The Power of Public Health in Early Childhood Mental Health Systems of Care

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Welcome!

Listen to this:  What I am by Will.i.am

Think about this:

What color best describes how you are feeling?

What **one** word best embodies “what you are”?

Do this:

Take a piece of paper in this color (or the closest we have to it). Write down your word, filling the whole paper.
Agenda

1. Welcome and Introductions
2. Content
3. Small Group Work
4. Large Group Process
5. Closing
Let’s begin with some numbers...
+1,000,000
MORE THAN 1 MILLION

18
18 MONTHS

90-100
90-100%

3:1
3:1 ODDS

4-9
4-9 DOLLARS

Center on the Developing Child (2017)
Brain Growth

![Brain Growth Graph](chart.png)

- **X-axis**: Age in Years
- **Y-axis**: Percentage of Adult Brain Weight

Graph showing the growth of the brain from birth to adulthood, reaching near-maximum growth by age 18.
LIFE-SAVING RELATIONSHIPS

New research details how important close emotional connections are for health and well-being, prompting psychologists to call for making strong relationships a public health priority.

BY KIRSTEN WEIR
Spending on Programs to “Change the Brain”

Brain’s Capacity for Change

Age

0 3 6 9 12 15 18 20

Mental Health  Juvenile Justice

Headstart  Public Education  Substance Abuse Tx

Bruce D. Perry, M.D., Ph.D.
What is Early Childhood Mental Health?

Early Childhood Mental Health (ECMH) refers to the developing capacity of the child to:

• Experience, regulate, and express emotions;
• Form close and secure interpersonal relationships;
• And explore the environment and learn;

All in the context of family, community, and cultural expectations for young children.

Infant mental health is synonymous with healthy social and emotional development. (Zero to Three)
Common ECMH Concerns

- Parental stress/mental health
- Adjustment and loss (new sibling, loss of caregiver, moving into a shelter, recent immigration)
- Behavior concerns
- Infant crying
- Social development
- New parent support
- Activity level
- Anxiety/extreme shyness/separation anxiety
- Adjusting to/managing medical concerns
- School concerns (evaluations, communication with teacher, making friends)
10 Essentials of Public Health

1. Monitor Health
2. Diagnose and Investigate
3. Inform, Educate, & Empower
4. Mobilize Community Partnerships
5. Develop Policies
6. Enforce Laws
7. Link to/Provide Care
8. Assure Competent Workforce
9. Evaluate
10. Evaluate

https://www.accesskent.com/Health/HiAP/default.htm
The SOC Model

MA Multi-City Young Children's Mental Health SOC Project

Local Health Department

Primary Care Center

Family Partner + Intensive Care Coordinator
(Services reimbursed by Medicaid)

#LEADINGCHANGE
Family enters system via primary care.

Primary Care

LHD facilitates the local SOC, building capacity to serve young children and their families.

Barriers and needs are communicated and addressed on city level with SOC partners.

PCP initiates “hand-off” to SOC service delivery team

Service is integrated with PCP with systems of communication approved by family.

Grant funding flows from LHD to service delivery sites

Family Partner and ICC
Our “Ask” of Pediatric Primary Care

ECMH Medical Home Model

Holistic Service Delivery

Family Partner & ECMH Clinician

Family Centered

Integrated in Pediatric Primary Care

Promotion, Prevention, & Intervention
Why the Medical Home?

• Regularity of well visits in infancy & early childhood (15 routine visits by age 6!)

• Relatively high parent trust for child's pediatrician diminishes barriers to mental health care

• Powerful, non-stigmatizing point of entry into community-based services

• AAP vision of medical home as hub for comprehensive care

• Increasing momentum of medical home model
**Integration at Service Level**

**Primary Care Visit**
- Young child attends pediatric primary care visit with Caregiver.
- Primary Care Provider identifies children with social and emotional needs

**Engagement and Assessment in ECMH**
Series of visits with ECMH Clinician/ICC and Family Partner to build relationship and identify strengths and needs

**Warm Handoff** to direct service team
Family Partner or ECMH Clinician/ICC introduced to Caregiver at end of primary care visit

**Feedback to Primary Care Providers**
The ECMH Team Model
Early Childhood Mental Health within Pediatric Primary Care

Pediatrics

Primary Care Champion

Family Partner

ECMH Clinician/ICC

Behavioral Health

Administrator

Behavioral Health Integrated into Pediatric Medical Home

- ECMH Clinician/ICC and Family Partner embedded in primary care
- Primary Care Champion as liaison
- Administrator (from Pediatrics or Behavioral Health) to promote supportive policy context, identify financing issues
- Team participation in Medical Home Learning Collaborative
Risk Factors – Prevent – Protective Factors

- Child
- Parents
- Caregivers
- Siblings
- Employment
- Food Security
- Violence
- Housing
- Health

Promote

Trainings Institutes

University of Maryland, Baltimore Washington, D.C.
Strategic Partners in Early Childhood Work

- Parents and Family
- Close Family Friends/Neighbors
- Primary Care Provider/Center
- Early Intervention Worker
- Teachers/School Staff
- Daycare Provider
- Home Visitors
- Mental Health Provider
- Community Resources/Agencies
- Public Health
**A Snapshot of SOC Systems-Building Efforts Across Massachusetts**

**Key Local Partners**: Gandara, Behavioral Health Network (BHN), The Davis Foundation, Square One, Home City Families, Springfield Parent and Community Engagement Center, Springfield Adolescent Health Clinic,YWCA of Western Massachusetts, Holyoke-Chicopee-Springfield Head Start

**SOC Community Engagement/Social Marketing**: SOC Meetings, The Raising of America screening w/ Square One at Mercy Hospital, Back to School Bash with Gandara at Szot Park, Trunk or Treat with Baystate and BHN at High Street Health Center, Winter Carnival with Baystate and BHN at High School of Commerce, Family Engagement Summit at Forest Park, Springfield Department of Health and Human Services Open House, Springfield Early Childhood Summit with Square One at Shriner's Hospital

**Key Local Partners**: Worcester Family Partnership, Community HealthLink, Worcester Addresses Childhood Trauma, Becker College, Parent Professional Advocacy League, Edward Street Child Services, Worcester Community Connections Coalition, YOU Inc., South Bay Mental Health, Guild of Saint Agnes, City of Worcester Youth Office, Together For Kids

**SOC Community Engagement/Social Marketing**: SOC Meetings, 2018 Day of Play, Worcester Family Partnerships Annual Health and Safety Fair, DCF Worcester East Annual Baby Shower, Resilience Film Screening, Dr. Nadine Burke Harris Presentation, Plumley Village Annual Health Fair and Cookout, The Raising of America Film Screening, Life is Good Playmakers 101

**Key Local Partners**: ABCD Head Start, Boston Children’s Hospital, Boston Family Engagement Network, Boston Public Health Commission, Boston Public Schools, Boston Youth Sanctuary, Boys and Girls Club, Codman Square Health Center, Community Services of Roxbury, Countdown to Kindergarten, Department of Children and Families (DCF), Department of Early Education & Care, Department of Mental Health, Dorchester House Health Center, East Boston Social Center, Educators 4 Excellence, Healthy Families, Horizons for Homeless Children, Jewish Family & Children’s Service, The Leggett Group, MassHealth, Mothers for Justice & Equality, North Suffolk Mental Health, Outdoors Rx, Parent Members, Parent Professional Advocacy League (PPAL), Regional Consultation Program, Roslindale Pediatrics, South Boston Neighborhood House (SBNH), SOC Parent Council Members, The SPARK Center, The Home for Little Wanderers, Thorn Boston Metro Early Intervention, UMASS Boston, United Way of Mass Bay, Vital Village Network, Young Children’s Council

**SOC Community Engagement/Social Marketing**: Mental Health Awareness Day * Boston Alliance for Young Children’s Social Emotional Wellness * Parent Engagement Fair * Family Engagement Summit at the Zoo * StoryBook walks at local schools
The Toolkit: Find it at ECMHMatters.org
The Toolkit: Find it at ECMHMatters.org

Early Childhood Mental Health Toolkit:
Integrating Mental Health Services into the Pediatric Medical Home

A small change at the pediatrician’s office can make a large difference for all U.S. children. Integrating early childhood mental health staff, services, and systems into pediatric practices, also known as medical homes, transforms primary care visits into holistic visits that care for the physical and mental health of a young child.

In 2009, the Massachusetts Executive Office of Health and Human Services, the Massachusetts Department of Public Health, and the Boston Public Health Commission received funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to create a model of early childhood mental health programs to be modeled in pediatric medical home.

The model is based on a partnership between a family partner and mental health clinician dedicated to early childhood mental health. Acknowledging that many practices may not have the capacity to employ these positions in the current healthcare payment environment, BPHC has created a toolkit that can provide guidance for providers. The Toolkit is a comprehensive collection of tools and guidance for integrating early childhood mental health staff, including a family partner, into the pediatric primary care setting, including:

1. Building a Core Team to Champion Children’s Social and Emotional Health: Find tools to identify, hire, and train/support early childhood mental health staff. Guidance on assessing resources, identifying areas of need, and beginning to plan a service delivery model is also outlined here.

2. Providing Family Centered Care for Children’s Social and Emotional Health: Find tools to design a full spectrum of early childhood mental health services, including sample referral criteria, care plan templates, and group activities. Tools for promotion, prevention, and intervention focused services are supplied.

3. Creating Medical Home Systems to Support Mental Health Integration: Find tools to develop and refine systems across the medical home to assure successful service integration, including communication systems, medical record use, home and community based services, and addressing adult mental health needs in the pediatric setting.

4. Financing and Sustaining the Early Childhood Mental Health Model of Integrated Care: Find tools to guide evaluation and sustainability efforts, including sustainability strategies for each practice.

The Early Childhood Mental Health Partnership continues to work toward a reality that allows all children and families — particularly the most vulnerable — to have equitable access to high quality early childhood mental health enhanced medical homes.
Section 1
Building a Core Team to Champion Children’s Social and Emotional Health

Section 2
Providing Family-Centered Care for Children’s Social and Emotional Health

Section 3
Creating Medical Home Systems to Support Mental Health Integration

Section 4
Financing and Sustaining the Early Childhood Mental Health Model of Integrated Care

#LEADINGCHANGE
Billing Considerations

Billable Hours
In mental health clinics, generally clinicians bill for 22-30 hours per week to cover a full-time position. If there is funding either through a grant, from medical home operational funds or from another source for part of the clinician’s time, the hours spent providing traditional therapy can be reduced, allowing more opportunities for promotion and prevention activities.

Co-Billing
One creative way to capture funds for behavioral health integration activities is to co-bill for a mental health clinician with a medical professional. This can be done either in an individual appointment or in a group. In an individual appointment, a medical provider can schedule and bill for a behavior check visit with a behavioral health provider.

After a brief time, the medical professional can attend to another patient while the behavioral health clinician completes the visit. In a group setting, a medical professional and a behavioral health staff could co-facilitate a group on a shared issue, such as ADHD, nutrition, anxiety or similar topics.

Family Partners and Billing
Our experience has revealed only one way to bill for Family Partner services, and that is to partner with a mental health agency, as described above (see Third-Party Reimbursement information in the previous pages). In this model, the mental health agency employs and bills for the FP, but outstations the FP to a medical home site. A major constraint of this option is that it limits FPs to work with children who have diagnoses, making this a short-term and partial strategy for covering the role at best.

There are fewer options for reimbursement for FPs than clinicians, and due to the pivotal role the FP plays, we recommend prioritizing use of other funds to cover the salary and benefits for an FP.
### Quick Links to Referral Document Samples

<table>
<thead>
<tr>
<th><strong>Clear Referral Criteria:</strong> A written description of the target population for services within your health practice, including age range and spectrum of need (promotion, prevention, intervention). Guidance for creating your criteria is provided in section 1 of this toolkit, <em>Building a Core Team.</em></th>
<th><strong>Referral Criteria,</strong> MYCHILD</th>
</tr>
</thead>
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<tr>
<td><strong>Referral Template:</strong> A standard referral template for medical home providers to use in referring families. Include the reason for referral and family’s level of concern as well as indication that the referral was discussed with the family. This same template can guide the Family Partner and Mental Health Clinician in talking with families who call to self-refer.</td>
<td><strong>Referral Template,</strong> MYCHILD</td>
</tr>
</tbody>
</table>
| **Referral Protocol:** Evaluate the most effective way of communicating referrals between providers; use of the EMR system is ideal where possible. There should be a subsequent protocol on how many days the FP and MHC have to contact the family and what to do if the family cannot be reached. | **Clinic Room Cards,** MYCHILD  
**Script for PCPs to Introduce the Referral,** MYCHILD |
| **Provider Awareness:** Providers need to be aware of this service, eligibility criteria, services delivered and protocols for contacting families referred. Providers need to be able to clearly articulate the service to the caregiver, so that families understand what the referral means and what to expect. Strategies to build awareness include sample Primary Care Provider introduction to services, clinic room poster, presentations at provider meetings, and co-location presence of FP/MHC during pediatric clinics. | **Referral Guidance to PCPs,** LAUNCH  
**Referral Reminder Poster,** LAUNCH  
**Referral Reminder Poster,** MYCHILD |
| **Tracking System:** Track referrals to ensure timely follow up and maintain a record of initial communication with families. This document can help the FP and MHC coordinate outreach efforts to newly referred families, to enhance engagement and reduce duplication of efforts. | **Service Tracking Document** |

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*Early Childhood Mental Health Integration Toolkit, Boston Public Health Commission, 2013*
Additional Considerations for MHC Selection

Experience
Although experience working with children and families can be helpful, if a candidate's experience is with older children, it is really not adequate. A passionate and skilled Clinician whose experience is solely with school-age children, as long as some of that experience is with children as young as 6 or 7, could be appropriate.

But a Clinician whose family treatment experience is only with latency age and/or adolescent youth is likely to lack the kind of experience necessary to understand normal and atypical early childhood development, nor be skilled in techniques appropriate for families at this stage.

Dyadic Approach
Most children come attached to parents. Clinicians who love working with children but are challenged to be empathic toward or engaged with adults will not be able to provide the appropriate range of services. This treatment is and should be a dyadic-focused model.

You should avoid a candidate who does not have experience with and/or interest in dyadic treatment.

Being a Parent
Being a parent is helpful. This is not a requirement, but parents who are experiencing behavioral or emotional/social challenges with themselves or their children are quick to experience judgment.

Often parents report feeling more comfortable and less criticized when working with someone who really understands the inherent challenges of being a parent. Being a parent may also help the Clinician to form a strong partnership with the Family Partner.

Culturally Responsive
It is essential for all Clinicians to be culturally responsive.

When working with very young children and their families, where the primary goal is to support the healthy social and emotional development of that child, a Clinician's strong support and understanding of and commitment to that family's values, customs and beliefs are a great necessity. Those beliefs will be the umbrella under which that child will be raised and taught.
## Table of Contents

### Objectives

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<th>1) Enhancing Provider Communication</th>
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<td>➢ Identify the Core Team’s Role in Improving Communication Between Primary Care and Behavioral Health Providers</td>
</tr>
<tr>
<td>➢ Identify Strategies the Core Team Can Implement to Enhance Communication Between the Family Partner, Clinician and Other Medical Home Providers</td>
</tr>
</tbody>
</table>

### Quick Links

- Intro: Enhancing Provider Communication
- Strategies to Facilitate FP-Clinician Communication with Other Medical Home Providers
### 2) Family Partner Documentation in Medical Records

- Identify Strategies for Supporting FP to Effectively and Succinctly Document the Services they Provide Families

- Develop a Standard for Family Partner Documentation in Your Medical Home Using Examples from a Demonstration Site

- **Intro:** Family Partner Documentation in Medical Records
- **Tip Sheet:** Supporting FP Documentation in the Medical Home

- **Developing Our Standard for Family Partner Documentation, MYCHILD QI**
- **Sample:** Standard for Family Partner Progress Notes
### Highlights from Section 3

#### 3) Building Medical Home Systems for Home and Community Visits

- Recognize the Value and Challenges of Home Visiting as a Service Strategy and Discuss Characteristics to Consider When Determining Whether Home Visits Are the Right Fit
- Identify Medical Home Processes that Must Be Developed for the Family Partner and Clinician to Conduct Home Visits

- **Intro:** Building Medical Home Systems for Home and Community Visits
- **Table and Checklist:** Is Home Visiting the Right Strategy?
- **Checklist:** Preparing A Health Practice for Home Visiting
Highlights from Section 3

4) Integrating Caregiver-Child Mental Health Services

- Recognize the Interdependence of Caregiver Wellness and Children’s Social and Emotional Development

- Identify the Pediatric Medical Home as a Key Opportunity to Screen Caregivers and Select Specific Screening Tools Your Medical Home Will Use

- List Strategies to Effectively Connect Caregivers to Adult Mental Health Services

- Discuss the Trade-Offs Between Caregiver Privacy and Family-Centered Care-Coordination, and Identify Strategies for Documenting Caregiver Mental Health

  - Intro: Integrating Child-Caregiver Mental Health Services
  - Screening Tools for Caregiver Depression and Stress
  - Tips for Connecting Caregivers to Mental Health Services
  - The Challenge of Documenting Caregiver Mental Health in Pediatrics
### 5) Parent Voice in Shaping Medical Home Services/Systems

- **Identify Strategies for Bringing Parent Voice to Healthcare Services and Systems Improvement, Recognizing the Advantages and Challenges of Each Strategy**

- **Identify any Current or Previous Strategies Employed by Your Medical Home to Engage Parents in Improvement; Discuss Lessons Learned from these Efforts**

- **Intro: Parent Voice in Shaping Medical Home Services/Systems**

- **Strategies for Bringing Parent Voice to Systems Improvement**

- **Core Team Worksheet: What’s Your Health Practice’s Experience with Parent Feedback**

- **Tips for Creating a Patient Survey**
  - Sample Family Experience Survey, LAUNCH QI
  - Sample Family Experience Survey, MYCHILD QI
### 5) Parent Voice in Shaping Medical Home Services/Systems

- **Recognize Parent Representatives as Key Assets in Meaningfully Informing Medical Home Systems and Discuss the Potential Roles Parent Leaders Can Play in Your Medical Home**

- **Brainstorm Feasible Strategies Your Core Team Could Implement to Partner with Parents on Improvement Using Examples from Demonstration Sites (Surveys, Parent Council Materials)**

- **VIDEO: Parent Representatives as Colleagues in Systems Change**
  - **COMING SOON**
  - **Assembling Parent Leadership Groups and Fostering Parent-Professional Partnerships**
    - **Challenges of Parent Leadership**
    - **Employing Parent Leaders**
    - **Parent Council Recruitment Process and Selection Criteria**
    - **Parent Council Roles and Responsibilities**

- **Parent Council Materials, MA Partnership for ECMH**
  - **Parent Council Recruitment Flyer**
  - **BPHC’s Parent Council Handbook**
  - **Parent Leadership Series Curriculum Outline**
    - **Example Curriculum Activity: Developing Your Personal Story**
    - **Example Letter: Preparing Parents to Participate in Multi-disciplinary Meetings**
  - **Leadership Opportunities for Parent Representatives**
6) Engaging in Quality Improvement Efforts

- Recognize the Utility of a Structured QI Process to Guide Service Improvement Efforts
  - Intro: Engaging in Quality Improvement Efforts
  - QI Process Snapshot

- Engage in a Continuous Quality Improvement Process as a Core Team Using Guidance Provided by MA Partnership for ECMH and TA Resources
  - Examples of QI Goals and Projects from Demonstration Sites
  - MYCHILD-LAUNCH Learning Collaborative QI Process
  - Quality Improvement Worksheets for the Core Team
    - Worksheet 1: Setting a QI Goal
    - Deliver: Doing the Change
    - Worksheet 2: Assessing the Status of Your Goal
    - Worksheet 3: Pursuing the Current Goal and Re-strategizing

- Raise Awareness of Your Quality Improvement Project Throughout Your Medical Home and Spread Successful Changes Across Primary Care/Behavioral Health Departments
  - Raise Awareness of Your QI Project and Seek Feedback
  - Building Capacity in Medical Homes: Stories from Project LAUNCH Sites
Small group time

The goal:

1. ID Sections of the Toolkit you want to spend more time exploring.

2. Draft next-steps for bring pieces of the Toolkit to your own work.
Section 3

1. Enhancing Provider Communication
2. Family Partner Documentation in Medical Records
3. Building Medical Home Systems for Home and Community Visits
4. Integrating Caregiver-Child Mental Health Services
5. Parent Voice in Shaping Medical Home Services/Systems
6. Engaging in Quality Improvement Efforts
Directions

1. Choose a piece of Section 3...or use your own device to select a section from the online version.

2. Move to the table where others are looking at the same piece...or work alone/with neighbor.

3. Use the worksheet if it is helpful or a facilitator.

4. We will come back together to process/share before closing.
Let’s Process

1. What is a next step you feel 85% confident about?
2. Which partners are you going to contact this month?
3. What is your fear/obstacle to overcome?
4. When will you reach out for encouragement?
Thank you for being here!

Think about this:

What **one** word best embodies your feelings after this session?

Do this:

Turn your paper over and write your word.

Share:

Turn to a neighbor and spend 1 minute sharing, then 1 minute listening.