

Mental Health Screening in the Primary Care Setting

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Why Screen?

- Suicide is the 3rd cause of death in children 11-18
- 1 in 5 children in the US suffers from a diagnosable mental disorder
- Only 20% to 25% of affected children receive treatment
- Approximately 90% of teens who die by suicide suffer from a treatable mental illness at the time of their death

Recommendations from US Preventive Services Task Force, April 2009

- The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive or interpersonal), and follow-up.

– Pediatrics 2009; 123:1223-1228.

Benefits of Screening Early & Often

- Raises awareness of mood issues as a possible concern
- Lets teen know these topics can be discussed
- Accurately identifies at risk adolescents
- Allows for early intervention and treatment

AAP & AACAP Joint Position Statement

- Primary care clinicians can and should deliver mental health services to children and adolescents in the primary care setting.
- 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

Barriers to screening

- Once disorders are identified coordinated services are inadequate
- Re-imburement is insufficient for services related to assessing and treating mental health disorders
- Primary care providers may lack training for treating mental/behavioral disorders

Mental Health Checkups

- Incorporate screen into routine visits
- Utilize evidence-based practices
- Identify mental illness early
- Prevent suicide
- Connect to services in the school and community

Creating a Plan of Action

- Choosing a screening tool
- Triaging the positive screen
- Collaboration
- Medication options and follow-up
- Coding and re-imburement
- Implementing screening

Choosing a Screening Tool

- PHQ-9 Modified
- Pediatric Symptom Checklist
- Beck Depression Inventory – Primary Care Version
- Vanderbilt
- SCARED

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

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

- 0 – not at all
- 1 - Several days
- 2 – More than half the days
- 3 - Nearly every day
- 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 11 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

Pediatric Symptom Checklist

- 35-item youth self report questionnaire
- Identifies behavioral and psychosocial problems
- Includes internalizing, attention and externalizing problems
- Takes 5 minutes to complete and score
- 2 additional questions pertain to suicidality

Beck Depression Inventory for Primary Care (BDI-PC)

- 9-item self-report measure of depressive symptoms
- Referenced by USPSTF report
- Proprietary

Vanderbilt

- Primarily utilized for assessing ADHD
- Includes questions pertaining to ODD, CD and anxiety
- Does not specifically identify depression
- Complementary testing may be useful
- Familiar to primary care providers

Screen for Child Anxiety Related Disorders - SCARED

- 41-question self-report screen
- Pertains specifically to anxiety
- May be used concurrently with depression screen or alone if primary concern is anxiety

Next Level Screens

- Reynolds Adolescent and child screens for depression – RADS and RCDS
- Multidimensional Anxiety Scale for Children – MASC
- Child Behavior Checklist
- Most are proprietary
- AAP Bright Futures reference on mental health screening tools

Quick screen

- Not validated but very useful!
- On a scale of 1 to 5 how sad, worried and angry are you?
- They always answer!

Quick Screen Example for Anger

- “On a scale of 1-5 on feeling mad, 1 is not at all and 5 is...”
 - For boys “punching walls, breaking things, the police are at my house”
 - For girls “irritable, mean, crabby, bitchy, my friends hate me”
- ...how do you feel?”
- Kids get this and usually laugh!

Triaging the Positive Screen

- What Now?

Determine Severity

- Tier 1 – mild severity
- Tier 2 – moderate severity
- Tier 3 - severe

Tier 1

- Mild distress
- Often present with somatic symptoms
- Schedule re-check to assess further
- Refer to mental health provider/school

Tier 2

- Moderate distress
- Functional impairment
- Often co-morbid conditions
 - School failure
 - Substance abuse
 - Mood disorders
- May require several levels of intervention including medication

Tier 3

- Severe distress and impairment
- Requires immediate intervention
 - Mental health provider referral
 - Medication
 - Psychiatry referral if available
 - Hospitalization

Suicide symptoms are very similar to depression symptoms but may also include:

- Violence, running away
- Substance use
- Feeling bad, "rotten"
- Putting affairs in order
- Suddenly cheerful after period of depression
- Signs of psychosis

Actively thinking about suicide is a medical emergency and may require a 911 call!

Have a plan in place for a mental health crisis!

Collaboration

- Establish connections
 - Psychiatry
 - Mental Health Providers
 - Community Mental Health Agencies
 - Schools
 - Other local agencies
- “The Kalamazoo Project” – Southwest Michigan Children’s Mental Health Coalition
- AAP Mental Health Toolkit

Collaboration

- Routinely obtain reciprocal consents with mental health providers, schools, and pertinent agencies
- Showing your interest in collaborating is appreciated and valued
- Working with others lessens your workload and improves care

Treatment:

- “The PCP has the capacity to have a positive impact on a child’s mental health without knowing precisely the child’s diagnosis” AAP Mental Health Task Force

You may not be a therapist but you
can offer therapeutic intervention!

Utilize the HELP Acronym

- H – Hope
- E – Empathy
- L – Language (the child and families) and Loyalty (yours to the family)
- P – Permission to help, Partnership with the family, and A PLAN!

Pediatrics Supplement June 2010 – vol. 125 – Supplement 3

Medication Options and Treatment

- Please refer to Dr. Sloane's discussion materials for primary care treatment guidelines
- AAP Mental Health Toolkit
- Glad PC- Toolkit for Depression
- TRAAAY – Guidelines for treating aggression
- Psychiatry referral/hospitalization

Coding & Re-imburement

- To maximize re-imburement code for time to guide your E/M level
- State "greater than 50% of the appointment was spent on counseling and coordination of care"
- Document total time of the appointment
- A summary of the counseling discussion should be included with the note

Coding for Time

- 99213 – 15 minutes
- 99214 - 25 minutes
- 99215 - 40 minutes
- If more than 70 minutes add extended time code 99354. This indicates to payer an additional 30 minutes or more was spent.
- If you spend 30-74 minutes or more discussing the case or arranging services with the school or therapist you could use 99358 – non face-to-face services.

Coding & the 25 Modifier

- The 25 modifier indicates that the visit is “different”
- Indicates separately identifiable E/M service plus preventive code if illness or abnormality requires significant work
- May be used to acknowledge screening performed

Developmental Testing/Screening

- 96110 Developmental testing of a limited nature (PHQ-9, Vanderbilt etc...)
- Often reported when performed in the context of preventive medicine services
- May be reported when screening is performed with other E/M services
- Reimbursed by many commercial carriers and Medicaid
- May use code for each screen administered up to 3 per visit

Care Plan Oversight

- Non face-to-face time for coordination of services, record review or consultation with specialist/therapist/schools
- 99339 – 15 to 29 minutes per month
- 99340 – 30 minutes per month
- Keep a log for documentation

Other Codes

- 99408 and 99409 –substance abuse structured screening (other than tobacco)
- 99406-99407 Smoking/tobacco use
- 99401-99404 – Preventive codes for individual risk factor reduction counseling

ICD-9 Codes

- V79.8 special screening exam for mental health disorders and developmental handicaps
- V40.0 mental and behavioral health problems

Coding References

- AAP Mental Health Toolkit
- Pediatrics Supplement – June 2010
Enhancing Pediatric Mental Health
Care: Report From the AAP Task Force
on Mental Health
- TeenScreen National Center for Mental
Health Checkups Guide to Referral and
Reimbursement www.teenscreen.org

Are You Ready?

- Normalize mental health care
- Routinely provide mental health assessment and treatment
- Train staff that mental health though chronic is treatable and not anyone's fault
- Have contingency plans in place
- Collaborate (did I already say this?!)

Implementing Screening

- Provide in-service for staff
- Identify who will administer and score the screen
- Provide parents with information about screening
- Review time needs and appointment types for behavioral services
- Compile a list of referral resources to share with patients, families and staff
- Code for services rendered

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

Remember

- Behavioral concerns are the third reason children come to your offices
- 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!

You make a difference!