Handbook of Pediatric Psychological Screening and Assessment in Primary Care

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Integrated Behavioral Health in Pediatric Primary Care Settings

Using Screening Processes as Ports of Entry for Children and Families

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Nationally, access to mental health services for children and adolescents is limited despite prevalence rates of nearly 20% and an estimated $247 billion in annual mental health care expenditures (Perou et al., 2013). Unfortunately, even when children are referred for services, they are unlikely to connect with and utilize traditional mental health resources. This is particularly problematic for low-income youth, who are at greater risk for poor mental health, developmental, and health outcomes (Ekono, Yang, & Smith, 2016). Barriers to referring children to community-based mental health services include long wait times for appointments, limited access to qualified professionals (e.g., child psychiatrists and early childhood mental health specialists), services that are not culturally responsive, and social stigma about seeking mental health services.

In light of barriers to accessing and receiving mental health services, integrating behavioral health into primary care settings serving pediatric populations provides a critical port of entry into assessing and promoting the health and well-being of children and families (Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health, 2009; Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000; Stancin & Perrin, 2014; Talmi et al., 2016; Wissow, Van Ginneken, Chandna, & Rahman, 2016). One-third of patients in a national survey reported receiving mental health treatment solely from primary care providers (Anderson, Chen, Perrin, & Van Cleave, 2015). Within pediatric populations, between one quarter and one third of concerns raised in primary care settings pertain to behavioral health or development (Boreman, Thomasgard, Fernandez, & Coury, 2007).

Limited pediatric resources and a shift toward value-based payment models that emphasize screening, referral, and adherence to wellness means screening and assessment in primary care settings provide crucial opportunities for practice transformation and integration of behavioral health services along a full continuum of care. Screening efforts will not only support practices in reaching alternative payment methodology goals but will also provide mechanisms for integrating behavioral health clinicians (BHCs) into workflows while supporting anticipatory guidance, referral, and case-based consultation. Integrated BHCs provide expertise, reassurance, and guidance around pregnancy related depression,
developmental screenings, teen and caregiver depression screening, and assessment and conceptualization of how psychosocial needs relate to population health management strategies for individual patients/families and pediatric practices. The pediatric integrated behavioral health models and programs described in this chapter vary in the extent to which they utilize and incorporate screening and assessment into their approaches to care, reimbursement, and long-term sustainability.

**Consultation in Mental Health and Behavior: Project CLIMB**

Project CLIMB (Consultation Liaison in Mental Health and Behavior) is an innovative program that addresses the need for collaborative services between mental health and primary care professionals by providing direct service, training and education, and program development and evaluation in the context of a residency training clinic located in an urban, academic medical setting. The Child Health Clinic (CHC) is a major teaching clinic where 40 general pediatric residents, 20 family medicine residents, 24 physician assistant students, and approximately 60 medical students are taught primary care pediatrics each year. The clinic provides more than 30,000 primary care visits to children aged birth through 18 each year. Nearly 85% of children seen in clinic rely on Medicaid or other public insurance for health benefits.

The CLIMB Team provides behavioral health services and is comprised of psychologists, psychiatrists, a full-time community mental health clinician, psychology fellows, child psychiatry fellows, psychology interns, and psychology externs. The CLIMB Team’s primary role is to support pediatric primary care providers as they care for children and families during pediatric visits. Central to the work is the ongoing collaboration with primary care providers in developing and delivering coordinated and comprehensive services to children and their families that include both pediatric and mental health components.

To achieve these goals, CLIMB providers engage in numerous clinical and educational activities. Clinical work includes case consultation, screening, and treatment of infants, children, and adolescents and their families in the primary care setting. Treatment modalities include developmental and psychoeducational interventions during well-child visits, HealthySteps (www.healthysteps.org) clinic and home visits (Buchholz & Talmi, 2012), consultation, assessment, screening, and brief intervention for developmental, psychological, and behavioral difficulties. Educational activities include information gathering and sharing (e.g., identifying resources for providers to give to families), developing and delivering talks, presentations, and trainings, and supporting attending providers in delivering educational content to pediatric health trainees.

Patients in the CHC are seen by provider teams that include faculty attending physicians, nurses, medical assistants, pediatric residents, physician’s assistant trainees, medical students, and resource partners. Patients are empaneled to providers in specific pods and receive their well-child, follow-up, and acute care in the same pod to ensure continuity of care. Residents provide continuity care to children coming in for their well-child visits. CLIMB providers work closely with continuity residents and attending providers to support
well-child care and long-term continuity for children and families who are seen by the same provider over time in the context of a medical home.

The CHC also has a team of resource partners including social workers, family navigators, community health liaisons, and other care coordination staff who work collaboratively with the CLIMB Team. Social workers typically become involved in cases of abuse/neglect, mandatory reporting, Department of Human Services involvement, family or community violence, or cases with significant psychosocial needs. The clinic currently has two bilingual family navigators who work to help families navigate various social, medical, and educational systems (e.g., Individual Education Plan and school evaluations, benefits eligibility) and two bilingual community health liaisons who are able to provide resource support to families in clinic, their homes, and the community. Resource partners address food insecurity, housing instability, and resource needs (e.g., car seats, portable cribs for safe sleep, transportation) with the intent of promoting optimal access and self-sufficiency while simultaneously maximizing appropriate resource allocation and utilization. Additional staff are hired as needed to support projects and programs in clinic.

**Program Development**

Project CLIMB was developed through close collaboration among the departments of psychiatry and pediatrics at the University of Colorado School of Medicine, leadership of the Child Health Clinic, the Children’s Hospital Colorado Foundation, and two community foundations with interest in increasing access to mental health services and training and education of health care providers. These groups identified access to mental health, behavioral, and developmental services along with the education of pediatric health professionals as critical for addressing the well-being of a largely underserved, high-need population of children in the metropolitan Denver area. Initial funding for Project CLIMB was provided through foundation grants. Subsequently, revenue from screening efforts, contracts, and other initiatives has allowed the program to expand. At present, the program is staffed with 2.5 FTE for psychologists, 0.4 FTE psychiatrists, 2.0 FTE for psychology postdoctoral fellows, a full-time community mental health clinician, and a psychology intern who is in clinic two half days each week.

**Training and Education**

Opportunities for teaching and training range from bedside, collaborative, case-based education to formal didactics and training programs around specific content. Training efforts are designed to engage a diverse set of learners with a broad range of experience with and exposure to behavioral health in pediatric populations in expanding their knowledge, comfort, and practice using developmentally appropriate exposure and providing the necessary support (Kelsay, Bunik, Buchholz, Burnett, & Talmi, 2017). Psychology and psychiatry faculty members precept pediatric cases, supporting both pediatric and behavioral health learners in identifying and addressing concerns raised in the context of providing primary care services. Preceptors are available during clinic hours to review cases, shadow learners, and provide collaborative care. The CLIMB Team is integrally involved in
formal educational efforts including preclinic didactics, monthly preclinic teaching sessions, development and delivery of content around new behavioral health initiatives, and other innovations (e.g., psychosocial rounding, Balint groups; see Roberts, 2012).

**Implementation**

Project CLIMB has been providing integrated behavioral health services in the context of a residency training clinic since 2005. Since its inception, thousands of children and families have received mental health, behavioral, and developmental services (Talmi et al., 2016) and tens of thousands have been screened for development, parental and family well-being, and their own mental health. With respect to screening, Project CLIMB initiated screening efforts as follows: pregnancy-related depression screening (newborn to 4 months), psychosocial screening (all well-child checks), developmental screening (well-child visits from 2 months to 5 years), and teen depression screening (well-child visits for ages 11 and up). Screening efforts have been central in expanding the scope of integrated behavioral health providers and in improving access to care, particularly for vulnerable populations whose needs are not being adequately assessed or identified in other settings.

**Screening Processes**

While screeners are an essential aspect of identifying patients’ and families’ needs, pediatric settings tend to be fast paced and serve high volumes of patients, creating challenges in implementation of screening processes. Operational and clinical factors must be considered when designing screening protocols and workflows. Utilizing integrated behavioral health providers and other resource navigators to help facilitate screening and referral processes can ease the burden on primary care providers and increase the likelihood of successful implementation of screening processes.

**Introducing New Screeners**

The introduction of a new screening tool into a primary care setting entails thoughtful consideration related to workflows, electronic record system updates and maintenance, staff role definition and clarification, clinic-wide communication strategies, and a response protocol for positive screens. Having dedicated staff to monitor, track, and respond to these aspects of a new screening tool is critical for success. Additionally, staff may need a variety of mechanisms to understand and incorporate the workflow for the tool into their day-to-day practice. These include interactive trainings with opportunities for questions, activities such as role plays and case discussions, written step-by-step guides for the tool, and visual aids to guide a user through a new tool and process. A pilot period is often essential when launching a new tool within an established practice. This gives staff the opportunity to weigh in regarding how a draft workflow is operating, tweak tools meant to support the screener, look for avenues to increase efficiency and effectiveness, and ensure data reporting systems are functioning. Staff engagement and
satisfaction with these processes can be critical, as medical providers are doing more in their visits, and staff are encouraged to practice at the top of their scopes in workflows that allow all levels of staff to efficiently and effectively participate and contribute their expertise when and where it is required (i.e., medical assistants distributing and scoring screening instruments, nurses managing medication refills). Staff burnout related to new initiatives is a risk when introducing new tools and workflows. Ensuring the implementation process fits within the Quadruple AIM (Bodenheimer & Sinsky, 2014) is an important area of focus during all phases of implementation.

Due to the frequency of routine health supervision visits and caregiver propensities to bring children to primary care when concerns arise, pediatric settings are uniquely positioned to screen at the child and family levels and offer support and resources when concerns are identified. However, pediatric primary care settings also face challenges related to appropriately documenting, billing, and tracking data related to caregiver screeners. For measures that entail any risk assessment, it is critical to develop and utilize policies and procedures for assessing differing levels of risk, with clear role assignment.

**Developmental Screening: Supporting Young Child Well-Being**

Integrated BHCs are in a unique position to assist PCPs in providing comprehensive care to young children and their families by facilitating implementation of standardized developmental screening and referral processes. Working collaboratively with office staff and PCPs, integrated clinicians develop clinic-specific screening and referral protocols that meet the needs of families and also fit within a practice’s workflow and structure. In addition to physical health monitoring, the American Academy of Pediatrics (AAP) also recognizes the importance of developmental surveillance and screening at well-child visits and recommends that physicians utilize standardized developmental screening tools at a minimum of three well-child visits in the first 30 months of life (AAP, 2006).

Developmental screening allows PCPs to identify children who are at risk for delay and refer them for early intervention services, which has been demonstrated to improve developmental trajectories early in the child’s life (Schor, 2007). PCPs who augment their medical judgment with a standardized developmental screening tool more effectively identify children at risk for developmental delay than those who use medical judgment alone (Regalado & Halfon, 2001). Beyond screening and identifying young children in need of further evaluation, PCPs need to refer children identified as at risk for developmental delay to appropriate community services. National data suggests that children at risk for developmental delays (e.g., those with scores in the abnormal range on screening tools or whose caregivers are concerned about developmental progress) are underreferred to early intervention services (IDC IDEA Data Center, 2011; Rosenberg, Zhang, & Robinson, 2008). Although approximately 12 to 13% of children should qualify for services (e.g., speech, occupational, physical therapies), only about 3% of children under the age of 3 are referred to Early Intervention for evaluation (IDC IDEA Data Center, 2011).

Ideally, screening in pediatric primary care should occur in a collaborative manner, with families providing information about young children and PCPs reviewing the information and conducting additional assessment as needed. Given the significant time constraints pediatric providers face, implementation of thorough screening processes is challenging.
Time-saving methods including reliance on clinical judgment or elicitation of parental concerns without the use of standardized screening tools compromise accurate identification. These more informal surveillance methods present challenges including unstandardized administration, lack of a norm-referenced group for comparison, and insufficient data to generate referrals when concerns are identified.

In order to effectively refer children to early intervention services, PCPs must first understand the referral process themselves so that they can explain the process to families. While much work has been done to put formalized referral processes in place, PCPs and families still struggle to navigate a confusing and complicated system. Using a standardized developmental screening tool can both aid PCPs in deciding when a referral is necessary and provide concrete data for explaining why a referral is needed. This, in turn, could lead to better referrals and improved referral rates.

As with any screening process, thoughtful implementation of developmental screening is critical to its long-term success and sustainability in pediatric primary care. Screening protocols must be clearly delineated for all providers. Developmental screening processes are most likely to be successful when supported by integrated BHCs. BHCs expand the process to include screening, identification, referral, and follow-up in a way that is in line with the ideals of a medical home and meets the needs of the family. Standardized developmental screening and referral are important pieces of a medical home, helping to strategically place the PCP at the center of a child’s care. Therefore, in addition to screening and referral processes, PCPs also need to be informed about the outcomes of referrals made.

**Implementation Example**

Project CLIMB effectively implemented developmental screening processes in the CHC. Initially, screening administration was piloted by the CLIMB team. After two months, screening responsibilities were transferred to the medical providers (see Figure 19.1) with significant attention to training and support during the transition. Challenges of screening in this setting include lack of bidirectional communication regarding referral outcomes with community partners, accurate documentation of actions taken on a positive screener, ensuring that providers were referring in a consistent way and according to the workflow (Talmi et al., 2014), and tracking screening, referral, and billing rates.

Once screening processes were fully implemented in clinic, Project CLIMB clinicians piloted these efforts in three community-based clinics to determine if implementation of developmental screening efforts would be improved by the presence of an embedded BHC in a nonresidency training clinic. Each of the three clinics implemented developmental screening and referral processes with the support of an integrated BHC over the course of a year. All three practices’ referral rates to Early Intervention significantly increased with the introduction of a standardized screening and referral process. The results demonstrated the value of implementing screening processes in the context of an integrated behavioral health setting where early identification, early referral, and follow-up activities are supported in the context of a medical home (Buchholz, Dunn, & Badwan, 2012).
Pregnancy-Related Depression: Addressing Maternal and Relational Well-Being

Pregnancy-related depression is the most common side effect of pregnancy (Wisner et al., 2013), affecting up to one in nine women. Pediatric primary care is an optimal setting to screen for pregnancy-related depression because of the frequency and timing of visits in the first days and weeks of a child’s life. In the first several weeks of life, infants are seen by their primary care providers a minimum of two to four times, whereas most mothers do not see their obstetrician until their infants are about six weeks old. Visits with the child’s primary care provider offer important opportunities to screen and provide early identification, intervention, and referrals for maternal mental health concerns.

Despite having early access to mothers with young children, pediatric primary care providers are often hesitant to screen for pregnancy-related depression and other maternal mood issues due to concerns that parental mental health is outside of the scope of pediatric care and that assessing individuals other than the identified patient (i.e., the child) is complicated from a documentation and billing perspective. Additionally, pediatricians often...
feel underprepared to address maternal mental health concerns in the context of pediatric primary care, especially when adequate community resources to address identified concerns are lacking. However, identifying and addressing maternal mood concerns is critical to child health. Maternal mental health has a significant impact on child well-being and development (National Research Council and Institute of Medicine, 2009) and is therefore an important consideration for pediatric primary care providers.

One solution for addressing providers' concerns about screening for pregnancy-related depression is to embed screening, identification, referral, and treatment processes in settings where mental health is integrated into the primary care practice. Having integrated BHCs available to support providers as they screen and address postpartum mood concerns can reduce the perceived challenges of screening for pregnancy-related mood concerns.

Project CLIMB supported universal implementation of the Edinburgh Postnatal Depression Scale (EPDS) in the Child Health Clinic in 2008. A screening protocol was developed and disseminated to faculty providers and medical trainees (Lovell, Roemer, & Talmi, 2014). Mothers are screened using the EPDS at every visit through 4 months of age. The protocol (see Figure 19.2) indicates that when a mother screens a 10 or above or scores anything but a zero on question number 10 (self-harm question), the medical team is to consult with Project CLIMB. The team can also consult with CLIMB when a provider has concerns about a mother's affect regardless of the EPDS score. In either case, a CLIMB provider will discuss the case with the medical provider and see the family while they are in clinic. The CLIMB provider will assess risk, discuss social support, explore options for self-care and other strategies to address mood concerns, and may refer the mother to mental health supports in the community. The CLIMB provider and the medical provider then collaborate to make an appropriate follow-up plan to adequately address the family's needs.
As an example, the Colorado Department of Public Health and Environment (CDPHE) convened a workgroup to develop a Pregnancy-Related Depression and Anxiety Guidance document in 2013 (CDPHE, 2014). The document is geared toward providers who work with women of childbearing age or their children. It provides a background for pregnancy-related mood concerns, suggestions for beginning conversations with mothers, recommendations for screening and treatment approaches, and a lifestyle tool that can assist providers with clinical care. After these guidelines were developed, CDPHE continued the statewide advisory committee to determine how to disseminate the guidelines and support the creation of state action plans to address pregnancy-related depression. The committee assisted with the development of a pregnancy-related depression public awareness campaign and continues to provide guidance to the state around strategies and next steps. In addition to being offered to families who are identified as struggling with maternal mood issues, these resources, including the Guidance document and the public-awareness materials, are used in Project CLIMB’s teaching efforts in the CHC. A monthly presentation to a rotating group of pediatric residents includes review of the Guidance document, ensuring
that the medical providers have a thorough understanding of the importance of screening and identifying pregnancy-related mood concerns in pediatric primary care.

**Psychosocial Screening: Identifying Social Determinants of Health**

Many studies have identified long-term health impacts that can occur when children are exposed to adverse childhood experiences (ACEs). A study conducted by the Centers for Disease Control and Prevention and Kaiser Health Plans found that frequent and prolonged exposure to ACEs can lead to a toxic stress response, which can have significant negative impacts later in a child’s life and into adulthood (Felitti et al., 1998). These adverse experiences include abuse, neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship in the absence of nurturing relationships that can mitigate these stressors. Although these factors play a critical role in child well-being, there is currently no universal screening tool that specifically screens for these psychosocial factors prospectively. As a result, providers and families often miss the opportunity to identify psychosocial needs early enough to prevent or ameliorate the onset of health and behavioral health problems. Families must be asked, in direct terms, whether they are experiencing adversity. Ideally, if they are, immediate resources and supports to address that family’s needs should be offered.

Project CLIMB initiated a psychosocial screening process in the Child Health Clinic. Due to the high volume of patients seen in this clinic (13,000 plus annually) and patient demographics (more than 80% publicly insured through Medicaid/CHP+), this setting was an ideal environment for robust practice transformation in a fast-paced training clinic. The screener was adapted from a psychosocial screening tool developed for use in pediatric primary care settings (Talmi & Poole, 2010) by a workgroup examining social determinants of health in pediatric populations.

**Pilot Phase**

Prior to implementation, the clinic chose one of four pods to pilot the psychosocial screener. The steering committee, comprised of clinic leadership and team leaders from medical assistants to the medical director, met weekly for 3 months to discuss the workflows, medical record needs, documentation needs, response protocols for items, and quality-improvement measures. The screener was translated into 10 languages and comprised of 13 items ranging from housing and food security to safety, substance use, and mental health (see Figure 19.3 for screener items and workflow).

The CLIMB team provided three half-day trainings for all clinic staff on the topic of ACES, toxic stress, and the impact on child development and health. Prior to the launch, the team met with the selected pilot pod to review the proposed workflows and response protocols and answer questions during a “Lunch and Launch” meeting. While the pod was excited about the opportunity to support their families and learn more about their needs, the theme of stress related to impact on time to review and triage screeners at all levels of the provider team emerged. The high number of medical trainees in the clinic and their rotations in and
out of the pilot pod necessitated additional 2-hour trainings with all medical residents prior to the launch.

**Figure 19.3** Psychosocial screening workflow

Grant funding for psychosocial screening efforts allowed us to designate an implementation manager to oversee the micro and macro components of the screening process prior to launching and who then was available to the pod for live support as it launched. On the first day, many unanticipated questions arose as the screener was administered. Some workflow and processes were tweaked immediately following that initial clinic shift. Providers and staff expressed gratitude that someone was available for support as questions and issues emerged, especially given the high volume of positive screeners.

During the 3-month pilot, the pod encountered barriers to the screening related to scheduling and time, literacy issues, staffing changes, electronic health record glitches, and data abstraction issues. The CLIMB team and clinic leadership met with the pilot pod three times to review and process how things were going and to solicit staff input on solutions to challenging situations. The implementation manager coordinated with translation services, information technology, quality improvement, and team leaders. Data analysis and chart review ensured adherence to screening protocol, and ongoing technical assistance was provided to the pod for continuous process improvement.

**Universal Implementation**

When the screener was ready to be launched clinicwide, most “glitches” had been addressed, and the steering committee had a clearer picture of what types of errors were occurring and
why, what tools would be most helpful in our clinic setting, and what the response protocol for positive items should entail. A key to feeling prepared for the universal launch was having floating medical assistants and nursing staff participate during the pilot phase. As a result, most medical assistants and nursing staff members had been exposed to the screener and workflow before officially launching in their “home” pods. The revised workflow emphasized the medical assistant and nurse responsibilities, which made implementation of the screener proceed more smoothly.

**Figure 19.4** Psychosocial screening protocol

**Figure 19.3** depicts the workflow that was developed to guide providers and staff through the psychosocial screening process. Critical items, the response system for the items, and documentation guidance were key components for ensuring a complete, clinical administration and review of the screening instrument. **Figure 19.4** was developed as a guide specific to learners (such as medical students and residents) to provide them with prompts and basic scripting around reviewing screening results with families. The CLIMB team developed these protocols after the pilot period to address those areas with the highest rates of provider and staff errors around charting and processes. Though implementing universal screening meant a quadruple increase in the volume of screens (more than 1,100 screens were administered in one month of universal screening), charting and process errors decreased.
Case Example

Anna, a 4-year-old female, is the child of immigrant, monolingual Spanish-speaking parents. Anna had been a patient of the CHC since birth, and pregnancy-related depression (PRD) screening using the Edinburgh Postnatal Depression Scale (EPDS) early on indicated risk for pregnancy-related depression for her mother. Her mother was isolated and had little social support besides her husband, as the majority of her extended family resided in Central America. The CLIMB team was involved with the family in the first several months of Anna’s life, providing the family with support and referrals to Spanish-speaking mental health resources. At her 4-year well-child visit, Anna’s developmental screening results using the Ages and Stages Questionnaire-3 (ASQ-3) indicated that her development was within the normal range. However, Anna had unmanaged asthma and presented to the emergency department frequently. Despite being seen regularly in primary care for asthma management and well-child care, it appeared her family was not adhering to guidance and to her asthma plan. Anna’s parents were given the psychosocial screener at Anna’s well-child check. Her parents endorsed several resource issues and specific barriers to navigating public transportation and accessing a pharmacy.

Upon reviewing the psychosocial screener with the family, the medical provider and family navigator discovered that Anna’s family did not know what a pharmacy was or how to locate a nearby one to pick up Anna’s medications. This explained the underlying issues related to poor asthma management. The family navigator was able to support the family in accessing more community benefits for which they qualified and involved a community health worker, who met with the family to walk them through using public transportation, finding a pharmacy, ordering medication refills, and picking up prescriptions. The provider team remarked that they had experienced frustration with the poor adherence to the plan but now understood the barriers in communication, resources, and culture that they otherwise would not have known were significantly impacting the family and Anna’s health.

Systems Efforts to Advance Screening Processes

Enhancing and improving access to resources and behavioral health services in pediatric settings cannot occur in a vacuum. Changes in patient care and direct service at the micro level must compliment and be supported by co-occurring changes at the larger macro level of the system in which the child and family exist. In order to successfully integrate behavioral health services into primary care settings serving pediatric populations, parallel changes must span pediatric settings, the health care and behavioral health landscapes, and state and local policies.

Colorado Children’s Healthcare Access Program (CCHAP)

The Colorado Children’s Access Program (CCHAP, 2017; www.cchap.org) is a nonprofit organization that was initially developed to increase access to pediatric primary care for children on Medicaid. Over the course of more than 10 years, this program successfully
increased enrollment of Medicaid patients in primary care through pediatric practice outreach and education efforts, practice engagement and training, and facilitation of several grant-funded projects that supported this work throughout the state.

Today, CCHAP provides several services to family medicine and pediatric practices throughout Colorado and nationally related to practice transformation, integrated behavioral health, the State Innovation Model, trainings, and advocacy and policy work at the state level. CCHAP uses a relationship-based model to engage practices by meeting them where they are, providing technical assistance on site in the practice, and integrating systems to best meet the needs of the changing health care landscape. The importance of a relationship-based approach to this work cannot be emphasized enough. Each practice has its own culture, resources and needs. In a geographically diverse, local control state such as Colorado, it is essential that tailored approaches be used to engage practices and facilitate transformation versus a “one size fits all” model.

CCHAP's mission and vision have evolved as children have successfully accessed care. CCHAP now has a specific focus on enhancing and supporting behavioral health initiatives in pediatric primary care settings. Currently, there are several projects underway that highlight these initiatives. CCHAP works with Project CLIMB to provide technical assistance and training to practices engaged in the Behavioral Health Integration in Pediatric Populations: 0–5 (BHIPP:0–5) project, bringing expertise in the areas of practice management, facilitation, and systems change.

Many of the current projects CCHAP supports (BHIPP:0–5, SIM, Medicaid APM, Maternal Infant Funding Strategies workgroup, Maternal Health Policy Coalition, Early Childhood Policy Coalition, Early Childhood Funding Steering Committee) involve caregiver PRD screening as a key indicator, or links to how caregiver screening in pediatrics impacts and shapes child health and development. CCHAP’s statewide work with practices has provided the opportunity to uncover many barriers to efficacious PRD screening in pediatric settings, despite the availability of an AAP Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice guidance (Earls, 2010)—on the subject. CCHAP applied for and was awarded funding to specifically examine areas to increase the clinical, operational, and regulatory processes for screening and referral in the pediatric setting. CCHAP has produced a white paper that highlights findings, guidance, opportunities for future advancement, and policy levers.

Additionally, CCHAP works with the State Innovation Model (SIM) office to support trainings for PRD screening for participants across the state in this project. SIM received a federal grant from the Centers for Medicare & Medicaid Services to decrease Medicare and Medicaid expenditures by increasing behavioral health integration. CCHAP plans to expand this work to include trainings and technical assistance to statewide practices on culture and PRD screening, as well as piloting the use of tablet technology and screening. CCHAP’s consultant model allows them to engage and deploy those with special skill sets to practices across the state and to incorporate other practice transformation providers (such as a pediatric psychologist) as needed to support practices in their endeavors.

**HealthySteps**
HealthySteps is an evidence-based early childhood integrated behavioral health model that is embedded in pediatric primary care settings (Zero to Three, 2017; www.healthysteps.org). The model pairs an early childhood mental health specialist (HealthySteps specialist, or HSS) with a pediatric primary care provider, and together, the team sees a family at every well-child visit in the first 3 years of life. The goal of the program is to provide enhanced primary care experiences to young children and their families by focusing on the needs of the whole child and family: physical, psychosocial, developmental, and intellectual. In addition to meeting families at well-child visits and other clinic-based visits, families are offered home visits by the HSS to further enhance the relationship with the HSS and provide additional support to families. HSSs support screening processes, provide developmental guidance, and connect families to community resources as needed.

The HealthySteps literature has demonstrated that children who participate in the program are more likely to attend well-child visits and receive vaccinations on time and are less likely to visit the emergency room for injuries; moreover, parents are more likely to read to their child and engage in positive discipline strategies and are more satisfied with their child’s pediatric care (Minkovitz et al., 2003; Caughy, Huang, Miller, & Genevro, 2004). Additionally, research indicates that pediatric providers are satisfied with the program and believe it helps families and enhances their practice (Minkovitz et al., 2003). When families are enrolled in HealthySteps, important developmental topics such as language development, routines, home safety, and pregnancy-related depression are discussed more often during well-child visits than when families are not enrolled in the program (Buchholz & Talmi, 2012). Because of the emphasis on enhanced, family-centered primary care, HealthySteps is a perfect fit for a residency training clinic. In the CHC, residents are encouraged to conduct joint medical visits with HSSs, and the model provides ample opportunity for residents to gain increased knowledge of child development and early childhood mental health.

The CHC first implemented HealthySteps as a component of Project CLIMB in 2006 and serves approximately 500 families in this model. HealthySteps promotes a focus on health promotion and prevention in the first 3 years of life and provides valuable support to families during this critical time in development. Families are provided with enhanced support in the context of their well-child visits, frequently in response to screening results. Oftentimes, families are identified as potentially benefiting from the program due to elevated pregnancy-related depression screening results. Results of concern on pregnancy-related depression, developmental, and psychosocial screening can be more fully addressed in the context of the enhanced services that HealthySteps provides to families. HealthySteps specialists support care coordination efforts in clinic and with community resources when needs are identified on the various screeners.

**Summary**

Screening and assessment are core functions of integrated BHCs working with pediatric populations in primary care settings. As described in this chapter, screening efforts around mental health, behavior, development, and contextual factors in pediatric populations encompass a broad range of tools, activities, and outcomes. Project CLIMB, an integrated
behavioral health services program, has been instrumental in spearheading screening efforts in a large residency training clinic and in community-based primary care practices across the Metro Denver area. Developing and implementing effective screening processes takes considerable time and intentionality. Integrated behavioral health teams are well positioned to provide support and resources around implementation and evaluation of screening efforts.

The efficacy of screening is very limited without attention to building a comprehensive system in which screening is conducted. Importantly, screening is necessary but not sufficient to provide access to care for individuals struggling with mental health issues. A comprehensive system that (a) provides access to care in response to referrals, (b) appropriately interfaces with PCPs to reduce frustration around poor communication regarding referral outcomes and patient care, and (c) coordinates the care is required. CCHAP, a community-based nonprofit whose mission involves supporting primary care practices and providers in serving vulnerable populations, has been engaged in technical assistance and practice transformation efforts that yield sustainable screening processes to meet the needs of children and families.

PCPs are not likely to screen and refer appropriately without support. The two most significant barriers to screening implementation are (1) PCPs’ lack of comfort identifying mental health issues without knowing what the plan will be if someone screens positive and (2) poor communication with external referral resources around referral completion and service eligibility (Wong & Talmi, 2015). The ideal support to PCPs is provided through on-site mental health clinicians that can serve as liaisons to community entities and, at the same time, can provide mental health services directly to patients and do warm handoffs to community mental health services when the mental health needs are beyond what can be addressed in the context of primary care.

Importantly, integrated BHCs working in primary care settings require specific training and education to be successful in medical settings. A competent, high-quality workforce will ensure that the services provided in the context of primary care can appropriately meet the needs of a population whose only access to health and mental health services may be through their PCP. In other words, taking outpatient mental health clinicians and inserting them into primary care settings is not sufficient. Mental health clinicians need training and supervision to successfully integrate into primary care and be effective in their practice (Talmi et al., 2015).

Finally, screening for adult mental health issues in adult primary care settings is very different than screening for postpartum depression and anxiety in the context of pediatric primary care. States that are at the cutting edge of health care reform apply two-generation Medicaid billing in which screening for parental mental health and well-being and psychosocial factors in pediatric primary care is reimbursable. Questions remain regarding how PCPs get reimbursed for screening family factors that directly impact the health and well-being of children in the context of primary care when the billing is based on the child and regarding the legality of documenting parental mental health concerns in a child’s medical record. Fortunately, questions, processes, and systems barriers have not deterred primary care settings serving pediatric populations from providing comprehensive screening and intervention services to address the needs of the children and families who come through their doors.
References


