be responsible for self-monitoring and reporting on cost, quality and other measures. The Medicare Shared Savings program allows ACOs to receive financial rewards for efficient delivery of services. Current regulations for ACOs apply to Medicare recipients, but it is anticipated similar rules will be developed for Medicaid beneficiaries.

The children's service systems in Wayne County have experience in coordinating the delivery of a variety of individualized services through Systems of Care (SOC) approaches. Over the past 15 years a body of national research demonstrates that employing SOC methods to implement individualized service plans results in improved outcomes for children/youth relative to: school attendance, behavior and grades; improvements in emotional and behavioral functioning; fewer suicide attempts and contacts with law enforcement; reduced reliance on institutional care; and increased stability in living arrangements. Benefits for caregivers in families involved in SOC include: reduced stress and mental health issues; fewer days of work missed; increases in family resources; and improvements in family functioning (Manteuffel, et al., 2008).

Individualized services delivered within a SOC have proven to be cost-effective allowing cost savings to be redirected to more preventive and community-based services. Due to their success, SOC are found in virtually every state. The SOC model is particularly useful for children with multiple physical and behavioral disorders enabling them to function at optimum levels and enjoy a high quality of life from infancy through the transition to young adulthood. Children and youth with multiple health and other disorders typically receive services from multiple systems (education, primary care, specialty health care providers, substance abuse and mental health providers, and developmental disability providers). Thus they are involved in multiple service systems with overwhelmed and exhausted parents trying to serve as care

Table 3: Integrated Health Care is the Common Denominator

Health Reform	Accountable Care Organizations (ACO)	Patient Centered Medical Home (PCMH)	Systems of Care
<ul style="list-style-type: none"> • Requires expansion of access to health coverage. • Creates an essential benefits package which includes mental health treatment. • Permit Medicaid enrollees with at least one serious and persistent mental health condition to designate a provider as a health home • Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011) • Establishes the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services for low-income uninsured and under insured populations. • Calls for the creation of Accountable Care Organizations. 	<ul style="list-style-type: none"> • ACOs create incentives for health care providers to work together to treat an individual patient across care settings including: doctor's offices, hospitals, and long-term care facilities. • The goal of an ACO is to deliver seamless, high quality care. • The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions. • Quality measures in 5 key areas of care: satisfaction, care coordination, patient safety, preventative health and at risk populations. • Accountable care requires better communication between providers, more attention to care coordination, and higher levels of patient engagement. • Providers must ensure that all required services are delivered without duplicative or unnecessary services. 	<ul style="list-style-type: none"> • The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. • The PCMH is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care • A designated PCMH must possess 7 features: <ol style="list-style-type: none"> 1. Personal physician 2. Team approach 3. Whole person orientation 4. Coordinated/ integrated care 5. Quality and safety guidelines 6. Enhanced access to care 7. Payment reform 	<ul style="list-style-type: none"> • Systems of care are a service delivery approach that builds partnerships to create a broad, integrated process for meeting families' multiple needs. • This approach is based on the principles of interagency collaboration; individualized, strengths-based care practices; cultural competence; community-based services; accountability; and full participation of families and youth at all levels of the system • A centralized focus of systems of care is building the infrastructure needed to result in positive outcomes for children, youth, and families.

coordinators. “Involvement in multiple systems often results in fragmented and inadequate care” (Wotring & Stroul, 2011).

When the guiding principles of the SOC concept are superimposed on the concept of integrated care, it is clear there is a natural fit. A few guiding principles of SOC include:

- Needed services are available and accessible.
- Services are developmentally appropriate.
- Services are individualized to meet the child/youth’s needs.
- Services and supports are delivered within the least restrictive, most normative environment.
- Families and children/youth are full partners in planning for their care and service delivery.
- There is cross-system collaboration in service planning and delivery.
- Care management is an operational service that ensures coordination and integration.

Patient Centered Medical Homes

The patient centered medical home (PCMH) concept is rooted in the 1960’s and was adopted by pediatricians to address chronic childhood illnesses. In 2007, the major primary care professional organizations issued joint principles for PCMHs (American Academy of Family Physicians, 2007). In Michigan, Blue Cross/Blue Shield (BC/BS) operates the nation’s largest Physician Group Incentive Program (PGIP) for providers implementing a PCMH approach. In 2009, 304 primary care practices operating as providers for BC/BS were designated as PCMH practices in 2009. The Michigan BC/BS PCMH program may affect close to two million state residents. Designated practices utilizing the PCMH model receive fiscal incentives from BC/BS for Evaluation and Management (E &M) codes and T-codes for care management. Due to its efficacy, other health plans are increasingly offering incentives to health care providers implementing PCMH processes and health systems are increasingly adopting the model. The PCMH concept is accepted as the standard to be achieved in Michigan as our health care system is transformed.

The definition of a patient centered medical home specifically identifies integrated care as a key and central component:

1. Personal physician,
2. Team approach,
3. Whole-person orientation,
4. Coordinated/integrated care,
5. Quality and safety,
6. Enhanced access to care, and
7. Payment reform.

Integration in Wayne County

Pediatricians are often the first professional to interact with a child. The pediatrician’s office is in an ideal position to identify a child’s behavioral health issues and to provide needed services.

Integrated care is the perfect vehicle to impact the increasing prevalence of mental illness among young children. Emerging evidence about effective preventive interventions also makes a strong case for early identification and intervention.

The second most common health care access point for school-age children and adolescents is the school setting. In Wayne County very few schools employ school nurses; which leaves children's care at school unsupervised by a health professional. Children on medication or who have special health care needs are frequently unmonitored. Children with behavioral health needs which have been undetected unfortunately end up being detected only after being involved in a school discipline program. School-based health centers (SBHCs) and school-linked health centers (SLHCs) are an important resource for children/youth, many of whom use the SBHC/SLHC as their medical home. There are 30 state or otherwise funded SBHC/SLHCs in Wayne County. Nine are in Detroit. Several of these SBHC/SLHCs already offer behavioral health and oral health services in addition to primary care services. By including SBHC/SLHCs in the PIHC plan conceptual framework more children with behavioral health needs can be detected and served appropriately, monitored and linked to needed resources.

THE PEDIATRIC INTEGRATED HEALTH CARE PLAN

Bi-Directional Pediatric Integrated Health Care

Currently, when a child receives specialty mental health services, the mental health provider is required to notify the child's PCP and coordinate their care. Although written notification is made to the PCP, collaboration is minimal as reimbursement is not available to PCP's and specialty mental health providers for activities related to coordinating a child's care. This leaves the child's parent in the role of intermediary between the PCP and specialty mental health provider, providing information to each system on their child's treatment and medication(s). If the child receives psychiatric services, it is unlikely the psychiatrist and PCP confer on the child's services. The result is confusion and frustration for the parent, PCP and specialty health provider. This confusion and lack of coordination can be dangerous if medications are involved. A bi-directional approach mitigates these problems.

The Wayne County PIHC model is bi-directional, involving placing a BHS on the primary health care team and/or including a medical provider on the specialty mental health team. The Four Quadrant Model identifies four specific scenarios for service provision depending on the health care needs of the child. For children who have more severe mental health needs and/or require more intensive system coordination, their specialty mental health provider will likely be the child's medical home. For those with more severe physical health care needs the pediatrician/physical health care provider is the presumptive medical home.

Many children, especially teenagers have no access to health care services according to a 2011 study by the Centers for Disease Control National Center for Health Statistics. One-third of children have no usual place where they receive health care (31percent) and 17 percent have not received health care services in two years. Schools may be the only access to health care providers on a consistent basis for many children. Integrating behavioral health into SBHCs/SLHCs is also a natural fit to accommodate the behavioral health care needs of children. Schools with SBHCs/SLHCs report increased school attendance, decreased drop-out

rates and suspensions, fewer teen pregnancies and higher graduation rates (McNall, et al., 2008; Lichty, McNall, Mavis, & Bates, 2008). On December 8, 2011, the Health Care Resource Services Administration (HRSA) sent out a press release announcing that more than \$14 million was awarded to 45 school based health centers across the Country through the ACA. Sixteen of these centers were in Michigan. These funds were primarily used for needed medical equipment and to expand oral health and behavioral health services. This is a positive step toward further addressing a child's health and overall wellness. However the need remains for further investment in integrated SBHCs/SLHCs. These centers are an important resource for children who can be served in Quadrant I of the Four Quadrant Model.

Table 4 presents an example of how an integrated approach might work for an eight year old child experiencing serious emotional disturbance who receives specialty mental health services from a Community Mental Health (CMH) provider.

Table 4: Behavioral Health Intervention With and Without an Integrated Care Approach

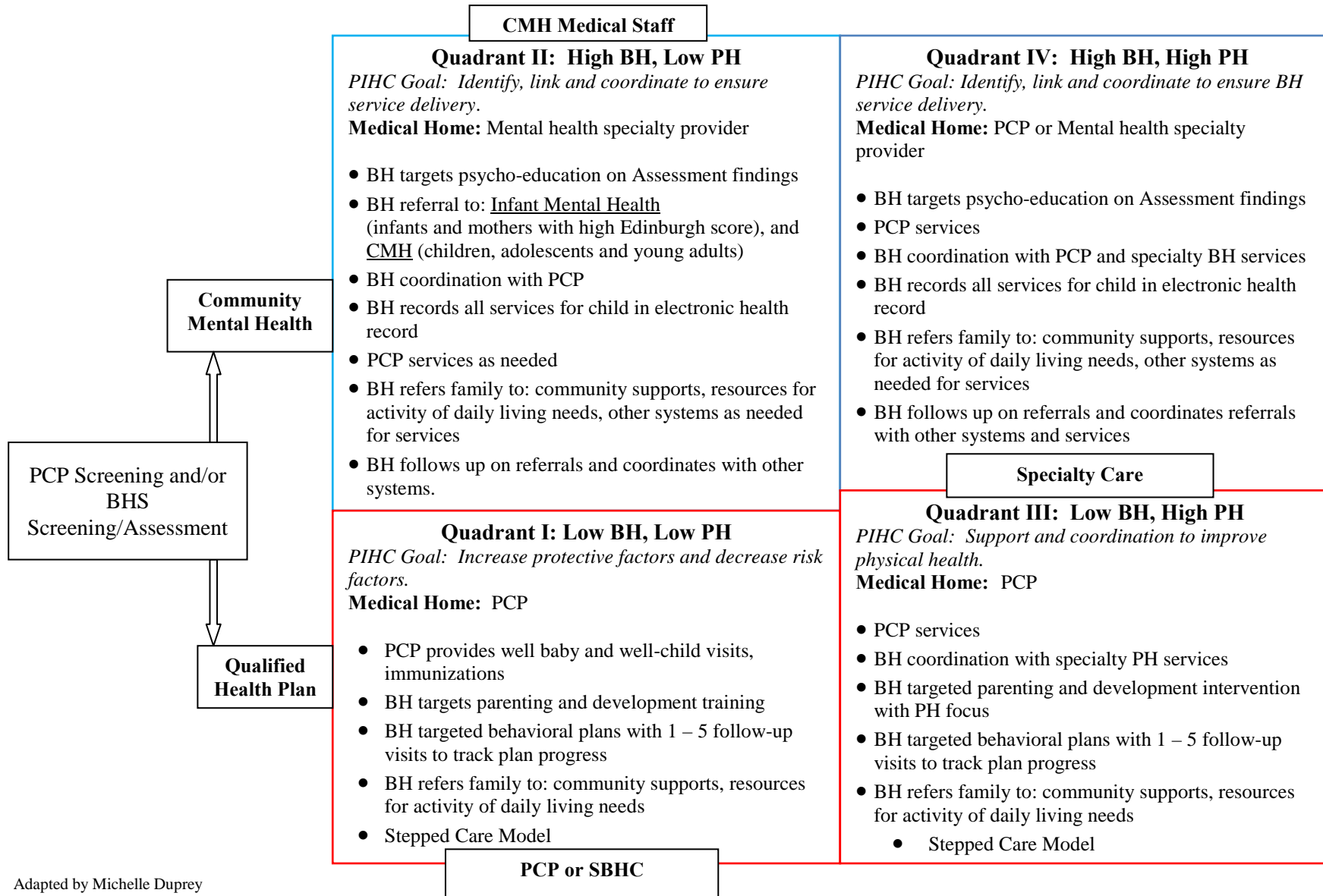
Without Integrated Health Care	With Integrated Health Care
<ol style="list-style-type: none"> 1. Therapist notifies PCP that client is enrolled in specialty mental health services and requests medical records. 2. PCP receives notification and may or may not follow through on sending medical records. Notification may or may not end up in client's medical record. 3. Client receives psychiatric evaluation and relies on parent/guardian to inform on medical conditions and/or current medications child is receiving. 4. Therapist notifies PCP on psychiatric medications prescribed which may or may not be included in clients PCP record. 5. Parent/guardian takes child to a doctor's appointment and is relied upon to inform PCP of specialty mental health services and medications child may be on, if the information is not in the child's medical record. 6. Parent is required to inform specialty mental health provider of medications the PCP may prescribe. 	<ol style="list-style-type: none"> 1. Therapist refers child to medical provider located in the specialty mental health practice. 2. Medical provider provides general medical care including blood work. 3. Medical provider documents client's physical health issues in the client's record. 4. Client receives psychiatric evaluation with psychiatrist having access to medical information. 5. Psychiatrist prescribes medication and documents in the child's record. 6. If child needs to visit the medical provider for routine medical care, the medical provider has access to the child's chart and can collaborate in person with the child's psychiatrist if necessary.

Proposed Pediatric Integrated Service Delivery Model

Objective: Pediatric Integrated Health Care Services are provided for children/youth.

The PIHC model can assist medical providers in treating children/youth's top health issues/risk behaviors (e.g., obesity, asthma, use of alcohol, tobacco and other drugs, and sexual activity) by providing psycho-education, and targeted plans, interventions and follow-up. Using the Four Quadrant Model practitioners can decide who is in the lead and who is in a supportive role to ensure the multiple needs of children and youth are met. The model is presented in Figure 2 and the four quadrants are described on the following pages. This discussion is

Figure 2: Pediatric Integrated Health Care Four Quadrant Model



Adapted by Michelle Duprey

succeeded by the description of detection/screening instruments, training/workforce development, monitoring/ evaluation, and financing components of the PIHC.

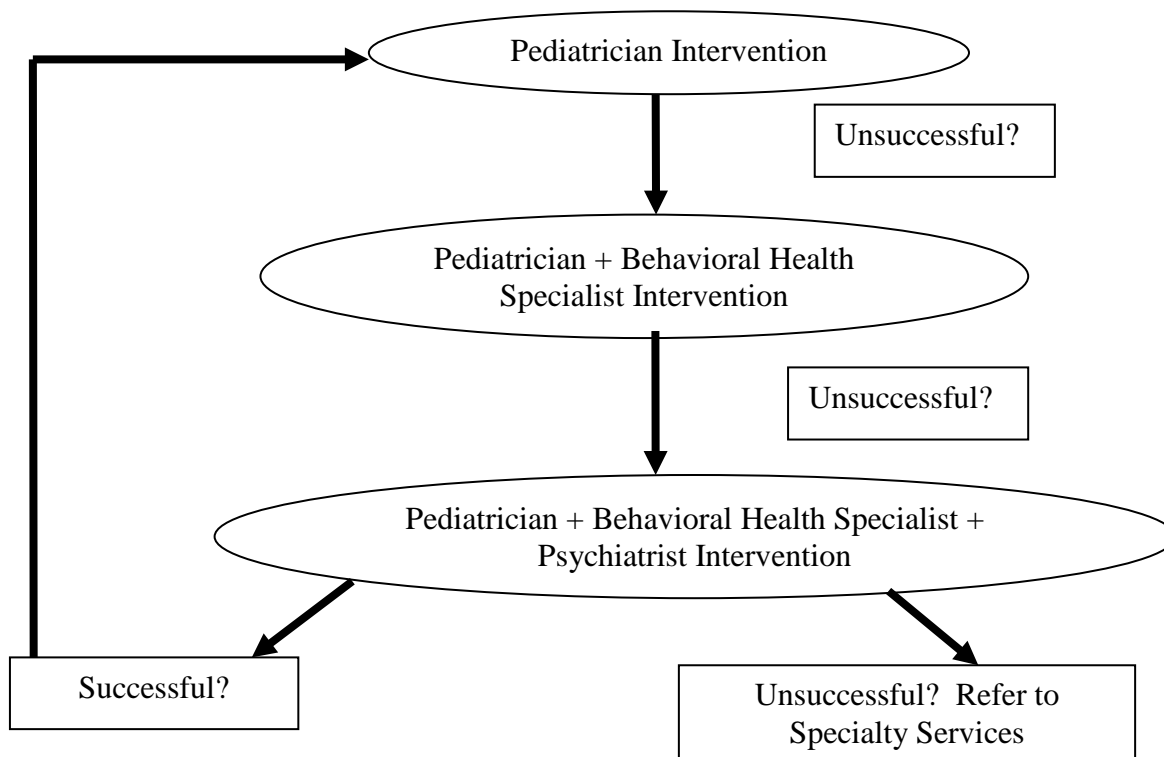
Quadrant I: Goal of PIHC: To increase protective factors and decrease risk factors.

Quadrant I appropriate children present as: Low behavioral health (BH) needs, low physical health complexity/risk, served in primary care with BHS on-site; very low need children are served by the PCP (or within the SBHC/SLHC) with behavioral health serving those with slightly elevated health or behavioral health risk.

The medical home is the PCP. The PCP provides primary care services and uses standard BH screening tools identified by developmental age. The role of the primary care based BHS is to provide formal and informal consultation to the PCP and PCP staff, provide behavioral health triage to the PCP center, referral to community supports, and referrals for activities of daily living for any identified patient. For patients with positive screening results, the BHS will provide a behavioral based screening/assessment based on the child's age and developmental level.

The BHS and PCP work together using a Stepped Care Model (Figure 3), the BHS will provide targeted behavioral and developmental training and interventions to address any needs identified by the assessment which may include psycho-education, behavioral plans, and/or recommended structured activities. One to five follow-up visits may be scheduled and should coincide with any follow-up PCP visits scheduled when possible.

**Figure 3: Stepped Care Model
For Quadrants I and III**



Quadrant II: Goal of PIHC: To identify, link and coordinate to ensure service delivery.

Quadrant II appropriate children present as: high behavioral health needs, low physical health complexity/risk, served in a specialty behavioral health system that coordinates with the PCP.

The medical home for Quadrant II is the mental health specialty provider and in the best case scenario, the specialty mental health provider has an embedded medical provider. When not bi-directionally integrated, the PCP provides primary care services and collaborates with the specialty behavioral health system through the BHS to assure coordinated care, including any psychotropic medications. The role of the BHS if a PCP is not integrated into the mental health specialty site is to complete the developmentally appropriate assessment, provide targeted psycho-education to the parent on the findings of the assessment, and make a referral to the appropriate behavioral health specialty services: Infant Mental Health, Community Mental Health, Developmental Disability, and/or Substance Abuse.

The BHS records all specialty behavioral health services that the child was referred to in the medical record, and follows up on the referral with the parent/child until specialty behavioral health services are provided. The BHS will remain the primary contact point for needed communications between the PCP and the specialty behavioral health provider and will coordinate care as needed with the specialty mental health providers care coordinator. The BHS will also provide referrals for community supports and activities of daily living and follow-up on these referrals until the child receives case management services from the specialty behavioral health provider.

Quadrant III: Goal of PIHC: To provide support and coordination to improve physical health.

Quadrant III appropriate children present as: low behavioral health needs, high physical health complexity/risk, served in the primary care/medical specialty system with BHS on site in PCP.

The medical home for Quadrant III is the PCP. The PCP provides primary care services and refers/works with specialty medical providers and disease managers to manage the physical health issues of the child. The BHS participates in a Stepped Care Model as depicted in Figure 3, and provides developmentally appropriate screening/assessments, and targeted parenting/developmental interventions on identified issues. These identified BH issues will have a high probability of being related to the child's physical health needs. Interventions by the BHS could include psycho-education, health education, chronic health condition education, behavioral plans, and/or recommended structured activities. One-to-five follow-up visits may be scheduled and should coincide with any follow-up PCP visits scheduled when possible. The BHS will also provide formal and informal consultation to the PCP and PCP staffs; provide BH triage to the PCP center, referral to community supports, and referrals for daily living activities for any identified patient.

Quadrant IV: Goal of PIHC: To identify, link and coordinate to ensure behavioral and physical health services.

Quadrant IV appropriate children present as: high behavioral health needs and high physical health complexity/risk, served both in the specialty behavioral health system and the primary care/medical specialty system.

Either the PCP or the specialty mental health provider may be the medical home. The PCP works with the medical specialty providers to manage the physical health issues of the child while collaborating with the BH specialty system in the planning and delivery of the behavioral health clinical and support services. Coordination between the PCP and the behavioral health and physical health specialty services is done through the BHS located at the PCP site.

The role of the BHS is to complete the developmentally appropriate assessment, provide targeted psycho-education to the parent on the findings of the assessment, and refer to the behavioral health specialty services: Infant Mental Health, Community Mental Health, Developmental Disability, and/or Substance Abuse.

The BHS records all specialty behavioral health services that the child was referred to in the medical record, including any follow-up and coordination completed with the medical specialty providers, and act on the referral with the parent/child until specialty behavioral health services are provided. The BHS will remain the primary contact point for any needed communications between the PCP and the specialty behavioral health provider.

The BHS will also provide referrals for community supports and activities of daily living and monitors these referrals until the child receives case management services from the specialty behavioral health provider.

Best Practices for Service Provision

The PIHC Workgroup offers six best practice recommendations for integrated service provision for children and youth.

Care Coordination: For all the reasons cited in early sections of this paper coordination of care is imperative in providing services to children and youth. The current fragmented structure of physical and behavioral health care delivery has the potential to be harmful to children and youth, especially when psychotropic medications or chronic physical health issues are present. Care coordination is an integral part of service integration and allows for parents/guardians to access and utilize resources successfully. It allows for the tracking, monitoring and appropriate treatment for children and youth which keeps them safe and saves resources when used to provide services across all health domains. The National Center of Medical Home Initiative for Children with Special Health Care Needs and Cincinnati Children's Hospital Medical Center developed a *Care Coordination Toolkit* (2006), and several states including Connecticut <http://www.huskyhealthct.org/> and Wisconsin and Minnesota <http://www.icsi.org/> have developed websites to provide guidance on care coordination to providers and consumers.

A Dedicated Medical Home: Regardless of the medical home chosen from the Four Quadrant Model it must include integration and coordination of care. All children and youth, due to their

unique developmental needs, should be considered a vulnerable population and the medical home model offers the protection that children and youth deserve through integration and collaboration. Moreover, children with mental health disorders and serious emotional disturbance are included in the Title V definition of children with special health care needs.

Psychiatric Consults for Quadrants I and III: When a child/youth has low behavioral health needs and either low physical health needs or high physical health needs and their medical home is the PCP, providers should contract with a local psychiatrist to provide consults as needed. Best practice for children on medication in Quadrants I and III is to have a psychiatric evaluation and monitoring of medications in addition to their PCP services. The BHS can then coordinate the child/youth's care in a safe and efficient manner.

Telepsychiatry: As of 2009 there were only 200 child psychiatrists in Michigan (Detroit Free Press, 2009). The shortage of child psychiatrists leaves many children without proper psychiatric detection, service provision and monitoring. The PIHC Workgroup supports the use of and payment for use of technological advancements in order to serve children and youth. Certain telepsychiatry services can be billed for per Medical Services Administration (MSA) Bulletin 06-22.

Culturally Responsible Services: Integrated health services are most effective when delivered in a culturally responsible manner. To develop a culturally competent integrated health care plan, planners must:

1. Assess and understand the community's composition;
2. Identify culture-related needs of the community;
3. Be knowledgeable about formal and informal community institutions that can help meet diverse mental health needs;
4. Gather information from and establish working relationships with trusted organizations, service providers, and cultural group leaders and gatekeepers; and
5. Anticipate and identify solutions to cultural problems that may arise (www.SAMHSA.gov).

Provide Transition Services: PIHC providers should ensure a transition into the adult health and behavioral health systems. With the integration of health care for children/youth, a dedicated professional who is knowledgeable about resources and systems of care can facilitate a transition from the child/youth serving system to the adult care system. Coordination of care during this transition is essential for meeting the health care needs of individuals and is a cost saving measure as well.

Screening, Assessment and Detection Protocols

Objective: Children with behavioral health care needs will be identified through appropriate screening.

Federal regulations require state Medicaid programs to offer comprehensive and preventive health care services via the EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) benefit to eligible Medicaid beneficiaries to 21 years of age. This benefit focuses on *Early* assessment and identification of problems, and health check-ups at *Periodic* age appropriate intervals in accordance with periodicity schedules established by the American Academy of

Pediatricians. *Screening* services to detect potential problems include: physical, mental, developmental, dental, hearing, and vision. When screening detects a health risk or possible disorder additional *Diagnostic* tests should be performed. For example initial intake screening reveals an adolescent is sexually active, appropriate laboratory tests for sexually transmitted infections is indicated for diagnostic and treatment purposes. The provision of *Treatment* services to mitigate and ameliorate identified health conditions are also mandated under EPSDT.

When the first Medical Assistance ID Card is issued for a child, it is mailed with the Michigan Department of Community Mental Health (MDCH) Pub 492 “A Hug Shows You Care” (in English, Spanish, and Arabic text). Pub 492 explains the benefits of a well-child visit, indicates the recommended periodicity schedule, describes procedures included in the free health checkup, and presents information about transportation (Michigan Medical Services Administration, 2011). These well-child visits provide a golden opportunity to implement the PIHC Workgroup recommendations for screening and detection. For school-age children and adolescents the optimum opportunity is when there is a doctor’s visit for immunizations and school physicals. The PIHC Workgroup recommendations for screening/assessment instruments for detecting children and youth’s health and behavioral health conditions are presented in Appendix B.

Best Practices for Screening and Detection

EPSDT: All pediatric physical and behavioral health care sites should have policy and procedures in place to ensure that all children and youth are screened in compliance with EPSDT standards, policies and procedures.

Training: All service delivery staff at pediatric physical and behavioral health care sites should be trained by the appropriate academy (Pediatrics, Family Medicine) on the use of screening tools for children and youth. Service delivery sites should take responsibility for having the appropriate screening tools available.

Autism Screenings: All pediatric physical and behavioral health care sites should use the Modified Checklist for Autism in Toddlers (M-CHAT) for autism screenings (Robins, Fein, Barton, & Green, 2001). The M-CHAT is designed to screen for Autism Spectrum Disorders in toddlers (i.e., over the age of 12 months, and ideally over the age of 18 months). A parent can complete the items independently. The M-CHAT does not allow a clinician to make a diagnosis of an Autism Spectrum Disorder, but is a very useful clinical tool that has excellent sensitivity and specificity. Positive results suggest a high risk for an Autism Spectrum Disorder, and may necessitate referral.

Technology-based Screening: The use of innovative, technology based screenings for child/youth and adolescent developmental stages is recommended. Providers should utilize the most current, evidence-based and innovative screenings to determine the needs of children/youth/adolescents (for example, the M-CHAT can be administered and scored online).

Best Practices for PIHC Training and Workforce Development

Objective: Everyone is informed about, and trained on pediatric integrated health care models.

The PIHC Workgroup recommends the education of stakeholders as a priority for the implementation of PIHC. Stakeholders are divided into two groups: professionals and consumers.

Consumer stakeholders are defined as: Parents, school-age children, teenagers/young adults, foster parents, adoptive parents, kin caregivers, and guardians.

Education strategies for consumers include:

- Create PIHC brochures: one for parents/caregivers, and one for youth.
- Create a Wayne County PIHC website.
- Use social media to reach youth and young adults.
- Include PIHC in trainings for foster parents, adoptive parents, kin caregivers, and guardians.
- Include PIHC in all consumer informed parenting groups.

Education of several groups of professional stakeholders is critical to making a PIHC work. Professional stakeholders are clustered by profession or services system: medical, education, behavioral health, social services, and legal.

Medical: Pediatricians, general practitioners, Obstetrician/Gynecologist (OB/GYN), doctors-practice administrators and all employees including nurses, medical assistants and front desk staff; public health entities such as local public health departments, Federally Qualified Health Centers (FQHCs) and FQHC look-alikes.

School systems: Principals, teachers, school nurses all need education on general integrated health and school-based integrated health, assist schools without school nurses or SBHCs to develop Health Care Management Plans that address integrated health.

Early Childhood Education: Head Start teachers, health coordinators, and mental health coordinators; private child care providers

Social Services: Department of Human Services (DHS) foster care and protective services staff, health liaisons, and contracted agencies.

Behavioral Health: Mental health, substance abuse and developmental disability service providers

Criminal Justice: Law enforcement entities, juvenile justice service providers, and court personnel including members of the bar and judiciary.

Education strategies for professionals' include:

- Present at local, county and state conferences.
- Present at DHS, social service agencies juvenile justice, statewide school nurse meetings and Child and Adolescent Health Centers.
- Create a webinar.
- Publish articles in agency newsletters.

- Create trainings and offer Continuing Education Units (CEU)/Continuing Medical Education (CME).
- Create a PIHC certificate training program through the Virtual Center for Excellence (VCE).
- Create a lecture on PIHC to be offered each semester at local Medical Schools and Social Work graduate schools (create a pilot of this at Wayne State University (WSU), get a grant to fund and evaluate and then roll out across other schools).
- Partner with the American Academy of Pediatricians to create a brochure or one page informational flyer specifically for doctors.
- Connect with larger providers' advertising/public relation departments to include PIHC in advertising campaigns.

In-service Training: Pediatric health care sites must provide in-service training to ensure that all staff is knowledgeable about the benefits of, service delivery principles and techniques relative to integrated service delivery in a PIHC.

Hiring BHS: When hiring a BHS to integrate a physical health care center, it is important that the person has the appropriate knowledge and skills to work in an integrated setting, and is adequately trained. See sample job descriptions in Appendix C.

Professional Development: It is recommended that any PIHC practice provide trainings and encourage participation at conferences for BHS and PCP's to ensure up-to-date best practices for PIHCs.

Best Practices for PIHC Monitoring

Objective: Services and outcomes are documented and monitored.

Electronic health records (EHR) are an increasingly important mechanism for documenting diagnosis, service delivery and service outcomes. The American Recovery and Reinvestment Act of 2009 (ACRA), and the ACA have added further impetus for the use of EHRs. ACRA also authorized incentive payments through Medicaid and Medicare for eligible medical professionals and hospitals that implement upgrade or otherwise demonstrate the meaningful use of certified EHR technology (MDCH, 2011). Often EHRs also referred to as electronic medical records (EMRs) have focused on billing documentation instead of prioritizing clinical care. Transforming the health care system requires a focus on clinical care and EHRs need to allow multiple health and behavioral health providers to access these records to coordinate the best possible clinical care (Crabtree, et. al., 2010). There are numerous technical and privacy issues relative to EHRs that are being addressed through the development of standards by the Federal Trade Commission and other government entities in implementing the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 (Blumenthal, 2010). The Agency for Healthcare Research and Quality (AHRQ) website publication data base offers dozens of resources including toolkits for health information technology that protects patient privacy.

http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919/privacy_security

The PIHC Workgroup offers the following five recommendations for documenting and monitoring all services delivered and the outcomes of the services on all health domains. Two of the recommendations relate directly to the Four Quadrant Model and others are applicable to all forms of PIHC.

Integrated Health Record in Quadrants I and III: When a BHS is integrated into a pediatric practice the medical record should also be integrated. It is imperative that the BHS and the PCP operate as a team and as such, information should be readily available to each discipline in order to best serve and coordinate the patient care. The integrated health record should also include an integrated health treatment plan in order to best coordinate all aspects of the patient's needs and services.

Organized Health Care Agreement (OHCA) in Quadrants II and IV: Health care providers and other [covered entities](#) that participate in an OHCA may use a single, joint notice that covers all of the participating covered entities (provided that the conditions at [45 CFR 164.520\(d\)](#) are met), or may each maintain separate notices (U.S. Department of Health and Human Services, 2006).

Health Information Exchange: The Michigan Health Information Network (MiHIN) is the state of Michigan's initiative to improve health care quality, cost, efficiency, and patient safety through electronic exchange of health information. The MiHIN is a joint effort MDCH, the Michigan Department of Information Technology (MDIT), and a broad group of stakeholders from across the state. The MiHIN is essential to ensuring that Michigan's health care providers can utilize EHRs in a meaningful way that allows for a patient's health information to be available when they need it most - at the point of care. The MiHIN provides an infrastructure that mobilizes existing electronic health information in a manner that allows healthcare providers to access and exchange it regardless of individual technology choices (<http://www.michigan.gov/mihin>).

Use Computerized and Centralized Ages and Stages Questionnaire (ASQ) Screening: Wayne County is currently implementing a grant funded project with the overall goal of increasing routine developmental screenings. Increased screenings and centralization of these results in a data base will enable Wayne County to access community data for future service planning as well as advocacy efforts.

The computerized and centralized ASQ-3/Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) project offers the community the opportunity to: 1) develop a community database on young children's development, and 2) build school readiness trend data for a better understanding of service gaps and needs. By increasing access and use of the ASQ and ASQ-SE and by utilizing the data provided from the scores, the adults in children's lives will be better prepared and better informed to help children develop the skills for academic, professional and economic success. Comprehensive data analysis will be used to create a public community dashboard to measure and track current developmental scores.

Outcome Measurement: All PIHC initiatives must measure their outcomes. This is essential for the acceptance and growth of PIHC as a model in Wayne County PIHC. There are many methods for measuring outcomes and no particular method is being endorsed at this time by the PIHC Workgroup. Michigan State University has published a compendium of instruments

to measure quality in medical homes that may be instructive for assessing the quality of a PIHC (Malouin & Merten, 2010). However, whichever outcome measurement is chosen practitioners should consider the following principles:

1. Adopting one set of consumer oriented indicators for all parts of the system.
2. Measure what is important for improving care at the person level and aggregate that information for population-level data, quality improvement and planning.
3. Have person-level indicators for all consumers and some indicators targeted to risk and a person's condition.
4. Require all the functions of a person-centered healthcare home where ongoing, trusting relationships are developed to support the patient.
5. Require transparent, shared access to person-level data to be used for individual consumer decision making.
6. Priority criteria for indicators:
 - Indicators that identify untreated yet treatable conditions,
 - Indicators that are already defined and in use in general healthcare,
 - Indicators that are meaningful to consumers and are culturally competent,
 - Indicators that represent patient satisfaction,
 - Primary prevention indicators (e.g., risk factor screening),
 - Secondary prevention indicators (e.g., screening for current conditions), and
 - Tertiary prevention indicators (e.g., monitoring of specific indicators related to a current condition) (National Association of State Mental Health Program Directors, 2008).

Best Practices in PIHC Financing

Objective: Services are financed and sustainable

Most of the children and youth served under the PIHC bi-directional model in Wayne County are funded through Medicaid and MICHild. Under the current payment and service delivery structure MI Child recipients receive mental health and substance abuse services through MDCH contracts with Community Mental Health Services Programs (CMHSPs) and Coordinating Agencies (CA). MICHild beneficiaries in need of behavioral health services are referred by health plans and are not enrolled with the CMHSPs and CAs who are reimbursed on a per member per month capitation basis. This is similar to the process for Medicaid beneficiaries, in that CMHSPs and CAs are responsible for behavioral health services on a capitation basis (for persons with serious mental illness/emotional disturbance) and the health plans are responsible for physical health care and mild to moderate mental/emotional disorders on a capitation basis.

This current payment structure does not promote integration. The Michigan Primary Association's (MPCA) Behavioral Health Integration Interactive Mapping project which documents efforts to develop and implement integrated models of care delivery found over 100 integration endeavors underway, but fewer than ten statewide that were fully integrated

<http://www.mPCA.net/integrationmap>. The metric for integration MPCA used was Dougherty's Six Levels of Collaboration, which was also used by the Community Planning Council when conducting its assessment of collaboration in Wayne County (1995).

The few models that do exist tend to be FQHCs, Rural Health Centers (RHCs) and SBHCs. FQHC's and RHCs utilize direct funding under grants from HRSA and supplement these through Medicaid reimbursement for specialty services to medically needy populations as determined by the state Medicaid agency. At the behest of the Centers for Medicaid and Medicare (CMS) some state Medicaid agencies have authorized same day billing for two services in one day for FQHCs and RHCs (HRSA Bureau of Primary Health Care Program Information Notice 2004-05 issued October 31, 2003). Michigan is one of those states currently paying FQHCs for two services in one day. The ability to bill for two services in one day and to bill for both medical and behavioral health services in one day by one organization is critical to integration as is the ability to bill for community-based care coordination and navigation support (Hamblin, Verdier & Au, 2011). The Substance Abuse and Mental Health Services Administration (SAMHSA) has created interim billing worksheets for each state for mental health services and services that support integration. These worksheets present the billing codes, appropriate credentialed providers and organizations that may use these codes (www.integration.samhsa.gov).

The Medicaid Services Administration in Michigan has authorized SBHCs/SLHCs to be reimbursed by Medicaid contracted qualified health plans (QHPs) on a fee-for-service basis for Medicaid reimbursable services provided to health plan enrollees regardless of health plan authorization as long as a credentialed medical or behavioral health care providers delivers the services (MDCH, Medical Services Administration Bulletin MSA 97-14, October 31, 1997; MDCH, Medical Services Administration Bulletin MSA 06-22, April 1, 2006). However, the billing of behavioral health and physical health care services often entails billing two different payers for these services.

The billing model in use by many FQHCs and SBHC/SLHCs offering behavioral health services can be used in PCP and PCMH settings. Behavioral health services in the PCP setting allows for a specialty therapist to provide therapy services in a PCP setting by following the Mental Health coding rules which include being a credentialed provider for each of the many Medicaid Health Plans, and obtaining prior authorization for services. The therapist can then follow the standard methods for providing therapy services by billing the health plans using the mental health billing codes (90801, 90806, 90847, etc.).

Until recently only SBHCs/SLHCs and Children's Special Health Care Services (CSHCS) providers have been able to operate on a fee-for-service basis. In 2011 and 2012 the state has been planning for, and by November 2012 will in all likelihood move the CSHCS population into managed care capitated health plans. A condition of being a CSHCS provider under this new approach will be the ability to provide specialty services. The CHCS population includes children in need of behavioral health services.

Behavioral health services are not federally mandated services under Medicaid rules but can be offered as optional services if states authorize these services. Currently, children who are identified as having any behavioral health needs have three options: no intervention, therapy intervention using their QHP, or CMHSP services. There are codes for the state of Michigan

to provide integrated health care by a BHS which are not currently billable to Medicaid. These codes exist, including billing codes for critically important care coordination services, however they are not “turned on”. These codes could be used by the BHS in a primary care practice to bill for the services they would provide as part of the PCP team. These codes are 96150, 96151, 96152, 96153, 96154, and 95155) There is also a code for risk screening which is not currently “turned on” in Michigan (99420). Turning on these codes would not be the “cure all” for the financing and sustainability of PIHC but would certainly go a long way toward reaching the ultimate goal of financial sustainability. Until such time as these codes are turned on, co-location or contractual business models are the most obvious mechanism for integration. Two co-located providers (physical and behavioral health) can coordinate scheduling of appointments on the same day for common customers and then the behavioral health provider bills for behavioral health services under their provider number and the physical health provider bills using their provider number.

Use Correct Billing Codes: Each year, in the U. S., health care insurers process over five billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The Health Care Common Procedure Codes (HCPCS) Level II Code Set is one of the standard code sets used for this purpose. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS. Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. These health care professionals use the CPT to identify services and procedures for which they bill public or private health insurance programs. Decisions regarding the addition, deletion, or revision of CPT codes are made by the AMA. The CPT codes are republished and updated annually by the AMA. Level I of the HCPCS, the CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes were established for submitting claims for these items. The development and use of Level II of the HCPCS began in the 1980's. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits, while CPT codes are identified using five numeric digits.

EPSDT well-child visits or health checkups for newborns, well baby, and well-child exams represented by CPT Preventive Medicine Services Procedure Codes 99431, 99432, 99381-99385, and 99391-99395 and E & M Procedure Codes 99201-99205 and 99211-99215 if they are used in conjunction with International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes V20.0 – V20.2, V70.0, and/or V70.9. Providers should start preparing now for the roll out of the ICD-10-CM on October 1, 2014. The ICD-10-CM requires greater specificity in diagnostic code/description where the ICD-9 had one code for Attention Deficit Hyperactivity Disorder (ADHD) 314.01; the ICD-10 has four

codes/descriptions for ADHD. CMS has created a variety of resources that can be linked to through <http://alliancepracticeanddatamanagement.wikispaces.com/ICD-10Implementation>.

Provider Credentialing: In addition to using the correct billing codes, the selected medical home model for PIHC should ensure staff are appropriately licensed with MDCH and other licensing entities and credentialed with QHPs and third-party payers to make sure submitted claims are honored by these payers.

Accurate Documentation of Services: Having the technology supports to guarantee all billable services are accurately documented is equally important to claims substantiation and services sustainability.

The bottom line of financing integrated health care is that contracts for health care services must support it. This is the final best practice recommendation of the PIHC Workgroup.

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Where a joint notice is provided to an individual by any one of the covered entities to which the joint notice applies, the Privacy Rule's requirements for providing the notice are satisfied for all others covered by the joint notice. If the joint notice is provided to an individual by a direct treatment provider participating in the OHCA, the provider must make a good faith effort to obtain the individual's written acknowledgment of receipt of the joint notice. Where the joint notice is provided to the individual by a participating covered entity other than a direct treatment provider, no acknowledgment need be obtained. However, where covered entities participating in an OHCA choose to maintain separate notices, each covered entity from which an individual obtains services must provide its notice to the individual in accordance with the applicable requirements of 45 CFR 164.520(c). In addition, each direct treatment provider within the OHCA must make a good faith effort to obtain the individual's acknowledgment of the notice he or she provides.

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APPENDIX A: PIHC WORKGROUP MEMBERS AND REVIEWERS

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APPENDIX B: RECOMMENDED SCREENING AND ASSESSMENT INSTRUMENTS BY AGE GROUP

Instrument Name & Target Age Group	Administration Schedule & Administrator	Instrument Description
Ages and Stages Questionnaire (ASQ) Infants and Toddlers: Ages 0 to 3 years	Appropriate for children ages four to 60 months (five years old), administered at six month intervals. ✓ Pediatrician	The ASQ is a series of parent completed questionnaires designed to screen children's developmental performance in multiple domains of development (Squires, 2002). Performance areas include: 1) communication, 2) gross motor skills, 3) fine motor skills, 4) problem solving, 5) personal-social skills, and 6) overall development over time.
Edinburgh Postnatal Depression Scale (EPDS) Infants and Toddlers: Ages 0 to 3	Pregnant and Post-partum mothers ✓ Pediatrician	Postpartum depression is the most common complication of childbearing. Maternal depression is also a correlate of child abuse/neglect, poor attachment, failure to thrive and low birth weight. The 10 question <i>Edinburgh</i> is a valuable and efficient way of identifying patients at risk for "perinatal" depression. Patients can fill out the screening form while in the waiting or exam room (Cox, Chapman, Murray & Jones, 1996).
Devereux Early Childhood Assessment Infants and Toddlers: Ages 0 to 3	DECA Infant: 4 weeks to 18 months DECA Toddler: 8 months to 36 months ✓ Behavioral Health Specialist	The DECA is a standardized, referenced, strength-based assessment that assesses protective factor scales which are: 1) Initiative, 2) Attachment/Relationships, 3) Self-Regulation (toddler), and 4) Total Protective Factors Scale (LeBuffe & Naglieri, 2009). One of the most effective ways to prevent social, emotional and behavioral disorders is to encourage the development of healthy social and emotional skills during infancy and early childhood. Research shows that when a child's environments are nurturing, safe and consistent, they can help to reduce the risk of harm and foster resiliency.
Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) Infants - Preschoolers: Ages 4 months to 60 months	At six month intervals ✓ Behavioral Health Specialist	The ASQ-SE is a series of parent completed questionnaires designed to screen the children's social and emotional behavior, the result allow professionals to recognize if young children are at risk for social or emotional challenges, and the need for further assessment (Squires, 2009).
Pediatric Symptom Checklist (PSC) Parent Version Preschoolers: Ages 4 – 5 years School-age Children: Ages 6 -12 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The PSC is a psychosocial screening instrument designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible (Jellinek, M.S., et al., 1999).
Pediatric Symptom Checklist Youth (Y-PSC) School-age Children: Ages 11-17 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The <i>PSC-Youth</i> is a youth self-report version is the same as the Parent Version, but worded so that the child/youth can fill out the form (Jellinek, M.S., et al., 1999).

Instrument Name & Target Age Group	Administration Schedule & Administrator	Instrument Description
Patient Health Questionnaire-Adolescent (PHQ-A) Adolescents: Ages 13 – 17 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The <i>PHQ-A</i> is a validated, self-administered instrument that screens for anxiety, eating, mood, and substance use disorders among adolescents in a primary care setting (Johnson, Harris, Spitzer, Williams, 2002).
Generalized Anxiety Disorder 7 (GAD-7) Adolescents: Ages 13-17 years Young Adult: Ages 18 – 20 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The GAD-7 is a validated screening tool for generalized anxiety, panic disorder, social anxiety and Post-Traumatic Stress Disorder. (Spritzer, et al., 2006)
Rapid Assessment of Adolescent Preventive Services (RAAPS) Adolescent: Ages 13 – 17 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The RAAPS is a validated, reliable and evidence-based screening tool which screens for adolescent risk behaviors. (Salerno et. Al, 2011)
Patient Health Questionnaire-9 (PHQ-9) -Adult Version Young Adult: Ages 18 – 20 years	Once to determine the need for further evaluation by a qualified mental health professional ✓ Pediatrician	The <i>PHQ-A</i> is a validated, self-administered instrument that screens for anxiety, eating, mood, and substance use disorders among adolescents in a primary care setting (Johnson, Harris, Spitzer, Williams, 2002).
Preschool and Early Childhood Functional Assessment Scale (PECFAS) Young Children: Ages 3 – 7 years	Administered quarterly ✓ Behavioral Health Specialist	The PECFAS assesses a young child's day-to day functioning across critical life domains and for determining progress over time. Life domain areas include: 1) School/Preschool/Day Care, 2) Home, 3) Community, 4) Behavior Towards Others, 5) Moods/Emotions, 6) Self-Harm Behaviors, and 7) Thinking/Communication (Hodges, 1994).
Child and Adolescent Functional Assessment Scale (CAFAS) Children – Adolescents: Ages 7 -17 years Young Adults: Ages 18 – 20 years	Administered quarterly ✓ Behavioral Health Specialist	The CAFAS is backed by 20 years of research supporting the instrument's validity and sensitivity to detecting change in behavior. It is widely used to inform decisions about level of care, type and intensity of treatment, placement and need for referral (Hodges). The CAFAS is used to assess a child and or adolescent's day to day functioning across critical life domains and for determining progress over time. Life domain areas include: 1) School, 2) Home, 3) Community, 4) Behavior Towards Others, 5) Moods/Emotions, 6) Self-Harm Behaviors, 7) Thinking/Communication, and 8) Substance Use (Hodges, 1994).

Instrument Name & Target Age Group	Administration Schedule & Administrator	Instrument Description
CRAFFT® Adolescents – Young Adults: Ages 14 – 21 years	Administered once as a screening tool for substance use √ Pediatrician √ Behavioral Health Specialist	The CRAFFT is a behavioral health screening tool which is recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. It consists of a series of 6 questions developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is a short, effective screening tool meant to assess whether a longer conversation about the context of use, frequency, and other risks and consequences of alcohol and other drug use is warranted (Knight et. al, 2002)
Modified Checklist for Autism in Toddlers (M-CHAT) Toddlers: Ages 18 months and over	Administered once as a screening tool for Autism Spectrum Disorder √ Pediatrician √ Behavioral Health Specialist	The M-CHAT is designed to screen for Autism Spectrum Disorders in toddlers (Robins, Fein, Barton, & Green, 2001). A parent can complete the items independently.

APPENDIX C: SAMPLE JOB DESCRIPTIONS

Job Title: Director of Medical Services

Reports To: Chief Operations Officer

FLSA Status: Exempt

Summary: To provide leadership, consultation, and training in organizational efforts with regard to medical services. This position represents the organization in providing consultation services to external clients.

Essential Duties and Responsibilities

Provide direct and indirect medical services to patients at assigned clinic.

Conduct meetings for direct patient assessment and intervention.

Attend conferences, workshops, seminars, and classes to maintain knowledge of changes and developments in the health care industry.

Stays informed with the latest research trends in medical care.

Consult with medical providers to develop assessment and treatment protocols as well as designing training programs for providers.

Provide leadership to medical providers and staff to include Physicians, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, Medical Assistants and other direct service delivery personnel.

Design and implement formal training programs relative to Standards of Practice and Treatment Protocols for all affected medical services personnel.

Provide consultation and development of integrated delivery systems in collaboration with members of the management team.

Provides leadership with Family Practice Fellows and students associated with college/university Bachelor's and Master's level Nursing Programs

Qualifications

Education/Experience: M.D. from an accredited Medical School; or four to ten years of related experience and/or training; or equivalent combination of education and experience.

Computer Skills: To perform this job successfully, an individual should have knowledge of Word Processing software.

Certificates and Licenses: Licensed Medical Doctor in the state of Michigan.

Supervisory Responsibilities: Provides leadership to Physicians, Nurse Practitioners, Nursing Staff, Family Practice Fellows, and Nursing Students.

Job Title: Director of Integrated Services

Reports To: Chief Operations Officer

FLSA Status: Exempt

Summary: To provide leadership, consultation, and training in organizational efforts to design and implement care programs throughout appropriate sites. This position represents the organization in providing consultation services to external clients.

Essential Duties and Responsibilities

Provide direct and indirect integrated care clinical services.

Conduct meetings for direct patient assessment and intervention.

Consult with medical providers to develop assessment and treatment protocols as well as designing training programs for providers.

Provide direct supervision of Clinical Therapists to include doctoral level psychologists and/or masters' level social workers.

Design and implement formal training programs relative to specific topics on integrated care for primary care and behavioral health providers.

Provide consultation and development of integrated delivery systems in collaboration with members of the management team.

Responsible for the development of clinical curriculum, administrative tools, and collaboration with educational institutions for internship programs.

Provides leadership in the admission process for selecting candidates to enter internship program.

Responsible for submitting application and gaining approval to be recognized as an APA/APPIC accredited internship program.

Will coordinate Integrated Care rotation and serve as clinical supervisor to interns.

Other duties as assigned.

Qualifications

Education/Experience: PhD or Speed in Psychology; or LMSW; or four to ten years of related experience and/or training; or equivalent combination of education and experience.

Computer Skills: To perform this job successfully, an individual should have knowledge of Word Processing software.

Certificates and Licenses: Licensed Psychologist in the state of Michigan

Supervisory Responsibilities: Provides clinical supervision to Behaviorists, including interns.

Job Title: Director of Psychiatric Services

Reports To: Chief Operating Officer

FLSA Status: Exempt

Summary: Collaborates with Primary Care Physicians and Behavioral Health Specialists to monitor and promote mind/body wellness.

Essential Duties and Responsibilities

Monitors access and quality of care.

Recruits psychiatrists that understand and practices integrated care.

Determines nature and extent of mental disorder, and formulates treatment program.

Promotes health, recovery, and patient self-management.

Maintains patient confidentiality.

Actively participates in meetings that support integrated health care model to provide comprehensive care for clients.

Provides effective treatment planning and assisting clients in successfully achieving goals.

Stays informed with the latest research trends in medical care.

Provides leadership to providers and staff to include Psychiatrists, Psych Nurses, and Psych Nurse Practitioners.

Designs and implement formal training programs relative to Standards of Practice and

Treatment Protocols for all affected behavioral health personnel.

Provides consultation and development of integrated delivery systems in collaboration with members of management team.

Other duties as assigned.

Qualifications

Education/Experience: M.D. degree and completion of psychiatric residency. Must obtain certification or eligibility, and license to practice in Michigan.

Supervisory Responsibilities: Directly supervise psychiatrists and nurses in Behavioral Health Services. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws.

Certificates and Licenses: Medical Degree, Residency training with Board Certification, Medical Licensing by State of Michigan.

Job Title: Behavioral Health Specialist

Reports To: Director of Integrated Services

FLSA Status: Exempt

Summary: Provide behavioral health consultation to children, adolescents, adults and families in order to improve psychosocial functioning.

Essential Duties and Responsibilities

Provide comprehensive assessment and diagnosis of behavioral health clients.

Provide effective treatment planning and assisting clients in successfully achieving goals.

Evaluate crisis situations and apply appropriate interventions.

Actively participate in meetings that support integrated health care model to provide comprehensive care for clients.

Assist in the detection of “at risk” patients and development of plans to prevent further psychological or physical deterioration.

Assist the primary care team in developing care management processes such as the use of guidelines, disease management techniques, case management, and patient education to improve self-management of chronic disease.

Provide assessment, consultation, and brief intervention for psychological/psychiatric problems and/or disorders.

Teach patients, families, and staff care, prevention, and treatment enhancement techniques.

Monitor the site’s behavioral health program, identifying problems related to patient services and making recommendations for improvement.

Other duties as assigned.

Qualifications

Education/Experience: Masters’ Degree in Social Work or PhD in Clinical Psychology

Computer Skills: To perform this job successfully, an individual should have knowledge of Word Processing software.

Certificates and Licenses: Licensed in the State of Michigan as a Licensed Clinical Social Worker (LCSW) or a Licensed Psychologist.

Requirements

Excellent working knowledge of behavioral medicine and evidence-based treatments for medical and mental health conditions.

Ability to work through brief patient contacts as well as to make quick and accurate clinical assessments of mental and behavioral conditions.

Should be comfortable with the pace of primary care, working with an interdisciplinary team, and have strong communication skills.

Good knowledge of psycho-pharmacology

Ability to design and implement clinical pathways and protocols for treatment of selected chronic conditions.

(Cherokee Health Systems, 2012)