FLINT WATER RESPONSE

HEALTHCARE PROVIDER WEDNESDAY UPDATES

FROM THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 11, 2016

Developmental Screening in A Lead Exposed Population: What Every Provider Should Know (Part II)

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MDHHS
Michigan Department of Health & Human Services

Objectives

- Review the rationale for, and benefits of screening for mental and behavioral health problems in youth and teens
- Familiarize audience with Michigan Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines and screening tools in older youth and teens
- Familiarize audience with Michigan Child Collaborative Care (MC3) program potential to support implementation of screening in office practices

NOTE

- The information in this webinar is subject to change.
- This information is what is known of risks and outcomes as of May 11, 2016.
- For an overview of behavioral issues in lead exposed youth see webinar March 30, 2016
- For Developmental Screening Part I see webinar April 13, 2016
- michigan.gov/flintwater for the most updated information on lead exposure

Screening in Primary Care

Rationale for Screening Youth in Flint

- Lead is one exposure in a series of adverse childhood events (trauma, poverty, separation, parental illness) for many children in Flint/Genesee
- Screening identifies behavioral conditions early (autism, depression, ADHD, anxiety/trauma) and identifies those at risk for suicide
- Screening enables connection to services in the school and community being made available to youth
- This may fundamentally change these children's life trajectory!

AAP Position Statement

- No other illnesses so damage so many children so seriously. On the other hand, early identification and treatment of children with mental health problems has the potential to reduce the burden of mental illness and its many consequences.
    - Pediatrics vol. 123, Number 4, April 2009

Developmental and Behavioral Screening

- Developmental and behavioral health screening part of well child EPSDT visits in pediatric practices for Medicaid children
  - EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
- Validated, age appropriate tools
- Screening will occur for the age range of children 1 month to 21 years

EPSDT

- EPSDT is a federal Medicaid benefit that provides comprehensive and preventative health care services for children under age 21.
- Services include the screening of children and youth to identify physical, developmental and behavioral health issues.
- The Michigan Medicaid Provider Manual formalizes the implementation of EPSDT.
- The EPSDT section on Developmental/Behavioral Health provides guidance for the administration of validated, standardized screening tools based on the AAP Periodicity Schedule.

L-LETTER COMMUNICATION

- MDHHS is developing an L-Letter communication for Genesee County and Flint primary care practitioners that summarizes the guidance for developmental and behavioral health screening tools delineated in the Medicaid Provider Manual for children 1 month to 21 years of age.
- The April 13 Webinar focused on the screening tools for children less than 6 years of age. It should be noted that for this age range there are currently several organizations in Flint who are performing developmental screenings (generally the ASQ 3) for very young children. Efforts are currently underway through the CHAP partnerships to coordinate and identify a data/web based system to assist with reporting screenings and avoid duplication.

PURPOSE OF WEBINAR

- Today's Webinar is to provide the background for and review of the screening tools for children over 6 years of age.

- Information will also be provided about the Michigan Child Collaborative Care Program(MC3) and support of screening

Screening Tools

- Young Children Under Age 6
  - ASQ and ASQ-SE (SE screener to 72 months of age)
  - M-Chat (Autism)
  - SCQ (4 years/older - Autism)
- School-Age Children through Adolescents
  - Pediatric Symptoms Checklist (SE screener)
  - Strength and Difficulties Questionnaire (SE screener)
  - SCQ (4 years and older- Autism)
- Teens and Young Adults
  - PHQ (depression)
  - CRAFFT (Substance Abuse)

We Will Cover Today Children Over 6 Years…

- Social Communication Questionnaire (SCQ)
- Social Emotional Screening Options
  - Pediatric Symptom Checklist (PSC)
  - Strength/Difficulties Questionnaire (SDQ)
- Depression Screening (PHQ-2 and PHQ-9 for teens)
- Substance Abuse Screening (CRAFFT)

Developmental Screening

AAP Recommendations

- The American Academy of Pediatrics (AAP) recommends that screening for psychosocial-behavioral assessment occur at every well-child preventive care visit throughout infancy, childhood and adolescence.
- The American Academy of Pediatrics (AAP) recommends that screening for depression and substance abuse occur at every well-child preventive care visit between 11 and 21 years.

http://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html

Bright Futures (AAP)

MDHHS Michigan Department of Health & Human Services

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[9]								●			●		●																			
Autism Screening[10]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																
Newborn Blood Screening[15]		←	●	→																												
Critical Congenital Heart Defect Screening[16]		●																														
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★																
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	←	●	→	★	★	★	★	★	★	←	●	→	★	★
STI/HIV Screening[23]																						★	★	★	★	★	←	●	→	★	★	★	
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
Fluoride Varnish[26]							←				●		→																			
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride,

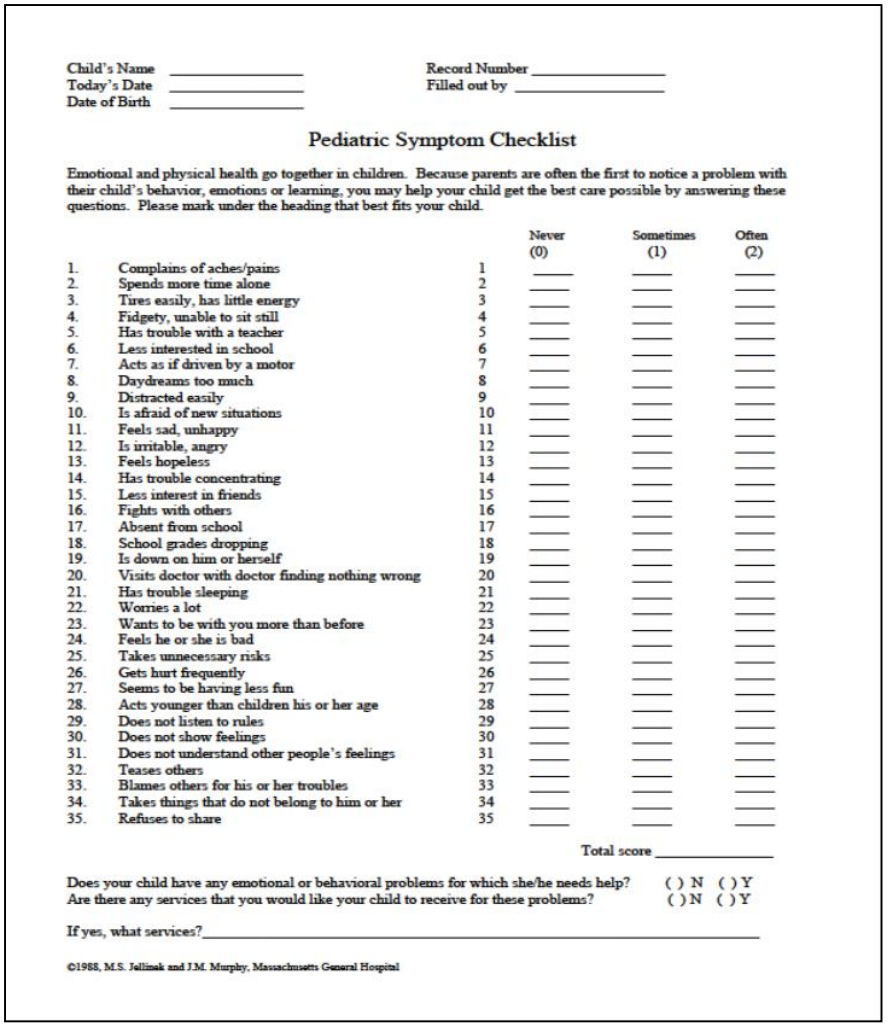
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Pediatric Symptom Check List

- A broad screen for social-emotional functioning
- Available free of charge
- Relatively brief
- Parent report until through age 18; child self-report begins at age 13
- It is available in multiple language as well as pictorial version

Pediatric Symptom Check List

- Broad social-emotional screener
- Relatively brief with both a full length (35 item) and shortened (17 item) option.
- No expense
- Ages 4-18 years



Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	____	____	____
2.	Spends more time alone	2	____	____	____
3.	Tires easily, has little energy	3	____	____	____
4.	Fidgety, unable to sit still	4	____	____	____
5.	Has trouble with a teacher	5	____	____	____
6.	Less interested in school	6	____	____	____
7.	Acts as if driven by a motor	7	____	____	____
8.	Daydreams too much	8	____	____	____
9.	Distracted easily	9	____	____	____
10.	Is afraid of new situations	10	____	____	____
11.	Feels sad, unhappy	11	____	____	____
12.	Is irritable, angry	12	____	____	____
13.	Feels hopeless	13	____	____	____
14.	Has trouble concentrating	14	____	____	____
15.	Less interest in friends	15	____	____	____
16.	Fights with others	16	____	____	____
17.	Absent from school	17	____	____	____
18.	School grades dropping	18	____	____	____
19.	Is down on him or herself	19	____	____	____
20.	Visits doctor with doctor finding nothing wrong	20	____	____	____
21.	Has trouble sleeping	21	____	____	____
22.	Worries a lot	22	____	____	____
23.	Wants to be with you more than before	23	____	____	____
24.	Feels he or she is bad	24	____	____	____
25.	Takes unnecessary risks	25	____	____	____
26.	Gets hurt frequently	26	____	____	____
27.	Seems to be having less fun	27	____	____	____
28.	Acts younger than children his or her age	28	____	____	____
29.	Does not listen to rules	29	____	____	____
30.	Does not show feelings	30	____	____	____
31.	Does not understand other people's feelings	31	____	____	____
32.	Teases others	32	____	____	____
33.	Blames others for his or her troubles	33	____	____	____
34.	Takes things that do not belong to him or her	34	____	____	____
35.	Refuses to share	35	____	____	____

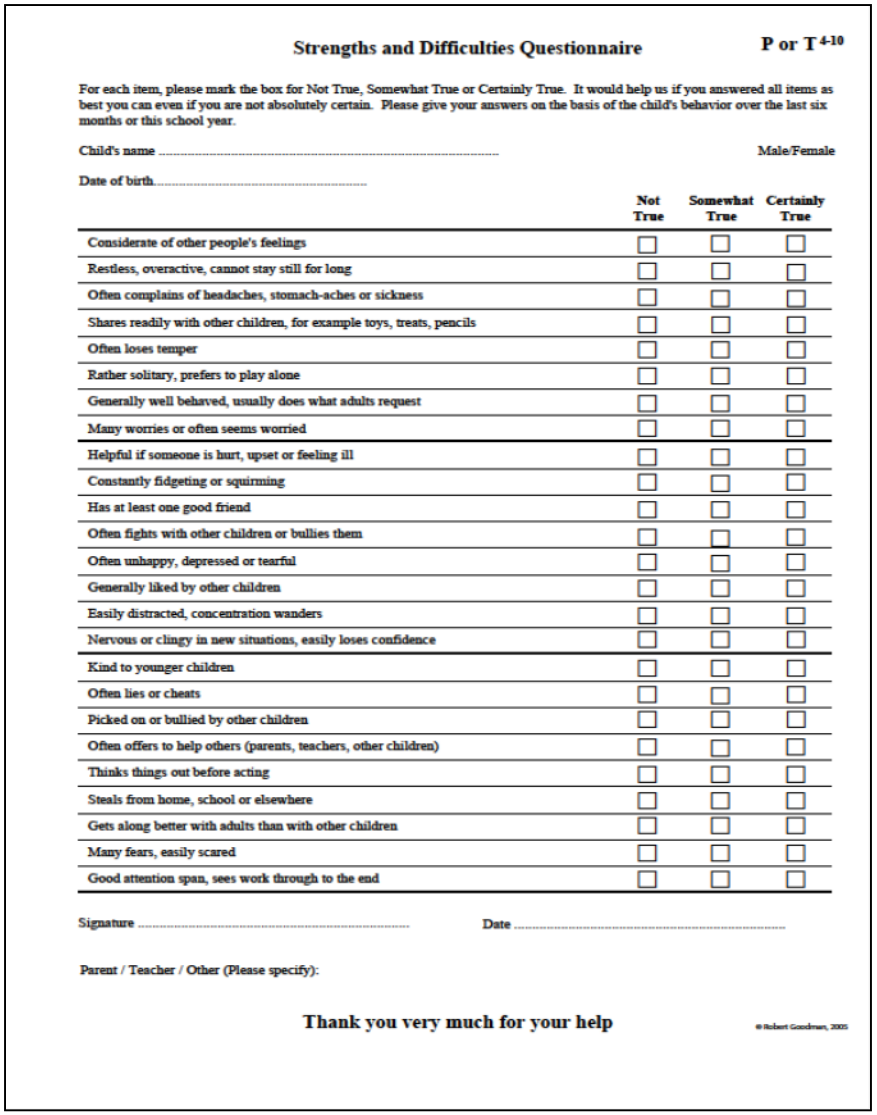
Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

Strengths and Difficulties Questionnaire

- Broad social-emotional screener for 3-16 year olds
- Relatively brief (25 items)
- No expense
- Parent report
- Several versions available for different ages
- Available in multiple languages



Strengths and Difficulties Questionnaire P or T 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Strength and Difficulties Questionnaire (SDQ)

Michigan Department of Health & Human Services

Problem Subscales:

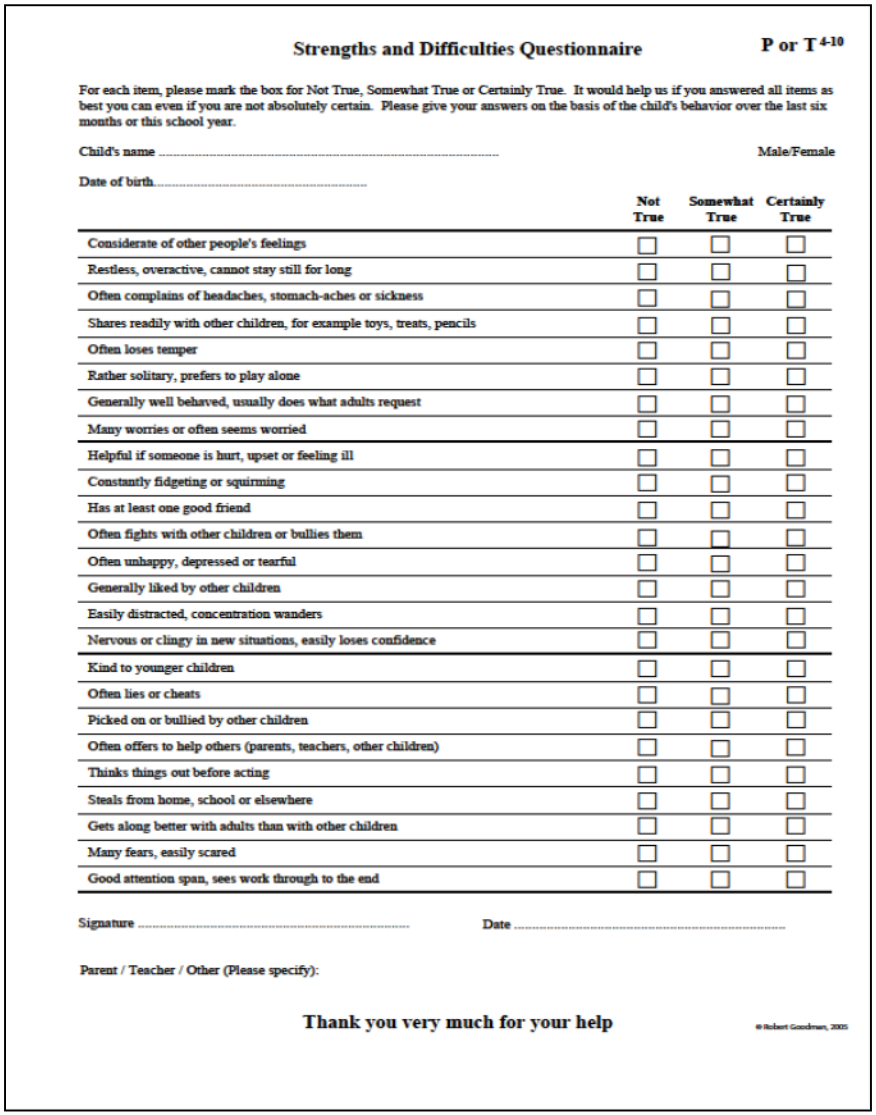
- Emotional
- Conduct
- Hyperactivity
- Peer Relationships

Scores of 6-10 considered clinical range

Positive Subscale:

- Prosocial

Scores 6-10 considered normal range (parent/teacher report)



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Often loses temper	☐	☐	☐
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Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

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Social Communication Questionnaire

- Many children are not recognized in toddler years; and frequently autism is missed
- Sometimes symptoms become more apparent as children move into school
- Critical to continue to screen; using the SCQ for children above 4 years (mental age >2 years); in which suspicion is raised.

Social Communication Questionnaire

- Parent questionnaire, 40 items based on the Autism Diagnostic Interview
- Scores 13-15 raise concern for autism; with scores greater than 15 signaling clear need for additional testing (ADOS)
- Refer for evaluation at Genesee Health System (GHS) (Community Mental Health) at **810-257-3740**

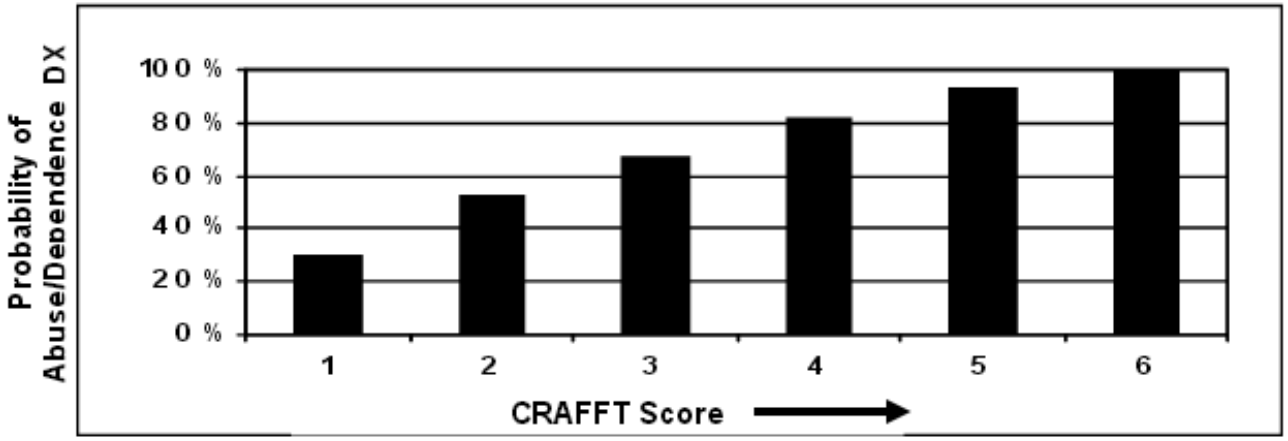
CRAFFT

- Substance use screener
- CRAFFT is an acronym made from the questions on the screener
- Self-report form for adolescents

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 drugs while you are by yourself, *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?

Scoring of CRAFFT

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

PHQ-2 Initial Screening Option

- Over the past 2 weeks how often have you been bothered by any of the following problems: little interest or pleasure in doing things
- Feeling Down Depressed or Hopeless

Key:

0 – not at all

1 - Several days

2 – More than half the days

3 - Nearly every day

PHQ-9 Modified for Teens

- 9 item self report questionnaire
- Depression screen
- Takes 5 minutes to take and score
- Incorporates 2 key suicide questions.
  - Has there been a time in the past month when you have had serious thoughts about ending your life?
  - Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?

PHQ-9 Modified

1. Feeling down, depressed, irritable or hopeless?
2. Little interest or pleasure in doing things
3. Trouble falling asleep, staying asleep, or sleeping too much?
4. Poor appetite, weight loss, or overeating?
5. Feeling tired, or having little energy

PHQ-9 Modified

6. Trouble concentrating on things like school work, reading or watching TV?
7. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual
9. Thought that you would be better off dead, or of hurting yourself in some way?

Scoring the PHQ-9

Key:

0 – not at all

1 - Several days

2 – More than half the days

3 - Nearly every day

Total Score Interpretation:

1-4 minimal depression

5-9 mild depression

10-14 moderately severe depression

20-27 severe depression

Scoring the PHQ-9 Modified

- A score of 10 or higher is a positive
- Regardless of the PHQ-9 total score, serious suicidal ideation or past suicide attempt should be considered a positive screen worthy of your attention

Positive Social-Emotional Screens

- PCP may utilize the Behavioral Health Clinician in or linked to the practice for further assessment or determination of referral sources.
- If provider does not have access to a BHC, they should contact Genesee Health System (Community Mental Health) Access Center at (810) 257-3740 for those children with a positive screen to learn more about resources available or to arrange for an assessment.

Suicide Prevalence

- Suicide is a significant public health issue [1]
  - 3rd leading cause of death 10-14 year olds
  - 2nd leading cause of death 15-24 year olds
- NY Times April 22, 2016-Suicide has surged to the highest levels in nearly 30 years with increases in every age group except older adults.
- Psychiatric illness is as contributing factor
  - Up to 90 percent of suicide victims suffer from a mental or emotional disorder at the time of death[2]
- People who die by suicide are frequently experiencing undiagnosed, undertreated, or untreated depression.
- Contact with primary care providers in the time leading up to suicide is common[3]

Detecting Suicide Risk

1. Review each patient's personal and family medical history for suicide risk factors.
2. Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool.
3. Review screening questionnaires before the patient leaves the appointment or is discharged.

(*Sentinel Event Alert* The Joint Commission, February 24, 2016)

Take Action

- **Patients in acute suicidal crisis**
  - Keep in a safe health care environment under one-to-one observation. Do not leave these patients by themselves. Provide immediate access to care through an emergency department, inpatient psychiatric unit, respite center, or crisis resources.
- **Patients at lower risk of suicide**
  - Make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment,8 rather than leaving it up to the patient to make the appointment.

(*Sentinel Event Alert* The Joint Commission, February 24, 2016)

For All Patients with Suicide Ideation and Family Members

- **Crisis and support resources**
  - National Suicide Prevention Lifeline, 1-800-273-TALK (8255), as well as to local crisis and peer support contacts
- **Conduct safety planning**
  - Collaboratively identify possible coping strategies with the patient and by providing resources for reducing risks
- **Restrict access to lethal means**
  - Assess whether the patient has access to firearms or other lethal means, such as prescription medications and chemicals, and discuss ways of removing or locking up firearms and other weapons during crisis periods.

(*Sentinel Event Alert* The Joint Commission, February 24, 2016)

Implementing Screening

In-office Preparation

- Provide in-service for staff
- Identify who will administer and score the screen
- Review time needs and appointment types for screening
- Code for services rendered
- MC3 can assist with this
  - We will further discuss

Remember

- Behavioral concerns are the third reason children come to your offices
- In areas of high concentration of poverty such as Genesee Co. rates may be as high as 50%
- As many as 2 in 3 depressed youth are not identified by their primary care clinicians and do not receive any kind of care
- Mental illness is treatable and early intervention may prevent a suicide
- If you ask they will tell!

Trauma and Children

- Adverse Childhood Events (ACEs) including interpersonal violence, exposure to gun violence, poverty, incarceration, loss of loved ones, parental mental illness, physical and sexual abuse, neglect adversely affect young children
- Trauma screening may help identify youth at risk for psychosocial and behavioral sequelae of adverse childhood events.
- An upcoming webinar will further address trauma in children (date, June 2016).

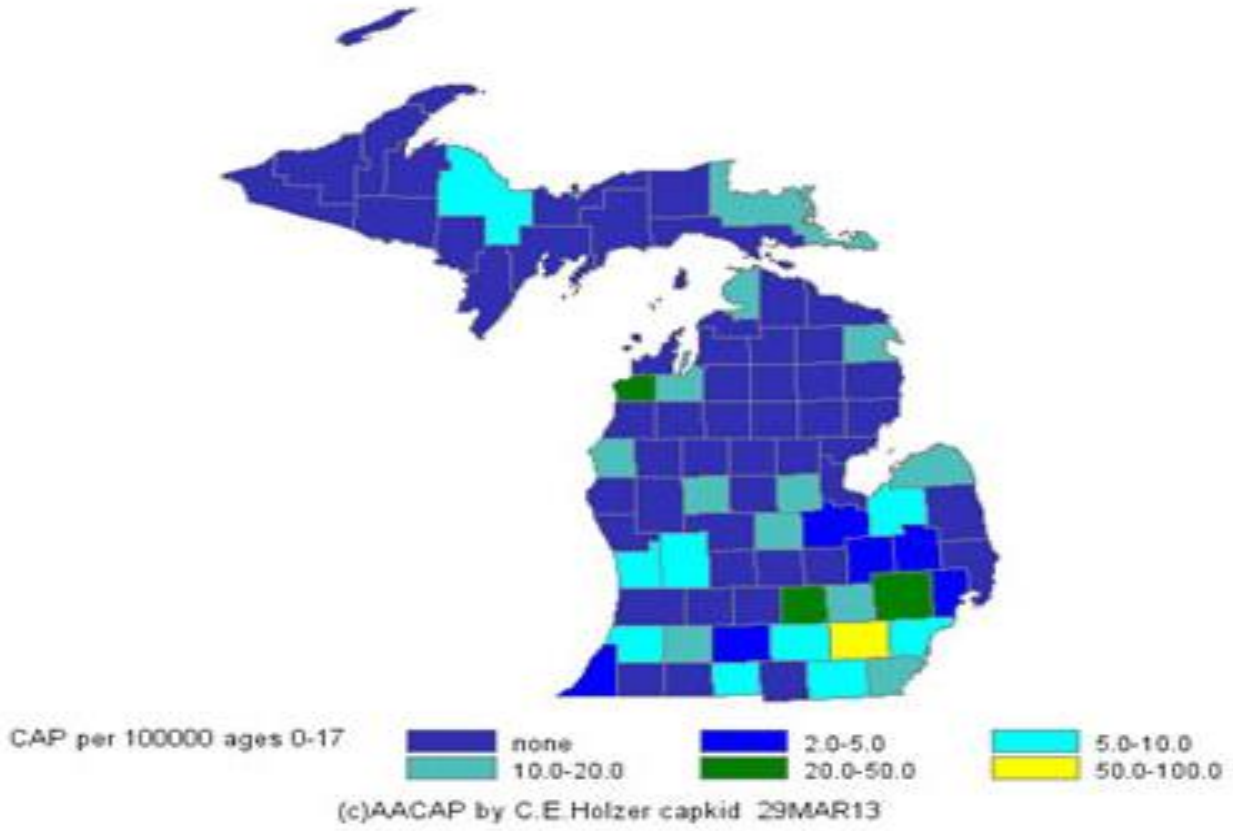
The Michigan Child Collaborative Care Program (MC3) and Support of Screening

Why Is Child Psychiatry Access A Problem?

MDHHS Michigan Department of Health & Human Services

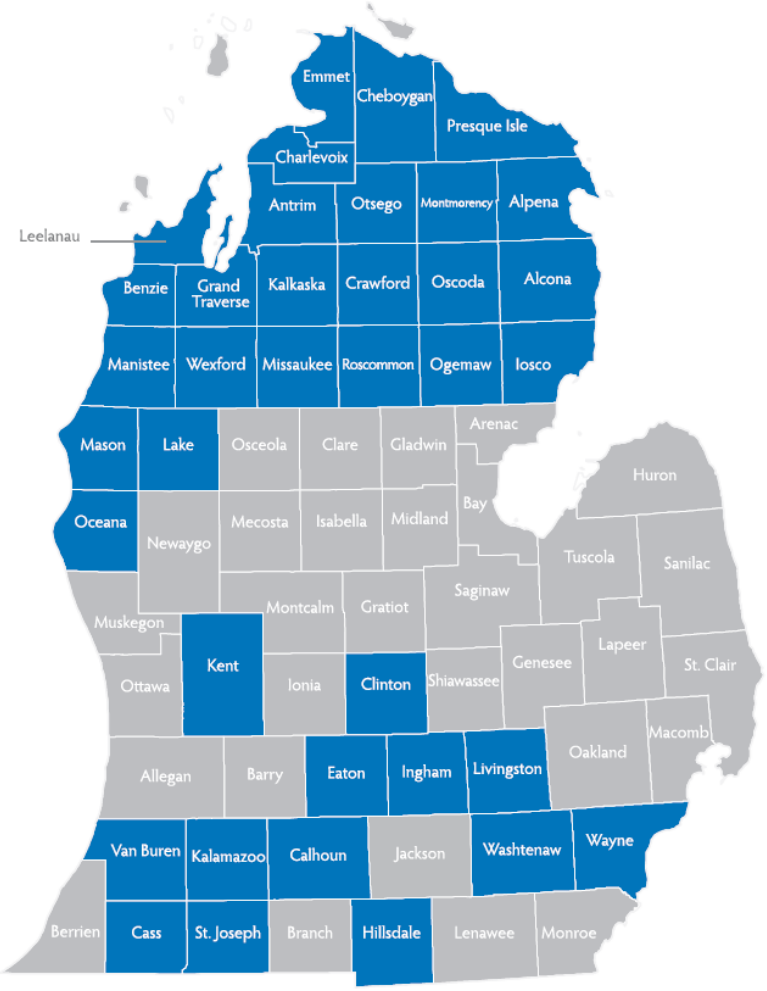
- Supply and Demand: A Perfect Storm
- Common Illnesses: Up to 20% of children and 50% of impoverished children
- Far too few child psychiatrists especially in rural areas
- This is how programs like MC3 got their start

Michigan: Practicing Child and Adolescent Psychiatrists



2012 Rate per 100,000 children age 0-17

MC3 Counties To Date



Who Does MC3 Serve?

- Infants and children ages infancy through 26
- High risk women during pregnancy and postpartum

What Is MC3

- Telephone Access: “Answers in real time” to PCPs
- Tele psychiatry = 90 Minute Assessment/Child/Dyad
- Embedded Care: Placing BHCs in offices or available remotely
- Support For Screening
- Education: webinars, ongoing case consultations and panel reviews
- Outcomes: clinical, adherence, service utilization

Screening

- MC3 can assist with
  - Implementation of screening into PCP workflow (along with PCP and clinic staff)
  - Triaging positive screens (BHC)
  - Identifying local resources for referral for children who are identified through the screening process (BHC)
  - Diagnostic clarification (BHC/Psychiatrist)
  - Medication consultation/telepsych (Psychiatrist/CAP)

Create a Plan of Action: Role of MC3

- Assist in diagnostic clarification for positive screens
- Identify mental health resources for therapy and school-based services (BHC)
- Consultation with psychiatrist as desired
  - Individual phone calls from PCP and panel reviews with BHC
- Consider medication
  - MC3 psychiatrists can support PCP with decision making; and ongoing care

For Further Information on MC3

Contact Anne Kramer at
University of Michigan
(ack@med.umich.edu)
or 734-764-7179

THANK YOU!

QUESTIONS?

Resources

- AAP Mental Health Toolkit
- Pediatrics June 2010 Supplement – Mental Health
- Bright Futures
- Teenscreen.org
- MentalHealthCheckups@childpsych.columbia.edu
- The REACH Institute
- US Preventive Services Task Force April 2009 Recommendation Statement: Screening and Treatment for Major Depressive Disorder in Children and Adolescents

References

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