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# Integrated Behavioral Health Prevention in Pediatric Primary Care

OHIO COLLEGES OF MEDICINE
GOVERNMENT RESOURCE CENTER

MedTAPP
Medicaid Technical Assistance and Policy Program

Ohio | Department of Medicaid

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# I. Introduction

Integrated behavioral health (IBH) is increasingly recognized as one of the most important strategies to providing behavioral healthcare to children and adults.[1] By providing services in the clinic, many barriers and challenges to obtaining behavioral healthcare are overcome. Emerging behavioral health problems can be prevented or detected early, and behavioral health is incorporated into a model of individual health and wellness. Pediatric clinics, with their emphasis on prevention and wellness, are ideal settings in which to offer IBH. The universality of attending well-child visits in the pediatric clinic provides tremendous opportunities for extending reach and impact of behavioral health services. For this reason, the American Academy of Pediatrics encourages pediatric clinics to include behavioral health in their practices, and to strongly consider integrated behavioral health as a primary strategy for accomplishing this.[2]

To date, most IBH approaches in pediatrics have emphasized early identification and treatment of behavioral disorders.[3] Yet, the greatest potential impact of IBH is in prevention and promotion of healthy development. Building parental skills and capacity to provide young children with a nurturing, responsive, and stimulating environment is the most effective way to offset the forces that drive psychological maladjustment and behavioral health problems.[4] Despite a consensus that preventive approaches hold the most promise in reversing the epidemic of emotional and behavioral problems in childhood, there are few models for service delivery that are operationalized and scalable, particularly in children aged 0–5 years.

This Change Package is designed to address this need. In 2017, Cincinnati Children's Hospital Medical Center received a contract from the Ohio Department of Medicaid through their Ohio Medicaid Technical Assistance and Policy Program (MEDTAPP) to use quality improvement methods to operationalize and clearly delineate the elements of IBH-Prevention (IBH-P). As leaders in the application of quality improvement methods in pediatrics, we were well-positioned to refine and enhance this approach to preventing emotional and behavioral problems in young children. In this Change Package, we describe the rationale for IBH-P, the key elements of the approach, and our findings from implementation. What we learned from our quality improvement tests are described to illustrate key elements of the IBH-P intervention. Case examples are presented and links to additional resources are provided. The goal of the Change Package is to assist pediatric practices in adopting IBH-P, in it we provide guidance on clinical strategies, required infrastructure and supports, and metrics. The field is changing rapidly, and we fully expect that IBH-P will evolve and adapt as the future unfolds. It is our hope that this Change Package will facilitate widespread adoption of IBH-P and contribute to the growth and success of the field.

### Acronyms Used in Change Package:

IBH-P = Integrated Behavioral Health-Prevention

WCV = well-child visit

SDOH = social determinants of health

PCP = primary care provider

SAMHSA = Substance Abuse and Mental Health Services Administration

CCHMC = Cincinnati Children's Hospital Medical Center

# II. What is Integrated Behavioral Health-Prevention?

Integrated behavioral health-prevention (IBH-P) is an extension of the movement to provide behavioral health services in the pediatric setting.[5] IBH was first developed in adult patient populations, and an extensive body of research has accrued documenting its effectiveness and cost savings.[6] Only recently, however, has the focus moved to the pediatric setting,[3] and to providing preventive services in addition to treatment.[7] IBH reflects the direct and active involvement of behavioral health professionals in the pediatric care of children. The Substance Abuse and Mental Health Services Administration (SAMHSA)[8] identified six levels of a continuum of integrated care with adults and children. These range from the lowest level of integration, minimal collaboration—which describes different locations of behavioral health and pediatric care and "as needed" remote communication, through the highest level—full collaboration in a transformed/integrated practice, in which behavioral and pediatric care is offered in a shared location with frequent and intentional communication. Full integration provides seamless delivery of behavioral health care and pediatric care. As noted by SAMHSA, integrated behavioral health requires multiple roles of the behavioral health provider:

- Part of the primary care team
- Conducting screening of emotional and behavioral health
- Providing rapid response based on positive screening
- Providing brief interventions or, as needed, short- and long-term treatment
- Facilitating referrals and transitions to specialized behavioral health providers
- Communicating with outside care and other service providers

One of the most important roles for psychologists in an integrated practice is prevention. Prevention can be delivered in less time and focuses on building parenting capacity, child resilience, and mitigating risk factors that contribute to the development of mental health problems. Offered to all patients during well-child visits (WCVs), IBH-P is a universal

approach that is delivered for 15 minutes or longer if needed based on presentation and need. Brief delivery of preventive services fits well into the busy practice environment and maximizes the ability to see as many patients and families as possible. With 12 WCVs recommended in the first three years of life, there are many opportunities to educate and support parents in achieving healthy emotional and behavioral development in young children. The table below shows the contrast between three levels of integration.

Addressing behavioral health concerns in typical pediatric primary care, co-located behavioral health and the IBH-P approach.

| | Typical Pediatric Care | Co-located Behavioral Health | IBH-Prevention |
|---|---|---|---|
| Identification of behavioral health problems | Parental report<br>Pediatrician assessment<br>May use screen | Referral from pediatrician | Scheduled screening<br>Psychologist assessment<br>Conferring with pediatric care team |
| Prevention of behavioral health problems | Minimal guidance<br>Didactic | No provision of preventive services | Preventive visits at all WCVs<br>Interactive and experiential learning<br>Building trust |
| Role of behavioral health clinician | Minimal interaction with community-based clinicians | Collaboration as needed | "In the moment" collaboration with team<br>Provide 15-minute prevention visits<br>Provide short-term treatment as needed<br>Provide intervention as "bridge" to more intensive outside services<br>Formal and informal training of pediatric care team |
| Relationship to pediatric care team | Behavioral health clinician not member of team | Consults with team | Full member of team |
| Flexibility of behavioral health intervention delivery | Dependent on availability, accessibility, and capacity | Dependent on availability and capacity | Highly flexible and responsive |
| Referrals to outside behavioral health clinicians or other social services | Initiated by pediatrician | Initiated by pediatrician or behavioral health clinician as needed | Initiated by psychologist in consultation with team and in collaboration with family |
| Handling of behavioral health crises | Referral to outside services | Dependent on availability | Intervention by psychologist |

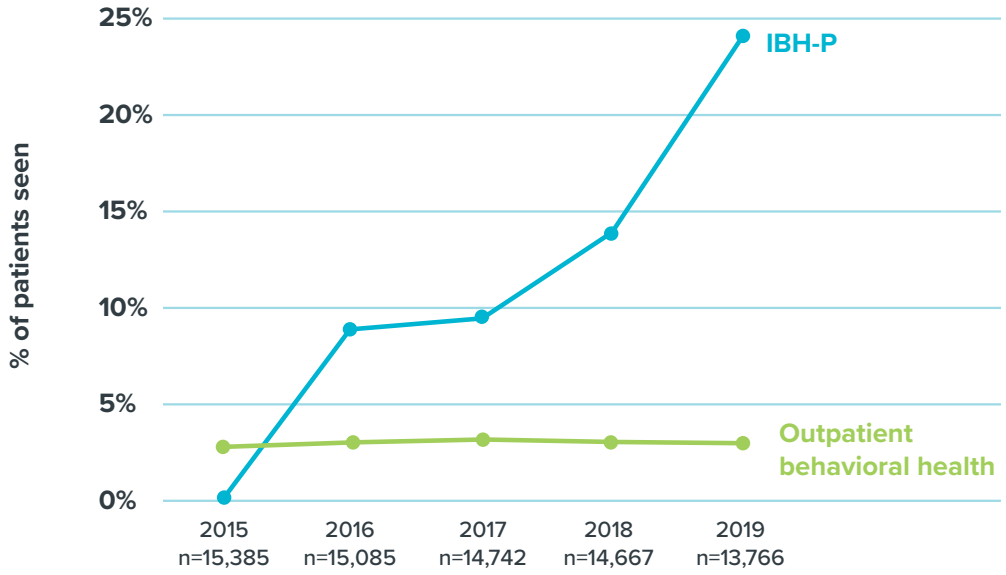
## III. Why Add Integrated Behavioral Health-Prevention?

**Most children see their pediatricians.** Research has shown that up to 90% of children through age 5 received a WCV in the past year.[9] Embedding integrated behavioral health into pediatric primary care introduces families to a psychologist early in the child's life, providing opportunities for education, guidance, intervention, and identification and treatment of emerging mental health problems, potentially preventing more severe presentation at later ages. Regular screening, using standardized measures of emotional and behavioral adjustment, is easily conducted and consistent with other health and safety screens that are routinely administered during WCVs.

The potential for broad access to behavioral health through integration in primary care is evident in the results obtained in the CCHMC implementation of IBH-P. As demonstrated in the figure below, through intentional deployment of psychologists in three primary care clinics, we were able to dramatically increase the proportion of patients who received behavioral health services.

**Behavioral issues typically first present to pediatric primary care.** Families tend to express concerns about emotional and behavioral health to their pediatricians. Integrated behavioral health leverages that trust to support families in addressing issues related to emotional and behavioral health at the onset of concerns.

Introduction of IBH-P dramatically increases the number and percent of children 0 – 5 years who receive behavioral health services compared to external behavioral health services




**Number of unique patients seen in primary care by year**

**Prevention is a core construct in pediatric primary care.** Prevention of health problems is integral to pediatric primary care, and foundational to the recommendation of well-child visits in the first five years of life. Integrated behavioral health prevention visits have been found to increase adherence to WCVs and timely completion of immunizations.

**Integrated behavioral health prevention visits promote valuing of emotional and behavioral health.** Through frequent check-ins, education, and guidance around emotional and behavioral development early in life, the psychologist can reframe emotional and behavioral health as integral to overall health, unmooring it from societal biases and prejudices regarding mental health problems.

**Prevention is effective and saves money.** A study by the RAND Corporation found that for every $1 spent on behavioral health prevention there is a savings of $7.[10] Embedding behavioral health prevention in pediatric primary care through integrated psychologists increases the reach of preventive interventions and has potential for sizable cost savings.

**Vulnerable populations have difficulty accessing behavioral health care, and pediatric primary care addresses many of these barriers.** Families living in poverty, racial and ethnic minorities, and other underserved populations face substantial challenges to obtaining effective behavioral health care. Capacity is often limited, and long waiting lists are common in community mental health centers. Lack of transportation and childcare limits the ability of many families to travel to mental health clinics. Structural racism affects the quality of care provided and leads to negative experiences with the mental health system and subsequent reluctance to seek their services. The instability and disruptive features of poverty make it difficult for families to consistently attend regular treatment sessions, and mental health systems may have inflexible health care access practices that further discourages families. Stigma around mental health concerns leads to shame and embarrassment, an additional contributor to avoidance of seeking assistance. In contrast, the pediatric setting provides supports for addressing these challenges and barriers. The focus on prevention inculcates an appreciation and valuing of behavioral health, offsetting stigma. By providing behavioral health care in pediatric primary care, families have a “one stop shop” that is sensitive to the difficulties faced by families such as transportation, childcare, and needing to visit multiple providers.

**Integrated behavioral health improves the behavioral health competence of the pediatric clinic.** In integrated behavioral health, the psychologist raises the level of behavioral health competence in providers. As psychologists are part of the team, there are many opportunities for interaction, sharing of information, and formal and informal training. Pediatricians become more confident in their capacity to address behavioral health concerns, as they acquire new skills through working with the psychologist. Prescribing practices may change, as psychologists address behavioral issues that might otherwise have been handled with medicine, including areas such as sleep, fussiness, and feeding. Regular screening, combined with delivery of IBH-P visits, leads to identification of emerging behavioral health issues that may require treatment. Treatment can be provided in the pediatric setting, a familiar location for the family with providers that are trusted and knowledgeable. Alternatively, more severe behavioral problems can be addressed through an outside referral to specialists facilitated by a trusted behavioral health provider.

# IV. Implementation of Integrated Behavioral Health-Prevention in the Pediatric Practice

## IV-a. IBH-P Processes in the clinic

The process map below describes the flow of the patient and family through the IBH-P visit. Developed through our quality improvement activities, the process map shows how the psychologist, medical provider, and multidisciplinary team coordinate the provision of IBH-P in the context of the WCV. Through seamless integration, the clinic flow is efficient and responsive to patient and family needs. Different practices may have additional steps and procedures, and modifications to the process map may be needed to fit these settings.

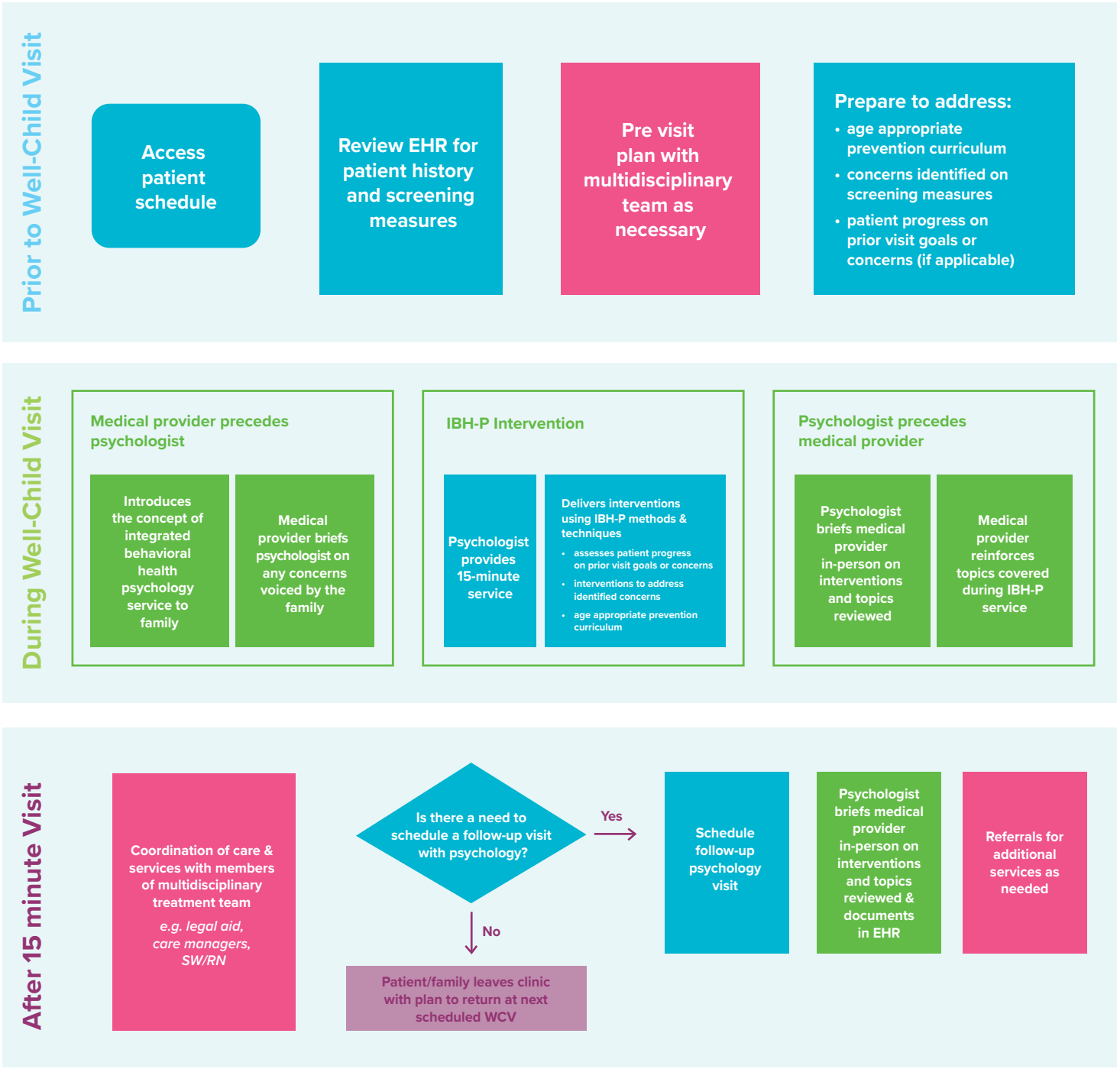
### Integrated Behavioral Health Primary Care Process

**Collaboration across encounter**

Psychologist & patient/family

Psychologist & medical provider

Psychologist & multidisciplinary team

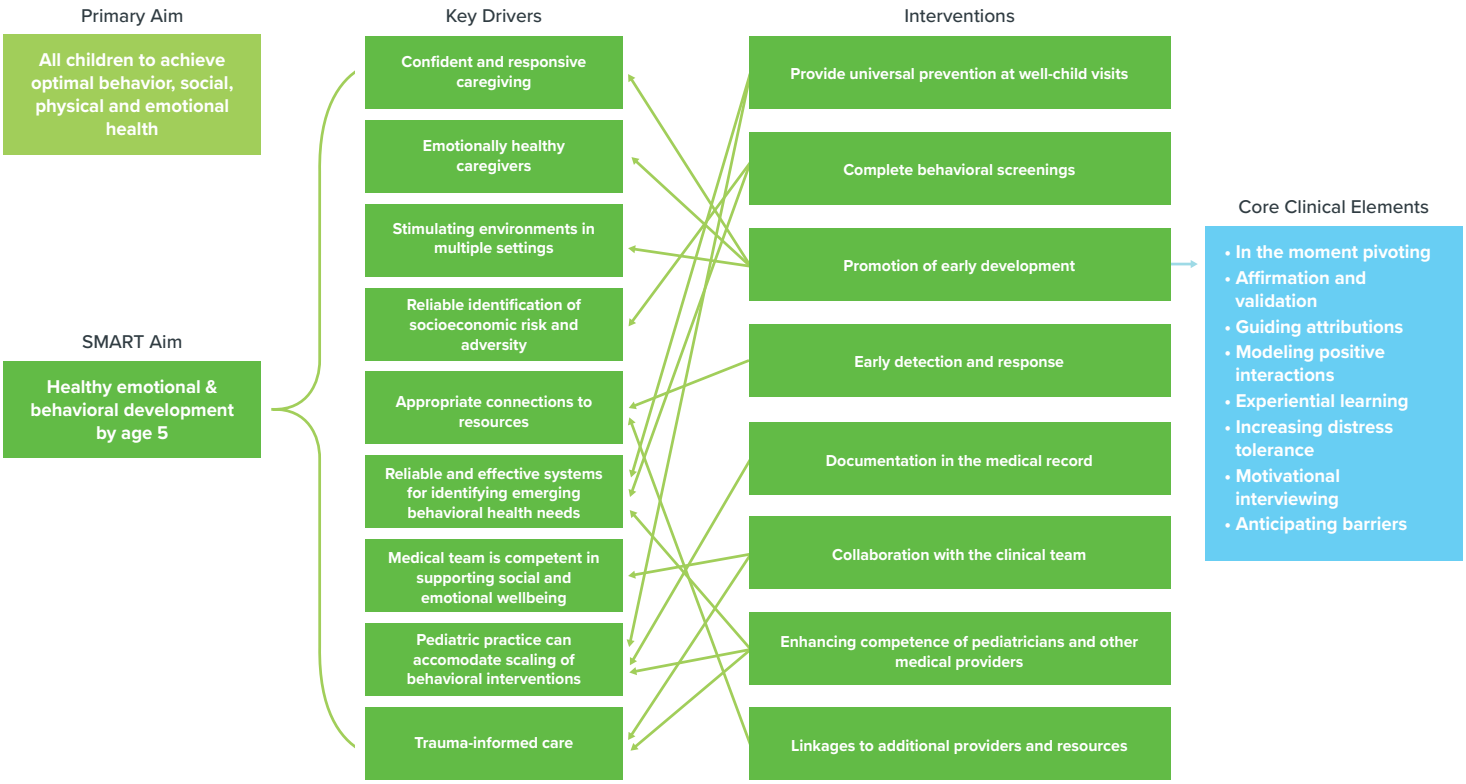


## IV-b. Key Drivers

A key driver diagram (KDD) is a visual reflection of contributors and interventions needed to achieve a primary aim. The figure below shows the key driver diagram for IBH-P in the pediatric setting. The SMART (Specific, Measurable, Applicable, Realistic, and Timely) aim presents the overarching focus of IBH-P for young children: healthy emotional and behavioral development by age 5. The primary aim: all children to achieve optimal behavioral, social, physical, and emotional health. We developed the KDD to ensure that the content and strategies of IBH-P contained those essential elements required to meet the needs of all children. Nine drivers were generated, each of which is important to achieving the primary and SMART aims. These drivers reflect characteristics of families, social environments, and the pediatric practice. They were identified through a review of the developmental science literature which has, in the last two decades, produced significant advances and discoveries about how young children develop optimally. More detailed descriptions of each driver are described in the Appendix.

### Universal integrated behavioral health prevention

**Integrated Behavioral Health-Prevention Key Driver Diagram**




## IV-c. Interventions

### IV-c-i. Provide universal prevention at well-child visits

Well-child visits (WCVs) are an ideal time to deliver IBH-P visits. IBH-P fits readily into the well-child visit framework. Provided to all children (universal), the prevention focus of IBH-P mirrors the overall focus on promoting healthy development. WCVs are times when parents are especially encouraged to express concerns or pose questions about their child's functioning, and as these often involve emotional and behavioral health the psychologist is in the best position to address these issues.

### IV-c-ii. Complete behavioral screenings

The American Academy of Pediatrics recommends scheduled screening for emotional and behavioral health problems.[11] Screening permits the identification of emerging emotional and behavioral concerns. Screening is an essential element of IBH-P. By asking caregivers to complete screeners, it is communicated that the pediatric practice views emotional and behavioral health as an important aspect of child health. Repeated screening teaches caregivers what to look for in their children, and how to communicate with providers about concerns that they may have. Psychologists use the screen to guide their approach with caregivers and children. Standardized cutoffs can be used to identify children at risk, and subscale scores and endorsement of individual items can lead to deeper inquiries with caregivers about their concerns and observations. Even if a screen is not elevated, emerging concerns can be identified by parental endorsement of individual items. Negative screens are also important, as they suggest that the child is on-track in emotional and behavioral development.

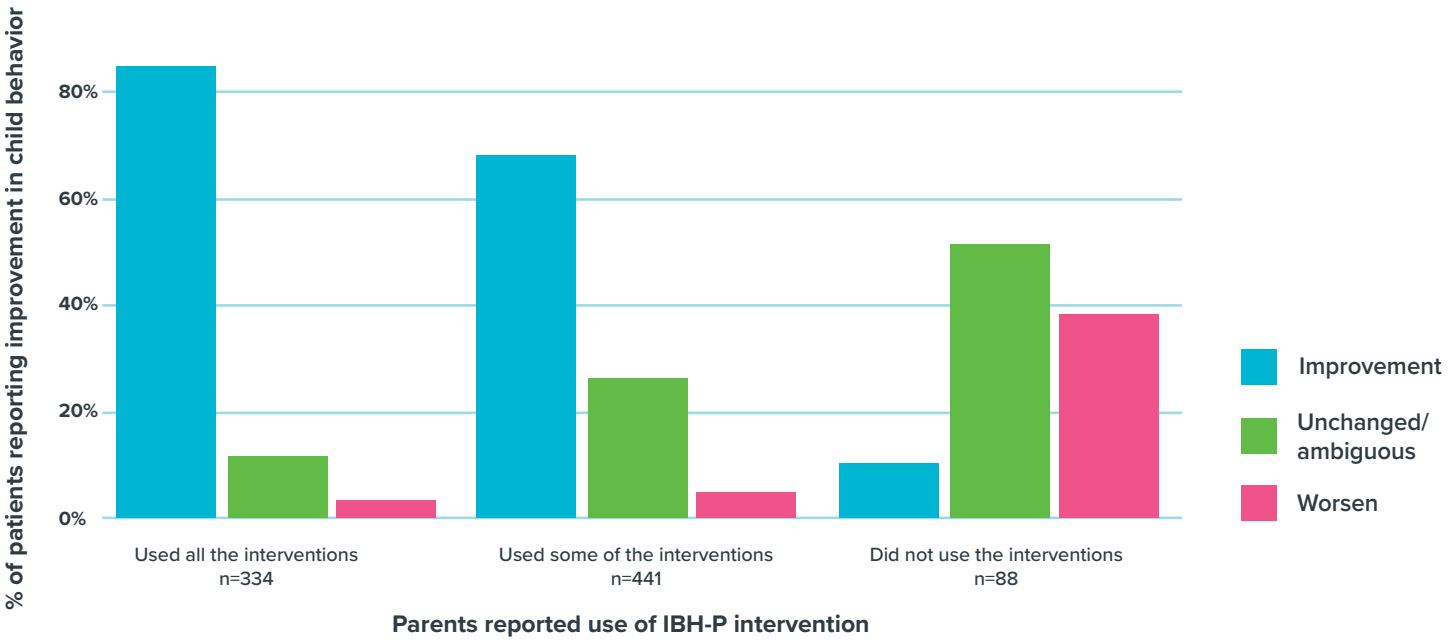
When should screens be administered? We recommend that screens be administered starting at the 6-month WCV. Earlier screening may be informative, but this is an age when emotional and behavioral concerns begin to emerge. It is advisable to screen annually at WCVs through age 5.

What does the practice need to incorporate screening into clinic workflow? Someone in the practice should be assigned the task of ensuring that the screen is administered to parents. Completing the screen in the waiting room is ideal. Completing the measure online, through a tablet or kiosk, and having the form scored automatically and inserted in the electronic health record is most desirable.

### IV-c-iii. Promotion of early development

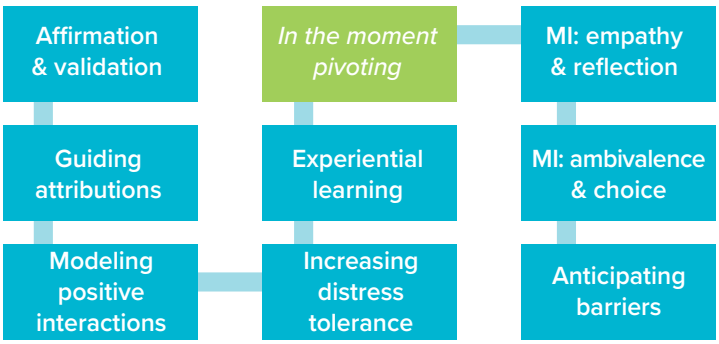
Promotion of early developmental milestones is a cornerstone of IBH-P visits and the HealthySteps model.[12,13] This curriculum aligns with the Bright Futures Guidelines, which are led by the American Academy of Pediatrics and supported by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Maternal and Child Health Bureau (MCHB). The IBH-P curriculum takes the Bright Futures Guidelines evidence-based anticipatory guidance and builds a curriculum tailored to the strengths and needs of vulnerable patient populations. This ensures that guidance is culturally-sensitive and accessible to all families. Additionally, social-emotional development underlies all other domains of development. Case studies are presented in the Appendix to illustrate some of these strategies used in promoting early development. The value of IBH-P to caregivers is demonstrated in the graph below, reflecting the quality improvement efforts at CCHMC. Caregivers were asked whether or not they had used methods and tools presented in the prior WCV, and if their child's behavior problems had changed since that time. Ninety-two percent reported using what was learned, and improvement in child behavior was strongly related to frequency of used techniques.

**The majority of patients (92%) report using all (40%) or some (52%) of the IBH-P interventions and a corresponding improvement in child behavior concerns**




Psychologists deliver the IBH-P intervention in a way that is flexible and responsive to the needs of the child and caregivers. It focuses on 2–3 core skills and strategies at each visit, which helps to ensure that each topic receives sufficient breadth and depth. In contrast to the Bright Futures Guidelines, which provide extensive guidance at prevention visits, this curated focus ensures that families adequately learn new information and practice development-promoting skills. The strategies for each visit were designed through a clinical needs assessment, whereby psychologists identify common concerns and challenges of families at specific developmental stages. The curriculum addresses these topics at the visit preceding the time of the concern. For example, by 12 months old, many families interpret normal externalizing behaviors as the toddler being "bad" and willfully disrespecting them. In consideration of social determinants of health (SDOH), such as family concerns that a lack of compliance could put their child at risk of safety concerns in the future (e.g., encounters with the police), the psychologist addresses normal externalizing behaviors at the 6- and 9-month visits. These behaviors are framed as a sign of the character strengths families have built and the psychologist discusses the caregiver's role as helping the toddler understand the rules of the world (e.g., cannot hit others).

### Core clinical elements of IBH-P




The core clinical elements of IBH-P are a foundational feature of the IBH-P visits. While developmental guidance in primary care is traditionally delivered as verbal or written didactic information, the psychologist uses specific clinical strategies to build parenting capacity that strengthens children and caregivers over the course of development. These core clinical elements were identified, refined, and operationalized through our quality improvement process. The core clinical elements are displayed in the diagram above. In the moment pivoting is highlighted as it is a singular clinical skill that is applied throughout the visit in response to patient and family presentation and needs.

**In the moment pivoting.** Psychologists use the caregiver's report and observations to discuss normal development, developmental concerns, and development promoting strategies. Responding to the presentation of the caregiver and child is a hallmark of IBH-P. It results in the efficient use of limited time and ensures that caregiver needs are adequately addressed. Psychologists then work with the family to build strategies to promote attunement to cues, soothing strategies, and building confidence in addressing fussiness. This often requires moving between topics and clinical strategies in order to be responsive to patient and family presentation.

***1-month WCV***

*INFANT: Crying*

*IBH-P PSYCHOLOGIST: I see how fussy baby is right now. At this age, it's normal for babies to start to cry more, even when they are not hungry, tired, or wet. This is what we call the Crying Curve and it can be really stressful for families because it's hard to figure out what is causing the fussiness.*

*CAREGIVER: I have noticed that she has started to cry more and just thought it was my fault…*

**Affirmation and validation.** Psychologists use reflection to share observations about the child's behavior and development and the caregiver's strategies to promote development. This calls attention to the caregivers' role in the child's development and establishes a tone of partnership and collaboration. Validation of caregiver strategies that are nurturing and stimulating reinforces positive parenting behaviors that lead to healthy emotional and behavioral development. Affirmation increases caregiver confidence and sense of control.

***2-month WCV***

*CAREGIVER (talking to baby): I hear you crying. I'm getting your bottle ready.*

*IBH-P PSYCHOLOGIST: I love how you know exactly what she wants. You're so good at responding to her cues and are making her so smart by these back-and-forth interactions with her.*

**Guiding attributions.** During the IBH-P visit, psychologists comment in real-time on the child's behavior through the lens of development. This builds caregiver ability to accurately interpret child's cues, addresses misattributions, and instructs caregivers on how to support health development.

***4-month WCV***

*CAREGIVER: He is always looking so mean. He never smiles and just stares.*

*IBH-P PSYCHOLOGIST: You've noticed that he's really interested in looking at new people and new things. When he is really focused, he doesn't smile. This can hurt your feelings because you want him to smile and show you that he is interested in you.*

**Modeling positive interactions.** Throughout the IBH-P visit, psychologists interact with the child. This provides opportunities to model positive interactions and strategies for promoting healthy development. Modeling interactions demonstrates how developmental activities can flexibly fit within the context of families' busy lives. This models both positive parenting strategies (e.g., praise, behavioral descriptions) and language promotion strategies that do not require any special time or tools.

***9-month WCV***

*INFANT: [sitting on exam table, dropping toys]*

*IBH-P PSYCHOLOGIST: You're trying to show mom how strong you are. You're learning how gravity works by dropping the book and picking it up. You're being so kind by holding out the book to mom to share it with her.*

**Experiential learning.** Experiential learning enables caregivers to use the strategies modeled by the psychologist and develop their own skills. Through feedback about the caregivers' strengths, suggestions for improvement, and reflection of the impact on the child, caregivers are able to learn how to incorporate anticipatory guidance into strategies used at home to promote development. Caregiver demonstration and practice of parenting skills during the visit is a powerful learning experience that facilitates rapid acquisition and retention of new strategies.

***12-month WCV***

*IBH-P PSYCHOLOGIST: Praising him when he does a behavior that you like is a great way to increase positive behaviors. For example, right now you can tell him how you like that he is sharing with you.*

*CAREGIVER: Thank you for handing me that toy!*

**Increasing distress tolerance.** All caregivers experience distress during parenting, such as during their infant's first set of shots. Caregivers who have experienced trauma are more likely to struggle with distress tolerance. As a result, building caregiver capacity to experience and manage distress is a focus during all interventions. For caregivers who experience distress while implementing new developmental strategies (e.g., tummy time with a baby who initially cries while on their stomach, active ignoring of a toddler tantrum), psychologists can support and coach caregivers on how to manage their discomfort, anxiety, or irritability.

***18-month WCV***

*CAREGIVER: Just hold still! You're making it worse by moving. Stop crying!*

*IBH-P PSYCHOLOGIST: It's really hard to see him so upset. You're doing a great job of hugging him tight. As you start to take some deep breaths, you will start to relax your body. Calming your body down helps to calm his body down. I know this is really hard right now, but you're both being really brave.*

**Motivational interviewing.** Motivational interviewing (MI) promotes partnership with caregivers through collaborative decision making.[14] MI is a set of practitioner behaviors that builds a strong working relationship and supports caregivers in committing to behavior change. Psychologists use empathy, reflection, and other clinical strategies to guide caregivers in building a sense of agency and ownership of their own behavior. Empathy and reflection build a strong working alliance and a trusting relationship. By exploring ambivalence, psychologists can address caregiver concerns about adopting new strategies to support their child's development and overcome barriers and challenges.

***24-month WCV***

*CAREGIVER: She'll learn to talk when she's ready. I don't know why the doctor is worried.*

*IBH-P PSYCHOLOGIST: You know that she's smart and you know her so well that she's able to communicate her needs to you. The doctor's concerns don't match with what you see. Would it be ok if I gave you a little more information about language development in 2-year-olds?*

**Anticipating barriers.** Caregivers often face barriers to providing safe, stimulating, and nurturing environments for their children. Even when they acquire new skills in the clinic, they may encounter impediments applying them at home. Challenges include caregiver mental health problems, inadequate housing, financial hardship, and community violence to name a few. The IBH-P visit is a time to discuss SDOH and other concerns that may interfere with effective and nurturing parenting. Problem-solving approaches can be used to explore options and alternatives.

***30-month WCV***

*CAREGIVER: I am ready to start the plan we made to address his waking up and climbing into bed with me every night.*

*IBH-P PSYCHOLOGIST: You're really committed to working on his sleep. And you have been working long hours and sleeping in the same room as him. Is it ok if we talk about how to plan for these challenges?*

### IV-c-iv. Early detection and response

The 15-minute IBH-P visit provides opportunities for identifying emerging psychological disorders or mental health conditions in need of more intensive treatment. Although screening for emotional and behavioral adjustment using standardized measures can identify children with elevated scores warranting a follow-up assessment, such measures can also misclassify children or miss emerging concerns that parents do not report on a screen. Based on presentation, the psychologist may elevate the level and intensity of service, including (1) increase the prevention visit to 30–60 minutes, (2) recommend 1–6 outpatient psychotherapy visits to be delivered in the pediatric practice, or (3) referral to more specialized clinical services for further assessment and treatment.

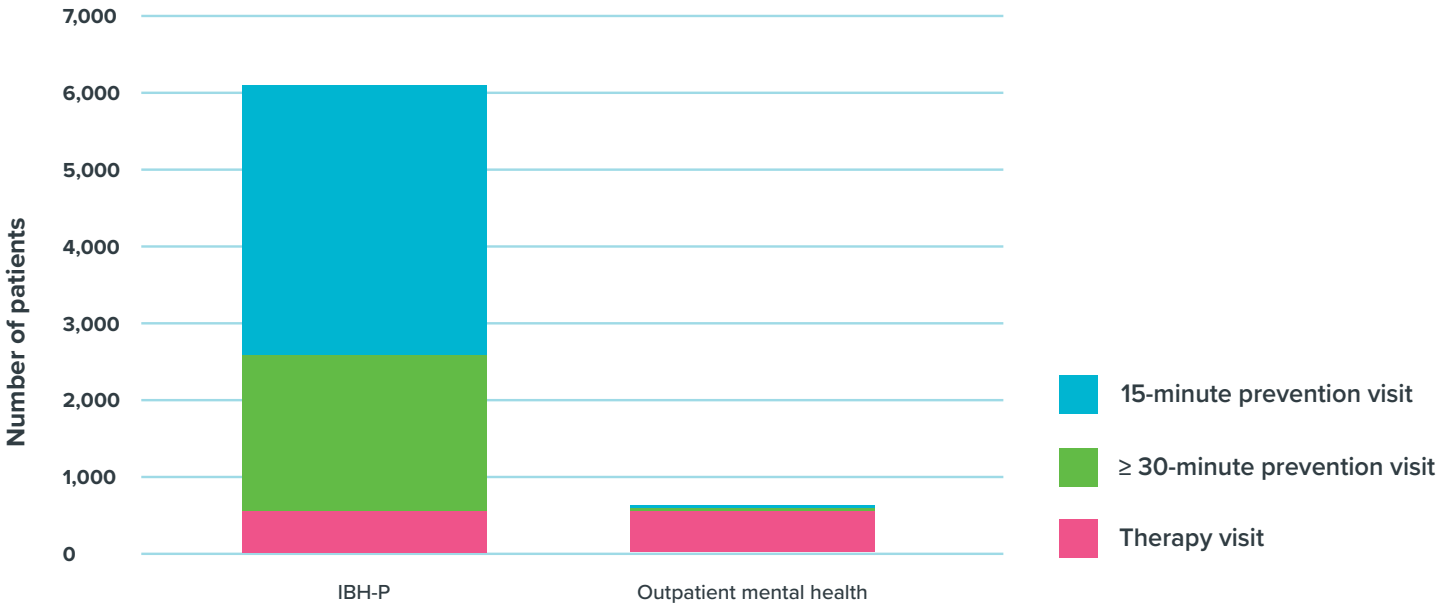
Through the quality improvement efforts at CCHMC, we demonstrated that the overwhelming proportion of children aged 0-5 in primary care received their first contact with behavioral health in the form of the IBH-P visit. This is shown in the graph below. For most of these children, the 15-minute visit was the predominant code, although many of them received a longer prevention visit based on presentation and need. In contrast, only a small proportion of visits reflected behavioral health treatment provided in an outpatient setting other than primary care.

### IV-c-v. Documentation in the medical record

Standardization in the electronic health record (EHR) has two aims: (1) shaping and capturing intervention strategies, and (2) documenting outcomes and applying learnings. Standardized documentation promotes the psychologists' ability to enter into an IBH-P visit with a family they have not seen before and build upon and expand on the work done in previous visits. Common interventions, observations of quality of the relationship between the child and caregivers, and information

about family strengths and challenges should be built into the EHR note template. Psychologists complete standard documentation regarding family report of their implementation of strategies discussed at the previous visit and degree to which the parent reports the target domain (e.g., sleep, feeding) has improved. Standardized documentation of outcomes allows for continual input and remodeling to account for provider, staff, and patient feedback. On-going quality improvement outcome and process measure reports (e.g., screening rates, screening results, WCV adherence) shape IBH-P implementation.

**Using IBH-P 15-minutes visits more children 0–5 receive behavioral health services compared to traditional models**




### IV-c-vi. Collaboration with the clinical team

Collaboration with clinic treatment providers is a core feature of the IBH program. Psychologists are familiar with the standard anticipatory guidance provided by PCPs and team members, as well as the role of each team member in the clinic. The clinical team offers divergent and complementary skills. In addition to pediatricians, there are nurses, social workers, medical assistants, and others. Understanding the standard content already provided by the team enables the psychologist to focus their portion of the IBH-P visit on expanding the breadth of anticipatory guidance to highlight emotional and behavioral health topics and/or increasing the depth of guidance on a topic introduced by other team members. Warm handoff discussions provide opportunities for bidirectional sharing of specific visit details. Because both the psychologist and other team members have a high level of awareness of the standard content covered by each team member, these warm handoff conversations can briefly convey a high level of information without needing to describe exactly what was discussed with the family. With all members of the clinical team working together, the quality and responsiveness of service to family needs are enhanced.

### IV-c-vii. Enhancing competence of pediatricians and other medical providers

An important goal of IBH-P is the enhancement of the pediatric practice in understanding of and competency in delivering behavioral health care. Many pediatricians feel uncomfortable addressing behavioral health concerns, and IBH provides an opportunity for increasing confidence and competence. Indeed, the American Academy of Pediatrics has identified competency in behavioral health as an essential aspect of providing pediatric care. The psychologist is in an excellent position to increase competency and effectiveness of behavioral healthcare throughout the practice, including training of medical residents. This is accomplished in three ways. First, the psychologist can offer trainings to staff in behavioral health and psychological techniques and methods (e.g., motivational interviewing). Second, during team meetings, huddles, and consultations, psychologists can offer guidance, perspectives, and suggestions on how to approach behavioral health concerns. Third, pediatric providers observe the psychologist "in action" during visits with families, and psychologist models IBH-P approaches that can subsequently be used by others in different situations.

### IV-c-viii. Linkages to additional providers and resources

One of the most significant challenges encountered by pediatric practices in responding to behavioral health needs is linking to outside services. These include specialized behavioral health providers, home visiting services, educational resources, or legal aid. In the absence of an integrated psychologist, practices rely on referring children and families with significant emotional and behavioral health needs to other specialists or organizations in the community. Often these referrals are unsuccessful. This is because families sometimes change their minds about following through, other specialists or organizations have waiting lists or are

difficult to navigate, and families are wary of other services with which they are unfamiliar and less trusting. Even when families are able to link with other service providers, inadequate communication may impinge on effective coordination and collaboration between providers. The IBH-P psychologist can improve the referral process. They can be a point of contact for behavioral health specialists outside of the practice, or provide short-term interventions in between the time the referral is made and services become available. The psychologist is also able to provide information about the child's emotional and behavioral health to non-clinical professionals, including day care settings and schools.

## V. Metrics for Monitoring Processes and Outcomes

Collecting data on the implementation of IBH-P drives quality improvement and documenting outcomes. Below, we list recommended metrics that can be readily incorporated into the pediatric practice. The EHR may need to be configured to create templates that facilitate data collection and extraction. It is not essential that all pediatric clinics use the same metrics, nor the same surveys and measures.

### Demographic and Clinical Characteristics

- Patient age and gender
- Patient race and ethnicity
- Insurance status
- Family composition and living arrangements
- Social determinants of health

### IBH-P Implementation

- Delivery of IBH-P (specific CPT codes)
- Primary topics addressed
- Implementation of core clinical elements of IBH-P
- Behavioral health recommendations provided to families
- Behavioral screening rates

### Patient Outcomes

- Scores on standardized screening measure of emotional and behavioral health tracked longitudinally
- Caregiver use of recommended strategies and reported change in child behavior
- Caregiver satisfaction with services

## VI. Getting Started: Resources and Helpful Information

### VI-a. Practice readiness

In order to adopt an integrated behavioral health program, pediatric practices need to be prepared in terms of infrastructure, procedures, and how to use the psychologist. Our experience introducing integrated behavioral health into CCHMC clinics has taught us that readiness is key to a smooth adoption and implementation. Initial concerns about how the psychologist would fit into the team, how parents would react to seeing a psychologist, and how providers in the practice would work together, quickly evaporated because of adequate preparation. Below is a checklist of elements to consider in preparing for an integrated behavioral health program.

- Assess current state: how behavioral health is addressed, processes for response to emotional and behavioral health needs, gaps and needs
- Practice adopts clear vision of the value of integrated behavioral health
- Commitment to prevention as essential to pediatric care
- Practice uses a team model of care
- Procedures are in place for collaboration and coordinated care
- Shared access to the medical record
- Work space available for psychologist
- All providers in the practice have embraced an integrated behavioral health model
- Consideration and leverage of behavioral health training and expertise among clinical team members
- Screens for emotional and behavioral health, results are shared with clinical team in a timely manner
- Process and outcome data are collected and tracked for quality improvement purposes

### VI-b. Resources and Links

There are several professional organizations, issue briefs, and web-sites that provide guidance on how to integrate behavioral health in the medical setting. Some are specific to pediatrics, and others are more focused on adult healthcare but still offer helpful information for consideration. The links below will help pediatric practices get started by learning more about IBH.

**American Psychological Association: Integrated Health Care** [apa.org/health/integrated-health-care]

**Bright Futures (American Academy of Pediatrics)** [brightfutures.aap.org/Pages/default.aspx]

**Collaborative Family Healthcare Association** [www.cfha.net]

**Health Resources and Service Administration: Integrated Practice Assessment Tool** [www.hrsa.gov/behavioral-health/integrated-practice-assessment-tool-ipat]

**HealthySteps (Zero to Three)** [www.healthysteps.org]

**Society of Pediatric Psychology: Integrated Primary Care** [societyofpediatricpsychology.org/content/integrated-primary-care]

**Substance Abuse and Mental Health Services Administration: Center for Integrated Health Solutions** [www.samhsa.gov/integrated-health-solutions]

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# Appendix

## Description of Key Drivers

**Confident and responsive caregiving.** Warm, sensitive, and responsive caregiving has been found to be the most important determinant of healthy development. Parents who have experienced adversity and hardship frequently struggle to provide consistent, nurturing parenting, often because they had few models in their own upbringings.

**Emotionally healthy caregivers.** Parental emotional health is essential to raising emotionally and behaviorally healthy children. The pediatric setting is an important setting in which to screen for parental mental health problems, particularly depression, so that parents can be linked to mental health treatment.

**Stimulating environments in multiple settings.** Stimulating environments rich in learning materials and diverse experiences promote healthy emotional, behavioral, social, cognitive, and language development. Although pediatricians frequently provide guidance in this area, this can be strengthened through IBH-P by offering a context for understanding stimulating environments as a driver for overall emotional and behavioral health.

**Reliable identification of socioeconomic risk and adversity.** Recognition of social stress and adversity to family functioning and child health underscores the importance of screening for social determinants of health.

**Appropriate connection to resources.** The pediatric clinic is an anchor healthcare site in which families can be connected to other resources and care providers. These include health care specialists, social service agencies, and legal aid.

**Reliable and effective systems for identifying emerging behavioral health needs.** Screening for health issues in children is a critical element of well-child care. Screening for emotional and behavioral adjustment is an important activity in pediatrics.

**Medical team is competent in supporting social and emotional well-being.** Supporting emotional and behavioral health in young children requires the whole pediatric practice to be able to provide encouragement and guidance to families.

**Pediatric practice can accommodate scaling of behavioral interventions.** The pediatric practice needs the infrastructure and procedures to accommodate integrated behavioral health, including adaptations to clinic flow, forums for huddles and team meetings, documentation in the medical record, and adequate space and administrative support.

**Trauma-informed care.** Trauma-informed service delivery emphasizes choice and empowerment, creates a safe environment for discussion of trauma experiences and their role in health behavior, is non-judgmental and supportive, emphasizes strengths and resilience, and is sensitive to triggers that may lead to re-traumatization.

## Case Studies

"Sunny Johnson" is a 15-month old African American female seen in primary care for her WCV. Her PCP expressed concerns about behavior and safety. Ms. Johnson reported that Sunny "cries too much", labeled her as bad and mean, and expressed anger and resentment that Sunny was too clingy and desired too much attention. Observations by the PCP indicated Sunny's behavior was within normal limits. Given Ms. Johnson's negative assessment of the situation and lack of responsiveness to Sunny's age-appropriate communication about her needs (e.g., hungry, tired), the IBH-P psychologist decided that the family would benefit from more frequent follow up visits with her.

Sunny was first seen for an IBH-P prevention visit at her 1 month WCV. Sunny was falling off the growth curve and the PCP expressed concerns about Ms. Johnson's ability to care for Sunny. The IBH-P psychologist clarified that the source of these feeding difficulties was the mother's cognitive abilities; she was mixing formula incorrectly. The IBH-P psychologist developed a visual guide and helped Ms. Johnson set reminders on her phone to scaffold her ability to follow the feeding plan. However, Ms. Johnson was unable to follow this plan so the team decided to give her ready-to-feed formula. The IBH-P psychologist reached out to Sunny's home visitor to coordinate care and promote mother's ability to adequately meet Sunny's nutritional needs and her growth began to track appropriately on the chart.

Over the next year, Sunny's feeding and weight gain improved, but the IBH-P psychologist continued to worry about Ms. Johnson's ability to adequately meet Sunny's developmental and emotional needs. The IBH-P psychologist discovered multiple other risk factors: Ms. Johnson was in an emotionally abusive relationship, Ms. Johnson and Sunny were socially isolated, and Ms. Johnson's only source of income was social security payments. Ms. Johnson became increasingly open and communicative with the IBH-P psychologist, demonstrating an increased ability to implement basic developmental guidance discussed, modeled, and practiced in visits.

Incorporating her knowledge of the family's challenges and strengths, the IBH-P psychologist recognized that the Johnson family's presentation at the 15-month WCV represented the culmination of stressors including the family's extreme isolation (i.e., only left the apartment to go to the store or medical appointments); developmentally appropriate separation anxiety; and the triggering of Ms. Johnson's trauma from her emotionally abusive relationship. The IBH-P psychologist worked to help Ms. Johnson empathize with Sunny's anxiety, modeling and coaching her on using strategies to identify triggers to clinginess and appropriate ways to soothe Sunny. She adapted her intervention based on Ms. Johnson's cognitive functioning, giving concrete, immediate examples, and frequent repetition of concepts. She coordinated these efforts with Sunny's home visitor to

ensure that the recommendations were concise and consistent across the care team. She identified Ms. Johnson's goals, finding daycare for Sunny and employment for herself, and helped her achieve these goals. Ms. Johnson was able to shift her assessment of Sunny's clinginess, seeing it as a need for co-regulation that Ms. Johnson could offer. Ms. Johnson began to feel more confident and assertive in her own life as she gained these skills, seeking out healthy relationships with her family and broadening her support network. Through consistent engagement in Sunny's care through universal prevention visits, the psychologist was able to engage a high-risk family in services they would not have otherwise received, effectively tailoring interventions and facilitating coordination of care.

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"Tamara Smith" is a 1-month old African American female seen in primary care for her WCC. Her PCP noted that Tamara looked healthy, but she had a difficult time engaging Ms. Smith in the visit. The IBH-P psychologist saw the family as a part of the universal prevention program. Ms. Smith reported that Tamara was her first baby and she was happy to be a mother. However, Ms. Smith expressed concerns that Tamara was fussy and Ms. Smith worried that she was "doing something wrong. Ms. Smith initially did not make eye contact with the provider and gave short responses to the psychologist's questions. Through the use of pivoting in the moment, making positive comments about Tamara and Ms. Smith's interactions with her, Ms. Smith began to engage with the psychologist.

At the 2-month WCV, Ms. Smith asked her nurse who roomed her whether she would see the IBH-P psychologist. The nurse communicated this request to the PCP and the IBH-P psychologist and the team decided to prioritize the family's time with the psychologist during the visit. This meant the psychologist would start the visit with the family, obtaining pertinent history and providing anticipatory guidance and the PCP would complete the medical exam and reinforce the guidance given by the psychologist. As the psychologist began the visit with Ms. Smith, she noticed that Ms. Smith was attuned to Tamara and excited to talk about her development but Ms. Smith avoided any questions about her own adjustment. The psychologist observed this pattern then used validation and affirmations to draw attention to Ms. Smith's strengths as a mother. Ms. Smith then began to disclose an extensive trauma history and treatment for anger, depression, and PTSD. Ms. Smith sobbed as she shared worries that her mental health would negatively impact Tamara. The psychologist reflected Ms. Smith's dedication to Tamara and praised Ms. Smith's awareness of her dyadic relationship with Tamara. Using motivational interviewing, the psychologist and Ms. Smith decided to refer Ms. Smith to a co-located maternal depression program.

Over the next year, Ms. Smith completed the maternal depression program and formed a close relationship with the IBH-P psychologist and Tamara's medical team. Ms. Smith frequently reflected on her own childhood, including years in foster care, the lack of warm and supporting relationships, and the shame she felt when she needed to ask for help. During WCVs, the IBH-P psychologist worked with the PCPs to intentionally highlight the ways in which Ms. Smith was creating a different trajectory for Tamara through a safe and stimulating home environment and warm and responsive parenting. Ms. Smith grew more confident in her parenting ability and expressed pride in her role in Tamara's development.

The following year, Ms. Smith called the IBH-P psychologist to set up a follow up visit in clinic. She shared that she was pregnant with an unplanned pregnancy. She noted that she trusted the IBH-P psychologist to collaboratively reflect on the potential impact of this pregnancy on Tamara and the life Ms. Smith had created. The psychologist helped Ms. Smith consider her options and how they fit with her goals and values. Ms. Smith ultimately decided to continue with the pregnancy. She had a mild onset of depressive symptoms post-partum but was able to use the strategies she previously learned in therapy with the help of the IBH-P psychologist. Unlike with Tamara, Ms. Smith was confident and calm with her new infant and arrived to visits early so she could talk to other mothers with new babies in the waiting room. She expressed pride in her mothering and her ability to be a support to others.