**Pediatric Provider Toolkit**

**Purpose**
To provide templates and best practices for increasing communication between primary care providers and behavioral health providers about specific patient care.

**Intended audience**
- Primary care providers who want to improve the referral process with behavioral health providers.
- Behavioral health providers who want to improve communication and collaboration with primary care.
- Entities that are designing integration workflows and recommendations.
- Other caregivers who are interested in increasing care coordination for patients.

**Access**
Templates and recommendations available for free online at waportal.org, pediatrictcpi.org, and wcaap.org.

Fully integrated Medicaid payment for primary care and behavioral health care will be in place by January, 2020 in Washington State. This is a grand step toward fulfilling the promise of whole person care. How can we improve care for children and youth by making bi-directional communication and workflow a reality now? As part of our Pediatric Transforming Clinical Practice Initiative, WCAAP has created and vetted a toolkit of resources to turn to regardless of where you are on the road to integration.
Recommended steps to increase communication between providers:

1. **Identify who provides care to children in your community.** Primary care providers will identify who provides accessible behavioral health care for children and youth, and behavioral health providers will determine who offers primary care for children and youth.

2. **Determine the appropriate leaders to work with.** Primary care providers consider working with a manager for children’s services in a behavioral health agency, for instance. Behavioral health providers might want to work with the medical director or other interested provider(s) within a primary care clinic.

3. **Meet, and agree on a common referral agreement.** Use our template as a starting point. Include a Department of Health Practice Facilitator in your plans in order to arrange for your incentive. Remember, P-TPCI clinics receive an incentive payment of $1000 each for each bi-directional agreement they reach.

4. **Set a schedule for regular meetings.** Build in a time frame for reviewing the referral process you agreed on. How is it going? What needs to improve?

5. **Utilize the PDSA improvement process:**
   a. PLAN: Identify common goals. Set aims.
   b. DO: Implement solutions and improvements.
   c. STUDY: Monitor progress. What is working? What isn’t working?
      Modify the improvement efforts as needed.
   d. ACT: Implement improvements.

6. **Repeat, as necessary.** (Hint: it will always be necessary!)

7. **Continue to meet each other.** Forge ongoing and productive relationships. Share resources.
# Pediatric Provider Toolkit

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* from AAP toolkit

Some materials appear courtesy of SAMSHA and AAP. Toolkit created by WCAAP, under P-TCPI
Primary Care and Behavioral Health Integration Memorandum of Agreement

I understand that one of the Aims of the Pediatric Transforming Clinical Practice Initiative (P-TCPI) is to make access to Behavioral Health available for all children of WA State. I agree to work with neighboring Primary Care practices in order to reach this.

Working with neighboring Primary Care Practices will include:

- The undersigned Primary Care and Behavioral Health providers agree to meet (phone, in person, regional group meeting) at least once every 3 months to discuss progress.
- Document an agreed upon process on how both parties are going to work together.
- The undersigned Primary Care and Behavioral Health clinics will work together to close any and all care and referral gaps.
- In the event that the agreement is no longer feasible for either party, this agreement can be terminated with 30 days written notice.

Our clinic commits to work with the WA State Department of Health, undersigned Behavioral Health and Primary Care clinic.

The signature at the end of this letter indicates both parties commitment to work together to incorporate Behavioral Health and Primary Care.

Behavioral Health Provider Signature: _____________________________________________

Primary Care Signature: ___________________________________________________________
Improving the Referral Process
**REFERRING PRIMARY CARE PHYSICIAN: CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Name of provider making referral:</th>
<th>Address:</th>
<th>City:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td></td>
<td>Office Phone:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office Fax:</td>
<td>Alternative Preferred Phone Number:</td>
</tr>
</tbody>
</table>

**PATIENT CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian:</td>
<td>Home Address:</td>
</tr>
<tr>
<td>Primary Phone:</td>
<td>Primary Language:</td>
</tr>
</tbody>
</table>

**CONSENT FOR RELEASE OF INFORMATION FOR CARE COORDINATION**

I, ________________________ (print patient’s name if 13 or older OR guardian’s name if 12 or younger), give permission for my child’s health provider ____________________ (print provider’s name), to share any and all pertinent information regarding myself/my child, ______________________ (print patient’s name), with Behavioral Health resources.

<table>
<thead>
<tr>
<th>Patient Signature (if 13 or older):</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature (if 12 or under):</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**PROVIDER: REASON FOR REFERRAL**

<table>
<thead>
<tr>
<th>Date of Referral:</th>
<th>Reason for Referral:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Substance Use:</th>
<th>Suspected ___; Confirmed (by UA or report) ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Medical History:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Medications:</th>
</tr>
</thead>
</table>

**OUTCOME OF REFERRAL (to be completed by Behavioral Health)**

<table>
<thead>
<tr>
<th>Behavioral Health Agency:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Office Phone:</td>
<td></td>
</tr>
<tr>
<td>Office Fax:</td>
<td>Alternative Preferred Phone Number:</td>
</tr>
</tbody>
</table>

- [ ] Client does not have appropriate insurance
- [ ] Client lives outside service area
- [ ] No response to phone outreach
- [ ] Information provided - client declined services
- [ ] Information provided - Intake scheduled by not kept
- [ ] Intake Completed

**Date of Intake/Assessment:**

**Outcome of assessment:**

- [ ] Client does not meet Access to Care Criteria;
- [ ] Client meets Access to Care

**Assigned BH Clinician:**

**Qualifying Diagnosis:**

**Date and time of next appt:**

**Other:**

**5/23/2017**
PRIMAR Y CARE REFERE LA AND FEEDBACK FORM

Date: ____________ ( ) Initial ( ) Follow-up

Referring Physician Name: __________________________________________________________

Address: ___________________________ City ___________________________ State Zip

Street/PO Box) (______) Fax: ___________________________ Phone: (______) DOB: ____________

Patient's Name: ___________________________ Address: ___________________________ Phone:

Parent's Name: ___________________________ Address: ___________________________ Phone:

Date(s) Patient Seen: ___________________________

Reason(s) for Referral: _____________________________________________________________

Any Specific Questions or Requests

Referring Physician's Printed Name/Signature

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

Consultant's Report

Date(s) Patient Seen:

☐ Patient did not make appointment. ☐ Patient made an appointment but did not keep appointment.

☐ Patient not seen within 60 days.

Initial Diagnoses:

1. ___________________________________________________________

2. ___________________________________________________________

3. ___________________________________________________________

Recommendations:

Medications Prescribed:

Follow-up Arranged or Provided by Consultant:

☐ Further diagnostic testing ___________

☐ Individual therapy ___________

☐ Group therapy ___________

☐ Family therapy ___________

☐ Lab tests ___________

☐ Medication management ___________

☐ Return visit ___________

Other Care Needed:

☐ Medication management by PCC ___________

☐ Referrals recommended ___________

☐ Follow-up recommended ___________

☐ Other ___________

Name (type or print) ___________________________ FAX to ___________________________

Signature ___________________________ contact person ___________________________

Add disclaimer statement per your institution here:

doi: 10.1542/peds. 2010-0788Q
Behavioral Health Resources Primary Care Provider (PCP) Referral Form

**CLIENT CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Client’s Name:</th>
<th>Date of Birth: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian:</td>
<td>Relationship to the Client:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>County:</td>
</tr>
<tr>
<td>Primary Phone:</td>
<td>Other Phone:</td>
</tr>
<tr>
<td>Primary Language:</td>
<td>Interpreter Needed: □ Yes □ No</td>
</tr>
</tbody>
</table>

**CONSENT FOR RELEASE OF INFORMATION**

Consent for release of medical information (HIPAA)*

I, ________________________________ (print client’s name if 13 or older OR guardian’s name if 12 or younger), give permission for my/my child’s health provider ________________________________ (print providers name), to share any and all pertinent information regarding myself/my child, ________________________________ (print client’s name), with Behavioral Health Resources.

<table>
<thead>
<tr>
<th>Client Signature (if 13 or older):</th>
<th>Date: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature (if 12 or under):</td>
<td>Date: <em><strong>/</strong></em>/____</td>
</tr>
</tbody>
</table>

**PROVIDER: REASON FOR REFERRAL**

Date of Referral: ______________________

Reason for Referral:

☐ Therapy/Counseling  ☐ Medication Management (ongoing) at BHR  ☐ Diagnostic Clarification

☐ Medication Consultation/Recommendations (may require one or more visits)

☐ Other:

______________________________________________________________________________

______________________________________________________________________________

Signs/Symptoms:

☐ Anxiety  ☐ Depression  ☐ Suicidal Ideation  ☐ Self-Harming Behaviors  ☐ Anergia  ☐ Mood Instability  ☐ Anger/Irritability

☐ Aggression  ☐ Impulsivity  ☐ Behavioral Problems  ☐ Mania  ☐ Psychosis  ☐ Thought Disorder  ☐ Cognitive Problems

☐ Sleep Problems  ☐ Other: ________________________________

Clinical Question/Concern:

______________________________________________________________________________

______________________________________________________________________________

Substance Use:

☐ N/A  ☐ Alcohol  ☐ Marijuana  ☐ Opiates  ☐ Hallucinogens  ☐ Amphetamines  ☐ Cocaine  ☐ Benzodiazepines

☐ Prescription Drugs  ☐ Nicotine  ☐ Caffeine  ☐ Other: ________________________________

Criminal Justice System Involvement: ☐ No  ☐ Yes: ________________________________

Significant Medical History and Diagnoses: __________________________________________

______________________________________________________________________________

Currenty taking psychotropic medications: ☐ No  ☐ Yes

**REFERRING PROVIDER: CONTACT INFORMATION**

Name of provider making referral: ____________________________________________

Address: ________________________________

City: ____________________ State: _____ Zip: _____ Office Phone: ________ Office Fax: ________

Alternative Preferred Phone Number: ____________

Please fax referral form to BHR at (360)292-4249 (Children) or (360)438-2926 (Adults) along with:

☐ Relevant Clinical Notes  ☐ Current Medication List  ☐ Last Laboratory and/or Other Pertinent Tests
### Behavioral Health Resources Primary Care Provider (PCP) Feedback Form

#### REFERRING PROVIDER: CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Name of provider making referral:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td>Office Phone:</td>
<td>Office Fax:</td>
</tr>
</tbody>
</table>

#### CLIENT

<table>
<thead>
<tr>
<th>Client's Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian:</td>
<td>Relationship to the Client:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>County:</td>
</tr>
<tr>
<td>Primary Phone:</td>
<td>Other Phone:</td>
</tr>
</tbody>
</table>

#### OUTCOME OF REFERRAL

- [ ] Client does not have appropriate funding - No outreach made
- [ ] Client lives outside the Thurston-Mason BHO - Referred to service provider in client’s BHO
- [ ] No response to phone outreach
- [ ] Information provided - Client declined services
- [ ] Information provided - Client will walk in for assessment
- [ ] Intake completed
  - Date of Assessment: 
  - Outcome of Assessment: [ ] Client does not meet Access to Care Criteria  [ ] Client meets Access to Care Criteria
  - Assigned Clinician: 
  - Qualifying Diagnosis: 
  - Date and Time of First Scheduled Appointment: 
- [ ] Other:

#### MEDICATION MANAGEMENT FOLLOW UP

- [ ] A referral for Medication Management through BHR was made at the time of the Intake Assessment.
  - Assigned Provider: 
  - Date and Time of First Scheduled Appointment: 
- [ ] A referral for Medication Management through BHR was not made at the time of the Intake Assessment. The client’s assigned clinician will continue to evaluate, in coordination with his or her supervisor and BHR’s medical team, whether sufficient symptom abatement can be achieved with counseling interventions, whether referral back to a Primary Care Provider is warranted, or whether a referral for Medication Management through BHR is appropriate.
- [ ] Other:

---

If you have additional questions or concerns, please contact the Clinical Manager of Adult Services or Child, Youth, and Family Services at (360) 704-7170
PCP’s Role in Children’s Behavioral Health Care
Enhancing Pediatric Mental Health Care: Algorithms for Primary Care

In 2004, the American Academy of Pediatrics (AAP) Board of Directors appointed the Task Force on Mental Health and charged it to assist pediatricians and other primary care clinicians in enhancing the mental health care they provide. The task force determined that 3 goals were important to accomplishing its purpose:

Goal 1: Facilitate system changes
Goal 2: Build skills
Goal 3: Incrementally change practice

The task force recommended addressing the goals sequentially; that is, before implementing the clinical process proposed in this report, clinicians need to (1) accomplish system changes such as payment for mental health services provided by primary care clinicians and development of clinical relationships with mental health specialists, (2) achieve mental health competencies, and (3) enhance their office systems by applying chronic care methods to the care of children with mental health problems. Strategies the task force used to address these goals are summarized in the introduction to this supplement.

In this report, the task force proposes a clinical process for delivering mental health services in pediatric primary care settings. The report summarizes key features of this clinical process, then provides algorithms developed in collaboration with informaticians from the AAP Council on Clinical Information Technology; these algorithms are intended to ensure clarity of the proposed process and facilitate its translation to electronic systems. Appendix S5 lists procedural codes that can be used in billing for each step of the process. An accompanying toolkit to assist with implementation is scheduled for distribution in spring 2010.

The concepts and process proposed in this report were developed by consensus of 4 groups, the members of which are listed in

*Throughout this document, the term “primary care clinicians” is intended to encompass pediatricians, family physicians, nurse practitioners, and physician assistants who provide primary care to infants, children, and adolescents.
†Throughout this statement, the term “mental” is intended to encompass “behavioral,” “neurodevelopmental,” “psychiatric,” “psychological,” “social-emotional,” and “substance abuse,” as well as adjustment to stressors such as child abuse and neglect, foster care, separation or divorce of parents, domestic violence, parental or family mental health issues, natural disasters, school crises, military deployment of children’s loved ones, and the grief and loss accompanying any of these issues or the illness or death of family members. It also encompasses somatic manifestations of mental health issues, such as fatigue, headaches, eating disorders, and functional gastrointestinal symptoms. This is not to suggest that the full range or severity of all mental health problems is primarily managed by pediatric primary care clinicians but, rather, that children and adolescents may suffer from the full range and severity of mental health conditions and psychosocial stressors. As such, children with mental health needs, just as children with special physical and developmental needs, are children for whom pediatricians, family physicians, nurse practitioners, and physician assistants provide a medical home.
Appendix S6. These members recognized that the “primary care advantage” is the opportunity for longitudinal relationships with children and families—relationships that engender the trust to raise difficult issues and provide clinicians the insight necessary to note changes or concerns of their own. The psychiatry literature validates that a trusting therapeutic alliance predicts a person’s engagement in care for mental illness and a favorable outcome of that care over and above any specific treatment including medications.8

KEY FEATURES OF THE RECOMMENDED PROCESS FOR ADDRESSING CHILDREN’S MENTAL HEALTH NEEDS IN PRIMARY CARE SETTINGS

The task force members determined that the primary care process for mental health care should:

- Build on the unique skills of primary care clinicians and the unique opportunities of the primary care setting. These opportunities include promotion of social-emotional health and resilience in children and families; recognition of adverse childhood experiences and environmental stressors associated with emotional and behavioral problems in children and adolescents; intervention to prevent mental health problems and/or to address emerging mental health problems; and care of children with mental health disorders in a non-stigmatizing and supportive medical home, coordinated with mental health specialty services, school, child care, and social services. Among the most important of the primary care opportunities is the primary care clinician’s capacity to have a positive impact on a child’s mental health problems without knowing precisely the child’s diagnosis: evidence-based “generic” or “common-factors” interventions (see Table 1).

- Fit the rapid pace of primary care practice and not place additional burdens on clinicians already stressed by a full agenda and productivity requirements.

- Normalize conversations about mental health and substance use to communicate the importance of children’s mental health, signal the clinician’s openness to mental health concerns, and destigmatize mental health/substance use topics.

- Reflect confidence in the child’s and family’s capacity to be or to become mentally healthy or to maximize function in the face of mental illness. Rather than the traditional medical model, which focuses solely on problems and risks, a process for effective mental health care builds on child and family strengths and protective factors. (For more information, see Table 2 and Fig 1 in the accompanying task force report, “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community.”)

TABLE 1 Generic or Common-Factors Interventions: HELP

| H | Hope: increase the family’s hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family. |
| E | Empathy: communicate empathy by listening attentively. |
| L | Language: use the child or family’s own language to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions. |
| P | Permission: ask the family’s permission for you to ask more in-depth questions or make suggestions for further evaluation or management. |
| L | Loyalty: communicate loyalty to the family by expressing your support and your commitment to help. |

Considerable evidence suggests that medical generalists can readily learn and retain these techniques.12–14
- Incorporate tools for assessing the functioning of the child and family—routinely during health supervision visits, when faced with social-emotional challenges or symptoms, and periodically to monitor progress in mental health care.

- Take into consideration the many factors that may impede families from seeking or using mental health services for their children (eg, stigma, family conflict or dysfunction, cultural differences in conceptualizing mental health problems, a sense of hopelessness about recovery, inadequate financial resources or insurance coverage, or inaccessibility of specialty mental health services).

- Provide for effective partnership of primary care clinicians, families, mental health professionals, developmental-behavioral and adolescent specialists, educators, and agency personnel in both the assessment and care processes (see the accompanying task force reports “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” and “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice”). It is critically important that relationships and procedures, worked out in advance, include protocols for sharing information among health professionals, schools, and agencies and for managing psychiatric and social emergencies identified by the primary care clinician.

- Reflect the many factors that contribute to decision-making about mental health care, including urgency of the needs, comfort of the primary care clinician, family preferences, and access to resources.

- Be consistent with evidence-based best practices, to the extent the evidence exists.

- Reflect the prevalence of substance use among children and adolescence, not just of illegal substances but prescription drugs that are readily accessible in many households (see Table 3). Not only do substances have a direct effect on the developing brains of young people and on their behavior, but their use also has an indirect effect through association with violence, car crashes, sexual activity, interpersonal conflict, and academic failure.

- Recognize the chronicity of many mental health problems in childhood and adolescence and incorporate evidence-based principles of chronic care management, such as those applied to asthma and diabetes, without losing sight of each child’s potential for recovery (see “Strategies for Preparing a Primary Care Practice”).

- Ensure appropriate payment of primary care clinicians.

For definitions, see the introduction to this supplement.

**ALGORITHMS THAT DESCRIBE THE PROCESS**

The following algorithms represent an idealized process for the mental health care of children in primary care settings. The figures in the algorithm do not represent a particular time frame: several steps in the process may take place at 1 contact, and 1 step in the process may require several contacts. For points at which data from outside sources are needed or referrals are

**TABLE 2** Protective (Resilience) Factors in Children and Youth

<table>
<thead>
<tr>
<th>Demonstrates physical, cognitive, emotional, social, and moral competencies</th>
<th>Engages in behaviors that promote wellness and contribute to a healthy lifestyle</th>
<th>Forms caring, supportive relationships with family, other adults, and peers</th>
<th>Engages in a positive way with the life of the community</th>
<th>Displays a sense of self-confidence, hopefulness, and well-being</th>
<th>Demonstrates resiliency when confronted with life stressors</th>
<th>Demonstrates increasingly responsible and independent decision-making</th>
</tr>
</thead>
</table>


**TABLE 3** Trends in Monthly and Annual Prevalence of Use of Various Drugs in Grades 8, 10, and 12

<table>
<thead>
<tr>
<th>8th-Graders, %</th>
<th>10th-Graders, %</th>
<th>12th-Graders, %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Year</strong></td>
<td><strong>Previous 30 d</strong></td>
<td><strong>Previous Year</strong></td>
</tr>
<tr>
<td>Alcohol: 30.3</td>
<td>Alcohol: 14.9</td>
<td>Alcohol: 52.8</td>
</tr>
<tr>
<td>Drunk: 12.2</td>
<td>Drunk: 5.4</td>
<td>Drunk: 31.2</td>
</tr>
<tr>
<td>Marijuana: 11.8</td>
<td>Marijuana: 6.5</td>
<td>Marijuana: 26.7</td>
</tr>
<tr>
<td>Inhalants: 8.1</td>
<td>Inhalants: 3.8</td>
<td>Inhalants: 3.8</td>
</tr>
<tr>
<td>Amphetamines: 4.1</td>
<td>Amphetamines: 1.9</td>
<td>Amphetamines: 7.1</td>
</tr>
<tr>
<td>OTC cough/cold medications: 3.8</td>
<td>OTC cough/cold medicines: 6.0</td>
<td>OTC cough/cold medications: 5.9</td>
</tr>
<tr>
<td>Tranquilizers: 2.9</td>
<td>Cigarettes: 6.5; smokeless tobacco: 3.7</td>
<td>Cigarettes: 13.1; smokeless tobacco: 6.5</td>
</tr>
</tbody>
</table>

OTC indicates over-the-counter.

*a* Prescription medication.
made, the process will necessarily extend to a return visit. A number of activities may occur before or after an encounter, such as preencounter parent/youth reports with validated tools. The task force invites clinicians to develop their own pace, informed by available resources, practice capacity, patient preferences, and circumstances.

Algorithm A (Fig 1) provides a framework for promoting social-emotional health and identifying and responding to new mental health concerns, whether raised by parents in scheduling the visit or suggested by the data-collection and assessment activities described. The ongoing care of children with identified mental health concerns is addressed in Algorithm B.

The task force suggests that primary care clinicians consider a sequence of implementation that begins with Algorithm B, ensuring sound procedures for managing children with identified conditions before attempting to identify additional children with occult mental health needs. (See “Strategies for Preparing a Primary Care Practice”9 for rationale and further discussion.)

Algorithm A: Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care

A1a: Visit (Prenatal, Nursery, or Primary Care) Scheduled

Scheduling of any visit at any age can trigger data-gathering in advance of the visit, as described in step A2a.

A2a: Collect and Review Previsit Data

To create efficiency during scheduled visits, clinicians can adopt the use of a previsit questionnaire, either paper or electronic, filled out at the patient’s home or in the waiting room. This questionnaire can incorporate validated instruments to screen for mental health problems and assess psychosocial functioning; these tools can be scored or interpreted before the visit. Such an approach enables the clinician to focus on building rapport and exploring findings rather than on rote data-gathering, while still being systematic in obtaining information. Such an approach is particularly important if a visit is scheduled for 1 of the following reasons:

- the parent or child has a mental health concern;
● the clinician has previously identified a mental health concern (e.g., at an acute care or emergency department visit) and asked the child to return for further assessment;
● the child is in foster care or the juvenile justice system or, for any reason, is at increased risk for psychosocial problems (e.g., homelessness, school dropout, death of a loved one, exposure to violence or other adverse childhood experience, parental mental illness);
● the child’s child care provider or teacher has expressed concern about the child’s development or behavior (or the child has been suspended or expelled); or
● the child has a chronic medical condition or disability that places him or her at greater risk than other children for mental health problems.†

A structured process, developed by the practice in advance (see “Strategies for Preparing a Primary Care Practice”5), should ensure that the following content is covered:
● the family’s priorities for the visit;
● family/social history (including stresses, support system, environmental risk assessment, trauma, separation, and loss);
● identification of the child’s and family’s strengths;
● functional assessment of the child and family by using validated instruments (see discussion in Supplemental Appendix S12);
● temperament19 and risk behaviors;
● school or child care reports, particularly if school or child care personnel have expressed concerns; and
● appropriate validated screening tool(s) for age (see discussion in Supplemental Appendix S12).

Electronic questionnaires provide an opportunity for the use of “item responses.” For example, the computer asks the respondent 2 or 3 basic questions. If the answer is no to those questions, the respondent moves on; if the answer is yes, the computer asks more questions. If previsit data collection is not feasible, the clinician will need to incorporate data collection into the clinical encounter. In this case, exploration of positive findings may require a follow-up encounter.

A3a: Provide Initial Clinical Assessment; Observe Child-Parent Interactions

During the face-to-face encounter, the primary care clinician can complete the following steps:
● Identify, elicit, or review the child’s and family’s priorities for the visit.
● Review previsit questionnaire, other data collected, progress on any previous concerns, and adjustment and progress in child care, preschool, or school.
● Broaden the agenda by indicating openness to mental health issues. For example, elicit further information about any current concerns, the child’s or family’s past or current sources of care for the concerns, and progress on previous concerns; if screening tools have been completed, use any positive responses as a springboard to further discussion and clarification. Ask broad, open-ended questions such as, “What has been the hardest part about taking care of Jonah?” followed by, “What has been the best part?” Such questions convey the clinician’s interest in family functioning and invite vexing questions that may have been posed to relatives and friends but may have not been felt appropriate for this medical setting. Whatever methods are used to gather information, include inquiry about parental well-being (looking particularly for problems with parental mood, affect, or attachment to the child), the child’s developmentally specific symptoms of emotional disturbance (see Table 1 in Supplemental Appendix S13), and the child’s and family’s strengths (see step A4a).
● Observe parent-child interaction.20,21
● Interact with the child.
● Complete interview and physical examination (including vision and hearing screening, because a sensory deficit may cause academic or behavioral difficulties).
● Identify the child’s and family’s strengths.

Primary care clinicians can gain additional insights from examining their own reaction to the parent and child and considering the family’s cultural context.22,23

Additional physical assessment may be indicated in response to mental health concerns. Developmental disorders, epilepsy, sleep disorders, and endocrine disturbances are among conditions that may first manifest with behavioral or emotional symptoms. The extent of the physical examination and related testing depends on the type and severity of concerns raised. Repeated somatic complaints or exacerbation of a chronic medical condition may be the initial presentation of an emotional difficulty, so these symptoms may prompt further mental health assessment. Interpretation of findings may vary according to age. For example, physical symptoms, such as growth failure, might signal mental or emotional concerns in infants and young children. During middle childhood, academic difficulties can signal
mental health concerns or learning disabilities. In adolescents, school dropout or risky behaviors such as sexual activity or substance use may be associated with mental health problems. See Table 2 in Supplemental Appendix S13 for additional information.

At this point in the algorithm, the clinician need not feel pressed to make a diagnosis but simply to determine if there may be a mental health concern in the child or family.

The increasing independence of adolescents, and the likelihood that parents and guardians may not be fully aware of their adolescents’ activities or feelings, reinforce the need for private, confidential discussions between clinicians and their adolescent patients. These discussions should augment, not replace, discussions with parents. Youth and parents differ in their ability to report on various mental health conditions: a parent may have a more accurate picture of the effects of externalizing symptoms (eg, hyperactivity, inattention, oppositionality), whereas youth may be better able to articulate the toll of internalizing symptoms or conditions (eg, anxiety or depression); or the youth and parents may disagree about the nature or importance of symptoms. As part of these discussions, clinicians are obliged to address confidentiality and its limits with both adolescents and their parents.24,25

A4a: Acknowledge and Reinforce Strengths

Effective mental health care requires that clinicians move from a medical model focused on problems to a more comprehensive view of the child’s and family’s capacities. There are 8 empirically determined independent “intelligences”: linguistic, logical-mathematical, spatial, bodily kinesthetic, musical, interpersonal, intrapersonal, and naturalistic.26 Acknowledging strengths (≥1 of these intelligences; talents; qualities such as resilience, generosity, courage, tenacity, goal-orientation, focus; social supports such as strong family bonds, extended family support, or good peer relations; healthy behaviors such as regular exercise/sleep routines, participation in extracurricular or spiritual/religious activities; or attitudes such as hope, optimism, and motivation to seek help) can build rapport, provide groundwork for an intervention plan, and facilitate accomplishment of subsequent steps.27 Diagnosing strengths may also stimulate the family to provide further opportunities for the child’s development of competence, serving as a buffer for the challenges and peer pressures of adolescence and offering alternatives to risky activities.27

A5a: Concerns (Symptoms, Functional Impairment, Risk Behaviors, Perceived Problems)?

No, There Are No Concerns

If the child and family show no signs of functional impairment or distress and no risk behaviors are identified and no mental health concerns are raised by the family, derived from screening or perceived by the clinician, the clinician can move to step A6a.

Yes, There Are Concerns

Any positive findings (functional impairment; symptoms concerning to the child, family, or clinician; family distress; family member with mental illness; exposure to trauma; environmental risks such as a weapon in the home of a child with suicidal or homicidal thoughts; risky behaviors; or perceived problems) necessitate further attention by the clinician, beginning with step A8a below.

A6a: Provide Anticipatory Guidance for Age per Bright Futures, Connected Kids, or KySS

Strategies to promote mental health and provide anticipatory guidance appropriate to the child’s age are provided in Bright Futures,26 Connected Kids,29 and KySS (Keep Your Children/Yourself Safe and Secure).30 See also “Strategies for Preparing a Primary Care Practice”5 and Appendix S2 and Appendix S7 for parenting resources and evidence-based programs for promoting mental health and enhancing school success.

A7a: Return to Routine Health Supervision

Clinicians can broaden the agenda to other issues and return to step A1a at the next scheduled contact.

A1b: Acute Care Visit

Because families sometimes miss routine health supervision visits, clinicians who are interested in eliciting mental health concerns will increase their effectiveness if they use the opportunity of acute care visits to elicit mental health concerns.

A2b: Incorporate Brief Mental Health Update

The task force has drawn from the expertise of its professional members, opinions of its youth and family members, and informal trials in primary care practices to develop the recommendation that clinicians use acute care visits as an opportunity to perform a brief mental health update (see “Strategies for Preparing a Primary Care Practice”). There is a compelling need for further research to document costs and benefits of this approach and to establish best practice. The task force recognizes that incorporating a mental health update during acute care visits may be daunting in some practice environments. Clinicians might consider implementing acute
care mental health activities incrementally, beginning perhaps with children who have missed routine health supervision visits or those in certain high-risk groups, such as children in foster care. Alternatively, clinicians can use the context of the acute care visit (eg, an injury) to lead naturally into mental health topics (eg, “Had you or your friends been drinking when this happened?” or “Has this person [the perpetrator of the injury] ever threatened you or injured you before?”).

Because of the association between sleep difficulties and mental health conditions, questions regarding sleep are helpful throughout childhood. The wording of such questions is important to adolescents, who may have conflict with their parents around sleep issues. The task force recommends that clinicians avoid questions that require only yes or no answers and phrasing such as, “Are you getting enough sleep?” Instead, clinicians might ask, for example, “How hard is it for you to fall asleep when you want to?”

Responses to these questions provide information that can alert clinicians to the need for more extensive assessment. In the absence of any concern, 3 to 5 general questions can be completed in as many minutes. Appendix S8 provides examples. If a concern is identified, the clinician can express interest, triage for emergencies as in step 8a, and plan with the family to address the concern at a scheduled follow-up visit (step 1a). (The HELP mnemonic, shown in Table 1, provides guidance for engaging the family and closing the visit supportively.)

During adolescence, it is important that the clinician address questions to the patient in a private setting and explain the conditional confidentiality of the conversation. The clinician can question younger children privately, depending on practice protocols and the comfort of the patient and parent. In all instances, the clinician should also direct questions to the parents. Discrepancies in responses between the parent and child may signal different levels of awareness, varying perceptions of the importance of an issue, or family conflict that should be explored further.

Adolescents caution that questions on substance abuse and other sensitive topics may seem intrusive and be unlikely to yield a candid response during a brief mental health update. A framing statement such as, “Many young people I’m seeing feel lots of stress this time of year” or “…lots of pressure to use drugs,” or a circular question such as “Do any of your friends smoke, drink, or use other drugs?” may be better received than direct questions about the adolescent’s behaviors. If the clinician has cause for concern, such as deteriorating school performance or injuries, or if this is an issue that he or she is already following, more specificity is warranted. The Adolescent Health Working Group’s Behavioral Health: An Adolescent Provider Toolkit provides tools to aid in conversing with adolescents. The number 1 reason that teenagers do not disclose sensitive information is that clinicians do not assure them of confidentiality.32

A3b: Concerns?
These might be the child’s, the family’s, or the clinician’s concerns.

No, There Are No Concerns
Proceed to step A7b.

Yes, There Are Concerns
If mental health or substance abuse concerns are raised by parents, children, youth, or the clinician as a result of the brief mental health update, the process moves on to triaging for emergencies: step A4b/A8a.

A7b: Return to Acute Care Visit
If no concerns are raised, clinicians can acknowledge the child’s and family’s strengths and return to the acute care visit.

A4b/A8a: Emergency?
The presence of a mental health, substance use, or social-emotional concern triggers the triage process. Psychiatric and social emergencies include sexual or physical abuse, suicidality, threat of violence to or by the child, psychosis, addiction to or withdrawal from substances, acute intoxication, and family dysfunction or social circumstances that threaten the safety of the child (eg, domestic violence). Inadequate family resources (eg, homelessness or hunger) may also pose urgent health and safety risks. Supplemental Appendix S14 provides a tool for assisting in identifying suicide risk.

Primary care clinicians must have a system in place to ensure immediate evaluation of children with suicidal thoughts (see “Strategies for Preparing a Primary Care Practice” or themselves ask key questions regarding suicidal thoughts, presence of a plan, access to lethal weapons such as firearms, and support systems. On the basis of responses, the clinician can assess the level of risk and determine if immediate intervention is indicated.

No, Findings Do Not Suggest an Emergency
Go to box A6b.

Yes, Findings Suggest an Emergency
Go to A5b/A9a.

A6b: Return to Acute Care Visit; Plan to Enter Algorithm at Step A1a
If there are no findings that suggest a psychiatric or social emergency, apply the generic skills represented by the HELP mnemonic (Table 1). The plan may involve an incremental first step...
toward addressing a barrier or returning to the algorithm at step A1a.

**A5b/A9a: Facilitate Referral for Specialty Services or Emergency Facility; Reenter Algorithm at Appropriate Point (or A1a)**

The presence of certain psychiatric or social emergencies (e.g., suspicion of abuse or neglect, risk of homicide) may require immediate action mandated by state law (e.g., reporting to social services or legal authorities) and steps to protect the safety of anyone threatened by the emergency, as well as referral for psychiatric care. Ideally, procedures would have been established in advance with mental health specialty and social service providers in the community or region (see “Strategies for Preparing a Community” and “Strategies for Preparing a Primary Care Practice”). The clinician should provide medical care as indicated, follow procedures for notification of authorities, provide reassurance to the child and family about the clinician’s ongoing interest in the child and family, and put in place a plan to follow-up and provide other medical home services.

The clinician can facilitate sharing of information with mental health specialty or social service providers by obtaining written permission from the family for exchange of information. After receiving mental health specialty care and/or social services for the emergent issue(s), children who are up-to-date on routine health supervision ideally reenter the primary care process at step B1b of Algorithm B; those who are not up-to-date would ideally reenter at step A1a of Algorithm A. In either case, information about the child’s and/or family’s progress in mental health specialty treatment and/or social services is critical to primary care follow-up.

**A10a: Provide Initial Intervention; Facilitate Referral of Family Member for Specialty Services if Indicated**

If there are no signs of an emergent situation, the clinician can provide initial common-factors interventions (see Table 1, HELP mnemonic). The plan of action might require multiple visits and include any of the following elements, in accordance with the family’s wishes:

- Offer to provide advice, if wanted, on parenting techniques to address acute problems (e.g., toileting, homework, sibling conflicts, anger outbursts) and general steps the family can take to enhance the child’s and family’s mental health, such as improving sleep hygiene or nutrition, reducing time spent watching television or using electronic media, increasing outdoor time, increasing physical activity, learning stress management techniques, or scheduling a special time each day for the parent to give 1-on-1 attention to each child. Resources include Bright Futures in Practice—Mental Health, the American Academy of Child and Adolescent Psychiatry Web site, the AAP Healthy Children Web site, and AAP publications and brochures.

- Inquire about any traumatic events or losses in the life of the child and family that may have triggered the child’s symptoms or may be contributing to the child’s or family’s problems in coping. Examples of such events or losses include the death of a loved one; a move; homelessness; conflict, separation, or divorce of parents; military deployment of the parent(s) or other loved ones; incarceration of the child or a loved one; breakup of a relationship; abuse or bullying by the child or targeting the child; exposure to violence (either directly or emotionally, through death or injury of a loved one); or a natural disaster. It is necessary to inquire separately of youth and parents, because some events that affect children and adolescents may go unrecognized by the parent or be confidential from the parent, and some parents may be reluctant to discuss some events or losses in front of their children. In the case of trauma exposure, the clinician should allow the child to share his or her own narrative of the experience but not lead the child and family into reliving the incident, which may result in further trauma to those who experienced it. Children vary widely in their reactions to trauma and loss, depending on their developmental level, temperament, previous state of mental health, coping mechanisms, parental responses, and support system.

It is important for the primary care clinician to express empathy, to assess the functional impact of the loss or trauma on the child and family, to offer support, to put in place a mechanism for monitoring the child’s and family’s short-term and long-term progress, and to continue offering empathy and support with each contact. Guides are available to help clinicians in this process. If the impact is severe and/or persistent, it may be appropriate to offer counseling through a community referral.

If a family member has medical, mental health problems, using this approach in multiple visits may yield additional benefits. The clinician can monitor the child’s progress by enlisting the parents to observe for persistence or worsening of symptoms, by making telephone contact with the family at appropriate intervals, and/or by inquiring at the time of return visits.

**A11a: Further Diagnostic Assessment Needed?**

**No**

In the absence of functional impairment or indications of a specific, treatable condition, further assessment may not be necessary. Examples include a 10-year-old who is attending a new school and experiencing decreased sociability; an adolescent mother with mild anxiety; sleeplessness after a minor motor vehicle crash; increased parent-child conflict at a time of family stress; and flare-ups of chronic but relatively mild problems related to temperament or delayed social skills.

**Yes**

Indications for further diagnostic assessment include impaired functioning; screening results that suggest the probability of a disorder; symptoms that worsen or persist despite initial intervention; a parent or child who manifests distress out of proportion to findings; and clinician concern or discomfort.

**A12a: Collect and Review Data From Collateral Sources**

If findings point to academic or behavioral problems in school or difficulty with peers, primary care clinicians need information from the child’s school and/or child care provider. Office procedures should ensure that parents of school-aged children complete a form that authorizes the school and primary care clinician to exchange information. Specifically, the primary care clinician is looking for details about the child’s functioning in the school setting and any discrepancy between cognitive ability and academic achievement that would suggest a learning disability. Developing a community understanding about the role of school personnel in collecting data for primary care clinicians and the role of primary care clinicians in informing school personnel about students’ medical and mental health needs greatly facilitates interaction between the primary care clinician and school personnel (see “Strategies for Preparing a Community” and “Strategies for Preparing a Primary Care Practice”). The primary care clinician can also request information about preschool-aged children from their child care provider(s).

If parents are separated, divorced, or in conflict, it is important to gather information from the parent who is not represented at the visit, if that parent is involved in the child’s life. If a grandparent, foster parent, or other guardian is involved in the care of the child, information from this individual is also important. Several validated tools have parent versions that can be used for this purpose (see Supplemental Appendix S12). Use of a tool does not substitute for including this caregiver in future discussions involving the child.

If there has been previous involvement of other agencies or health professionals with the child or family, clinicians need to obtain the youth’s and family’s (or guardian’s) consent to request records from these sources. For children in foster care, it is critically important to work through case workers to collect information from biological and foster parents if adults who are unfamiliar with the child’s history accompanied the child to the visit.

**A13a: Proceed to Algorithm B**

Algorithm B (Fig 2) describes the process of further assessment and care for children who present with or manifest mental health concerns that negatively affect their functioning and/or do not respond to initial intervention.

For some children and families, the need for additional assessment will cause increased anxiety, and some may respond to this anxiety with re-
Clinicians can comfort and reassure the child and family by fully understanding the family’s opinions, preferences, cultural perspective on seeking mental health care, resources (including health insurance coverage), and priorities; establishing agreement on the nature and implications of current concerns and the family’s readiness to seek further consultation or treatment; emphasizing strengths and assets; and rolling with resistance to further assessment (e.g., by offering a follow-up conference to discuss further if the family is not ready). If the assessment process is deferred to a subsequent visit because of time pressures, the need to collect further information, or the family’s lack of readiness, then clinicians may choose to follow-up with a telephone call. It is important to use office tracking mechanisms to ensure follow-up of children and families who are not yet ready to take action (see “Strategies for Preparing a Primary Care Practice”).
Algorithm B: Assessment and Care of Children With Identified Social-Emotional, Mental Health, or Substance Abuse Concerns, Ages 0 to 21 Years

B1a: Further Assessment Needed for Mental Health/Substance Abuse Concern

Enter the algorithm at this point if a social-emotional or mental health concern or functional impairment has been previously identified by the primary care clinician; if symptoms identified by screening instruments, questionnaire, interview, or observation suggest the probability of a disorder and/or do not respond to the initial intervention; or if the parent or child manifests distress out of proportion to findings. In making this decision, consider the persistence and severity of the problem and the family’s and child’s readiness to seek help. If the family or child is not ready to seek help, apply common-factors techniques (see the HELP mnemonic in Table 1) to reach agreement on an incremental step.

B1b: Child Receiving Mental Health/Substance Abuse Specialty Services

Enter the algorithm at this point if the child is currently involved in mental health specialty care. The primary care clinician can express interest in collaborating with the mental health specialist(s) and move on to step B2b/B4a. If the primary care clinician meets resistance, he or she can explore its roots as in Algorithm A, step A10a.

B2a: Who Will Provide Further Assessment?

At this point the clinician will consider findings from earlier steps in the process, his or her own competence to provide further assessment in the area(s) suggested by earlier findings; and family preferences and resources, including health insurance benefits and any health plan requirements for accessing mental health services. The task force offers the following as general guidance.

Children Younger Than 5 Years of Age

The task force has developed guidance for primary care clinicians in assessing and responding to social-emotional problems in children younger than 5 years of age and disturbances in parent-child relationships. This guidance includes indications for referral to a developmental-behavioral pediatrician, mental health specialist with expertise in early childhood, therapist for the parent or the parent-child dyad, specific professional (eg, speech pathologist), developmental evaluation team, or other community resource.

Every community in the United States has an agency assigned by the state to provide Early Intervention (EI) services. These include assessment and care coordination, as mandated by the Individuals With Disabilities Education Act (IDEA), for children from birth to 3 years of age with developmental problems; however, general and subspecialty pediatric assessment are often not included in the EI assessment process. Children 0 to 3 years of age who qualify for services (occupational, physical, or speech therapy; education) must receive them in the least restrictive environment (usually their home) on the basis of their documented delay in language, motor, personal social, and/or adaptive domains. Some states extend EI services to 0- to 36-month-old children who are at risk for developmental problems, as well as those with diagnosed problems. The IDEA specifies that states receiving certain categories of federal funding must provide assessment and an Individual Family Services Plan to all 0- to 3-year-olds who are substantiated as abused or neglected or who are identified as affected by illegal substance abuse or withdrawal symptoms that result from prenatal drug exposure. Developmental and educational services for children aged 3 to 5 years are also mandated and regulated by the IDEA. In most states, the public school system is responsible for developmental assessment and education of children with significant delays, whereas in other states, the EI programs continue to provide assessment and services for this age group.

Examples of problems that require further evaluation by 1 of these resources include disordered parent-child relationship, parental mental illness, language or communication delay, disruptive behavior with aggression, abuse or neglect of the child, and self-injury. See “Strategies for Preparing a Primary Care Practice”5 and Appendix S2 for evidence-based interventions for infants and young children, their parents, and/or caregivers. High-quality child care and preschool have a protective long-lasting benefit, especially for children at high developmental and behavioral risk; clinicians may also refer to these programs. When community resources are insufficient or ineffective, primary care clinicians can partner with developmental-behavioral pediatricians, early childhood educators, parent educators, and mental health providers to build or strengthen the critically important service system for this population.

Children Aged 5 to 21 Years

Primary care clinicians should consider referring to a mental health specialist for further evaluation children aged 5 to 21 years of age with 1 or more of the following problems:

- suicidal intent;
- severe functional impairment;
- rapid cycling mood;
- depressive symptoms in a preadolescent;
• extreme outbursts/problems with conduct;
• severe eating problems;
• psychotic thoughts or behavior;
• self-injury;
• comorbidity of substance abuse and mental health problems;
• a score of 2 or more on the CRAFFT (car, relax, alone, forget, friends, trouble) screening tool;
• attention-deficit/hyperactivity disorder (ADHD) with comorbidities; and
• any other problem that the clinician does not feel prepared to address.

Primary care clinicians with requisite competencies can effectively assess children 5 to 21 years of age with mild-to-moderate levels of functional impairment associated with the following symptom clusters:
• anxiety;
• inattention and impulsivity;
• disruptive behavior and aggression;
• depression;
• substance use; and
• learning difficulties.

Tools developed by the task force outline primary care assessment of children with symptoms in each of these clusters and suggest specific indications for specialty referral of children who experience symptoms in that cluster.

**B3a: Facilitate Referral to Specialist(s) for Further Assessment**

Clinicians in a wide range of disciplines can provide diagnostic assistance in these situations, including developmental-behavioral pediatricians, neurodevelopmental pediatricians, adolescent medicine specialists, pediatric neurologists, psychiatrists, EI specialists, clinical psychologists, school psychologists, clinical social workers, advanced practice nurses with specialized psychiatric training, and substance abuse specialists. These professionals may practice in public mental health or developmental clinics, in schools, in private practice, or in university settings.

If a mental health referral will require authorization by the family’s health insurance plan; entry into a carved-out, or parallel, private behavioral health insurance plan; or entry into the public mental health system, the family will likely need guidance and time to research the options. If so, the clinician can bring the visit to a close (again following the HELP mnemonic [Table 1]) and schedule a return visit or an appointment with a staff member to facilitate this process.

The decision to involve a specialist in diagnostic assessment means that the primary care clinician’s role will include communicating with the specialist. As with any other specialty referral, the process is enhanced by conveying to the specialist the nature of the concern and the primary care clinician’s specific questions, results of previous assessment and intervention efforts, and openness to discussion with the professional. Although the Health Insurance Portability and Accountability Act (HIPAA) allows exchange of information among professionals who are involved in the care of a mutual patient, many mental health professionals are reluctant to share information without express consent of the child and family. By obtaining written consent and sending it to the mental health professional, the primary care clinician can convey interest and facilitate communication.

Established relationships with specialists greatly facilitate the primary care clinician’s role in making an effective referral. The *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit* and the AAP Task Force on Mental Health reports “Strategies for Preparing a Community” and “Strategies for Preparing a Primary Care Practice” have a number of suggestions for building these relationships at the practice, community, regional, and state levels. Integration of a mental health professional within the primary care practice is a model that has particular promise. Primary care clinicians will likely experience growth in their own comfort and competence as a result of interaction with mental health professionals.

It is critical that the practice track children referred for specialty care. If the family is unsuccessful in acquiring a timely assessment for the child, the primary care clinician can offer generic intervention efforts (as described in Algorithm A), further primary care assessment and management strategies, or periodic telephone contacts to monitor for worsening or emergent problems. It may be necessary in some instances to use emergency procedures to obtain needed services.

**B2b/B4a: Collect Reports and Recommendations**

After requesting the (youth’s and) family’s permission to gather information from other professionals and agencies involved with the child, the primary care clinician can send requests.

**B5a: Provide Mental Health Assessment**

The primary care clinician and family may decide to proceed with assessment by the primary care clinician if the child or adolescent does not show signs of severe impairment and if the clinician feels comfortable with further steps in the assessment process, given the presenting symptoms. Using existing guidelines (eg, ADHD guidelines from the AAP, *Guidelines for Adolescent Depression in Primary Care* [GLAD-PC], and “Treatment Recommendations for the Use of Antidepressants in Children” from the AAP Task Force on Mental Health reports “Strategies for Preparing a Community” and “Strategies for Preparing a Primary Care Practice,” and “Strategies for Preparing a Community”).
psychotics for Aggressive Youth (TRAAY)\textsuperscript{51,52}; practice parameters\textsuperscript{53,54}; and expert opinion of task force members, the task force developed guidance to assist clinicians in further assessment of children with positive screening results or clinical findings that fall into the following clusters of symptoms:

- social-emotional problems in children from birth to 5 years of age
- anxiety;
- depression;
- inattention, impulsivity;
- disruptive behavior, aggression;
- substance use; and
- learning difficulties.

\textbf{B6: Interpret Findings to Family (and Youth as Appropriate); Convey Hopefulness About Treatment and Recovery}

This is a critical point in the process. As the provider of medical home services, the primary care clinician has a role in interpreting diagnostic findings to the family, educating the family about the child’s condition, reinforcing child and family strengths, and creating a sense of hopefulness about treatment and recovery. This conversation is critical regardless of whether or not the family will seek specialty care and may, in fact, contribute to the family’s readiness to seek that care. To facilitate this conversation and to offer some strategies for initiating care immediately, the task force has drawn from the common elements of effective psychosocial interventions to provide guidance in the primary care management of common symptom clusters (listed above).

The suggestions outlined in the cluster guidance do not replace specialty care but can offer the family some relief while awaiting specialty care or while achieving greater readiness to seek care. In some situations, particularly those that involve emerging conditions or conditions associated with mild functional impairment, these interventions may themselves constitute effective treatment.

If a specialist has been involved in the diagnostic process, the clinician may choose to invite this individual to the conference, depending on family preferences and logistic considerations. Some children with severe emotional disturbance may have a mental health or EI care manager involved in their care; if so, his or her participation is critically important to the process. The care manager may organize periodic meetings of teachers, social workers, and agency representatives involved with the child and family. In the mental health specialty system, such processes are part of a system-of-care approach—an evidence-based care-coordination system built around the family’s strengths and priorities (see “Strategies for Preparing a Community”\textsuperscript{5} and “Strategies for Preparing a Primary Care Practice”\textsuperscript{5}). If so, the primary care clinician (or his or her staff representative), although often inadvertently omitted, would likely be a welcome addition; joining that team may substitute for convening a primary care conference. Although participation in such activities is time-consuming, it may ultimately produce efficiencies in the care of children and adolescents with complex conditions.

If the inclusion of involved specialists is not feasible, the primary care clinician needs previous information from them to ensure understanding of the child’s problems and to discuss the options for further care with the family (and youth, as appropriate). It is important that the family not be placed in the position of transmitting information between professionals who are involved in their child’s care.

Families also may use this opportunity to inform and educate the clinician about the various facets of the child’s condition and specific preferences regarding treatment options.

\textbf{B7: Specialty Care § Needed?}

The answer will depend on clinical circumstances, family preferences, and the clinician’s comfort. If a child is in foster care, the decision may also depend on the preference or policy of the child welfare agency that is overseeing the child’s care.

To facilitate this conversation, the primary care clinician needs current information about evidence-based interventions appropriate to the child’s condition. Appendix S2, “Evidence-Based Child and Adolescent Psychosocial Interventions,” includes succinct and reliable sources for this information. The primary care clinician also needs to convey his or her own level of comfort with the child’s problem and its severity and the level of consultation and support available.

If the child’s problems fall into multiple diagnostic domains but there is a predominant area of concern, the clinician, in concert with the youth and/or family, may decide to address the predominant concern first. The clinician and family may decide to initiate care within the primary care setting and reassess the need for consultation at a later date. Depending on the child’s and family’s level of readiness to seek help, the primary care clinician can apply common-factors methods (see Table 1) to reach consensus on the next steps, which may involve implementing general management strategies or specific treatment by the primary care clinician or the involvement of specialist(s). If the family wishes to seek specialty care, the primary care clinician has a role in providing care until the child connects with the specialist and then collaborating with specialist(s) to monitor the child’s progress.

\textsuperscript{§}See definition, Appendix S9.
If the clinician and family decide to involve 1 or more specialists, there are a variety of collaborative models that can be developed (see “Strategies for Preparing a Primary Care Practice”). If the primary care clinician will be the sole provider of mental health care, the process continues at step B10.

**B8: Facilitate Involvement of Specialist(s)**

This step is similar to step B3a, in which the clinician and family choose to involve 1 or more specialists in assessment. If the child is younger than 5 years, the primary care clinician should consider referring him or her for an assessment by a developmental-behavioral pediatrician, mental health specialist with expertise in early childhood, a specific professional (eg, speech pathologist), and/or a developmental evaluation team. The local EI agency provides intervention and care-coordination services for children from birth to 3 years of age in addition to assessment as described in step B3a; this agency or another, such as the public school system, provides care coordination and education of children aged 3 to 5 years to comply with the IDEA. For children aged 5 to 21 years, the primary care clinician can involve a developmental-behavioral pediatrician, adolescent specialist, or mental health or substance abuse professional, depending on accessibility and family resources.

If mental health referral will require authorization by the family’s health insurance plan; entry into a carved-out, or parallel, private behavioral health insurance plan; or entry into the public mental health system, the family will likely need guidance and time to research the options; if so, the clinician can bring the visit to a close (again following the HELP mnemonic [Table 1]) and schedule a return visit or an appointment with a staff member to facilitate this process.

The decision to involve a specialist or agency in treatment means that the primary care clinician’s role will include communicating with other care providers. The process is enhanced by conveying to the referral source the results of previous assessment and intervention efforts and openness to discussion with the professional who will provide therapy. Although the HIPAA allows exchange of information among professionals involved in the care of a mutual patient, many mental health professionals are reluctant to share information without express consent of the child and family. By obtaining written consent (or, for children in foster care, enlisting the case worker’s help in obtaining written consent of the legal guardian) and sending it to the mental health professional, the primary care clinician can convey interest and facilitate communication.

As with referrals for diagnostic assessment, it is critical that the practice track children who have been referred for specialty treatment. If the family is unsuccessful in acquiring treatment in a timely way, the primary care clinician can offer to continue generic intervention efforts (as described in Algorithm A), initiate treatment, or make periodic telephone contacts to monitor for worsening or emergent problems. It may be necessary in some instances to use emergency procedures to obtain needed services.

**B9: Collect Reports and/or Convene Team to Review**

Once the specialist has met with the child and family to develop treatment recommendations, the primary care clinician needs feedback. Forms for exchange of information may facilitate this process (see “Strategies for Preparing a Primary Care Practice” and Appendix S11). Telephone and e-mail contacts may be helpful in some instances. Alternatively or additionally, the clinician may invite other providers of care (including case workers for children in foster care) to participate in a face-to-face meeting with the family. For children in the foster care system it is critically important not only to collect information from case workers but also to convey information back to the worker. If the child changes placement and the caregivers are unaware of what happened in the pediatrician’s office, the child does not receive the benefit of continuity of care in the new placement.

**B10: Collaboratively Develop a Family-Centered Care Plan**

This process requires that the professionals involved reach consensus with the family and with each other about a comprehensive plan of care. The focus of the care plan is seeking improvement in the child’s overall emotional health and functioning. The care plan articulates the child’s and the family’s goals; child and family strengths; service and educational needs; the roles of involved service providers, family members, and other caregivers; plans for follow-up and routine health supervision; plan for emergencies, if they should occur; and, ultimately, plans for self-care and/or family care, transition to adult primary care and specialty health services, and the other services and care coordination needed to support the young person’s achievement of his or her educational, social, and vocational goals in adulthood. Ideally, the family, other caregivers, school personnel, case workers, and service providers participate in the plan’s development, either by attending the conference or contributing recommendations before the conference. Together, they can set the timetable, determine need for involvement of
additional or alternative specialist(s), and select interventions. They can also establish a plan for monitoring treatment response and safety and create a common understanding of limits of confidentiality. For adolescents, direct input to the plan is critical for engagement and the success of treatment.

For children previously involved in mental health specialty care, a care plan may be in place and may omit primary care issues, such as healthy lifestyle (eg, nutrition, exercise, sleep, stress management, social support), routine health supervision, or care of chronic medical conditions. In this instance, the primary care clinician can point to the roles that he or she can play in coordinating and complementing the care of the mental health specialist(s).

It will be helpful for the primary care clinician to have available sample care plans for common mental health conditions and for common circumstances such as foster care placement and parental separation or divorce, which signal traumatic transitions and require frequent follow-up. For children and youth in foster care, some states are using Web-based medical “passports,” which include information on the child’s history, immunizations, medications, chronic conditions, etc. The AAP Task Force on Foster Care and the AAP Council in Clinical Information Technology are developing guidelines for medical passports (specifically, the health-information content needed and who should have access to the passport).

**B11: Implement Chronic Care Protocol**

Methods used to monitor children with chronic medical conditions such as asthma and diabetes can be useful in the care of children with mental health and substance abuse conditions. “Strategies for Preparing a Primary Care Practice” describes steps in implementing chronic care methods for children with mental health problems, as for other children and youth with special health care needs. It is important to institute a monitoring mechanism for children and youth who are not yet ready to seek or accept care for mental health problems, as well as for those who are.

The interval between contacts will be determined by the acuity and severity of the child’s condition; the child’s and family’s strengths, needs, and preferences; adverse effects and monitoring requirements of any treatments; and the level of the child’s impairment. Just as spirometry measures pulmonary function and assists the clinician in monitoring children with asthma, global functional assessment scales assist the primary care clinician in monitoring children with mental illness (see “Strategies for Preparing a Primary Care Practice”). There are existing pediatric guidelines for assessment and treatment of ADHD and adolescent depression, treatment algorithms for depression, and practice parameters from the American Academy of Child and Adolescent Psychiatry to assist clinicians who choose to proceed with assessment and treatment in the primary care office. When children are being followed by specialist(s), the primary care clinician and specialist(s) need to develop a coordinated follow-up plan in collaboration with the family (see “Strategies for Preparing a Primary Care Practice”).

**B12: Is Concern Persisting?**

Neither designation as a child or youth with special health care needs nor the identification or diagnosis of a mental health concern or condition is necessarily permanent. Children and families can and do recover. To assess the child’s current status, the primary care clinician needs to gather and review progress reports from other professionals involved in the child’s care; for school-aged children, review functional assessment scales completed by the parent, teacher, and youth; and perform his or her own clinical assessment. When pharmacologic agents are part of the treatment plan, clinicians may also need to obtain laboratory tests to monitor levels and/or adverse effects. At each contact, the clinician also needs to consider the routine health supervision requirements of the child and monitoring of comorbid medical conditions.

**Yes**

If a concern persists, the primary care clinician should periodically reconvene a conference with the family (and youth) to determine if further assessment and/or a change of plan is indicated.

**No**

If the child and family show no signs that the concern is persisting, the clinician can move to step B13.

**B13: Return to Routine Health Supervision and Monitor for Further Issues**

If and when a concern is resolved, children and youth can be returned to the process of care described in Algorithm A.

**CONCLUSIONS**

To enhance mental health practice, the task force recommends that primary care clinicians begin by addressing systemic issues such as payment and access to mental health specialty resources, achieving competence in core mental health skills, and preparing office systems that integrate mental health services and apply chronic care methods to children with mental health problems. The task force then...
proposes a clinical process, described in this report, for promoting the social-emotional health of all children and for addressing mental health concerns in primary care settings. Two algorithms describe this process, with text linking the reader to additional resources and references. The process is aimed at communicating the importance of mental health care to children and families, assisting parents in promoting their children’s social-emotional health, increasing the likelihood that concerns will be identified promptly and managed effectively, and enhancing children’s opportunity to recover from mental health problems.

AAP TASK FORCE ON MENTAL HEALTH

The AAP Task Force on Mental Health included Jane Meschan Foy, MD (chairperson, lead author), Paula Duncan, MD, Barbara Frankowski, MD, MPH, Kelly Kelleher, MD, MPH, Penelope K. Knapp, MD, Danielle Laraque, MD, Gary Peck, MD, Michael Regalado, MD, Jack Swanson, MD, and Mark Wolraich, MD; the consultants were Margaret Dolan, MD, Alain Joffe, MD, MPH, Patricia O’Malley, MD, James Perrin, MD, Thomas K. McHnery, MD, and Lynn Wegner, MD; the liaisons were Terry Carmichael, MSW (National Association of Social Workers), Darcy Gruttadaro, JD (National Alliance on Mental Illness), Garry Sigman, MD (Society for Adolescent Medicine), Myrtis Sullivan, MD, MPH (National Medical Association), and L. Read Sulik, MD (American Academy of Child and Adolescent Psychiatry); and the staff were Linda Paul and Aldina Hovde.

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Enhancing Pediatric Mental Health Care: Algorithms for Primary Care
Jane Meschan Foy and for the American Academy of Pediatrics Task Force on Mental Health

Pediatrics 2010;125;S109
DOI: 10.1542/peds.2010-0788F

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/125/Supplement_3/S109.full.html
There are several possible approaches for obtaining a mental health update. The following have been chosen by our experts for consideration.

Rosen: Brief Mental Health Update

Following are suggested questions for obtaining a brief mental health update. The first 5 are suggested for regular use. Additional questions can be offered depending on the child and situation.

1. “Tell me, in general, how you think things have been going for you lately?”
2. “Many of my other patients have been talking to me about stress; what are the things that are most stressful for you these days? How do you manage stress?”
3. “How would you describe your mood over the past few weeks? Does this seem any different from usual for you?”
4. “Does it seem that you’ve been feeling more irritable or angry lately?”
5. “What changes have you noticed lately in your sleeping?”
6. “How has your energy level been lately? Have you been feeling more tired or more restless than usual?”
7. “What types of fun things have you done lately?”
8. “Have there been any changes in how you are getting along with people, like your parents, your family, or your friends?”
9. “I notice that your weight has changed since the last time I saw you. What do you think about that?”

Source: David S. Rosen, MD, MPH, Professor of Pediatrics, Internal Medicine and Psychiatry, Chief, Section of Teenage and Young Adult Health, Department of Pediatrics, University of Michigan Medical School, D3237 MPB Box 5718, 1500 E Medical Center Dr, Ann Arbor, MI 48109-5718; rosend@med.umich.edu, 734/763-9326 (phone), 734/763-4208 (fax)

Dubowitz: Clinical Parent Screening Questionnaire

1. Lately, do you feel down, depressed, or hopeless?
2. During the past month, have you felt very little interest or pleasure in the things you used to enjoy?


CRAFFT: Substance Abuse Screening

The CRAFFT lead-in questions can be used during a brief encounter with an adolescent:

During the past 12 months, did you...
1. Drink any alcohol (more than a few sips)?
2. Smoke any marijuana or hashish?
3. Use anything else* to get high?

**“Anything else” includes illegal drugs, over-the-counter and prescription drugs, and things that you sniff or “huff.”**

If answers to any of these questions are yes, go to the full CRAFFT, below. (Positive CRAFFT screen is “yes” response to 2 or more questions). If no, ask the CAR question:

C: Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?
R: Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A: Do you ever use alcohol or other drugs while you are by yourself or ALONE?
F: Do you ever FORGET things you did while using alcohol or drugs?
F: Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T: Have you ever gotten into TROUBLE while you were using alcohol or drugs?

### Task Force on Mental Health Algorithm Teams: Brief Mental Health Update by Age

Using an Acute Care Visit for a Brief Mental Health Update:
Suggested Questions by Age*

<table>
<thead>
<tr>
<th>Ages 0 to 5 y</th>
<th>Ages 5 to 12 y</th>
<th>Ages 12 to 21 y (parent/child separately)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- How have things been going since our last visit?</td>
<td>- How have things been going since our last visit?</td>
<td>- How have things been going since our last visit?</td>
</tr>
<tr>
<td>- How are you coping with [the presenting acute illness]?</td>
<td>- How are you coping with [the presenting acute illness]?</td>
<td>- How are you/is your child coping with [the presenting acute illness]?</td>
</tr>
<tr>
<td>- How is [the illness] affecting your child, other than primary symptoms?</td>
<td>- How is [the illness] affecting your child, other than primary symptoms?</td>
<td>- How is [the illness] affecting you/your child, other than primary symptoms?</td>
</tr>
<tr>
<td>- (If an injury) How did it happen?</td>
<td>- (If an injury) How did it happen?</td>
<td>- (If an injury) How did it happen?</td>
</tr>
<tr>
<td>- How is your child sleeping, in general and in light of the condition?</td>
<td>- How is your child sleeping, in general and in light of the condition?</td>
<td>- Had anyone been drinking or using drugs?</td>
</tr>
<tr>
<td>- How are things going at home in general?</td>
<td>- How is everyone getting along at home?</td>
<td>- How are you/is your child sleeping, in general and in light of the condition?</td>
</tr>
<tr>
<td>- Is there anything else that's worrying you about parenting your child?</td>
<td>- Has your child been enjoying school? (To the child) How’s school going?</td>
<td>- How are you/is your child getting along at home? At school?</td>
</tr>
<tr>
<td>- What is the best part of parenting this child? What is the most difficult part?</td>
<td>- Do you have any worries or concerns about your child’s mental health, emotions, or behaviors?</td>
<td>- [Parents of] teenagers often mention that they are having difficulties with stress, worries, or changes in mood—has this been a problem for you/your child?</td>
</tr>
</tbody>
</table>

*Select questions as appropriate to the clinical circumstances and time available.

Source: Task Force on Mental Health algorithm teams, group discussion, fall 2005

**Brief Depression Screen (Validated for Adults): PHQ-2**

**Brief Substance Use Screen: CRAFFT Lead-in Questions**

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*The recommendations in this publication do not indicate or assure course of treatment, or serve as a standard of health care. When assessing individual circumstances, they may be appropriate. Original documents included in part of Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit. Copyright © 2001 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and it is not endorsed by AAP for any such changes.*
Appendix S8: Brief Mental Health Update

*Pediatrics* 2010;125;S159
DOI: 10.1542/peds.2010-0788N

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/125/Supplement_3/S159.citation
CODING FOR THE MENTAL HEALTH ALGORITHM STEPS

Introduction
This tool provides a guide to help code for particular steps in the mental health algorithms A and B introduced by the American Academy of Pediatrics (AAP) Task Force on Mental Health (TFOMH) in Pediatrics, July 2009. The steps in the proposed algorithms do not represent a particular time frame—several steps in the process may take place at one contact, and one step in the process may require several contacts. At points where data from outside sources are needed or referrals are made, the process will necessarily extend to a return visit. A number of activities may occur prior to or following an encounter, such as pre-encounter parental and youth reports using validated tools. The AAP TFOMH invites clinicians to develop their own pace, informed by available resources, practice capacity, patient preferences, and circumstances.

For these reasons, in the “CPT Codes for Algorithm A” and “CPT Codes for Algorithm B” sections later in this tool, the TFOMH has provided a variety of options for your consideration in coding primary care visits, some reflecting the possibility of an extended visit (ie, multiple steps in the algorithm during one encounter), others reflecting the possibility of a contact focused on that particular step. The TFOMH has also considered the possibility that you might collocate a licensed mental health professional in your practice to perform or assist with some steps; in some states, physicians employing such an individual may be able to bill in their own name for this person’s services under incident-to Centers for Medicare & Medicaid Services (CMS) rules, reflecting the increased complexity gained by the mental health professional’s involvement. (Incident-to services are described as those services furnished by an allied health professional, employed under the same tax identification number as the supervising physician, to an established patient incident to the physician’s professional services in the physician’s office [whether located in a separate office suite or within an institution] or in a patient’s home.) In other circumstances, the mental health professional will bill directly. Some codes offered in “CPT Codes for Algorithm A” and “CPT Codes for Algorithm B” will lend themselves to the mental health professional’s direct use.

Clinicians should note that some specific codes will not be paid under some insurance plans. Plan administrators and purchasers (eg, employers) may decide to pay for these procedures only after appropriate education and advocacy. AAP chapters may have a pediatric council to assist in these efforts. In any case, primary care clinicians should inform the family of a mental health patient up front that insurance might not cover the costs of evaluation and ongoing treatment, and that the clinician might be billing the family directly.

Whether addressing mental health concerns in a brief encounter, an extended visit, or non-face-to-face activities, primary care clinicians may find the following guidance helpful in achieving appropriate payment for their mental health services.

Evaluation and Management Services
The term evaluation and management (E/M) will be used throughout this document to describe the following Current Procedural Terminology (CPT®) codes:

- Office or other outpatient services (new patient) 99201–99205
- Office or other outpatient services (established patient) 99211–99215
- Office or other outpatient consultations (new or established patient) 99241–99245
- Preventive medicine services (new patient) 99381–99387
- Preventive medicine services (established patient) 99391–99397

The Primary Care Clinician as Mental Health Consultant
Under specific circumstances, a primary care clinician may serve as a consultant in addressing children’s mental health concerns (as well as other concerns). Because consultation codes have higher relative value units (RVUs) than office or other outpatient service codes, they are usually paid at a higher rate. The following criteria (the 3 Rs) must be met for a service to qualify as a consultation:

- A request for consultation must be made by an appropriate source (not a patient or family member) and documented in the chart.
- The consulting clinician must render an opinion or advice back to the requesting source.
- The consulting clinician must provide a (nonverbal) written report back to the requesting source.

If these criteria are met, a clinician can report consultation codes 99241–99245 for services provided. The request for consultation may come from any appropriate source, such as school personnel, another colleague in the same practice, a therapist, a nurse practitioner, or an attorney. The consulting clinician can be a physician or nonphysician practitioner (NPP) with expertise in the relevant clinical area. If an NPP
is performing the mental health consultation, code 90801 (psychiatric diagnostic interview evaluation) could be more appropriate for describing the service.

For more information on consultations, please see the Addendum at the end of this document.

The "Greater Than 50%" Rule

Frequently, mental health visits require considerable time spent in counseling or care coordination. When these aspects take up more than 50% of the face-to-face time spent with a patient, the clinician can use time as the key or controlling factor for a particular E/M service rather than the history, physical examination, or medical decision-making elements that would otherwise be necessary to support that code. To code these encounters, the clinician must carefully document the total time spent with the patient and the amount of that time spent in counseling or care coordination. Suppose, for example, the physician spends 25 minutes face-to-face with an established patient and 15 of those minutes are spent in counseling or care coordination. As shown in the Table, 25 minutes is the typical duration of code 99214. Because more than 50% of that time was spent in counseling or care coordination, the clinician could use 99214 regardless of the history, physical examination, or medical decision-making provided during that encounter.

Face-to-Face Prolonged Services

If the clinician spends at least 30 minutes more than the time typical for a particular visit (see Table), the clinician may additionally report prolonged service codes.

99354–99355 Outpatient face-to-face prolonged services; 30 to 74 minutes/more than 74 minutes (in 30-minute blocks of time; multiple units allowed)

Time must be spent on the same day as the visit but does not need to be continuous. The prolonged service codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or outpatient service codes).

It is essential to document the time and services provided to substantiate the use of these prolonged service codes. However, even correct coding and documentation in the medical record may not result in payment, and advocacy may be needed to change a payer policy. If the patient is on a capitated plan, the physician may request authorization to bill the family directly for these non-covered services. Note that when using time as your key factor in reporting an E/M service (as outlined above) you may only report face-to-face prolonged services if the time spent is 30 minutes above and beyond the typical time listed in the highest level code in the set (eg, 99205, 99215, 99245).

Non-Face-to-Face Prolonged Services

99358–99359 Non-face-to-face prolonged services in any setting; 30 to 74 minutes/more than 74 minutes (in 30-minute blocks of time; multiple units allowed)

Time must be spent on the same day and be a minimum of 30 minutes; however, the time spent does not need to be continuous. The non-face-to-face prolonged service codes are no longer add-on codes, meaning they can be reported as stand-alone codes. For example, for non-face-to-face prolonged services, time may include calling a colleague for advice or a referral on the day before or after a face-to-face service. Another example is a physician performing an extensive chart review a day or two prior to an initial face-to-face encounter. It is essential to document the time and services provided to substantiate the use of these prolonged service codes. However, even correct coding and documentation in the medical record may not result in payment, and advocacy may be needed to change a payer policy. If the patient is on a capitated plan, the physician may request authorization to bill the family directly for these non-covered services.

Current Procedural Terminology Codes and Time: Office or Outpatient Codes and Consultation Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Typical Time for Code (min)</th>
<th>Threshold Time to Bill Code 99354 (min)</th>
<th>Threshold Time to Bill Code 99354–99355 (min)</th>
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<tr>
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Payment for Non-Face-to-Face Services: Care Plan Oversight (99339-99340)

Providing a medical home for patients with complex emotional and behavioral conditions necessitates many non-face-to-face services. Primary care clinicians often develop virtual teams of community-based specialists to develop and implement comprehensive care plans for children with complex developmental and behavioral conditions. The primary care clinician will regularly review reports from other providers, receive or make contacts with other providers by telephone or in writing, and communicate with family members. One option for requesting payment for these needed services is through the use of care plan oversight codes (recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement) 99339 (15–29 minutes per month) and 99340 (30 minutes or more per month). These non-face-to-face services are reported once a month separately from E/M services by the physician who has the supervisory role in the patient’s care or is the sole provider. These 2 codes reflect the complexity and time required to supervise the care of the patient and are reported based on the amount of time spent per calendar month. Tasks appropriately included in this service are reviewing laboratory results as part of medication monitoring, assessing progress in therapies (e.g., speech/language, occupational, physical, behavioral), and documenting behavioral changes in the course of psychodynamic therapy through telephone calls or written communication with the child’s mental or behavioral health therapist or school. These codes are reported only once monthly and reflect the total time spent by the primary care physician as care manager. To ensure accuracy in calculating time spent in care plan oversight, a care log on which time and services are entered can be very helpful. A copy of this log can be attached when the billing sheet is submitted to the insurer if there are denials for this service.

Telephone Care (99441-99443)

If care plan oversight codes are regularly submitted, it would not be appropriate to submit bills for individual telephone calls. Telephone care, however, is a significant part of providing care for children with complex developmental and behavioral disorders. Communication between the primary care clinician and therapists, teachers, school counselors, and family members is important to optimal management. While telephone calls to nonfamily members might correctly be included in care plan oversight (provided they do not address topics more correctly considered post-service work of the previous face-to-face encounter with the patient/family), telephone care to the child’s family can be billed very appropriately as a separate and justifiable service if it meets the requirements of the codes (the calls must not occur within 7 days of a previous face-to-face encounter, the calls must originate from the patient/family, and the call may not result in an appointment within 24 hours of the call [or at the next available appointment time]).

Currently, there are 3 telephone codes with assigned RVUs for physician telephone calls: 99441 (5–10 minutes), 99442 (11–20 minutes), and 99443 (21–30 minutes). The RVUs for these 3 codes were published in 2008.

The physician must remember that even with correct code assignment and documentation of the telephone call in the medical record, payment may be refused by payers. If request for payment is denied, a clinician may ask for a written explanation of the denial by the payer. If the patient is on a capitated plan, the clinician may request authorization to bill the family directly for these non-covered services. If the clinician decides to charge families for these non-covered services, the clinician should send families a letter explaining that payment will be expected from them for these non-covered services and telling them what the fees will be.

Incident-to Rules

Under CMS incident-to rules, services performed by NPPs employed, leased, or contracted by a physician (or the same entity that employs the physician) may, under certain circumstances and under the supervision of the physician, be paid according to the physician fee schedule. In other words, the services NPPs perform may be reported as if they were performed by the physician. State Medicaid and commercial payers may follow CMS requirements or have their own specific rules addressing incident-to provisions. In states where Medicaid or commercial insurance plans allow mental health professionals (e.g., licensed clinical social workers, professional counselors, psychologists) to function as NPPs under incident-to rules, primary care physicians may have a business environment particularly favorable to the integration of a mental health professional within the primary care setting.

Physicians interested in billing for a mental health professional under incident-to rules will need to explore the rules in their own state Medicaid program and commercial insurance plans. They will need to determine which categories of mental health professionals fall under the incident-to rules, the specific supervisory requirements, the specific services the physician must perform, ways to apply CPT codes, and documentation requirements.
Following are the basic Medicare rules on which Medicaid incident-to rules are typically modeled:

- The services must be related to the physician service and be of a type commonly furnished in a physician office or clinic.
- The physician must supervise the NPP. Medicare requires that the supervising physician be on the premises, but this may not be the case in Medicaid or commercial plans.
- Under CMS incident-to rules, services can be provided only to an established patient; the physician must perform the initial visit and establish the plan of care and physician-patient relationship.
- Medicare requires that the physician evaluate and initiate the treatment of new problems; however, the physician is not required to be involved in each subsequent encounter. (Medicare requires the physician to see the patient every 3 to 4 visits.)
- The physician must perform all consultations. Medicare incident-to requirements prohibit reporting a consultation when it is performed as incident to the physician.
- E/M services must be reported based on the performance of the required key components (history, physical examination, medical decision-making). Time cannot be used as the controlling factor when the counseling or care coordination is performed by the NPP as incident to the physician.
- Under Medicare, split or shared services can be reported as incident to when the NPP and physician see the patient on the same day of service. The physician is required to perform some part of the key components of the E/M service, and the NPP and physician must document their portions of the service. The service must be reported based on the performance and documentation of the combined services as if the physician performed the entire service; however, only the physician’s face-to-face time is used to determine the level of E/M service if applying the “greater than 50%” rule.

Documentation of incident-to services must be meticulous. Under CMS incident-to rules, an NPP, a patient, or a family member can document a chief complaint, review of systems, and past, family, and social history. The physician must document the history of present illness (HPI). If the HPI is documented by an NPP, the medical record must reflect the physician’s actual review of the HPI and interaction by indicating agreement or disagreement or noting supplemental information. The supervising physician must document his or her supervision of the encounter and assign the encounter note. Documentation may be as simple as,

“Service performed/provided under the direct supervision of Dr X.” The supervising physician’s signature must be legible. When a split or shared service is performed, the physician and NPP must document their portions of the service. If the E/M service is reported based on counseling or care coordination, the physician must document the total time spent in counseling or care coordination and a summary of the issues discussed or coordination provided.
Algorithm A: Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care

**CPT Codes for Algorithm A**

**Step A2a: Collect and review pre-visit data**

**CPT Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99358–99359</td>
<td>Prolonged E/M service before or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals or patient and family)</td>
</tr>
</tbody>
</table>

Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.

**Step A3a: Provide initial clinical assessment; observe child-parent interactions.**

**CPT Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381–99385</td>
<td>Preventive medicine services; new patient</td>
</tr>
<tr>
<td>99391–99395</td>
<td>Preventive medicine services; established patient</td>
</tr>
<tr>
<td>99241–99245</td>
<td>Office or other outpatient consultation (new or established patient) (See Addendum for requirements of consultation.)</td>
</tr>
<tr>
<td>96150</td>
<td>Health and behavioral assessment, initial (face-to-face, each 15 minutes) (NPPs only)</td>
</tr>
<tr>
<td>99420</td>
<td>Health risk assessment instrument; individual</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status examination</td>
</tr>
</tbody>
</table>
Step A4a: Acknowledge and reinforce strengths

CPT Codes
This service is typically encompassed within the preventive medicine services or consultation coded at step A3a. However, if this service is significant and separately identifiable or requires a separate patient encounter, it may be reported with 99211-99215 (office or other outpatient services; established patient).

Step A6a: Provide anticipatory guidance for age per Bright Futures, Connected Kids, or KySS

CPT Codes
This service is a component of preventive medicine services coded at step A3a.

Step A8a: Emergency?

CPT Codes
This service may be encompassed within the preventive services or consultation coded at step A3a. Prolonged service codes (99354-99359) may be appended to the E/M code if the visit exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

Code additional services as follows:

96110 x Number of standardized screening forms used; developmental testing; limited
99420 Health risk assessment instrument; individual
90801-90802 Psychiatric diagnostic interview examination (nonphysician mental health professional)

If the clinician provides services that are significant and separately identifiable or the situation requires a patient encounter separate from the preventive services or consultation visit, code as follows:

99211-99215 Office or other outpatient services; established patient
99201-99205 Office or other outpatient visit; new patient

Step A9a: Facilitate referral for specialty services or emergency facility; re-enter algorithm at appropriate point (or A1a).

CPT Codes
This service may be included in the preventive medicine service or consultation reported at step A3a. Prolonged service codes (99354-99359) may be appended to the E/M code if the visit or non-face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

If the service is significant and separately identifiable or occurs on a different day from the preventive medicine service or consultation, report as follows:

99211-99215 Office or other outpatient services; established patient, if care is provided by a physician
96152-96154 Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

Step A10a: Provide initial intervention; facilitate referral of family member for specialty services, if indicated.

CPT Codes
This service may be included in the preventive medicine service or consultation reported at step A3a. Face-to-face prolonged service codes (99354-99355) may be appended to the E/M code if the visit exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service. Non-face-to-face prolonged services (99358-99359) can be reported if a minimum of 30 minutes is spent performing services without the patient or parent present. The time can be spent on the same date of service as a face-to-face encounter, or on a date previous or subsequent to a face-to-face encounter.

If the service is significant and separately identifiable or occurs on a different day from the preventive medicine service or consultation, report as follows:

99211-99215 Office or other outpatient services; established patient, if care is provided by a physician
96152-96154 Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

If educational materials are provided to family, consider

99070 Supplies and materials provided above those usually included with the office visit (Note: Report Healthcare Common Procedure Coding System Level II supply codes instead if available.)
**Step A12a: Collect and review data from collateral sources**

**CPT Codes**

- **90885**: Psychiatric review of medical records for medical diagnostic purposes (nonphysician mental health professional)
- **99211–99215**: Office or other outpatient services
- **99358–99359**: Prolonged physician services without direct (face-to-face) patient contact, if the requirements for 90885 are not met.

*Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.*

**Step A2b: Incorporate brief mental health update**

**CPT Codes**

- **99201–99205**: Office or other outpatient visit; new patient
- **99211–99215**: Office or other outpatient visit; established patient
- **96110**: x Number of standardized screening forms used; developmental testing; limited
- **99420**: Health risk assessment instrument; individual

**Step A4b: Emergency?**

**CPT Codes**

This service may be encompassed within the office or other outpatient service visit reported at step A2b. Prolonged service codes (99354–99359) may be appended to the E/M code if the visit or non-face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

Code additional services as follows:

- **96110**: x Number of standardized screening forms used; developmental testing; limited
- **99420**: Health risk assessment instrument; individual
- **90801–90802**: Psychiatric diagnostic interview examination (nonphysician mental health professional)

**Step A5b: Facilitate referral for specialty services or emergency facility; re-enter algorithm at appropriate point (or A1a).**

**CPT Codes**

This service may be included in the office or other outpatient service visit reported at step A2b. Face-to-face prolonged service codes (99354–99355) may be appended to the E/M code if the face-to-face time exceeds by at least 30 minutes the time expected for the level of service reported the same day. Non-face-to-face prolonged services (99358–99359) may also be added if a minimum of 30 minutes is spent performing services without the patient/parent present. This can also occur on a subsequent date.

If the service occurs on a different day from the office or other outpatient service visit reported at step A2b, code as follows:

- **99211–99215**: Office or other outpatient services; established patient, if care is provided by a physician
- **96152–96154**: Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

**Step A6b: Return to acute care visit. Plan to enter algorithm at step A1a.**

**CPT Codes**

This step is included in the office or other outpatient service visit reported at step A2b.
Algorithm B: Assessment and Care of Children with Identified Social-Emotional, Mental Health (MH) or Substance Abuse (SA) Concerns, Ages 0-21

CPT Codes for Algorithm B

Step B3a: Facilitate referral to specialist(s) for further assessment

CPT Codes
This service may be included in the E/M service reported at a previous step in the algorithm if it occurs at that same visit. Prolonged service codes (99354–99359) may be appended to the E/M code if the visit or non-face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

If the service occurs on a different day from previous algorithm steps, code as follows:
99211–99215 Office or other outpatient services; established patient, if care is provided by a physician

96152–96154 Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

Step B4a: Collect reports and recommendations

CPT Codes
90885 Psychiatric review of medical records for medical diagnostic purposes (nonphysician mental health professional) or
99211–99215 Office or other outpatient services; established patient plus
99358–99359 Prolonged physician services without direct (face-to-face) patient contact, if the requirements for 90885 are not met
Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.

Step B5a: Provide MH assessment

CPT Codes

99241–99245 Office or other outpatient consultation; new or established patient (See Addendum for requirements of consultation.)
or, if requirements of a consultation are not met,
99201–99205 Office or other outpatient visit; new patient
99211–99215 Office or other outpatient services; established patient

Prolonged service codes (99354–99359) may be appended to the E/M code if the visit or non–face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

The following codes may apply to other services provided:

96150 Health and behavior assessment, initial (face-to-face, each 15 minutes) (NPPs only)
96151 Health and behavior reassessment (face-to-face, each 15 minutes) (NPPs only)
99420 Health risk assessment instrument; individual
96116 Neurobehavioral status examination
96120 Neuropsychologic testing by computer with qualified health care professional interpretation and report
96111 Developmental testing; extended (optional objective assessment)
96110 x Number of standardized screening forms used; developmental testing; limited

Step B6: Interpret findings to family (and youth as appropriate); convey hopefulness about treatment and recovery.

CPT Codes

This service may be included in the E/M service reported at a previous step in the algorithm if it occurs on the same day as that service. Prolonged service codes (99354–99359) may be appended to the E/M code if the visit or non–face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

If the service occurs on a different day from previous algorithm steps, code as follows:

99211–99215 Office or other outpatient services; established patient, if care is provided by a physician
96152–96154 Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

If a nonphysician qualified health care professional leads the face-to-face interpretive conference and if at least 2 other qualified health care professionals from different specialties or disciplines participate with patient and family, the NPP can report the service as follows:

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional

Step B8: Facilitate involvement of specialist(s)

CPT Codes

This service may be included in the E/M service reported at a previous step in the algorithm if it occurs on the same day as that service. Prolonged service codes (99354–99359) may be appended to the E/M code if the visit or non–face-to-face work exceeds by at least 30 minutes the time expected for the highest level of a service on the same day as the E/M service.

If the service occurs on a different day from previous algorithm steps, code as follows:

99211–99215 Office or other outpatient services; established patient, if care is provided by a physician
96152–96154 Health and behavior intervention; face-to-face; each 15 minutes, if care is provided by a nonphysician

Step B9: Collect reports and/or convene team to review

CPT Codes

99367 Medical team conference with interdisciplinary team of health care professionals, patient or family not present, 30 minutes or more; participation by physician

If medical team conference occurs with patient or family present, the physician reports an office or other outpatient code (99211–99215) instead.

90885 Psychiatric review of medical records for medical diagnostic purposes (nonphysician mental health professional)
Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.

If a nonphysician qualified health care professional leads the interpretive conference and if at least 2 other qualified health care professionals from different specialties or disciplines participate without patient and family, the NPP can report the service as follows:

99368  
Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

If a nonphysician qualified health care professional leads the interpretive conference and if at least 2 other qualified health care professionals from different specialties or disciplines participate with patient and family, the NPP can report the service as follows:

99366  
Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional

---

**Step B10: Collaboratively develop a family-centered care plan**

**CPT Codes**

99367  
Medical team conference with interdisciplinary team of health care professionals, patient or family not present, 30 minutes or more; participation by physician

If medical team conference occurs with patient or family present, report an office or other outpatient code (99211–99215) instead.

90885  
Psychiatric review of medical records for medical diagnostic purposes (nonphysician mental health professional)

Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.

If a nonphysician qualified health care professional leads the interpretive conference and if at least 2 other qualified health care professionals from different specialties or disciplines participate without patient and family, the NPP can report the service as follows:

99368  
Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

---

**Step B11: Implement chronic care protocol**

**CPT Codes**

99367  
Medical team conference with interdisciplinary team of health care professionals, patient or family not present, 30 minutes or more; participation by physician

Consider care plan oversight codes (99339–99340) if this step takes place in the context of recurrent physician supervision of a complex patient or a patient who requires multidisciplinary care and ongoing physician involvement.

---

**Step B12: Is concern persisting?**

**CPT Codes**

99211–99215  
Office or other outpatient visit; established patient

99420  
Health risk assessment instrument; individual

96116  
Neurobehavioral status examination

96120  
Neuropsychologic testing by computer with qualified health care professional interpretation and report

96110  
X Number of standardized screening forms used; developmental testing; limited

96111  
Developmental testing; extended (optional objective assessment)
Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment (These codes are for physicians only; codes for NPPs [98966-98968] can alternatively be reported.)

Psychiatric review of medical records for medical diagnostic purposes (nonphysician mental health professional)

Online E/M service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network (This code is for physicians only; a code for NPPs [98969] can alternatively be reported.)

Health and behavior reassessment (face-to-face, each 15 minutes) (NPPs only)

Addendum

Current Procedural Terminology Requirements for Reporting a Consultation Modified for Mental Health Outpatient Practice

In January 2010, the CMS eliminated payment for the consultation codes in the Medicare program. So far, only a handful of non-Medicare payers have adopted this Medicare policy, which is why it is important to continue to report consultation codes when appropriate. For more information on the AAP position on this policy, see www.aap.org/moe/loadsecure.cfm/reimburse/PositiononMedicareConsultationPolicy.doc.

A consultation must be medically indicated and must meet specific criteria (the 3 Rs).

- A request for consultation must be made by an appropriate source (not a patient or family member) and documented in the chart.
- The consulting clinician must render an opinion or advice back to the requesting source.
- The consulting clinician must provide a (nonverbal) written report back to the requesting source.

Request for Consultation

CPT guidelines require that a consultation be provided by a physician whose opinion or advice is requested by another physician or other appropriate source for the E/M of a specific problem (but not the family or patient). Medicare further expands this definition by specifying that there must be intent for a consultative service. The intent of a consultation is defined as the need for advice, opinion, recommendations, suggestions, direction, or counsel for the evaluation and treatment of a patient from another physician or qualified NPP who has expertise in a specific area that is beyond the requesting physician’s or NPP’s professional knowledge.

The requesting physician or other appropriate source and the consulting physician must document in the medical record the request (whether verbal or written) and the reason or need for the consultation. The consultant must include the name of the requesting physician or other appropriate source. This documentation may be a shared medical record (e.g., hospital record, patient record in a multi-physician practice). Medicare-specific instructions add that the reason for the consultation must be included in the physician’s plan of care and may be documented on a physician order form by the requester in a shared medical record.

CPT imposes no restrictions on who may be considered another appropriate source. Medicare does not define or give examples of other appropriate sources. Therefore, other appropriate sources might include school nurses, psychologists, NPPs, attorneys, therapists, or dentists. A patient or family request is never an appropriate source for
the use of a consultation code under CPT and Medicare guidelines. If the patient or family makes such a request, a new or an established patient office or outpatient service code must be reported instead.

Consultations requested by another physician of the same group practice may be reported if the consultant is of a different specialty or if the physician of the same specialty has expertise in a specific medical area. However, Medicare policy specifically states that this cannot be a routine practice. A qualified NPP (eg, advanced nurse practitioner) may report consultations if they fall within the particular state’s licensure regulations pertaining to scope of practice and depending on payer requirements. Medicare incident-to guidelines apply to the consultation services provided by an NPP in that they require the patient to be established and the service to be performed under the direct supervision of the physician (ie, physician must be immediately available and in the office suite). Some state Medicaid programs and commercial payers follow Medicare incident-to requirements for reporting NPP services.

Medicare policy does not allow reporting consultations when they are performed as a split or shared service.

**Render an Opinion or Advice**

The consulting physician or NPP must render an opinion and recommendations. The consultant can initiate diagnostic or therapeutic services at the time of the consultation or at subsequent visits and can provide management of the patient when noted in the requesting physician’s documentation. This subsequent patient management or follow-up care is reported with subsequent patient visit codes (99211–99215; 99231–99233; 99307–99310) appropriate to the place and level of service.

Medicare written policy further clarifies that a consultation is not reported when there is a transfer of care or referral. Transfer of care occurs when another physician takes over the responsibility for managing the complete care of a patient’s condition at the request of another physician. A transfer of care is not a consultation because there is no request for opinion or advice. These services should be reported with the appropriate new or established patient service depending on the place and level of service performed and documented. The medical record should reflect the transfer of care to the service of the receiving physician.

**Written Report**

The consultant must provide a written report of findings and recommendations back to the requesting physician or other appropriate source and must maintain a copy of the report in the patient’s medical record. The written report may be a copy of the medical record progress note, a summary letter, or a completed form (eg, preoperative form, consultation report).

The Medicare program also specifies that when the medical record is shared between the requesting physician and the consultant, the request may be documented as part of the plan in the progress note, an order in the medical record, or a specific written request. In the office setting, the consultation report is a separate document. In a large group practice with shared medical records, it is acceptable to include the consultant’s report as part of the documentation; a separate letter or report is not required.

A copy of the report must always be maintained in the patient’s medical record.

**Follow-up Consultation Services**

The requirements for reporting follow-up consultations differ depending on where the service is provided. In the office setting, when an additional request for an opinion or advice is received from a physician or other appropriate source and the specific criteria for reporting consultations are met, office consultation codes (99241–99245) may be reported again. The consultation may be required for a new problem or the same problem for which the previous consultation was provided. Any continuing care initiated by the consultant must be reported using the appropriate-level established patient visit codes (99212–99215).

**Confirmatory Consultations and Second Opinions**

A confirmatory consultation may be reported using office or outpatient consultation codes (99241–99245) when the service meets CPT and payer requirements for reporting (ie, requested by a physician or other appropriate source, opinion or advice rendered, written report documented).

A confirmatory consultation requested by a patient or family cannot be reported because the requirements for reporting a consultation are not met (the patient or family is not considered an appropriate source). These services are reported with the appropriate office or outpatient service codes for a new or an established patient visit (99201–99215) or with subsequent care codes (99231–99233 or 99307–99310).

When a third-party payer requires a consultation or second opinion, a consultation may be reported with modifier 32 (mandated services) appended to the appropriate consultation code. The medical record documentation must include the name of the requesting source, reason for the consultation, and a copy of the written report that is sent to the requesting payer. Medicare does not recognize modifier 32 and does not cover second opinions.
Selection of Level of Care
Office or outpatient consultation codes (99241–99245) require all 3 key components—history, physical examination, and medical decision-making—to be performed and documented. Time may be used as the key or controlling factor in the selection of the code if more than 50% of the total face-to-face time is spent in counseling or care coordination. When reporting the service based on time, medical record documentation must include the total face-to-face time, the time spent in counseling or care coordination, and a summary of the issues discussed.

Always select the appropriate code for an initial or a confirmatory consultation based on CPT and payer requirements for reporting, the level of service performed and documented, and the appropriate place of service.

Reference

doi: 10.1542/peds.2010-0788K
Appendix S5: Coding for the Mental Health Algorithm Steps

*Pediatrics* 2010;125;S140
DOI: 10.1542/peds.2010-0788K

<table>
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Appendix S5: Coding for the Mental Health Algorithm Steps

*Pediatrics* 2010;125;S140
DOI: 10.1542/peds.2010-0788K

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/125/Supplement_3/S140.citation
The Mental Health Screening and Assessment Tools for Primary Care table provides a listing of mental health screening and assessment tools, summarizing their psychometric testing properties, cultural considerations, costs, and key references. It includes tools that are proprietary and those that are freely accessible. Products are listed for informational purposes only. Inclusion in this publication does not imply endorsement by the American Academy of Pediatrics.

Consideration for including screening tests in the table included the tests’ reliability, validity, sensitivity, and specificity.

- **Reliability** is the ability of a measure to produce consistent results.
- The **validity** of a screening test is its ability to discriminate between a child with a problem and one without such a problem.
- **Sensitivity** is the accuracy of the test in identifying a problem.
- **Specificity** is the accuracy of the test in identifying individuals who do not have a problem.¹

Sensitivity and specificity levels of 70% to 80% have been deemed acceptable for developmental screening tests²; these values are lower than generally accepted for medical screening tests.¹ Use of lower sensitivity and specificity values may identify children with symptoms that do not rise to the level of a *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* diagnosis³; however, these children may benefit from interventions in the primary care setting or community to address their symptoms or functional difficulties. These children may also benefit from close monitoring of their emotional health by their families, pediatric health professionals, and teachers or caregivers.

The table is organized to follow the clinical process described algorithmically by the Task Force on Mental Health.⁴ Clinicians at various stages in integrating a mental health approach into their practice may want to review the entire table first, gain some experience with a few tools, and use quality improvement strategies such as small planning, doing, studying, acting (PDSA) cycles to refine their approach. Team meetings with the practice clinicians and collaborative office rounds involving primary care clinicians and mental health or developmental specialists, with the aim of discussing clinical cases and the use of specific tools, may focus the implementation process. As the clinician and groups of clinicians gain more comfort, they can further revise their approach.

Engaging families by sending them an introductory letter to inform them of the practice’s interest in their child’s socio-emotional health, by directly asking their experience with the chosen tools, and by inviting them to be a part of a learning group may also facilitate adoption of a particular approach or tool.

The table is by no means exhaustive and the information is subject to change over time. Consideration was first given to tools that have strong psychometric properties and are appropriate for use in pediatric (ie, birth to 21 years) primary care settings. Those that are freely accessible are listed first. Proprietary tools are also listed if there is no equivalent tool in the public domain or if the tool is already well known to practitioners and has strong psychometric properties.

In addition to screening tools, the table includes tools that may be used for primary care assessment of children’s global functioning and assessment of children presenting with the most common problems encountered in primary care—anxiety, depression, inattention and impulsivity, disruptive behavior or aggression, substance abuse, learning difficulties, and symptoms of social-emotional disturbance in young children. Also included are tools to identify risks in the psychosocial environment, prior exposure to trauma, and problems with the child’s developmental trajectory and cognitive development.
<table>
<thead>
<tr>
<th>Psychosocial Measure</th>
<th>Tools and Description</th>
<th>Number of Items and Format</th>
<th>Age Group</th>
<th>Administration and Scoring Time Training (none, unless otherwise indicated)</th>
<th>Psychometric Properties</th>
<th>Cultural Consideration</th>
<th>Cost and Developer</th>
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<tbody>
<tr>
<td>Mental Health Update and Surveillance</td>
<td>Bright Futures Surveillance Questions&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Unlimited</td>
<td>0 to 21 y</td>
<td>Variable</td>
<td>Open-ended questions that invite participatory care. No psychometric properties reported.</td>
<td>Any language</td>
<td>AAP/MCHB</td>
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<tr>
<td></td>
<td>Bright Futures Previsit and Supplemental Questionnaires</td>
<td>Variable</td>
<td>0 to 21 y</td>
<td>Variable</td>
<td>Yes/No questions that invite participatory care and help elicit areas for further counseling. No psychometric properties reported.</td>
<td>English</td>
<td>AAP/MCHB</td>
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<td>GAPS (Guidelines for Adolescent Preventive Services)</td>
<td>72 items for younger adolescent; 61 items for older adolescent; 15 items for parent</td>
<td>Parent, young teen, older teen</td>
<td>NA</td>
<td>English, Spanish, Freely accessible</td>
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<td></td>
<td>HEADSSS&lt;sup&gt;7–9&lt;/sup&gt; Home, Education/employment, Activities, Drugs, Sexuality, Suicide/depression, Safety</td>
<td>Part of interview process</td>
<td></td>
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<td>Freely accessible</td>
<td></td>
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**Previsit Data Collection (Algorithm Step A2a): Screening for Mental Health and Substance Abuse Problems in Children and Adolescents**

| General Psychosocial Screening Tests         | PSC-17<sup>9</sup> (Pediatric Symptom Checklist—17 items)<sup>10–15</sup> | 17 items                   | 4 to 16 y | <5 min Scoring: 2 min                                                           | Subscales have obtained reasonable agreement with validated and accepted parent-report instruments. Cronbach alpha was high for each subscale. | English, Spanish, Chinese | Freely accessible |
|                                            | General psychosocial screening and functional assessment in the domains of attention, externalizing, and internalizing symptoms | Self-administered Parent or youth ≥11 y |           |                                                                                 |                                                                                       | Reading level: fifth to sixth grades                  |                   |
|                                            | PSC-35<sup>9</sup> (Pediatric Symptom Checklist—35 items)<sup>10–11,13–14</sup> | 35 items                   | 4 to 16 y | <5 min Scoring: 1 to 2 min                                                      | General psychosocial screen Sensitivity: 80% to 95% Specificity: 68% to 100%     | English, Spanish, Chinese, Japanese Pictorial version available | Freely accessible |
### Psychosocial Measure

<table>
<thead>
<tr>
<th>Tools and Description</th>
<th>Number of Items and Format</th>
<th>Age Group</th>
<th>Administration and Scoring Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ&lt;sup&gt;a&lt;/sup&gt; (Strengths and Difficulties Questionnaire)&lt;sup&gt;16–19&lt;/sup&gt;</td>
<td>25 items&lt;br&gt;Self-administered&lt;br&gt;Parent, teacher, or youth 11 to 17 y</td>
<td>3 to 17 y</td>
<td>10 min&lt;br&gt;Training (none, unless otherwise indicated)</td>
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<tr>
<td>Early Childhood Screening Assessment&lt;sup&gt;b&lt;/sup&gt;</td>
<td>40 items, 3-point Likert scale responses, and an additional option for parents to identify whether they are concerned and would like help with an item</td>
<td>18 to 60 mo</td>
<td>10 to 15 min to complete.&lt;br&gt;Scoring time: 1 to 2 min&lt;br&gt;Should be administered by health professional or mental health professional whose training and scope of practice include interpreting screening tests and interpreting positive or negative screens for parents.</td>
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<tr>
<td>ASQ-SE&lt;sup&gt;c&lt;/sup&gt; (Ages and Stages Questionnaire–Social Emotional)&lt;sup&gt;21&lt;/sup&gt;</td>
<td>From 19 items (6 mo) to 33 items (30 mo)&lt;br&gt;Parent report</td>
<td>6 to 60 mo</td>
<td>10 to 15 min&lt;br&gt;Scoring: 1 to 5 min (can be scored by paraprofessionals)</td>
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<tr>
<td>Substance Use</td>
<td>3 screener questions, then 6 items&lt;br&gt;Self-administered or youth report</td>
<td>Adolescents</td>
<td>1 to 2 min&lt;br&gt;Scoring: 5 min&lt;br&gt;Sensitivity: 76% to 92%&lt;br&gt;Specificity: 76% to 94%&lt;br&gt;PPV: 29% to 83%&lt;br&gt;NPV: 91% to 98%&lt;br&gt;No cross-cultural validity data&lt;br&gt;Freely accessible</td>
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#### Screening for Environmental Risk Factors (Algorithm Step A2a)

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<thead>
<tr>
<th>Parent/Family Screening</th>
<th>Number of Items</th>
<th>Age Group</th>
<th>Administration and Scoring Time</th>
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</thead>
<tbody>
<tr>
<td>Edinburgh Maternal Depression&lt;sup&gt;d&lt;/sup&gt;&lt;sup&gt;25–30&lt;/sup&gt;</td>
<td>10 items&lt;br&gt;Parent self-report</td>
<td>Peripartum women</td>
<td>&lt;5 min to administer&lt;br&gt;Scoring: 5 min&lt;br&gt;Sensitivity: 86%&lt;br&gt;Specificity: 78%&lt;br&gt;Has cross-cultural validity&lt;br&gt;Freely accessible</td>
</tr>
</tbody>
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<sup>a</sup>Psychometric properties: Sensitivity: 63% to 94%, Specificity: 88% to 98%

<sup>b</sup>Freely accessible

<sup>c</sup>Freely accessible

<sup>d</sup>Proprietary ($194.95/kit)
<table>
<thead>
<tr>
<th>Psychosocial Measure</th>
<th>Tools and Description</th>
<th>Number of Items and Format</th>
<th>Age Group</th>
<th>Administration and Scoring Time Training (none, unless otherwise indicated)</th>
<th>Psychometric Properties</th>
<th>Cultural Consideration</th>
<th>Cost and Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Intake Form (Family Psychosocial Screen)</td>
<td>Screens for parental depression, substance use, domestic violence, parental history of abuse, and social supports.</td>
<td>22 items</td>
<td>0 to 21 y</td>
<td>Variable</td>
<td>Not described</td>
<td>English</td>
<td>Freely accessible</td>
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<tr>
<td>PHQ-9 (Patient Health Questionnaire-9)</td>
<td>Screens adults for depression.</td>
<td>9 items</td>
<td>Adult</td>
<td>&lt;5 min to administer</td>
<td>Excellent internal reliability and test-retest reliability. Cutoff score of 10 or more</td>
<td>Not validated in languages other than English</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>PHQ-2b</td>
<td>first 2 items from PHQ-9&lt;sup&gt;33,34&lt;/sup&gt;</td>
<td>2 items</td>
<td>Adult</td>
<td>1 min</td>
<td>Overall Sensitivity: 83% to 87% Specificity: 78% to 92% PPV: not available</td>
<td>Not validated in languages other than English</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>AAS (Abuse Assessment Screen)&lt;sup&gt;b,37&lt;/sup&gt;</td>
<td>Screens for domestic violence.</td>
<td>5 to 6 items</td>
<td>Adolescent and adult women</td>
<td>About 45 seconds if all answers are “No”</td>
<td>Some studies indicate low sensitivity (&lt;40%) and high specificity (&gt;90%).</td>
<td>Still in development</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>McMaster General Functioning Scale&lt;sup&gt;38–41&lt;/sup&gt;</td>
<td>Assesses family functioning.</td>
<td>12 items</td>
<td>Adolescents and adults</td>
<td>&lt;5 min</td>
<td>Temporally stable, good internal consistency, and concurrent and construct validity.</td>
<td>Cross-cultural consideration. Translated into 24 languages.</td>
<td>Proprietary ($41.95)</td>
</tr>
<tr>
<td>MSPSS (Multidimensional Scale of Social Support Parent Stress Inventory)&lt;sup&gt;b,42–46&lt;/sup&gt;</td>
<td>Assesses social support.</td>
<td>12 items</td>
<td>Adult</td>
<td>2 to 5 min</td>
<td>Good test and retest coefficients</td>
<td>Cross-cultural studies done</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>Parent Screening Questionnaire&lt;sup&gt;47,48&lt;/sup&gt;</td>
<td>Screens adults for injury, tobacco, depression, intimate partner violence.</td>
<td>20 items</td>
<td>Parents</td>
<td>2 min</td>
<td>Low sensitivity (20%) for the intimate partner violence Specificity: 92% PPV: 41% NPV: 88%</td>
<td>Reading level: fourth grade</td>
<td>Free with permission (Contact Howard Dubowitz, MD, MS, at <a href="mailto:hdubowitz@peds.umaryland.edu">hdubowitz@peds.umaryland.edu</a>)</td>
</tr>
<tr>
<td>Psychosocial Measure</td>
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<td>Administration and Scoring Time Training (none, unless otherwise indicated)</td>
<td>Psychometric Properties</td>
<td>Cultural Consideration*</td>
<td>Cost and Developer</td>
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<tr>
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<td>PSI (Parent Stress Index), Third Edition[^59-51]</td>
<td>120 items plus 19 optional items Parent self-report</td>
<td>Parents of children 1 mo through 12 y</td>
<td>20 to 30 min</td>
<td>Distinguishes among difficult child, parent factors, and parent-child relationships factors Good internal consistency reliabilities measured by Cronbach alpha</td>
<td>Transcultural research has involved many populations (eg, Hispanics, Chinese, Portuguese, French, Canadian, Italian, Korean).</td>
<td>Proprietary ($185/kit)</td>
</tr>
<tr>
<td></td>
<td>SIPA (Stress Index for Parents of Adolescents)[^53]</td>
<td>112 items</td>
<td>Parents of adolescents 11 to 19 y</td>
<td>20 min</td>
<td>Internal consistency for subscales exceed 0.80. 4-week test-retest coefficients range from 0.74 to 0.91.</td>
<td>Not described</td>
<td>Proprietary ($144/kit)</td>
</tr>
<tr>
<td>Trauma/Exposure</td>
<td>PDS (Post-traumatic stress diagnostic scale)[^53,54]</td>
<td>49 items Paper/pencil or computer</td>
<td>18 to 65 y</td>
<td>10 to 15 min</td>
<td>High internal consistency</td>
<td>Reading level: eighth grade</td>
<td>Proprietary ($66.50/kit)</td>
</tr>
<tr>
<td></td>
<td>UCLA-PTSD RI (Post-traumatic Stress Disorder Reaction Index)[^56-57]</td>
<td>Child: 20 items Parent: 21 items Youth: 22 items Adapted version available in AAP Feelings Need Check Ups Too CD-ROM[^58] to assess trauma exposure</td>
<td>Child and parent: 7 to 12 y Youth: 13+ y</td>
<td>20 to 30 min to administer</td>
<td>Good test-retest with a coefficient of 0.84. A cutoff of 38 provides 0.93 sensitivity and 0.87 specificity.</td>
<td>English, Spanish</td>
<td>Available to International Society for Traumatic Stress Studies (ISTSS) members</td>
</tr>
<tr>
<td></td>
<td>TSCC (Trauma Symptom Checklist for Children)[^59,60]</td>
<td>54 items TSCC-A is a 44-item alternative version that does not contain sexual concern items. TSCYC is a 90-item caregiver-report instrument for young children</td>
<td>8 to 16 y</td>
<td>15 to 20 min</td>
<td>High internal consistency for 5 of 6 clinical scales (0.62 to 0.89)</td>
<td>English, Spanish</td>
<td>Proprietary ($168/kit)</td>
</tr>
<tr>
<td>Psychosocial Measure</td>
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<td>Psychometric Properties</td>
<td>Cultural Consideration</td>
<td>Cost and Developer</td>
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<tr>
<td><strong>Assessing Child and Adolescent Functioning (Algorithm Steps A2a, A12a, B5a, B12)</strong></td>
<td><strong>Global Functioning</strong></td>
<td><strong>BIS (Brief Impairment Scale)</strong> (Multi-dimensional)&lt;sup&gt;61&lt;/sup&gt;</td>
<td>23 items Parent report</td>
<td>4 to 17 y</td>
<td>10 min</td>
<td>Internal consistency (0.81 to 0.88 and 0.56 to 0.81) on the 3 subscales. Test-retest reliability for individual items ranged from fair to substantial in all but 6 items. The BIS has high convergent and concurrent validity. ROC suggest possible thresholds for different uses.</td>
<td>English, Spanish</td>
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<td><strong>CIS (Columbia Impairment Scale)</strong>—part of CWA/Adolescent Wellness Assessment)&lt;sup&gt;62,63&lt;/sup&gt;</td>
<td>13 items</td>
<td>Children and adolescents</td>
<td>5 min</td>
<td>Reliable and valid. Evaluates global impairment along 4 areas of dysfunction after 6 mo of treatment.</td>
<td>Data mainly on Caucasian and Hispanic children</td>
<td>Freely accessible</td>
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<td><strong>CGSQ (Caregiver Strain Questionnaire)</strong>—part of the CWA&lt;sup&gt;64,65&lt;/sup&gt;</td>
<td>21 items</td>
<td>Children and adolescents</td>
<td>5 to 10 min</td>
<td>Administered after 6 mo of treatment</td>
<td>Data mainly in Caucasian and Hispanic children</td>
<td>Freely accessible</td>
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<td><strong>C-GAS (Children’s Global Assessment Scale)</strong>&lt;sup&gt;66,67&lt;/sup&gt;</td>
<td>1 item Rated by clinician</td>
<td>4 to 16 y</td>
<td>Requires no administration time because it is based on prior clinical assessment. Time to integrate knowledge of the child into a single score is estimated to be 5 to 10 min.</td>
<td>Demonstrates discriminant and concurrent validity.</td>
<td>Not described</td>
<td>Freely accessible</td>
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<td></td>
<td><strong>SDQ Impact Scale</strong>&lt;sup&gt;68,69&lt;/sup&gt;</td>
<td>5 items Parent Teacher Youth ≥11 y</td>
<td>3 to 17 y</td>
<td>&lt;5 min</td>
<td>See earlier entry on SDQ; limited data on impact scale alone.</td>
<td>&gt;40 languages</td>
<td>Freely accessible</td>
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<tr>
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| Assessing Emergencies (Algorithm Steps A8a, A4b) | **Suicide Assessment** | Adapted-SAD PERSONS®<sup>®</sup>  
Sex, Age, Depression or affective disorder, Previous attempt, Ethanol-drug abuse, Rational thinking loss, Social supports lacking, Organized plan, Negligent parenting, significant family stressors, suicidal modeling by parents or siblings, School problems | 10-item assessment scale | Elementary and middle school students | Part of interview process | Not described | Not described | Freely accessible |
| | | **CSPI-2 (Childhood Severity of Psychiatric Illness)**<sup>®</sup>  
Assesses severity by eliciting risk factors, behavioral/emotional symptoms, functioning problems, involvement with juvenile justice and child protection, and caregiver needs and strengths. | 34 items Individual report | 3 to 21 y | 3 to 5 min after a routine crisis assessment  
25 to 30 min to complete if nothing is known of the child/family  
Training is generally recommended and demonstration of reliability (ie, certification) before use (by office staff in particular). There are a large number of trainers available and some Web-based training options. | High training and field reliability. Substantial evidence of concurrent and predictive validity. | Available in Spanish | Freely accessible | Available at [www.praedfoundation.org](http://www.praedfoundation.org) |
| | PHQ-9 severity items on suicide | See Modified PHQ-9 later in table. | | | | | |

<sup>®</sup> Psychometric Cultural Cost

*Not described
<table>
<thead>
<tr>
<th>Psychosocial Measure</th>
<th>Tools and Description</th>
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<th>Cultural Considerations</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Checklists</td>
<td>Child Behavior Checklist (CBCL)²⁰⁻²²</td>
<td>Parent or caregiver/teacher for 1.5 to 5 y: 99 items</td>
<td>1.5 to 5 y</td>
<td>15 to 20 min (both age groups)</td>
<td>Test-retest: 0.95 to 1.00  Inter-rater reliability: 0.93 to 0.96  Internal consistency: 0.78 to 0.97  Criterion validity was assessed and found to be acceptable.</td>
<td>Spanish can be ordered but tool has been translated in 74 languages;  Norms: African-American, Caucasian, Hispanic/Latino, other</td>
<td>Proprietary ($310 to $435/kit)</td>
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<td>DSM-oriented scales assess for</td>
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<td>Pervasive developmental problems</td>
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<td>Conduct problems</td>
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<td>(Both groups)</td>
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<td>Affective problems</td>
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<td>Anxiety problems</td>
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<td>Oppositional-defiant problems</td>
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<td>Attention-deficit/hyperactivity problems</td>
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<td>Parent/teacher: 118 items</td>
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<td>6 to 18 y</td>
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<tr>
<td>Rating Scales</td>
<td>Vanderbilt Diagnostic Rating Scales²³</td>
<td>Parent: 55 items</td>
<td>6 to 12 y</td>
<td>10 min</td>
<td>Internal consistency and factor structure are acceptable and consistent with DSM-IV and other accepted measures of ADHD. Rates inattention, impulsivity/hyperactivity, ODD, CD, depression/anxiety, and performance.  The performance section of the teacher version has high correlation with the performances questions of the SDQ (0.97). The performance section of the parent version does not have data about its concurrent validity at the current time, so that it is best used as a questionnaire to provide information about performance to be clarified in the interview the clinician has with the family.</td>
<td>English, Spanish  Freely accessible</td>
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<td>Elicits symptoms in domains of inattention, disruptive behavior, anxiety, and depression; separate scale assesses functioning in the area of school performance.</td>
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<tr>
<td>Conners Rating Scales–Revised&lt;sup&gt;14,75&lt;/sup&gt;</td>
<td>Elicits symptoms in domains of oppositionality, cognitive problems/inattention, hyperactivity, anxiety-shyness, perfectionism, social problems, psychosomatic problems.</td>
<td>Parent: 80 items Teacher: 59 items Self: 87 items</td>
<td>3 to 17 y for parent/teacher 12 to 17 y for self</td>
<td>20 min</td>
<td>6 distinct scales Age and gender norms based on more than 11,000 ratings.</td>
<td>English, Spanish</td>
<td>Proprietary ($273/kit)</td>
</tr>
<tr>
<td>SNAP-IV-C&lt;sup&gt;76–78&lt;/sup&gt;</td>
<td>Elicits symptoms of ADHD and other DSM-IV disorders that may overlap with or masquerade as ADHD.</td>
<td>90 items Parent Teacher</td>
<td>6 to 18 y</td>
<td>10 min</td>
<td>Coefficient alpha for overall parent ratings is 0.94. Internal consistency, item selection, and factor structure were found acceptable and consistent with the constructs in DSM-IV.</td>
<td>A number of languages: English, Chinese</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>SWAN (Strengths and Weaknesses of ADHD Symptoms and Normal Behavior Scale)&lt;sup&gt;79–81&lt;/sup&gt;</td>
<td>Elicits strengths and weaknesses in domains of attention, impulsivity/hyperactivity. Strength-based rating scales have the potential to evaluate the normal distribution of behaviors and to provide reliable cutoff defining abnormal behavior. Evaluates attention across a continuum.</td>
<td>18-item version and 30-item version</td>
<td>6 to 18 y</td>
<td>10 min</td>
<td>The information gathered with the SWAN-French is compatible with that obtained using the DISC-4.0 and Conners Rating Scale.</td>
<td>Available in French</td>
<td>Freely accessible</td>
</tr>
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<tr>
<td>BASC (Behavior Assessment System for Children)&lt;sup&gt;82-84&lt;/sup&gt;</td>
<td>Parent version: 134 to 160 items Teacher version: 100 to 139 items Youth version</td>
<td>2 to 21 y</td>
<td>Parent version: 10 to 20 min Teacher version: 10 to 20 min Youth version: 30 min Electronic scoring available Must be administered by qualified personnel</td>
<td>Acceptable to strong reliability and validity</td>
<td>English, Spanish</td>
<td>Proprietary ($132.20 to $1,655/kit)</td>
<td></td>
</tr>
<tr>
<td>ADHD Rating Scale-IV&lt;sup&gt;85,86&lt;/sup&gt;</td>
<td>Parent, teacher</td>
<td>5 to 17 y</td>
<td>10 to 20 min</td>
<td>Internal consistency (coefficient alphas) for inattention and hyperactivity-impulsivity factors greater than 0.90, test-retest reliability greater than 0.80 for both factors, and significant correlations with concurrent direct observations and with other behavior rating scales</td>
<td>English, Spanish</td>
<td>Proprietary ($46)</td>
<td></td>
</tr>
<tr>
<td>MOAS (Modified Overt Aggression Scale)&lt;sup&gt;87,88&lt;/sup&gt;</td>
<td>4 items Physician rating of aggression</td>
<td>Adults but has been used in adolescents</td>
<td>Administered as a semi-structured interview asking adolescent to report on aggressive behavior. 10 to 15 min</td>
<td>Internal consistency 0.84: strong correlation with anger and hostility measures</td>
<td>Shown to have discriminant validity when used in Nigeria&lt;sup&gt;89&lt;/sup&gt;</td>
<td>Freely accessible</td>
<td></td>
</tr>
<tr>
<td>Conduct Disorder Scale&lt;sup&gt;90&lt;/sup&gt;</td>
<td>40 items Parent Teachers Siblings</td>
<td>5 to 22 y</td>
<td>5 to 10 min</td>
<td>The test was standardized on 1,040 persons representing the following diagnostic groups: normal, gifted and talented, mentally retarded, ADHD, emotionally disturbed, learning disabled, physically handicapped, and persons with conduct disorder. Norms were developed based on 644 representative individuals with a conduct disorder.</td>
<td>Not described</td>
<td>Proprietary ($102/kit)</td>
<td></td>
</tr>
<tr>
<td>Modified PHQ-9&lt;sup&gt;91&lt;/sup&gt;</td>
<td>9 plus severity items</td>
<td>Adolescent</td>
<td>5 min Scoring: 1 min</td>
<td>Modified version never validated in a research setting; overall 88% sensitivity and 88% specificity</td>
<td>English, Spanish</td>
<td>Free with permission Available in the toolkit at <a href="http://www.gladpc.org">www.gladpc.org</a>.</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Measure</td>
<td>Tools and Description</td>
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<td>Cultural Considerations</td>
<td>Cost and Developer</td>
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<tr>
<td>KADS (Kutcher Adolescent Depression Scale)</td>
<td>Screens for depression.</td>
<td>6, 11, or 16 items</td>
<td>12 to 17 y</td>
<td>5 min Scoring: 1 min</td>
<td>Sensitivity: 92% Specificity: 71%</td>
<td>Not described</td>
<td>Free with permission Available at <a href="http://www.teenmentalhealth.org">www.teenmentalhealth.org</a></td>
</tr>
<tr>
<td>CES-D (Center for Epidemiological Studies–Depression Scale)</td>
<td>Screens for depression, emotional turmoil.</td>
<td>20 items</td>
<td>6 to 17 y</td>
<td>5 to 10 min Scores above 15 can be indicative of significant levels of depressive symptoms.</td>
<td>Used in adult populations. Modified version for children and adolescents may not discriminate well between depressed and nondepressed adolescents. Sensitivity: 71% Specificity: 57%</td>
<td>Mexican adolescents, French English, Spanish Reading level: sixth grade</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>DISC (Columbia Diagnostic Interview Schedule for Children Diagnostic Predictive Scales)</td>
<td>Computerized structure interview (yes/no) elicits symptoms of 36 mental health disorders, applying DSM-IV criteria.</td>
<td>22 items (Last item is not scored.) Youth self-administered 8-item abbreviated version available through TeenScreen</td>
<td>9 to 17 y</td>
<td>Depends on items endorsed Training needed</td>
<td>Sensitivities and specificities ranged from 80% to 100% for nearly all diagnostic scales. Positive predictive value was generally high (0.4–0.7). Test-retest reliabilities are good and had intraclass correlation coefficients ranging from 0.52 to 0.82.</td>
<td>Not described</td>
<td>Free with permission Contact <a href="http://www.TeenScreen.org">www.TeenScreen.org</a> for a copy of the 8-item version.</td>
</tr>
<tr>
<td>CDI (Child Depression Inventory)</td>
<td>Screens for depression.</td>
<td>Parent: 17 items Teacher: 12 items Youth: 27 items (Y Short-Form: 10 items)</td>
<td>7 to 17 y</td>
<td>5 to 10 min (27-item)</td>
<td>Internal consistency coefficients range from 0.71 to 0.89 and the test-retest coefficients range from 0.74 to 0.83.</td>
<td>English, Spanish Reading level: first grade</td>
<td>Proprietary ($250/kit)</td>
</tr>
<tr>
<td>SMFQ (Short Mood and Feelings Questionnaire)</td>
<td>Screens for depression.</td>
<td>13 items Self-report (child and parent)</td>
<td>8 to 16 y</td>
<td>&lt;5 min</td>
<td>For combined parent and child reports Sensitivity: 70% Specificity: 85%</td>
<td>Not described</td>
<td>Free with permission. Permission information available at <a href="http://devepi.duhs.duke.edu/mfq.html">http://devepi.duhs.duke.edu/mfq.html</a></td>
</tr>
<tr>
<td>Psychosocial Measure</td>
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<tr>
<td>PHQ-A (Patient Health Questionnaire for Adolescents)</td>
<td>Screens for anxiety, eating problems, mood problems, and substance abuse.</td>
<td>83 items Self-report (adolescents)</td>
<td>13 to 18 y</td>
<td>Scoring: &lt;5 min</td>
<td>Sensitivity: 75% Specificity: 92% Accuracy: 89% Diagnostic agreement: 0.65 Properties considered acceptable by US Preventive Services Task Force to screen adolescents for depression.¹⁰⁶</td>
<td>Not described</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>PHQ-A Depression Screen</td>
<td>Screens for depression.</td>
<td>Abbreviated 9-item screen specifically for depression</td>
<td>12 to 18 y</td>
<td>&lt;5 min to complete and score</td>
<td>Not described</td>
<td>Not described</td>
<td>Free with permission</td>
</tr>
<tr>
<td>BDI (Beck Depression Inventory)</td>
<td>Screens for depression.</td>
<td>21 items Self-administered or verbally administered by a trained administrator</td>
<td>14+ y</td>
<td>5 to 10 min Training required</td>
<td>Sensitivity: 84% Specificity: 81%</td>
<td>English, Spanish</td>
<td>Proprietary ($115/kit)</td>
</tr>
<tr>
<td>BDI-FS (Becks Depression Inventory—FastScreen)</td>
<td>Screens for depression.</td>
<td>7 items</td>
<td>13+ y</td>
<td>&lt;5 min</td>
<td>Sensitivity: 91% Specificity: 91% Properties considered acceptable by US Preventive Services Task Force to screen adolescents for depression.¹⁰⁶</td>
<td>Not described</td>
<td>Propriety. ($99/kit)</td>
</tr>
<tr>
<td>Spence Children’s Anxiety Scale</td>
<td>Screens for anxiety. Subscales include panic/agoraphobia, social anxiety, separation anxiety, generalized anxiety, obsessions/ compulsions, and fear of physical injury.</td>
<td>Parent: 35 to 45 Student: 34 to 45 Parent: 2.5 to 6.5 y Student: 8 to 12 y</td>
<td>8+ y</td>
<td>5 to 10 min</td>
<td>Coefficient alpha: 0.9 to 0.92 Test-retest: 0.60 to 0.63 Normative data: Available for males/females 8 to 19 y from various countries (no US data available)</td>
<td>Available in a variety of languages</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>SCARED (Self-Report for Childhood Anxiety Related Emotional Disorders)</td>
<td>Screens for anxiety—but not specifically OCD or PTSD.</td>
<td>41 items Parent Youth</td>
<td>8+ y</td>
<td>5 min</td>
<td>Coefficient alpha: 0.9</td>
<td>English</td>
<td>Freely accessible</td>
</tr>
<tr>
<td>Psychosocial Measure</td>
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<tr>
<td>CRIES (Children's Revised Impact of Event Scale) (^{13,114})</td>
<td>Assesses impact of traumatic events.</td>
<td>13 items total 4 items measuring intrusion 4 items measuring avoidance 5 items measuring arousal Self-report</td>
<td>8 y and older who can read</td>
<td>Training (none, unless otherwise indicated)</td>
<td>Cronbach alphas were as follows: Intrusion: 0.70 Avoidance: 0.73 Arousal: 0.60 Total: 0.80 No validation studies against independent clinical diagnosis have been conducted. As a screening, it is recommended that the results from the Intrusion and Avoidance scales only be used. A sum of the scores on these 2 scales of 17 or more indicates a high probability that the child will obtain a diagnosis of PTSD.</td>
<td>Available in several languages</td>
<td>Freely accessible. Instructions and forms available at childrenandwar.org</td>
</tr>
<tr>
<td>BRIEF (Behavior Rating Inventory of Executive Function) (^{115})</td>
<td>Assesses executive functioning in the home and school environments. Contributes to evaluation of learning disabilities, ADHD, traumatic brain injury, low birth weight, Tourette disorder, and pervasive developmental disorders/autism.</td>
<td>86 items Parent Teacher</td>
<td>5 to 18 y</td>
<td>Scoring: 15 to 20 min</td>
<td>High internal consistency (alphas: 0.80 to 0.98); test-retest reliability (Spearman’s rho: 0.82 for parents and 0.88 for teachers); and moderate correlations between teacher and parent ratings (Spearman’s rho: 0.32 to 0.34)</td>
<td>Not described</td>
<td>Proprietary ($230 to $385/kit)</td>
</tr>
<tr>
<td>BITSEA (Brief Infant Toddler Social Emotional Assessment) (^{116,117})</td>
<td>Screens for social-emotional problems in young children.</td>
<td>42 items Parent report Child care report</td>
<td>12 to 36 mo</td>
<td>Scoring: 7 to 10 min</td>
<td>Nationally standardized on 100 children. Excellent test-retest reliability. Detected 85% to 90% CBCL.</td>
<td>English, Spanish</td>
<td>Proprietary ($108.60/kit)</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>CHADIS-DSM (^{118})</td>
<td>Electronic Variable number of items depending on response—46 entry followed by algorithm</td>
<td>Birth on by parent</td>
<td></td>
<td></td>
<td>English, some Spanish</td>
<td>Proprietary (Cost not available)</td>
</tr>
<tr>
<td>Psychosocial Measure</td>
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<tr>
<td>DISC-IV (Diagnostic Interview Schedule for Children)</td>
<td>Assesses for more than 30 diagnoses using DSM-IV, DSM-III-R, and ICD-10 criteria.</td>
<td>The DISC employs a branching-tree question structure. Altogether, the DISC-Y contains 2,930 questions (the DISC-P contains a few more).</td>
<td>6 to 18 y</td>
<td>Administration time largely depends on how many symptoms are endorsed.</td>
<td>Test-retest agreement with DSM-IV Major Depression criterion A was good (k: 0.79 for parents, k: 0.67 for youths).</td>
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</tr>
</tbody>
</table>

### Collateral Information Tools (Algorithm Steps A12a, B2b, B9)

<table>
<thead>
<tr>
<th>Rating Scales</th>
<th>Vanderbilt</th>
<th>See previous entry in table.</th>
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<tr>
<td>Conners</td>
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<tr>
<td>SNAP-IV-C</td>
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<td>SWAN</td>
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<td>BASC</td>
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<tr>
<td>ADHD Rating Scale</td>
<td>See previous entry in table.</td>
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<tr>
<td>Conduct Disorder Scale</td>
<td>See previous entry in table.</td>
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<tr>
<td>Disruptive Behavior Rating Scale</td>
<td>Rates disruptive behaviors.</td>
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<tr>
<td>Early Childhood Screening Assessment</td>
<td>See previous entry in table.</td>
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<tr>
<td>BITSEA</td>
<td>See previous entry in table.</td>
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</tbody>
</table>

Rates disruptive behaviors. 45 items Parent/teacher 5 to 10 y 5 to 10 min Test-retest: 0.68 to 0.92 Inter-rater reliability: not assessed Internal consistency: 0.72 to 0.95 Criterion validity was assessed and found to be acceptable. Limited, Caucasian, other—sample from central Virginia Freely accessible
Mental Health Screening and Assessment Tools for Primary Care

<table>
<thead>
<tr>
<th>Psychosocial Measure</th>
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<tbody>
<tr>
<td>C-TRF (Caregiver-Teacher Report Form)</td>
<td>Assesses for emotionally reactive, anxious/depressed, somatic complaints, withdrawn, attention problems, and aggressive behavior.</td>
<td>99 items</td>
<td>1.5 to 5 y</td>
<td>Hand and computer scoring</td>
<td>Normed on 1,192 children. Consistent with DSM diagnostic categories.</td>
<td>English</td>
<td>Proprietary ($160/kit for hand scoring; $295/kit for computer scoring)</td>
</tr>
</tbody>
</table>

AAP: American Academy of Pediatrics; MCHB: Maternal and Child Health Bureau; NA, not applicable; PPV, positive predictive value; NPV, negative predictive value; ROC, receiver operator curve; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; ADHD, attention-deficit/hyperactivity disorder; ODD, oppositional-defiant disorder; CD, conduct disorder; OCD, obsessive-compulsive disorder; PTSD, post-traumatic stress disorder; DSM-III-R, Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised; ICD-10, International Classification of Diseases, 10th Edition.

* A good overview of cultural competence in the mental health is provided by Cultural Competency: A Practical Guide for Mental Health Service Providers, published by the Hogg Foundation for Mental Health at the University of Texas (www.hogg.utexas.edu/PDF/Saldana.pdf).

** Screening tool designed for large-scale screening; easily administered, scored, and interpreted.

References
Mental Health Screening and Assessment Tools for Primary Care


64. Brannan AM, Helfinger CA, Bickman L. The Caregiver Strain Questionnaire: measuring the impact on the family of living with a child with serious emotional disturbance. *J Emot Behav Disord.* 1997;5:212–222


## Evidence-Based Child and Adolescent Psychosocial Interventions

This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period October 2016 – April 2017 using the PracticeWise Evidence-Based Services (PWEBS) Database, available at www.practicewise.com. If this is not the most current version, please check the American Academy of Pediatrics (AAP) mental health Web site (www.aap.org/mentalhealth) for updates. Please note that this chart represents an independent analysis by PracticeWise and should not be construed as endorsement by the AAP. For an explanation of PracticeWise determination of evidence/level, please see below or visit www.practicewise.com/aap.

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1- BEST SUPPORT</th>
<th>Level 2- GOOD SUPPORT</th>
<th>Level 3- MODERATE SUPPORT</th>
<th>Level 4- MINIMAL SUPPORT</th>
<th>Level 5- NO SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT), CBT and Medication, CBT for Child and Parent, CBT with Parents, Education, Exposure, Modeling</td>
<td>Assertiveness Training, Attention, Attention Training, CBT and Music Therapy, CBT and Parent Management Training, CBT with Parents Only, Cultural Storytelling, Family Psychoeducation, Hypnosis, Relaxation, Stress Inoculation</td>
<td>Contingency Management, Group Therapy</td>
<td>Behavioral Activation and Exposure, Biofeedback, Parent Management Training, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy, Social Skills</td>
<td>Assessment/Monitoring, Attachment Therapy, Client Centered Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Pairing, Psychoeducation, Relationship Counseling, Teacher Psychoeducation</td>
</tr>
<tr>
<td>Depressive or Withdrawn Behaviors</td>
<td>CBT, CBT and Medication, CBT with Parents, Client Centered Therapy, Family Therapy</td>
<td>Cognitive Behavioral Psychoeducation, Expression, Interpersonal Therapy, Motivational Interviewing/Engagement and CBT, Problem Solving, Relaxation</td>
<td>None</td>
<td>Self-Control Training, Self Modeling</td>
<td>CBT and Behavioral Sleep Intervention, Goal Setting, Life Skills, Parent Management Training, Parent Management Training and Emotion Regulation, Play Therapy, Psychodynamic Therapy, Psychoeducation, Social Skills</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>CBT, Physical Exercise and Dietary Care and Behavioral Feedback</td>
<td>Family Systems Therapy, Family Therapy</td>
<td>None</td>
<td>Physical Exercise and Dietary Care</td>
<td>Behavioral Training and Dietary Care, CBT with Parents, Client Centered Therapy, Dietary Care, Education, Family Therapy with Parent Consultant, Family-Focused Therapy, Goal Setting, Psychoeducation, Yoga</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Level 2- GOOD SUPPORT</th>
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<th>Level 4- MINIMAL SUPPORT</th>
<th>Level 5- NO SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination Disorders</td>
<td>Behavior Alert, Behavior Alert and Behavioral Training, Behavioral Training, Behavioral Training and Biofeedback and Dietary Care and Medical Care, Behavioral Training and Dietary Care and Medical Care</td>
<td>Behavioral Training and Dietary Care, Behavioral Training and Hypnosis and Dietary Care, CBT</td>
<td>Behavior Alert and Medication</td>
<td>None</td>
<td>Assessment/Monitoring, Assessment/Monitoring and Medication, Behavioral Training and Medical Care, Biofeedback, Contingency Management, Dietary Care, Dietary Care and Medical Care, Hypnosis, Medical Care, Psychoeducation</td>
</tr>
<tr>
<td>Mania</td>
<td>None</td>
<td>CBT for Child and Parent, Cognitive Behavioral Psychoeducation</td>
<td>None</td>
<td>None</td>
<td>Dialectical Behavior Therapy and Medication, Family-Focused Therapy, Psychoeducation</td>
</tr>
<tr>
<td>Substance Use</td>
<td>CBT, Community Reinforcement, Contingency Management, Family Therapy, Motivational Interviewing (MI) /Engagement</td>
<td>Assertive Continuing Care, CBT and Contingency Management, CBT and Medication, CBT with Parents, Family Systems Therapy, Functional Family Therapy, Goal Setting/Monitoring, MI/Engagement and CBT, MI/Engagement and Expression, Multidimensional Family Therapy, Problem Solving, Purdue Brief Family Therapy</td>
<td>Drug Court, Drug Court and Multisystemic Therapy and Contingency Management, Eclectic Therapy</td>
<td>Goal Setting, Psychoeducation</td>
<td>Advice/Encouragement, Assessment/Monitoring, Behavioral Family Therapy, Case Management, CBT and Community Information Campaign, CBT and Functional Family Therapy, Client Centered Therapy, Drug Court and Multisystemic Therapy, Drug Education, Education, Family Court, Group Therapy, MI/Engagement and CBT and Family Therapy, Multisystemic Therapy, Parent Psychoeducation, Therapeutic Vocational Training</td>
</tr>
<tr>
<td>Suicidality</td>
<td>None</td>
<td>Attachment Therapy, Counselors Care, Counselors Care and Support Training, Interpersonal Therapy, Multisystemic Therapy, Parent Coping/Stress Management, Psychodynamic Therapy, Social Support</td>
<td>None</td>
<td>None</td>
<td>Accelerated Hospitalization, CBT, Communication Skills, Counselors Care and Anger Management</td>
</tr>
<tr>
<td>Traumatic Stress</td>
<td>CBT, CBT with Parents, Exposure, EMDR</td>
<td>None</td>
<td>None</td>
<td>Play Therapy, Psychodrama, Relaxation and Expression</td>
<td>Advice/Encouragement, Client Centered Therapy, CBT and Medication, CBT with Parents Only, Education, Interpersonal Therapy, Psychodynamic Therapy, Psychoeducation, Relaxation, Structured Listening</td>
</tr>
</tbody>
</table>

Adapted with permission from PracticeWise.

Note: Level 5 refers to treatments whose tests were unsupportive or inconclusive. This report updates and replaces the “Blue Menu” originally distributed by the Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence-Based Services Committee from 2002–2009.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.
Background

The American Academy of Pediatrics (AAP) “Evidence-Based Child and Adolescent Psychosocial Interventions” tool is created twice each year and posted on the AAP Web site at www.aap.org/mentalhealth, using data from the PracticeWise Evidence-Based Services Database, available at www.practicewise.com. The table is based on an ongoing review of randomized clinical psychosocial and combined treatment trials for children and adolescents with mental health needs. The contents of the table represent the treatments that best fit a patient’s characteristics, based on the primary problem (rows) and the strength of evidence behind the treatments (columns). Thus, when seeking an intervention with the best empirical support for an adolescent with depression, one might select from among cognitive behavior therapy (CBT) alone, CBT with medication, CBT with parents included, or family therapy. Each clinical trial must have been published in a peer-reviewed scientific journal, and each study is coded by 2 independent raters whose discrepancies are reviewed and resolved by a third expert judge. Prior to report development, data are subject to extensive quality analyses to identify and eliminate remaining errors, inconsistencies, or formatting problems.

Strength of Evidence Definitions

The strength of evidence classification uses a 5-level system that was originally adapted from the American Psychological Association Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures. These definitions can be seen in the Box below. Higher strength of evidence is an indicator of the reliability of the findings behind the treatment, not an index of the expected size of the effect.

Treatment Definitions

“Evidence-Based Child and Adolescent Psychosocial Interventions” uses a broad level of analysis for defining treatments, such that interventions sharing a majority of components with similar clinical strategies and theoretical underpinnings are considered to belong to a single treatment approach. For example, rather than list each CBT protocol for depression on its own, the tool handles these as a single group that collectively has achieved a particular level of scientific support. This approach focuses more on “generic” as opposed to “brand name” treatment modalities, and it also is designed to reduce the more than 500 distinct treatments that would otherwise be represented on this tool to a more practical level of analysis.

Problem Definition

The presenting problems represented in the table rows are coded using a checklist of 25 different problem areas (e.g., anxious or avoidant behaviors, eating disorders, substance use). The problem area refers to the condition that a treatment explicitly targeted and for which clinical outcomes were measured. These problem areas are inclusive of diagnostic conditions (e.g., all randomized trials targeting separation anxiety disorder are considered collectively within the “Anxious or Avoidant Behaviors” row) but also include the much larger number of research trials that tested treatments but did not use diagnosis as a study entry criterion. For example, many studies use elevated scores on behavior or emotion checklists or problems such as arrests or suicide attempts to define participants. Mental health diagnoses are therefore nested under these broader categories.

History of This Tool

This tool has its origins with the Child and Adolescent Mental Health Division of the Hawaii Department of Health. Under the leadership of then-division chief Christina Donkervoet, work was commissioned starting in 1999 to review child mental health treatment outcome literature and produce reports that could serve the mental health system in selecting appropriate treatments for its youth. Following an initial review of more than 120 randomized clinical trials, the division began to issue the results of these reviews in quarterly matrix reports known as the Blue Menu (named for the blue paper on which it was originally printed and distributed). This document was designed to be user-friendly and transportable, thereby making it amenable to broad and easy dissemination. As of 2010, the AAP supports the posting of the next generation of this tool. “Evidence-Based Child and Adolescent Psychosocial Interventions” now represents over 800 randomized trials of psychosocial treatments for youth. PracticeWise continues to identify, review, and code new research trials and plans to continue providing updates to this tool to the AAP for the foreseeable future.
References


See more on the PracticeWise publications page.

Strength of Evidence Definitions

Level 1: Best Support
I. At least 2 randomized trials demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to all other groups representing at least one level 1 or level 2 treatment in a study with adequate statistical power (30 participants per group on average) that showed significant pre-study to post-study change in the index group as well as the group(s) being tied. Ties of treatments that have previously qualified only through ties are ineligible.
II. Experiments must be conducted with treatment manuals.
III. Effects must have been demonstrated by at least 2 different investigator teams.

Level 2: Good Support
I. Two experiments showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. Manuals, specification of sample, and independent investigators are not required.
   OR
II. One between-group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either
   a. Superior to pill placebo, psychological placebo, or another treatment
   b. Equivalent to an already established treatment (See qualifying tie definition above.)

Level 3: Moderate Support
One between-group design experiment with clear specification of group and treatment approach and demonstrating efficacy by either
   a. Superior to pill placebo, psychological placebo, or another treatment
   b. Equivalent to an already established treatment in experiments with adequate statistical power (30 participants per group on average)

Level 4: Minimal Support
One experiment showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. Manuals, specification of sample, and independent investigators are not required.

Level 5: No Support
The treatment has been tested in at least one study but has failed to meet criteria for levels 1 through 4.
# SYMPTOMS AND SIGNS SUGGESTIVE OF MENTAL HEALTH AND SUBSTANCE ABUSE CONCERNS

## Table 1. Symptoms of Emotional Disturbance by Age Group

**Infants and Young Children**
- Excessive crying
- Feeding problems or poor weight gain
- Dysregulation (difficulty organizing feelings and emotions, difficulty being soothed or comforted, difficulty falling or staying asleep)
- Irritability
- Excessive clinginess for developmental stage
- Excessive fearfulness for developmental stage
- Poor eye contact or engagement with caregiver

**School-aged Children**
- Anger
- Bullying
- Fighting
- Irritability
- Fear of separation
- Fluctuating moods
- Sleep disturbance
- Academic decline
- Sadness
- Isolation

**Adolescents**
- Numbness or avoidance of feelings
- Anger
- Fearfulness
- Aggressive, fighting, rule- or lawbreaking
- Self-injury
- Poor school attendance; disciplinary problems; suspension or expulsion
- Appetite change, weight loss or gain
- Difficulty sleeping or excessive sleeping
- Exaggerated mood swings
- Academic decline
- Isolation, withdrawal from friends, loss of interest in usual activities
- Substance use, sexual promiscuity, or other risky behaviors

**All Age Groups**
- Chronic, recurrent, or unexplained physical symptoms (*See Table 2.*)
- Very disruptive or persistent nightmares
- Regression to earlier behavior
- Change in sleep pattern
- Exacerbation of chronic medical condition
## Table 2. Physical Symptoms and Signs Suggestive of Mental Health and Substance Abuse Concerns

### Sleep Problems
- Excessive sleep
- Significant change in sleep pattern
- Difficulty falling or staying asleep
- Nightmares

### Chronic, Recurrent, or Unexplained Physical Symptoms
- Abdominal pain
- Joint pain
- Headache
- Fatigue or low energy
- Loss of appetite
- Epigastric pain or gastritis (alcohol use)
- Chest pain or difficulty breathing (panic/anxiety attacks)
- Oligomenorrhea or amenorrhea, especially in women of low weight (anorexia, teen pregnancy)
- Irregular menses (anorexia, bulimia)

### Neurologic Symptoms
- Leg weakness
- Limb paralysis (conversion reaction)
- Pseudo-seizures
  - Non-physiologic neurologic symptoms
  - Difficulty concentrating, inattentiveness in school
  - Irritability, restlessness

### Physical Findings
- Excess weight gain or loss
- Parotid gland enlargement, dental enamel erosion, calluses or erosions on knuckles (purging)
- Cigarette burns, multiple linear cuts or patterns (self-harm, maltreatment)
- Metabolic abnormalities such as hypochloremic metabolic alkalosis, low potassium, or elevated amylase (purging)
- Recurrent injuries (maltreatment, self-harm)
- Isolated systolic hypertension (alcohol use)
- Chronic nasal congestion (cocaine use)
- Chronic red eyes (marijuana use)

### Other
- Worsening symptoms of previously well-managed chronic illness
- School absences

**doi: 10.1542/peds.2010-07885**
Supplemental Appendix S13: Symptoms and Signs Suggestive of Mental Health and Substance Abuse Concerns

*Pediatrics* 2010;125;S193

DOI: 10.1542/peds.2010-0788S

The online version of this article, along with updated information and services, is located on the World Wide Web at:

/content/125/Supplement_3/S193.citation
Every effort has been made to ensure this guide’s accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.
About this guide*

This publication takes effect October 1, 2016, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

<table>
<thead>
<tr>
<th>Subject</th>
<th>Change</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing and Claim Forms</td>
<td>Effective October 1, 2016, all claims must be filed electronically. See blue box notification.</td>
<td>Policy change to improve efficiency in processing claims</td>
</tr>
<tr>
<td>Are managed care clients eligible for EPSDT screenings?</td>
<td>Removed blue box stating that the agency covers referrals for mental health or substance abuse assessments outside the agency-contracted managed care organization</td>
<td>Correction</td>
</tr>
<tr>
<td>What is included in an EPSDT screening?</td>
<td>Added a sentence requiring that providers document EPSDT services provided</td>
<td>Clarification</td>
</tr>
<tr>
<td>How often should EPSDT screenings occur?</td>
<td>Added to the bullet for screening examinations recommended for children age 1 through 2 years, “with one screening recommended before the child is 15 months of age.”</td>
<td>Clarification</td>
</tr>
<tr>
<td></td>
<td>Added a blue box: “Children covered by managed care plans have coverage for the same frequency of exams described above, except for children age 7 through age 18. Children in this age group may receive an EPSDT exam annually. Managed care plans also offer a limitation extension for EPSDT exams with</td>
<td>Clarification</td>
</tr>
</tbody>
</table>

* This publication is a billing instruction.
Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program

prior authorization as described above for children who have medical necessity for more frequent exams.”

<table>
<thead>
<tr>
<th>Lead toxicity screening</th>
<th>Added a provision to the section requiring lead toxicity screening at age 12 months and 24 months for all Apple Health-enrolled children, specifying that this requirement includes managed care-enrolled children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarification</td>
<td></td>
</tr>
</tbody>
</table>

How can I get agency provider documents?

To access provider alerts, go to the agency’s provider alerts web page.

To access provider documents, go to the agency’s provider billing guides and fee schedules web page.

Copyright disclosure

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Mental Health and Substance Abuse Assessments

Note: Eligible clients may receive a mental health or substance abuse assessment without an EPSDT screening or referral.

Is mental health screening part of the EPSDT screening process?

Yes. Mental Health screenings may be done using standardized screening tools or through an interview. See EPSDT Mental Health/Substance Abuse Assessment Referral Indicators for a list of behaviors that may indicate mental health problems.

Clients age 20 and younger have access to mental health services. See Mental Health Services Billing Guide for details. However, if the client may meet BHO Access to Care Standards, then a referral to the Behavioral Health Organization (BHO) should be considered. Referral for assessment is based on professional judgment. See Behavioral Health Organization Contacts for a complete listing.

Screening guidelines

Mental health and substance abuse screenings are intended to identify children who are at risk for, or may have, mental health or substance abuse problems. Screenings do not result in a diagnosis. If a screen indicates a possible problem, the child is referred for an assessment where a diagnosis and plan of care are developed.

When child abuse or neglect is suspected, a report to Child Protective Services must be made, even if the child is also referred for a mental health assessment.

If an eligible client is suspected or identified through the EPSDT screening as having a mental health or substance abuse problem, providers may refer the client to a mental health or substance abuse provider and assist the client/family in making appointments and obtaining necessary treatment. This referral must be made within two weeks from the date the problem is identified, unless the problem is urgent. If the problem is urgent, a referral must be made immediately.

Document the need for the service in the client’s records. The diagnosing or treating mental health or substance abuse provider should communicate the results of the referral back to the primary care provider.
Urgent referrals

Some behaviors, symptoms, and risk factors may signal that a child is in crisis. In these cases the referral process must be sped up so that the child may be assessed and treated promptly. An immediate referral must be made by telephone to the mental health agency whenever the child exhibits any of the following:

- Fire-setting
- Suicidal behavior or suicidal ideation
- Self-destructive behavior
- Torturing animals
- Destroying property
- Substance abuse, either in conjunction with other mental health concerns or if the child is under the age of 12 years
- Sexual acting out
- Witnessing a death or other substantial physical violence
- Experiencing sexual or physical abuse
- Out of touch with reality, delusional (psychotic decompensation)
- Imminent risk of placement in a more restrictive setting

The crisis response system should be used only if the child is a danger to himself/herself or others.

Nonurgent referral

When screening for mental health problems, use professional judgment when deciding to refer the client for further assessment of other issues, such as:

- Family issues
- Problematic peer activities
- School issues
- Somatic symptoms
- Abnormal behaviors
- Unusual feelings and thoughts
- Unusual growth and development
- Social situation problems

Children may also be referred for a mental health assessment at a parent's request. Make a referral if the child or parent sees the behavior or symptom as problematic, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have shown to be the best predictors of mental health problems.
How are substance abuse screening and treatment provided?

Screening and treatment may be provided in any of the following ways:

**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

A comprehensive, evidence-based, public health practice designed to identify people who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. SBIRT services are provided in a wide variety of medical and community healthcare settings. See the agency’s [Physician-Related Services/Health Care Professional Services Billing Guide](#) for more details.

**Washington Recovery Help Line**

The Washington Recovery Help Line is the consolidated help line for substance abuse, problem gambling, and mental health. The help line provides anonymous and confidential crisis intervention and referral services for Washington State residents. Professionally trained volunteers and staff are available to provide emotional support 24 hours a day, and offer local treatment for substance abuse. To refer substance abuse cases, call the 24-hour Washington Recovery Help Line at 800-789-1511.
### EPSDT mental health/substance abuse assessment referral indicators

Consider these and other symptoms/behaviors when making a referral for an assessment.

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicators for a Mental Health Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>problems separating physical abuse or neglect psychological abuse sexual abuse domestic violence divorce/separation chronic physical or mental illness of parent</td>
</tr>
<tr>
<td>Peer activity</td>
<td>no confidence social isolation</td>
</tr>
<tr>
<td>Behaviors</td>
<td>temper tantrums fire setting stealing tics sexually acting out lying substance abuse destroys property aggressive</td>
</tr>
<tr>
<td>School</td>
<td>school failure school refusal</td>
</tr>
<tr>
<td>Feelings</td>
<td>anxiety or nervousness feeling depressed low self-esteem</td>
</tr>
<tr>
<td>Thoughts</td>
<td>delusions hallucinations</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>trouble sleeping sleepwalking night terrors</td>
</tr>
<tr>
<td>Social</td>
<td>lack of housing frequent moves financial problems</td>
</tr>
<tr>
<td>Growth and Development</td>
<td>slow weight gain nonorganic failure to thrive mentally retarded learning disabilities</td>
</tr>
</tbody>
</table>


The indicators listed above may be elicited from caregivers and children through interviews described in professional references (e.g., American Academy of Pediatrics: Guidelines for Child Health Supervision; and the Region X Nursing Network: Prenatal and Child Health Screening and Assessment Manual). It may be appropriate to interview the child separate from the caregiver beginning at age eight years. Screening infants and toddlers for mental health problems is an emerging science. Based on professional judgment, referral is appropriate when there are concerns that a family and social environment do not support the infant's mental wellness. Children with behaviors not listed on the checklist should also be referred for mental health services, if the parent desires. It is important to remember that if the child or parent sees the behavior or symptom as problematic, make a referral, even if the issues seem minor or within normal range to you. Parents' and teachers' perceptions have been shown to be the best predictors of mental health problems.
EXAMPLE referral explanation for teen or parent

SO YOU HAVE BEEN REFERRED FOR A MENTAL HEALTH/SUBSTANCE ABUSE ASSESSMENT...
NOW WHAT HAPPENS?

You and your health care provider have talked. The next step is to refer you for an assessment to find out if you need services.

A qualified professional will meet with you and may talk about several things such as:

- What worries you or others about you?
- What you and others have already done to help.
- Relationships at home, at school, day care, with other friends, etc.
- Your family history.
- How serious your problems may or may not be.

You and the worker will help choose the service that is right for you.

If you have questions about obtaining a mental health or substance abuse assessment, call the Washington Recovery Help Line at 800-789-1511.

If you have issues accessing an agency-approved provider, contact the Medical Assistance Customer Services line at 800-562-3022.
Sharing Resources
Behavioral Health Care Resources For Children And Teens In

(Insert Name Of Region/County Here)

Finding a mental/behavioral health counselor

• Counties/regions: list local agency(ies) here OR list BHO website to find list
• For those with Medicaid: contact your local Behavioral Health Organization (BHO):
  INSERT BHO name/phone/address/website here

• Those with private health insurance may also contact their insurance company for a list of providers.

Substance abuse services

• Counties/regions add local providers here
• Washington Recovery Help line: 1-866-789-1511 or www.warecoveryhelpline.org
• Counties/regions to add local detox info here:

Crisis services

• Crisis/acute mental health care:
  www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/acute-mental-health-care
• To access county/regional crisis line:
  www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/state-mental-health-crisis-lines
  OR call (Counties/regions insert local county/regional crisis line(s) here):

  (Note: anyone can call their local county crisis line regardless of insurance coverage)
• Teenlink: confidential teen-answered help line and computer chat service: 1-866-833-6546 or
  http://866teenlink.org
• NAMI crisis line: text NAMI to 741741

Suicide prevention and intervention resources

• US National Suicide Hotline: 1-800-SUICIDE or 1-800-273-TALK (8255)
• www.suicidepreventionlifeline.org
• Youth Suicide Prevention Program: www yspp.org
• The Trevor Project: 1-866-4-U-TREVOR (free, confidential hotline for suicidal teens who are gay, lesbian, bisexual, transgender)
• Crisis text line: Text START to 741-741 to talk to a trained counselor

Psychiatric inpatient services for youth

• Counties/regions add local facilities here
• Add local DMHP phone number
• Add local Emergency Dept phone number

continued on next page
Behavioral Healthcare Resources for Children and Teens

Family support organizations
• Counties/regions can add as they choose
• Parent Trust: www.parenttrust.org

Information/support about mental health/disorders
• National Alliance on Mental Illness (NAMI): resources, links to local support groups
  http://www.nami.org/
• Substance Abuse and Mental Health Services Administration (SAMHSA): resources, education, support:
  https://www.samhsa.gov/

General information
• Washington Recovery Help Line: 24-hour help for substance abuse, problem gambling, and mental health
  1-866-789-1511 www.warecoveryhelpline.org
• Washington Information Network
  Dial 2-1-1 www.resourcehouse.info/Win211
• Washington State Department of Social and Health Services
  Local office: insert phone/address/website here
• Apply for Health Insurance: https://www.wahealthplanfinder.org or 1-855-923-4633
  To report child abuse/neglect: 1-866-ENDHARM (1-866-363-4276)
Washington Mental Health Care Resources

General Information
- Washington Information Network 2-1-1 www.resourcehouse.info/Wi211
- Washington State Department of Social and Health Services www.dshs.wa.gov
- Apply for Health Insurance https://www.wahealthplanfinder.org

Accessing a Mental/Behavioral Health Therapist
- Find a therapist http://therapists.psychologytoday.com www.helppro.com
- For those with Medicaid, contact your local Behavioral Health Organization (BHO) https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery

If you have private insurance you may also contact your insurance company for a list of providers.

Family Support Organizations
- DSHS Resources for Parents https://www.dshs.wa.gov/ca/advancing-child-welfare/getting-help
- DSHS Children’s Administration www.dshs.wa.gov/ca/general/index.asp
- Parent Trust www.parenttrust.org
- Parent to Parent www.p2pusa.org

Developmental Disabilities Resources
- Developmental Disabilities Administration www.dshs.wa.gov/dda
- To apply for DD Services please request an application from your local office. Office locater: www.dshs.wa.gov/DDA/dda/find-an-office

Juvenile Justice Services
- Juvenile Rehabilitation www.dshs.wa.gov/ra/juvenile-rehabilitation
- Office of Juvenile Justice and Delinquency Prevention www.ojjdp.gov

Military Family Resources
- Home Base Program http://homebase.org
- Resources for Military and Veteran Families http://www.mghpact.org/for-parents/other-resources/for-military-and-veteran-families

Crisis Services
- Crisis/Acute Mental Health Care www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/acute-mental-health-care
- County Crisis Lines www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/state-mental-health-crisis-lines
*Please note — anyone can call their local county crisis line regardless of their insurance coverage.
- US National Suicide Hotlines 1-800-SUICIDE 1-800-273-TALK www.suicidepreventionlifeline.org
- Teenlink — A confidential teen-answered help line and computer chat service 1-866-833-6546 http://866teenlink.org

Substance Abuse Services
- Substance Abuse Information for Washington State www.dshs.wa.gov/bha
- Washington Recovery Help line 1-866-789-1511 www.warecoveryhelpline.org
- Alcoholics Anonymous http://aa.org
- Narcotics Anonymous http://na.org
- Treatment Locator http://findtreatment.samhsa.gov

Seattle Children’s
HOSPITAL • RESEARCH • FOUNDATION
Partnership Access Line
Mental Health Consultation Outreach

90
Assessing Integration
Instructions for Completing the MeHAF Site Self Assessment (SSA) Survey

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site’s current extent of integration for patient and family-centered primary care, behavioral and mental health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA.

Please respond in terms of your site’s current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle (or mark in a color or bold, if completing electronically) one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.

This form was adapted from similar formats used to assess primary care for chronic diseases.

Identifying Information:

Name of your site: ___________________________ Date: ___________________________

Name of person completing the SSA form: ___________________________ Your job role: ___________________________

Did you discuss these ratings with other members of your team? YES NO

Grantee Organization: ___________________________
### I. Integrated Services and Patient and Family-Centeredness

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Level of integration: primary care and mental/behavioral health care</td>
<td>none; consumers go to separate sites for services</td>
</tr>
<tr>
<td>2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)</td>
<td>are not done (in this site)</td>
</tr>
<tr>
<td>2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)</td>
<td></td>
</tr>
<tr>
<td>3. Treatment plan(s) for primary care and behavioral/mental health care</td>
<td>do not exist</td>
</tr>
<tr>
<td>4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care</td>
<td>does not exist in a systematic way</td>
</tr>
<tr>
<td>Score</td>
<td>MeHAF – Site Self Assessment</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Patient/family involvement in care plan</td>
</tr>
<tr>
<td>2</td>
<td>. . . does not occur</td>
</tr>
<tr>
<td>3</td>
<td>. . . is passive; clinician or educator directs care with occasional patient/family input</td>
</tr>
<tr>
<td>4</td>
<td>. . . is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)</td>
</tr>
<tr>
<td>5</td>
<td>. . . is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources</td>
</tr>
<tr>
<td>6</td>
<td>Communication with patients about integrated care</td>
</tr>
<tr>
<td>7</td>
<td>. . . does not occur</td>
</tr>
<tr>
<td>8</td>
<td>. . . occurs sporadically, or only by use of printed material; no tailoring to patient’s needs, culture, language, or learning style</td>
</tr>
<tr>
<td>9</td>
<td>. . . occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent</td>
</tr>
<tr>
<td>10</td>
<td>. . . is a systematic part of site’s integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care</td>
</tr>
<tr>
<td>1</td>
<td>Follow-up of assessments, tests, treatment, referrals and other services</td>
</tr>
<tr>
<td>2</td>
<td>. . . is done at the initiative of the patient/family members</td>
</tr>
<tr>
<td>3</td>
<td>. . . is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up</td>
</tr>
<tr>
<td>4</td>
<td>. . . is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments</td>
</tr>
<tr>
<td>5</td>
<td>. . . is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients’ needs, using varied methods; is proactive in outreach to patients who miss appointments</td>
</tr>
<tr>
<td>1</td>
<td>Social support (for patients to implement recommended treatment)</td>
</tr>
<tr>
<td>2</td>
<td>. . . is not addressed</td>
</tr>
<tr>
<td>3</td>
<td>. . . is discussed in general terms, not based on an assessment of patient’s individual needs or resources</td>
</tr>
<tr>
<td>4</td>
<td>. . . is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs</td>
</tr>
<tr>
<td>5</td>
<td>. . . is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources</td>
</tr>
<tr>
<td>1</td>
<td>Linking to Community Resources</td>
</tr>
<tr>
<td>2</td>
<td>. . . does not occur</td>
</tr>
<tr>
<td>3</td>
<td>. . . is limited to a list or pamphlet of contact information for relevant resources</td>
</tr>
<tr>
<td>4</td>
<td>. . . occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral</td>
</tr>
<tr>
<td>5</td>
<td>. . . is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations, and patients</td>
</tr>
<tr>
<td>MeHAF Plus Items</td>
<td>1</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications</td>
<td></td>
</tr>
<tr>
<td>... does not exist in a systematic way</td>
<td>1</td>
</tr>
<tr>
<td>... depends on each provider’s own use of the evidence; some shared evidence-based approaches occur in individual cases</td>
<td></td>
</tr>
<tr>
<td>... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers</td>
<td></td>
</tr>
<tr>
<td>... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert</td>
<td></td>
</tr>
<tr>
<td>11. Tracking of vulnerable patient groups that require additional monitoring and intervention</td>
<td></td>
</tr>
<tr>
<td>... does not occur</td>
<td>1</td>
</tr>
<tr>
<td>... is passive; clinician may track individual patients based on circumstances</td>
<td></td>
</tr>
<tr>
<td>... patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking</td>
<td></td>
</tr>
<tr>
<td>... patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team</td>
<td></td>
</tr>
<tr>
<td>12. Accessibility and efficiency of behavioral health practitioners</td>
<td></td>
</tr>
<tr>
<td>... behavioral health practitioner(s) are not readily available</td>
<td>1</td>
</tr>
<tr>
<td>... is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration behavioral health has into primary care population</td>
<td></td>
</tr>
<tr>
<td>... is partially present; behavioral health practitioners may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume)</td>
<td></td>
</tr>
<tr>
<td>... is fully present; behavioral health practitioners are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per clinician (or comparable number based on clinic volume)</td>
<td></td>
</tr>
</tbody>
</table>
### II. Practice/Organization

#### (Circle one NUMBER for each characteristic)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organizational leadership for integrated care</td>
<td>. . . does not exist or shows little interest                                                                                       . . . is supportive in a general way, but views this initiative as a “special project” rather than a change in usual care                                                                                     . . . is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)</td>
</tr>
<tr>
<td>2. Patient care team for implementing integrated care</td>
<td>. . . does not exist                                                                                                               . . . exists but has little cohesiveness among team members; not central to care delivery                                                                                                                   . . . is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills</td>
</tr>
<tr>
<td>3. Providers’ engagement with integrated care (“buy-in”)</td>
<td>. . . is minimal                                                                                                                   . . . engaged some of the time, but some providers not enthusiastic about integrated care                                                                                                               . . . is moderately consistent, but with some concerns; some providers not fully implementing intended integration components</td>
</tr>
<tr>
<td>4. Continuity of care between primary care and behavioral/mental health</td>
<td>. . . does not exist                                                                                                               . . . is not always assured; patients with multiple needs are responsible for their own coordination and follow-up                                                                                      . . . is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only</td>
</tr>
<tr>
<td>5. Coordination of referrals and specialists</td>
<td>. . . does not exist</td>
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<td>1 2 3 4</td>
<td>5 6 7</td>
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</tbody>
</table>

<table>
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<tr>
<th>6. Data systems/patient records</th>
<th>. . . are based on paper records only; separate records used by each provider</th>
<th>. . . are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps</th>
<th>. . . use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals</th>
<th>. . . has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4</td>
<td>5 6 7</td>
<td>8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Patient/family input to integration management</th>
<th>. . . does not occur</th>
<th>. . . occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions</th>
<th>. . . is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate</th>
<th>. . . is considered an essential part of management’s decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4</td>
<td>5 6 7</td>
<td>8 9 10</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Physician, team and staff education and training for integrated care</th>
<th>. . . does not occur</th>
<th>. . . occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic</th>
<th>. . . is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation</th>
<th>. . . is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4</td>
<td>5 6 7</td>
<td>8 9 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Funding sources/resources</td>
<td>. . . a single grant or funding source; no shared resource streams</td>
<td>. . . separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies</td>
<td>. . . separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training</td>
<td>. . . fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly</td>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
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</tbody>
</table>
A STANDARD FRAMEWORK FOR
LEVELS OF INTEGRATED HEALTHCARE

SAMHSA-HRSA
Center for Integrated Health Solutions
ACKNOWLEDGEMENTS

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SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the HHS/Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration, and run by the National Council for Community Behavioral Healthcare, CIHS provides training and technical assistance to community behavioral health organizations that received Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS’s wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

ABSTRACT: Integration of healthcare is essential to improve the individual’s experience of care, improve the health of the general population, and reduce per capita healthcare costs. The term “integration” is widely and inconsistently used to describe the bringing together of healthcare components. Integration has been used to reference everything from consultation to colocation to a setting of shared health values around treating the whole person, with blurred professional boundaries. There have been no fully updated taxonomies to describe the levels of integration since the 1996 Doherty, McDaniel, and Baird article, which initially proposed five levels of integration. Since this seminal issue brief and preliminary framework, there have been many informal and local adaptations. However, without a standard classification of integrated settings, discussions of integration lack clarity and precision, and research cannot confidently examine discrete aspects of integration. This issue brief reviews levels of integrated healthcare and proposes a functional standard framework for classifying sites according to these levels.

KEY WORDS: integration; collaborative care; mental health; behavioral health; collaboration; healthcare

BACKGROUND

Over the last several years, as healthcare reform has taken a prominent national position and mental health and substance abuse treatments have evolved, an increasing number of articles have been written on collaboration and the integration of traditional primary care and behavioral health* practices (Butler, Kane, & McAlpine, 2008; Collins, Hewson, Munger, & Wade, 2010; Funk & Ivbijaro, 2008; Lopez, Coleman-Beattie, & Sanchez, 2008; Mauer, 2006, 2009; Mauer & Jarvis, 2010; Miller, Kessler, & Peek, 2011; Robinson & Reiter, 2007; Russell, 2010). These articles have described a wide variety of collaborative, co-located, and integrated service models.

Developing a standard framework to describe integrated efforts is critical for meaningful dialogue about service design, as well as for research. Until there is a way to reliably categorize integration implementations, meaningful comparisons of implementations or associated health outcomes cannot occur. This point is made throughout the Miller et al. 2011 paper, which calls for a broader “lexicon for the common terms and components for collaborative care so that research questions can be framed in a consistently understood manner” (p. 2). On the clinical side, integrated care developers and implementers will benefit from recognizing the characteristics of practice change that support evolving integration models. Knowing what features of integrated healthcare implementations lead to the most favorable and stable health outcomes will be an important contribution to the health field.

A standard framework also contributes to the orderly evolution of national healthcare reform and aligns with the political and service realities defined by Berwick, Nolan and Whittington (2008). Integration is essential to achieving the triple aim of improved experience of care, improved health of populations, and reduced per capita healthcare cost advocated by Berwick, et al. The lessons learned from a reliable comparison of models and implementations provide the best foundation to inform policy decisions on the structure of more effective healthcare as care integration moves forward.

LEVELS OF INTEGRATION

Doherty, McDaniel, and Baird (1995, 1996) proposed the first classification by level of collaboration and integration. They proposed the five levels of primary care-behavioral healthcare collaboration, recognizing that collaboration and integration of care were evolving and being communicated in wide-ranging ways. Doherty et. al.’s classification involved both the extent of the occurrence of collaboration and the capacity for collaboration in the setting, but they did not focus on specific interactions. An underlying premise of the levels was that as collaboration increased, the adequate handling of complex patients would also increase. The levels recognized by Doherty et al. did not prescribe a particular model as best for all healthcare settings, but rather served as a foundation from which to tease apart the strengths and limitations of a variety of

* This issue brief uses the term behavioral health to describe mental health and substance use.
options. It was proposed that use of the levels would help organizations evaluate their setting in light of their goals for collaboration and to assist in researching outcomes and costs associated with different collaborative models with different patient populations.

In the original framework, Doherty et al. differentiated levels by where they were practiced, the cases adequately handled at each level, and the following descriptions:

- **LEVEL 1** - Minimal Collaboration: Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.

- **LEVEL 2** - Basic Collaboration at a Distance: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.

- **LEVEL 3** - Basic Collaboration Onsite: Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular.

- **LEVEL 4** - Close Collaboration in a Partly Integrated System: Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other’s roles and cultures.

- **LEVEL 5** - Close Collaboration in a Fully Integrated System: Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other’s roles and areas of expertise.

The following chart summarizes these five levels of collaboration:

<table>
<thead>
<tr>
<th>MINIMAL COLLABORATION</th>
<th>BASIC COLLABORATION FROM A DISTANCE</th>
<th>BASIC COLLABORATION ONSITE</th>
<th>CLOSE COLLABORATION/PARTLY INTEGRATED</th>
<th>FULLY INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Nobody knows my name. Who are you?&quot;</td>
<td>&quot;I help your consumers.&quot;</td>
<td>&quot;I am your consultant.&quot;</td>
<td>&quot;We are a team in the care of consumers&quot;</td>
<td>&quot;Together, we teach others how to be a team in care of consumers and design a care system.&quot;</td>
</tr>
</tbody>
</table>

Conversely, patients perceive their care differently:

-水平1：极低合作——精神健康和其他医疗保健提供者工作在不同的设施和系统，很少沟通。
-水平2：基本合作——医疗保健提供者在不同的地点和系统，但通过电话和信件偶尔沟通。提供者视彼此为资源。
-水平3：基本合作——医疗保健和医疗保健专业人员共享系统和设施，共享文化和角色。
-水平4：紧密合作——医疗保健和医疗保健专业人员在相同的设施和团队中，协作流程顺畅。
-水平5：完全整合——医疗保健和医疗保健专业人员在相同的设施和团队中，协作流程顺畅。

"Nobody knows my name. Who are you?"
"I help your consumers."
"I am your consultant."
"We are a team in the care of consumers"
"Together, we teach others how to be a team in care of consumers and design a care system."
These five levels have formed the foundation for most subsequent level adaptations. The idea that integration occurs along a continuum of collaboration and integration is widely supported (Collins, et. al., 2010; Miller, et. al., 2011; Peek, 2007; Reynolds, 2006; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996; Strohsal, 1998) and adaptations have differed in the number of levels (from three to 10) and the categories used to differentiate or describe levels.

The reason for classification, whether for clinical development or research, has influenced the choice of dimensions used to define each level. For example, Reynolds (2006) used the same five levels, but distinguishes between levels on the basis of functional practice categories, including access, services, funding, governance, evidence-based practice, and data usage. The goal of Reynolds’ adaptation is to better capture the patient and staff experience at the different levels; in doing so, it broadens the levels’ descriptions and characteristics.

Other papers and reports have classified integrated implementations somewhat differently. MaineHealth (2009) developed a site-specific rating of integration that has four levels along a continuum of integration, with one rating in the first level and three ratings in levels two, three, and four. There are 18 characteristics broadly categorized as integrated services, patient- and family-centeredness, and practice/organization. In the first category, characteristics such as colocation, patient/family involvement, and communication with patients about integrated care are rated. In the second category, characteristics such as organizational leadership for integrated care, providers’ engagement, and data systems/patient are rated.

More similar to Doherty et. al., Blount (2003) collapsed the five levels to three: coordinated, co-located, and integrated care. Recent work to develop a lexicon or common conceptual system for collaborative care between behavioral health and primary medical clinicians (Miller et. al., 2011) has also adopted these three levels in describing collaborative care practice.

The Milbank report, Evolving Models of Behavioral Health Integration in Primary Care (Collins et. al., 2010), describes eight models of integration across a variety of settings. This group uses Doherty et. al.’s five level structure and the terms coordinated, co-located, and integrated to differentiate these models.

**STANDARD FRAMEWORK**

Doherty et al. established the five levels of integration, recognizing differences in integrated implementations and the various forms collaboration took in each level. Based upon the initial efforts by Doherty et al. and the experience accumulated over the intervening 17 years, the authors of this paper propose a new version of the levels of collaboration/integration. The framework brings together valuable aspects that have evolved since the Doherty et al. paper. The framework also includes several enhancements that enable it to be comprehensive enough to serve as a national standard for future discussion about integrated healthcare, allow organizations implementing integration to gauge their degree of integration against acknowledged benchmarks, and serve as a foundation for comparing healthcare outcomes between integration levels.

Doherty et al. established the concept of levels of implementations that followed a continuum from collaboration to integration. The model in this issue brief retains some of the original categorical descriptions that continue to prove useful today. Blount’s use of coordination, colocation, and integration serve as overarching categories. The Milbank report, which brought together Doherty et. al.’s five levels and Blount’s broader categories, also informs this conceptual framework.

This new level of integration framework proposes six levels of collaboration/integration. While the overarching framework has three main categories — coordinated, co-located, and integrated care — there are two levels of degree within each category (see Table 1). It is designed to help organizations implementing integration to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.
Coordinated Care

LEVEL 1 — Minimal Collaboration
Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider’s need for specific information about a mutual patient.

LEVEL 2 — Basic Collaboration at a Distance
Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.

Co-Located Care

LEVEL 3 — Basic Collaboration Onsite
Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

LEVEL 4 — Close Collaboration with Some System Integration
There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other’s roles.

Integrated Care

LEVEL 5 — Close Collaboration Approaching an Integrated Practice
There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

LEVEL 6 — Full Collaboration in a Transformed/Merged Practice
The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Key elements were added to more clearly differentiate between the levels in each overarching category. For coordinated care, the key element is communication. The distinction between Level 1 and Level 2 is frequency and type of communication. With increased communication, providers have stronger relationships and greater understanding of the importance of integrated care and
the skills that different providers possess. This communication increases the coordination of care between separate healthcare entities.

Physical proximity is the key element for the co-located care category. Although colocation does not guarantee greater collaboration or integration, it can be beneficial. Taking advantage of close proximity increases collaboration through face-to-face contact at Level 3. It can also develop the opportunity for trust and relationship building, leading to more sharing of systems — the hallmark of beginning integration at Level 4. However, providers can be co-located and have no integration of their healthcare services. Each provider can still practice independently without communicating with others and with an integrated healthcare plan. Colocation reduces time spent travelling from one practitioner to another, but does not guarantee integration.

At Level 5 and Level 6, practice change is the key element. No site can be fully integrated without changing how both behavioral health and primary care are practiced. The requisite practice change features a blending or blurring of cultures, where no one discipline predominates. Across many integrated implementations at several levels, almost every practitioner wants integrated care, and believes it is the direction for healthcare to move towards, until they realize it requires they change how they practice. It is at that point they often try to change the concepts of their integration efforts to preserve how they currently practice.

A second modification proposed to the original Doherty et al. structure is the use of the terms “collaboration” and “integration.” In this framework, collaboration describes how resources — namely, the healthcare professionals — are brought together; integration describes how services are delivered and practices are organized and managed. This idea is similar to Strosahl’s (1998) concept that collaborative care involves behavioral health working with primary care, while integration is behavioral health working within and as part of primary care. Recent analysis (Mauer & Jarvis, 2010) indicates that collaboration and integration can effectively originate in either behavioral health or primary care and requires the transformation of both into a single whole. In this standard framework, both collaboration and integration (beginning at Level 3) increase in degree and complexity over the continuum for providers, while similarly decreasing for clients/individuals.

An important enhancement to the levels is also found in a restructuring of the descriptive characteristics defining each level (see Table 1). Each of the six levels begins with a general description followed by key differentiators (see Table 2A and 2B) under the headings clinical delivery, patient experience, practice/organization, and business model. These characteristics help differentiate the levels. They also incorporate some of the functional categories Reynolds (2006) identified in her consumer/staff experiential perspective of the levels of integration, Kodner’s (2009) integrated care domains, and MaineHealth’s (2009) Site Assessment. Finally, Table 3 describes the strengths and weaknesses of each level so that these can be built upon or addressed.

Although the term behavioral health has been used throughout this framework, integration of substance use treatment and primary care has not been as extensive or prevalent as integration of mental health with primary care. Further work is required to more effectively support substance use integration (Butler, et. al., 2008; Mauer, 2010).

It is worth noting that even if health outcomes improve as levels of integration increase, it is not reasonable to believe that all healthcare settings would be able to easily, or even with difficulty, move to increasing levels of integration. As primary care and behavioral health have evolved in their own professional silos, it has been the authors’ experience that the bringing together of these services and service perspectives (usually embodied in separate agencies) into a single, fully integrated healthcare system requires a large amount of administrative, political, and financial investments over a long-term, stepwise, evolutionary process. It is important to aspire to whichever level can be best achieved practically.

At Level 3, colocation may be a necessary and good starting point to build trust between separate, existing systems and to establish a shared history of improved outcomes. This could lead to closer collaboration and integration of vision that moves to Level 4 implementation, possibly leading from there to a Level 5 partnership. Such a partnership may be the highest level attainable or may, in years to come, lead to a joint venture or a merger of the organizations. While this has not been fully researched, merging primary and behavioral health organizations appears necessary at this point for achieving Level 6 integration.
From a data standpoint, this framework also posits that integrated services should be defined by location, not by an algorithm of service code combinations. A single service (e.g., blood pressure check or depression medication check) provided in an integrated site/setting is considered an integrated service because it is provided in the context of that integrated site’s whole person care. Conversely, multiple services provided in a single visit are not by definition integrated care; these services could be, and all too often are, provided by separate professionals without meaningful collaboration or integration. By defining the level of integration in terms of setting, the authors of this framework define the context of interventions and the values (e.g., care team, whole health, patient-centered) that form the basis of an integrated site and integrated services. The key performance indicators in an integrated care setting are population-based health status outcomes, not encounter-based process/service data. Individual staff productivity must accompany, and then be replaced by population-based outcomes by site.

Funding structures and accountability must also change. Integrated care is not supported by fee-for-service funding structures that stumble over same day billing restrictions and do not reimburse for consultations between providers, when the patient is not physically present, or electronic contacts or a large volume of care management — all of which are essential for improved health outcomes in an integrated healthcare system. Fee-for-service funding can emphasize the measurement of volume rather than quality. Global or blended funding structures do support integrated healthcare and will be fiscally justified by improved patient outcomes that reduce overall healthcare cost.

CONCLUSION

The level of integration framework is a manageable, practical, and conceptually sound six level framework for integrated healthcare that begins with collaboration (how resources are brought together) and moves through colocation and increasing levels of integration (how services are framed and delivered). This standard framework is needed for clarity and precision of communication, as well as to contribute to research and practice redesign. By implication, the numbering of levels suggests that the higher the level of collaboration/integration, the more potential for positive impact on health outcomes and patient experience. This belief remains a hypothesis and has not been empirically tested. With further research, these benefits of collaboration/integration can be more firmly stated and can identify which aspects of the collaboration, integration, or combination of the two contribute most directly to health outcomes.

Even if health outcomes improve as levels of integration increase, it is not practical to believe that every healthcare setting will be able, at least in the near term, to implement increasing levels of integration. Many integrated implementations will be constrained by community politics, trust between organizational systems, financing, and/or differing service values.

Lastly, this issue brief does not presume to establish a fuller lexicon for integration and healthcare, as much needed as it is. The authors leave that to others better suited to the task and hope that this paper will contribute to such a lexicon. The purpose is to help those delivering services today by presenting a conceptual framework to better understand and differentiate integrated healthcare implementations. The authors believe that this framework will inform discussions about integrated healthcare and that its use will provide opportunity for service redesign that will lead to better conceptual and practical models of care.
REFERENCES


### Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>Level</th>
<th>Key Element</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>COORDINATED</strong></td>
<td><strong>KEY ELEMENT: COMMUNICATION</strong></td>
<td></td>
</tr>
<tr>
<td>LEVEL 1</td>
<td>Minimal Collaboration</td>
<td>In separate facilities, where they:</td>
</tr>
<tr>
<td> </td>
<td>Have separate systems</td>
<td></td>
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<tr>
<td> </td>
<td>Communicate about cases only rarely and under compelling circumstances</td>
<td></td>
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<tr>
<td> </td>
<td>Communicate, driven by provider need</td>
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</tr>
<tr>
<td> </td>
<td>May never meet in person</td>
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</tr>
<tr>
<td> </td>
<td>Have limited understanding of each other’s roles</td>
<td></td>
</tr>
<tr>
<td>LEVEL 2</td>
<td>Basic Collaboration at a Distance</td>
<td>In separate facilities, where they:</td>
</tr>
<tr>
<td> </td>
<td>Have separate systems</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>Communicate periodically about shared patients</td>
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</tr>
<tr>
<td> </td>
<td>Communicate, driven by specific patient issues</td>
<td></td>
</tr>
<tr>
<td> </td>
<td>May meet as part of larger community</td>
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</tr>
<tr>
<td> </td>
<td>Appreciate each other’s roles as resources</td>
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<tr>
<td>LEVEL 3</td>
<td>Basic Collaboration Onsite</td>
<td>In same facility not necessarily same offices, where they:</td>
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<tr>
<td> </td>
<td>Have separate systems</td>
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<tr>
<td> </td>
<td>Communicate regularly about shared patients, by phone or e-mail</td>
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<tr>
<td> </td>
<td>Collaborate, driven by need for each other’s services and more reliable referral</td>
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<tr>
<td> </td>
<td>Meet occasionally to discuss cases due to close proximity</td>
<td></td>
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<tr>
<td> </td>
<td>Feel part of a larger yet non-formal team</td>
<td></td>
</tr>
<tr>
<td><strong>CO-LOCATED</strong></td>
<td><strong>KEY ELEMENT: PHYSICAL PROXIMITY</strong></td>
<td></td>
</tr>
<tr>
<td>LEVEL 4</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>In same space within the same facility, where they:</td>
</tr>
<tr>
<td> </td>
<td>Share some systems, like scheduling or medical records</td>
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<tr>
<td> </td>
<td>Communicate in person as needed</td>
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<tr>
<td> </td>
<td>Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
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<tr>
<td> </td>
<td>Have regular face-to-face interactions about some patients</td>
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</tr>
<tr>
<td> </td>
<td>Have a basic understanding of roles and culture</td>
<td></td>
</tr>
<tr>
<td>LEVEL 5</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>In same space within the same facility (some shared space), where they:</td>
</tr>
<tr>
<td> </td>
<td>Actively seek system solutions together or develop work-a-rounds</td>
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<tr>
<td> </td>
<td>Communicate frequently in person</td>
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<tr>
<td> </td>
<td>Collaborate, driven by desire to be a member of the care team</td>
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<tr>
<td> </td>
<td>Have regular team meetings to discuss overall patient care and specific patient issues</td>
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</tr>
<tr>
<td> </td>
<td>Have an in-depth understanding of roles and culture</td>
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</tr>
<tr>
<td>LEVEL 6</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
<td>In same space within the same facility, sharing all practice space, where they:</td>
</tr>
<tr>
<td> </td>
<td>Have resolved most or all system issues, functioning as one integrated system</td>
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<tr>
<td> </td>
<td>Communicate consistently at the system, team and individual levels</td>
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<tr>
<td> </td>
<td>Collaborate, driven by shared concept of team care</td>
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<tr>
<td> </td>
<td>Have formal and informal meetings to support integrated model of care</td>
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</tr>
<tr>
<td> </td>
<td>Have roles and cultures that blur or blend</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/ Merged Integrated Practice</td>
</tr>
</tbody>
</table>

#### Key Differentiator: Clinical Delivery

- **Table Rows:**
  - Screening and assessment done according to separate practice models
  - Separate treatment plans
  - Evidenced-based practices (EBP) implemented separately
  - Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges
  - Separate treatment plans shared based on established relationships between specific providers
  - Separate responsibility for care/EBPs
  - May agree on a specific screening or other criteria for more effective in-house referral
  - Separate service plans with some shared information that informs them
  - Some shared knowledge of each other’s EBPs, especially for high utilizers
  - May agree on a specific screening or other criteria for more effective in-house referral
  - Separate service plans with some shared information that informs them
  - Some shared knowledge of each other’s EBPs, especially for high utilizers
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  - May agree on a specific screening or other criteria for more effective in-house referral
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  - Some shared knowledge of each other’s EBPs, especially for high utilizers
  - May agree on a specific screening or other criteria for more effective in-house referral
  - Separate service plans with some shared information that informs them
  - Some shared knowledge of each other’s EBPs, especially for high utilizers

#### Key Differentiator: Patient Experience

- **Table Rows:**
  - Patient physical and behavioral health needs are treated as separate issues
  - Patient must negotiate separate practices and sites on their own with varying degrees of success
  - Patient health needs are treated separately, but records are shared, promoting better provider knowledge
  - Patients may be referred, but a variety of barriers prevent many patients from accessing care
  - Patient health needs are treated separately at the same location
  - Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider
  - Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers
  - Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services
  - Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others
  - Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop
  - Patient needs are treated for all patients by a team, who function effectively together
  - Patients experience a seamless response to all healthcare needs as they present, in a unified practice

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Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
</tr>
</thead>
<tbody>
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<td>Close Collaboration Approaching an Integrated Practice</td>
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</tr>
</tbody>
</table>

**Key Differentiator: Practice/Organization**

- **LEVEL 1**: No coordination or management of collaborative efforts
  - Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow

- **LEVEL 2**: Some practice leadership in more systematic information sharing
  - Some provider buy-into collaboration and value placed on having needed information

- **LEVEL 3**: Organization leaders supportive but often colocation is viewed as a project or program
  - Provider buy-in to making referrals work and appreciation of onsite availability

- **LEVEL 4**: Organization leaders support integration through mutual problem-solving of some system barriers
  - More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components

- **LEVEL 5**: Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced
  - Nearly all providers engaged in integrated model, Buy-in may not include change in practice strategy for individual providers

- **LEVEL 6**: Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development
  - Integrated care and all components embraced by all providers and active involvement in practice change

**Key Differentiator: Business Model**

- **LEVEL 1**: Separate funding
  - No sharing of resources
  - Separate billing practices

- **LEVEL 2**: Separate funding
  - May share resources for single projects
  - Separate billing practices

- **LEVEL 3**: Separate funding
  - May share facility expenses
  - Separate billing practices

- **LEVEL 4**: Separate funding, but may share grants
  - May share office expenses, staffing costs, or infrastructure
  - Separate billing due to system barriers

- **LEVEL 5**: Blended funding based on contracts, grants or agreements
  - Variety of ways to structure the sharing of all expenses
  - Billing function combined or agreed upon process

- **LEVEL 6**: Integrated funding, based on multiple sources of revenue
  - Resources shared and allocated across whole practice
  - Billing maximized for integrated model and single billing structure
Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

<table>
<thead>
<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
</tr>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
</tr>
</tbody>
</table>

### Advantages

- Each practice can make timely and autonomous decisions about care
- Maintains each practice’s basic operating structure, so change is not a disruptive factor
- Provides some coordination and information-sharing that is helpful to both patients and providers
- Services may overlap, be duplicated or even work against each other
- Sharing of information may not be systematic enough to effect overall patient care
- Proximity may not lead to greater collaboration, limiting value
- System issues may limit collaboration
- Practice changes may create lack of fit for some established providers
- Sustainability issues may stress the practice

- Colocation allows for more direct interaction and communication among professionals to impact patient care
- Referrals more successful due to proximity
- Opportunity to develop closer professional relationships
- Referrals may fail due to barriers, leading to patient and provider frustration
- Proximity may not be systematic enough to effect overall patient care
- Effort is required to develop relationships
- Potential for tension and conflicting agendas among providers as practice boundaries loosen
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care
- Outcome expectations not yet established

- Removal of some system barriers, like separate records, allows closer collaboration to occur
- Both behavioral health and medical providers can become more well-informed about what each can provide
- Patients are viewed as shared which facilitates more complete treatment plans
- Referrals may fail due to barriers, leading to patient and provider frustration
- System issues may limit collaboration
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care
- Outcome expectations not yet established

### Weaknesses

- Services may overlap, be duplicated or even work against each other
- Important aspects of care may not be addressed or take a long time to be diagnosed
- No guarantee that information will change plan or strategy of each provider
- Referrals may fail due to barriers, leading to patient and provider frustration
- Proximity may not be systematic enough to effect overall patient care
- Effort is required to develop relationships
- Limited flexibility, if traditional roles are maintained
- Practice changes may create lack of fit for some established providers
- Time is needed to collaborate at this high level and may affect practice productivity or cadence of care
- Outcome expectations not yet established

- High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans
- Provider flexibility increases as system issues and barriers are resolved
- Both provider and patient satisfaction may increase
- Opportunity to truly treat whole person
- All or almost all system barriers resolved, allowing providers to practice as high functioning team
- All patient needs addressed as they occur
- Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue

- Services may overlap, be duplicated or even work against each other
- Important aspects of care may not be addressed or take a long time to be diagnosed
- No guarantee that information will change plan or strategy of each provider
- Referrals may fail due to barriers, leading to patient and provider frustration
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