Pediatric behavioral health: Best practices for primary care

UPMC Health Plan

Title of course: Pediatric behavioral health: Best practices for primary care

Presenter: Alin Severance, MD

Date and location: Nov. 17, 2021, Webex—Recorded live and available to view virtually thereafter

Time: Noon – 1 p.m. (includes presentation and Q&A session)

Target audience: Doctors (family practice/pediatricians), nurses, and staff

Course director(s): Johanna Vidal-Phelan, MD, MBA, FAAP; Debra Zeh, RN, BSN; and Andrea Sweeney, RN

Moderator: Andrea Sweeney, RN

Accreditation statement: Provider is responsible for verifying CME eligibility.
In support of improving patient care, the University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the health care team.

Physician (CME): The University of Pittsburgh designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nursing (CNE): The maximum number of hours awarded for this Continuing Nursing Education activity is 1.0 contact hour.

Other health care professionals: Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

Faculty disclosure:

No members of the planning committee, speakers, presenters, authors, content reviewers, and/or anyone else in a position to control the content of this education activity have relevant financial relationships with any entity producing, marketing, reselling, or distributing health care goods or services, used on or consumed by patients to disclose.

The information presented at this CME program represents the views and opinions of the individual presenters, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC/University of Pittsburgh Medical Center or affiliates, and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

PRESENTER

Alin Severance, MD

Medical Director, Behavioral Health Services
UPMC Health Plan
Associate Medical Director,
Community Care Behavioral Health Organization

OBJECTIVES

By the end of this program, participants will:

- Review the epidemiology of behavioral health conditions in children and adolescents.
- Recommend best practices for screening and treatment for the most common behavioral health disorders, and when to refer out.
- Identify the range of referral and consultation resources available to support the care of pediatric patients.

AGENDA

Pediatric behavioral health: Best practices for primary care

- Background, rationale, and prevalence
- Best practices and billing
- Referral process and options

Disclaimers

- *UPMC Health Plan does not practice medicine or exercise control over the methods or professional judgments by which providers render medical services to members. Nothing in these materials should be construed to supersede or replace the clinical judgment of a provider.*
- *The provider of care is ultimately responsible for providing accurate and compliant information on all submission of claims and/or billing information.*
- *Not all benefits are applicable to all UPMC Health Plan products, and we reserve the right to change or cancel incentives without notice.*

01 Background, rationale, and prevalence

Background, rationale, and prevalence

- Lifetime prevalence of any mental illness among youth ages 13-18 (2001 – 2004) was 49.5%; 22.2% severe impairment[1]
- 1.2 million youth ages 12-17 (4.9%) identified as binge drinking in the past month in 2019[2]
- 4.5 million youth ages 12-17 (18.7%) had a substance use disorder or major depressive episode in 2019[2]
- 3.2 million youth ages 12-17 (13.3%) had at least one major depressive episode in 2017[3]
  - Highest among females ages 12-17 (20.0%) compared to males (6.8%)
  - Highest among youth reporting two or more races (16.9%), American Indian/Alaska Native (16.3%), and White (14.0%)
- 2.3 million youth ages 12-17 (9.4%) had at least one major depressive episode *with severe impairment* in 2017[3]
- Suicide is the second leading cause of death for people ages 10-34[4]

Treatment for depression[3]

19.6% received treatment by a health professional alone

17.9% received treatment combined health professional and medication

2.4% received treatment with medication alone

60.1% did not receive treatment

Treatment for co-occurring substance use (SU) and mental health (MH)[2]

66.3% of the 397,000 youth ages 12-17 in 2019 received either treatment for SU or MH in the past year

Physical-social-behavioral connection

Importance of behavioral health screenings

- Warning signs: Headaches, lethargy, sleep challenges (too much/too little), abrupt change in mood / aggression / impulsivity / attentiveness
- Thorough H&P and screening are essential:
  - Depression
  - Anxiety
  - SUDs
  - Suicide
  - Intimate partner violence among adolescents (adolescent relationship abuse/teen dating violence)
  - Adverse childhood experiences (ACEs)
  - Trauma
  - Social determinants of health

02 Best practices and billing

Major depressive disorder: Screening[5]

Depression often presents with secondary somatic complaints

Mnemonic: SIG E CAPS *(helps providers remember the secondary symptoms of depression)*

Minor or secondary symptoms of depression		
S	Sleep/Sex	Difficulty falling asleep, fitful sleeping, early awakening, increased sleep during the daytime, or decreased enjoyment of sexual activity
I	Interest	Loss of interest in activities they used to enjoy
G	Guilt	Feelings of guilt or worthlessness, increased self-blame
E	Energy	Low energy or constant fatigue
C	Concentration	Difficulty concentrating, especially at work
A	Appetite	Changes in appetite, decreased interest in food
P	Psychomotor	Agitation, anxiety, or lethargy; slow or hesitant speech
S	Suicidal	Thoughts of death, life feeling pointless; may have a plan

Screening for depression

PHQ-9 Modified for Teens (ages 12-18)

- Screen annually or more frequently if you suspect depression
- Use an evidence-based tool
- Initial screen can be PHQ-2; if positive, PHQ-9

PHQ-9 score	Provisional diagnosis	Treatment recommendation
0–4	• Normal	• No action
5–9	• Minimal symptoms	• Support • Tell to call if worsens • Request to return in one month
10–14	• Minor depression • Dysthymia • Major depression, mild	• Support • Watchful waiting • Antidepressant • Psychotherapy
15–19	• Major depression, moderately severe	• Antidepressant • Psychotherapy
20+	• Major depression, severe	• Antidepressant • Psychotherapy *(esp. if not improved on monotherapy)*

Other screening tests:
QIDS-A17-C – More detailed, esp. sleep
CES-DC[6] – 20-item self-assessment

For patients who are acutely suicidal or need immediate assistance, providers are encouraged to implement their established protocol for emergency situations (911, local crisis centers, nearest hospital, established psychiatric consultation partnerships, or transportation resources).

UPMC is also available to provide support and resources. Call UPMC at 1-888-777-8754 and ask for assistance.

Faulstich ME, Carey MP, Ruggiero L, et al. 1986.Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale forChildren (CES-DC). American Journal of Psychiatry. 143(8):1024–1027

Screening for anxiety symptoms

GAD-7, SCARED, and interpretation

GAD-7: 7 items scored 0-3

Score	Anxiety severity
0–4	Minimal or none
5–9	Mild
10–14	Moderate
15–21	Severe

Scores above 10 may benefit from pharmacotherapy, CBT, or both.

SCARED[7]
(Screen for child anxiety-related disorders)

- 41 items scored 0-2
- More sensitive for social anxiety, panic, separation anxiety
- 25+ suggestive of anxiety

Lifetime prevalence

- GAD: 5–12%
- Social anxiety: 5–12%
- PTSD: 6–9%
- Panic d/o: 5%
- OCD: 2%

Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

Screening for ADHD

SNAP-IV, SWAN, and Vanderbilt ADTRS

SNAP-IV – 26 items on 0-3 Likert scale
SWAN – 18 items on 0-3 scale
ADTRS – 47 items on 0-3 scale

1. All administered by teacher and/or parent
2. SNAP incorporates sx of ODD
3. SWAN differentiates between inattentive/hyperactive/combined types
4. ADTRS assesses for sx of ODD, conduct disorder, anxiety and depression

Majority of children diagnosed with ADHD continue to have ADHD as they grow up

- **ADHD associated with increased risk of substance use, teen pregnancies, accidents, injuries, and criminal behavior**

Psychological and neuropsychological testing indicated only if low general cognitive ability suspected, or if academic achievement is lower than expected based on intelligence

Most common comorbidities

- **54-84% – ODD or conduct disorder**
- **25-35% – Learning/language disorders**
- **15-19% – Substance use disorders**
- **33% – Anxiety disorders**

SNAP and SWAN:
Swanson, J. M., Schuck, S., Porter, M. M., Carlson, C., Hartman, C. A., Sergeant, J. A., Clevenger, W., Wasdell, M., McCleary, R., Lakes, K., & Wigal, T. (2012). Categorical and Dimensional Definitions and Evaluations of Symptoms of ADHD: History of the SNAP and the SWAN Rating Scales. The International journal of educational and psychological assessment, 10(1), 51–70.

ADTRS
Wolraich, Mark & Lambert, Warren & Schuchman, Melissa & Bickman, Leonard & Simmons, Tonya & Worley, Kim. (2004). Psychometric properties of the Vanderbilt ADHD diagnostic parent rating scale in a referred population. Journal of pediatric psychology. 28. 559-67.

Screening for conduct disorder

NCBRF-TIQ, SNAP-IV, and Vanderbilt ADTRS

NCBRF-TIQ – 66 items on 0-3 Likert scale
SNAP-IV – 26 items on 0-3 Likert scale
ADTRS – 47 items on 0-3 scale

1. All administered by teacher and/or parent
2. NCBRF-TIQ – assesses for disruptive behavior, ADHD sx as well as social competence
3. SNAP incorporates sx of ODD
4. ADTRS assesses for sx of ODD, conduct disorder, anxiety and depression

- **Prevalence 1.5-3.4%, compared to adult prevalence of ASPD 2.6%**
- **Boys:girls ratio 3-5:1 but narrows with age**
- **Highly associated with ACEs**

Mild cases may be better explained by other disorders, such as mood disorders, PTSD, etc.

Differential diagnosis
ADHD, IED, SUDs, mood disorders, PTSD, borderline PD, etc.

More likely to be diagnosed in ethnic minorities

Aman M, Leone S, Lecavalier L, Park L, Buican B, Coury D. The Nisonger Child Behavior Rating Form: typical IQ version. Int Clin Psychopharmacol. 2008 Jul;23(4):232-42. doi: 10.1097/YIC.0b013e3282f94ad0. PMID: 18545062.

Screening for substance use disorders

NIDA: Screening to Brief Intervention (S2BI) [10] and Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)[11]

Quick screening questions: In the past year, how often have you used the following:

- *Alcohol*
- *Tobacco products*
- *Marijuana*
- *Additional types of substances, if affirmative responses*

**Each substance can be categorized for risk level.*

(766) Adolescent Substance Use Screening tools in Primary Care Settings – YouTube

S2BI

Score	Level of risk
Never	No reported risk
Once/twice	Lower risk
Monthly+	Higher risk

BSTAD

Score	Level of risk
0 days	No reported risk
1 day	Lower risk
2+ days (alcohol/other drugs)	Higher risk
6+ days (tobacco)	Higher risk

Consider referral for lower risk; *arrange* referral for higher risk.

CRAFFT [8] – 6-item screen with focus on impact of substance use
CUDIT-R [9] – 8-item screen, rated 0-4; 12+ suggestive of CUD

Prevalence (by senior year of high school) [11]

- Alcohol: **70%** tried
- Illegal drug: **50%** have taken
- Tobacco: nearly **40%**
- Prescription drug for nonmedical reasons: More than **20%**

Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, Sellman JD. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alcohol Depend. 2010 Jul 1;110(1-2):137-43.

Best practices for treatment and follow-up of depression

Major depressive disorder, single episode or recurrent[13,14]

Combination of pharmacotherapy and psychotherapy has been associated with better outcomes, though either alone is effective.

- Psychotherapy:
  - No evidence that any one modality is superior; focus on psychoeducation and family/school involvement
  - Mild/Brief depression responds to supportive treatment

- Pharmacotherapy:
  - First-line—Generic SSRI or DNRI, generally
    - If ineffective or poorly tolerated, try a DNRI or different SSRI, possibly with different metabolism
  - Second-line—Try SNRI or mirtazapine
    - May augment with SGA, lithium, or T3
    - May add omega-3, SAMe, or light therapy
  - Beyond this point, depression is considered treatment-refractory

Unless prevented by side effects, dose should be increased to maximum therapeutic dose for 4 or more weeks before switching strategies

Side effect management:

- Sexual side effects less common with bupropion
- Diarrhea more common with sertraline
- Somnolence and weight gain more common with mirtazapine
- Discontinuation syndrome common with SNRIs when doses are missed or delayed

If effective, continue antidepressants for at least 6-12 months before slowly tapering.

Best practices for treatment and follow-up of anxiety

Generalized anxiety disorder, panic disorder, PTSD, OCD, etc.[13,14]

Combination of pharmacotherapy and psychotherapy has been associated with better outcomes, though either alone is effective.

- Psychotherapy:
  - No evidence that any one modality is superior
  - Focus on psychoeducation along with parent-child interactions and family problem solving

- Pharmacotherapy:
  - First-line: Generic SSRI
    - If ineffective or poorly tolerated, try a different SSRI, or an SNRI, possibly with different metabolism
  - Second-line: Augment or replace with buspirone
  - Third-line: Augment with hydroxyzine or benzodiazepine
    - Associated with worse long-term outcomes
  - Hyperarousal symptoms associated with PTSD or social anxiety can respond well to a sympatholytic

Unless prevented by side effects, the dose should be increased to maximum therapeutic dose for four or more weeks before switching strategies.

Side effect management:

- Diarrhea more common with sertraline
- Discontinuation syndrome common with SNRIs when doses are missed or delayed

If effective, continue medications for at least 6-12 months before slowly tapering.

Best practices for treatment and follow-up of ADHD

Stimulant medications for ADHD have effect size of 1.0 (Cohen's d) compared to placebo

- Psychotherapy:
  - Inferior to medications but appropriate for mild symptoms or when there is disagreement about use of medications
  - Behavior therapy focuses on token economy, time out, daily school report card, and parent training

- Pharmacotherapy:
  - Stimulants – MPH and amphetamine equally efficacious
    - Long-acting more convenient with greater adherence
    - Short-acting allow for more flexible dosing
    - Linear relationship between dose and response
  - Atomoxetine – NRI less effective than stimulants, but less disruption to sleep/appetite, and not associated with tics
  - Alpha-2 agonists – Used alone or in combination with above
    - Effective for impulsivity, hyperactivity, tics and sleep
    - Long-acting guanfacine FDA approved
    - IR guanfacine and clonidine also used

Common side effects include anorexia, weight loss, insomnia, and headache; less common are tics and mood lability

Side effect management:

- Dose adjustment, different stimulant, or adjunctive therapy to treat side effects

If symptom free even when doses are occasionally missed, continue medications for at least 12 months before slowly tapering (during time of low stress)

Best practices for treatment and follow-up of conduct disorder

Severe cases typically require a multimodal approach over many years, with medications as an adjunct for comorbid conditions.

- Psychotherapy:
  - Intervention in family, school and peer group
  - Psychosocial skill building to address externalizing behaviors
  - Examples include Parent Management Training, Functional Family Therapy, and Multisystemic Therapy
  - Goals of treatment – Reduce criminal behavior, address environmental risk factors, empower caregivers, reward prosocial behaviors and peer groups

- Pharmacotherapy:
  - Poor evidence for any particular strategy though behaviors may improve with treatment of comorbid disorders
  - Higher risk of antipsychotic Rx and polypharmacy when aggression present

Best practices for treatment and follow-up of substance use disorders

With a focus on opioid and alcohol use disorders

General principles: Abstinence goal but harm reduction more realistic; family therapy approaches with strongest evidence; least restrictive treatment setting to avoid disruption to their life/education; a limited evidence base in adolescents for use of MAUD/MOUD, though they can be life-saving in treatment-refractory cases

Opioid use disorder[15,16]

- Withdrawal management (detox) alone increases risk of overdose and is not recommended
- Buprenorphine available in SL and SC (qwk or qmo); doses below 16 mg/day not recommended
- No recommended time limit for treatment
- Risks of combining methadone/bup with sedative/hypnotics less than untreated OUD
- Oral naltrexone is not recommended; IM naltrexone has no effect on all-cause mortality, while methadone and buprenorphine reduce it by 53% and 37%, respectively

Alcohol use disorder[17]

CIWA-Ar scores of 19+ merit ER referral

- Naltrexone or acamprosate recommended for moderate to severe AUD
- Second-line treatments include disulfiram, gabapentin, and topiramate
  - No acamprosate with CKD 4+
  - No naltrexone with acute hepatitis or liver failure

Special populations and when to refer out

Know your areas of expertise

Special populations

- **Eating disorders/Disordered eating**
- **Self-injurious behaviors**
- **Consultation:** Call the TiPS Line.
- **Pregnancy:** Most BH medications can be continued during pregnancy.
  - Pregnancy is a bad time to test whether a medication is still needed.
  - Doses may need to be adjusted due to physical changes.

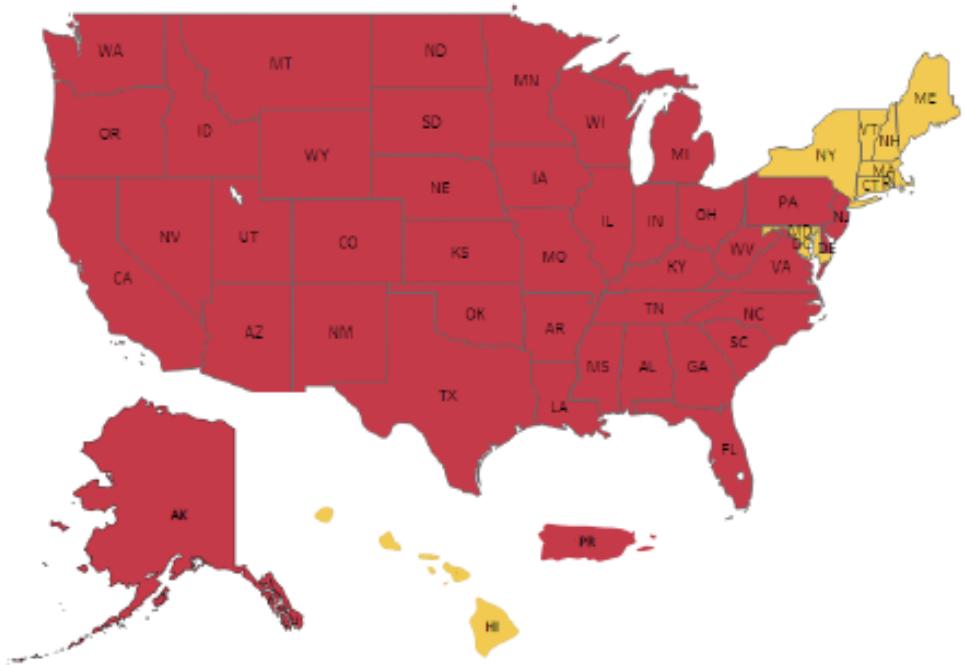
When to refer

- Frequent mental health crises
- Developmental problems
- Concerns about suicide
- Heavy substance use
- Failure to respond to multiple therapeutic medication trials
- Suspected mania or psychosis
- Nonadherence
- Trauma
- Childhood adverse experiences (ACEs)
- Autism
- Early Intervention

PENNSYLVANIA

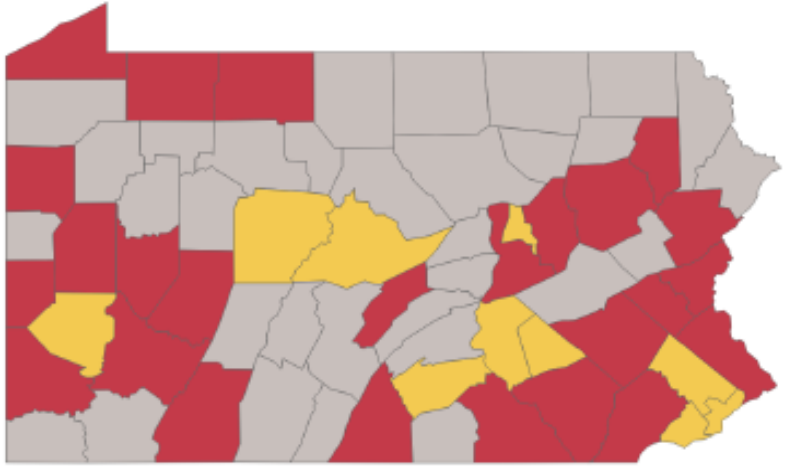
Child and Adolescent Psychiatrist (CAP) Workforce Distribution Map

Practicing Child and Adolescent Psychiatrists by State 2017
Rate per 100,000 children age 0-17



State CAPs per 100,000 children age 0-17

Practicing Child and Adolescent Psychiatrists by County 2017
Rate per 100,000 children age 0-17



CAPs Per 100K Children

- Mostly Sufficient Supply (>=47)
- High Shortage (18-46)*
- Severe Shortage (1-17)*
- No CAPs

Telephonic psychiatric services

(TiPS) overview

Real-time peer-to-peer (provider-to-provider) behavioral health consultative service available to all MA and CHIP patients up to age 21 for all plans in PA; also available to all patients with UPMC insurance up to age 21 (commercial).

To improve behavioral health treatment and access by providing psychiatric consultation to PCPs, PAs, NPs, and other prescribers.

TiPS teams are comprised of child psychiatrists, licensed therapists, care coordinators, and administrative support.

Teams are available within 30 minutes to assist any PCP or prescriber who sees children covered by Medical Assistance.

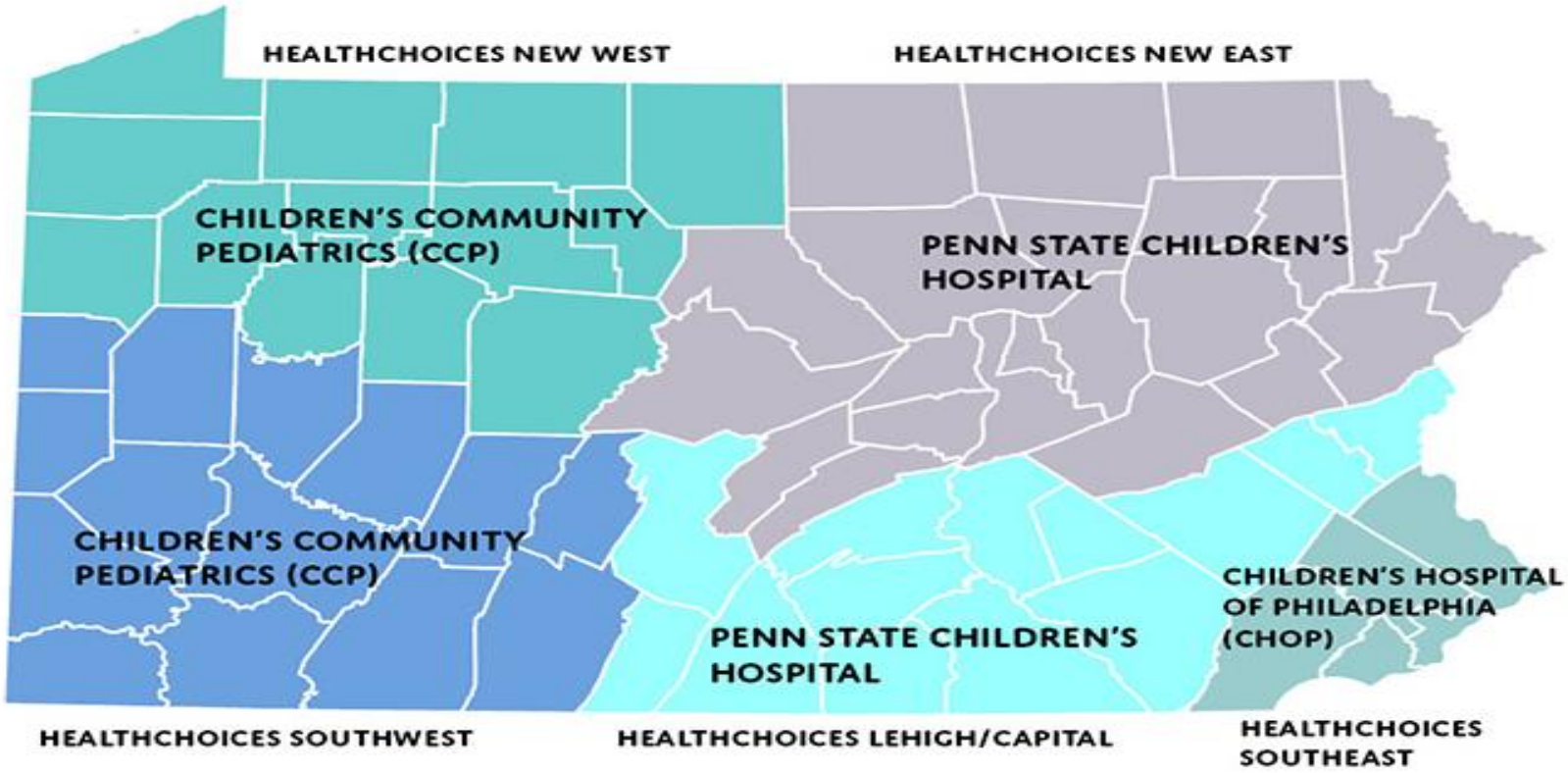
Phone inquiries can be patient-specific but can also be about any general question related to child psychiatry, behavioral health, medication, care coordination, or accessing community resources.

TiPS is a PH-MCO contract requirement; funded through capitation rates.

Three TiPS vendors serve the entire state (Hershey, CHOP, CCP) and Beacon (Mass) is centralized TiPS reporting vendor.

TiPS teams enroll practices in their zones, and conduct in-person provider trainings and education, based on the needs and desires of the practices.

Regional TiPS teams



CHILDREN'S COMMUNITY PEDIATRICS (CCP)
844-972-8477

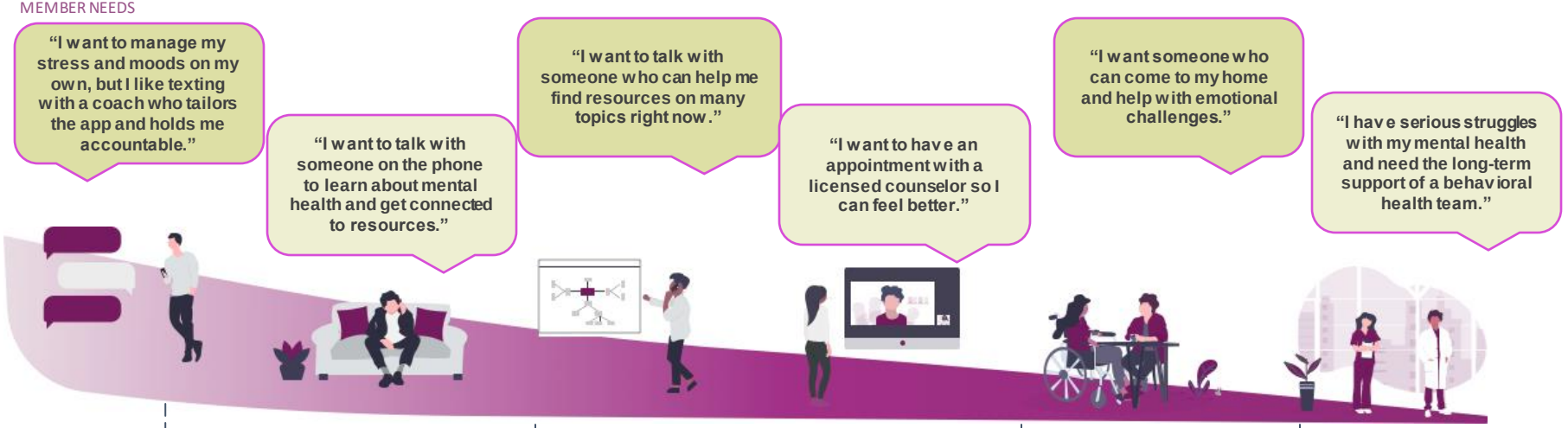
PENN STATE CHILDREN'S HOSPITAL
800-233-4082
"PRESS 4"

CHILDREN'S HOSPITAL OF PHILADELPHIA (CHOP)
267-426-1776

03 Referral process and options

Behavioral health resource continuum

MEMBER NEEDS



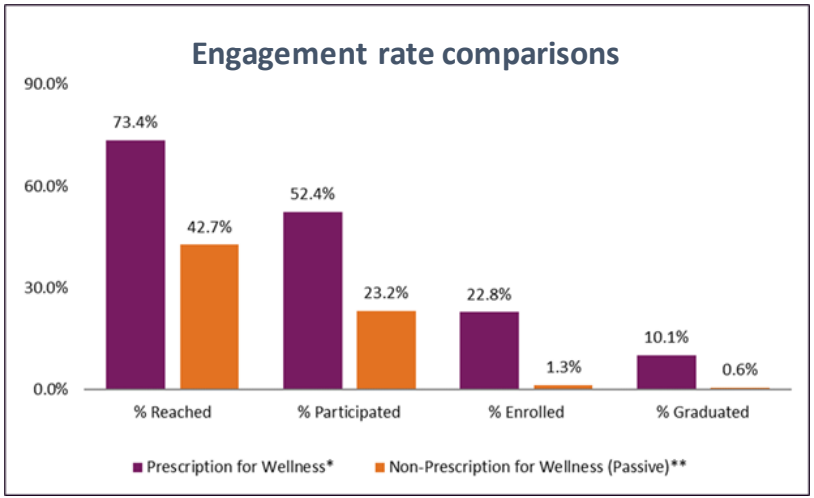
Rxwell	Behavioral health telephonic care management	Employee Assistance Program (EAP)		Community services teams	In-network providers
In-app CBT practices available to users 24/7; users can communicate with coaches via in-app chat	Scheduled calls with licensed BH professionals who can help members learn skills to manage their BH condition, coordinate treatment with an in-network provider, and provide crisis intervention	**Triage and referral** 24/7 resource navigation (finding community counselors, physicians, short-term virtual counseling)	**Counseling** Scheduled visits with licensed counselors for brief support	Behavioral health care management and care coordination	Crisis and scheduled care for treatment of all mental health issues

UPMC Prescription for Wellness

UPMC Prescription for Wellness

Physician-initiated prescription for behavior change and engagement

- An innovative, physician-prescribed coaching program that connects patients to evidence-based health interventions through UPMC Health Plan's board-certified health coaches
- Available to all UPMC Health Plan members at ***no cost***
- Physicians can enter orders directly through EpicCare or UPMC Health Plan's secure provider website, Provider OnLine
- Modeled after best-practice guiding principles:
- ***Physician initiates*** prescription for behavior change
- EMR and technology integration ***streamline notification***
- Link to UPMC Health Plan health coaches for ***follow-up support***
- Leverages role of office staff for ***reinforcement and updates***
- ***Minimizes patient barriers*** (no cost, widely available, remote options, and flexible hours)



*Referrals from 7/1/14-12/31/2019

**Passive referrals for all LOB, including incentivized, from CY16

[From *Am J Health Promot*][19]

How to order

UPMC Prescription for Wellness, RxWell, BH coaching and case management, and EAP

EpicCare

- Digital Care tab
  - *RxWell*
- Order Entry tab or smart set
  - *UPMC Prescription for Wellness*

Provider OnLine

- Prescription for Wellness tab
  - *Prescribe Wellness Program and click Place Referral (indicate which referral you are making)*

Prescription for Wellness is available to all members regardless of age.

Ordering options: Feedback from UPMC

What you can expect

EpicCare

- After an RxWell referral, providers can see a patient's app progress, assessment scores, top lessons, and crisis referrals.

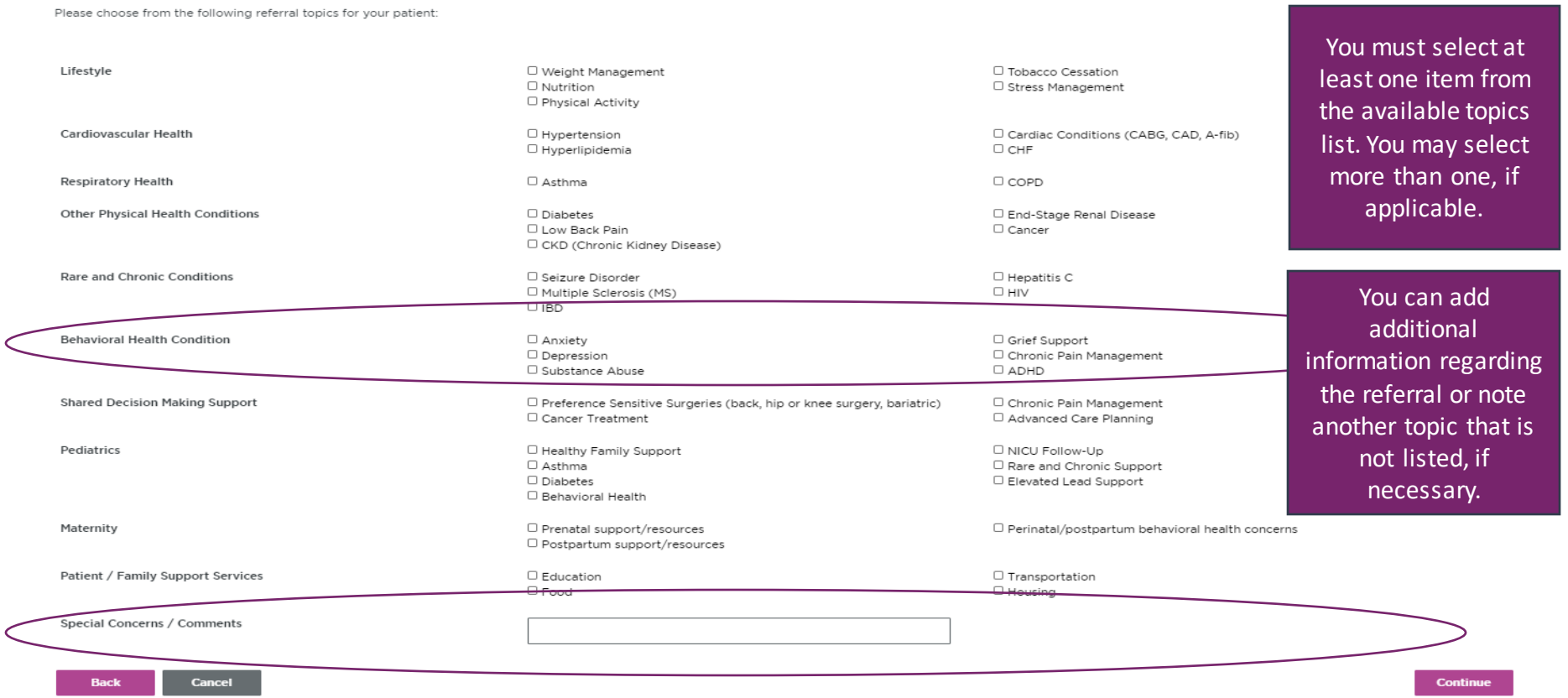
Provider OnLine

- If the member/patient has not initiated contact within 48 hours of prescription, health coaches reach out to the member/patient.
- The provider receives feedback within approximately 30 days of prescription. This feedback will include the patient's health coach's name, direct line, and a summary of the patient's outcome.

Our goal is to continue promoting patient engagement, behavior change, and care adherence.

Entering a Prescription for Wellness

Provider OnLine



You must select at least one item from the available topics list. You may select more than one, if applicable.

You can add additional information regarding the referral or note another topic that is not listed, if necessary.

Behavioral health coaching, case management, and the Employee Assistance Program

Behavioral health coaching: Overview

UPMC Health Plan's behavioral health resources for members

Behavioral health condition management
Anxiety, depression, substance use, pain management, grief, and ADHD

What is behavioral health coaching?

Behavioral health coaching is an interactive process through which members develop skills and set goals to manage their behavioral health conditions more effectively.

Who provides behavioral health coaching?

Our behavioral health team consists of licensed social workers, counselors, and nurses who have many years of clinical behavioral health experience.

Behavioral health coaches …

- Educate members about symptoms of their condition.
- Help members develop skills and set realistic goals to better manage their symptoms.
- Explore and address barriers that may prevent members from adequately managing their BH needs.
- Help members recognize worsening symptoms and know when to seek help.
- Encourage regular communication with the member's doctor.
- Address gaps in care, including preventive screenings.
- Engage with members to help them set and achieve their health goals.
- Develop an action plan for improving health.
- Provide ongoing motivation and support.

Behavioral health case management: Overview

UPMC Health Plan's behavioral health resources for members

What is behavioral health case management?

A process in which our coaches plan, coordinate, and monitor treatment services for individuals with substance use or mental health concerns.

Who provides behavioral health case management?

Our behavioral health team consists of licensed social workers, counselors, and nurses who have many years of behavioral health clinical experience.

As case managers, our behavioral health coaches can:

- Assess members' behavioral health needs.
- Assist with goal setting and problem solving related to behavioral health issues.
- Talk to members about possible treatment options.
- Provide therapist and psychiatrist referrals specific to members' needs.
- Facilitate obtaining behavioral health appointments.
- Link members to the Employee Assistance Program (EAP).
- Follow up with members after a hospital discharge to facilitate transition of care and provide support.
- Conduct crisis assessment and engage resources for necessary intervention.

Employee Assistance Program

LifeSolutions®

Services for employees and their family members

- 24/7 telephone access and support
- Coaching and counseling sessions
  - In person and by telephone
- Referrals to community resources
  - More than 100,000 in our database
- Engaging quarterly newsletters, topical fliers, and wallet cards

Coding for pediatric depression screening

Pediatric (ages 12-21) depression screening

Coding for depression screening

CPT codes:

G8431: Positive screen for clinical depression with a documented follow-up plan

G8510: Negative screen for clinical depression, follow-up not required

G0444: Annual depression screening, 15 minutes

96127: Brief emotional/behavioral assessment

Pediatric (ages 12-21) depression screening (cont'd)

Coding for depression screening

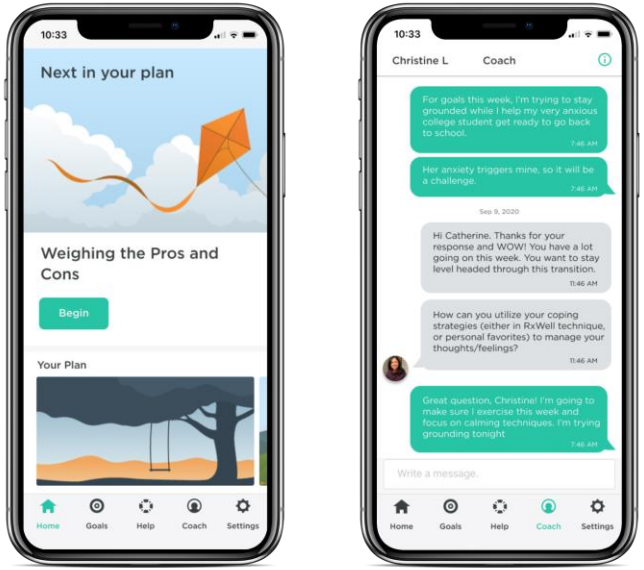
Example – Partner submits both the **96127** and **G8431** codes for one visit to meet EPSDT requirements and indicate that the result of the screening was positive:

- 96127 will count toward EPSDT requirements and will generate fee-for-service reimbursement.
- Use G8431 code to indicate a **positive** screen for clinical depression with a documented follow-up plan.

RxWell

RxWell

Prescription-strength health



RxWell overview video:
RxWell | UPMC Health Plan

RxWell offers programs that can help users manage their emotional and physical health.

- Users work with a health coach to …
  - Manage stress, anxiety, or depression.
  - Manage weight, eat healthy, increase physical activity, or quit using tobacco.
  - Learn techniques that can help them relax.

RxWell is …

- A low- to medium-intensity intervention.
- Available on users' smartphones 24/7.
- A tools for goal setting and instant relief from symptoms.
- Based on proven techniques.
- An easy way for members to connect with a health coach.

Tell your patients to download RxWell from the Apple App Store or Google Play today!

References

[1]Mental Illness. National Institute of Mental Health. Updated January 2021. Accessed Sept. 29, 2021. nimh.nih.gov/health/statistics/mental-illness.shtml

[2]Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). 2020. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR090120.htm

[3]Major Depression. National Institute of Mental Health. Updated Feb. 2019. Accessed Sept. 29, 2021. nimh.nih.gov/health/statistics/major-depression.shtml

[4]Suicide Prevention. Centers for Disease Control and Prevention. Updated March 23, 2021. Accessed Sept. 29, 2021. cdc.gov/suicide/facts/index.html

[5] Lieberman JA. The differential diagnosis of fatigue and executive dysfunction in primary care. *J Clin Psychiatry*. 2003;64 Suppl 14:40-43.

[6] Faulstich ME, Carey MP, Ruggiero L, et al. 1986. Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). American Journal of Psychiatry 143(8):1024–1027.

[7] Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230–6.

[8] Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.

[9] Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, Sellman JD. An improved brief measure of cannabis misuse: the Cannabis Use Disorders Identification Test-Revised (CUDIT-R). Drug Alcohol Depend. 2010 Jul 1;110(1-2):137-43. doi: 10.1016/j.drugalcdep.2010.02.017. Epub 2010 Mar 26. PMID: 20347232.

[10] Levy, S., Weiss, R., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., & Shrier, L. A. (2014). An electronic screen for triaging adolescent substance use by risk levels. JAMA pediatrics, 168(9), 822–828. doi.org/10.1001/jamapediatrics.2014.774

[11] Kelly, S. M., Gryczynski, J., Mitchell, S. G., Kirk, A., O'Grady, K. E., & Schwartz, R. P. (2014). Validity of brief screening instrument for adolescent tobacco, alcohol, and drug use. Pediatrics, 133(5), 819–826. doi.org/10.1542/peds.2013-2346

[12]NIDA. 2021, August 3. Introduction. Retrieved from drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/introduction on 2021, Sept. 27.

References, cont'd

[13]Psychopharmacology Algorithms. Psychopharmacology Algorithms Project at the Harvard South Shore Psychiatry Residency Training Program. Updated 2021. Accessed May 5, 2021.

[14]Depression in adults: recognition and management: Clinical guideline [CG90]. National Institute for Health and Care Excellence. Oct. 28, 2009. Accessed May 5, 2021.

[15]Larochelle MR, Bernson D, Land T, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Ann Intern Med*. 2018;169(3):137-145. doi:10.7326/M17-3107

[16]Peterson C, Li M, Xu L, Mikosz CA, Luo F. Assessment of Annual Cost of Substance Use Disorder in US Hospitals. *JAMA Netw Open.* 2021;4(3):e210242. March 1, 2021.

[17]asam.org

[18]Clinical Practice Guidelines. American Psychiatric Association. No date. Accessed May 5, 2021.

[19]Parkinson MD, Hammonds T, Keyser DJ, Wheeler JR, Peele PB. Impact of Physician Referral to Health Coaching on Patient Engagement and Health Risks: An Observational Study of UPMC's Prescription for Wellness. *Am J Health Promot*. 2020;34(4):366-375. doi:10.1177/0890117119900588

CME information

Pediatric Behavioral Health: Best Practices for Primary Care

Nov. 17, 2021 (Live—Virtual)

UPMC University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences

This is not your official certificate.

How to receive your continuing education credit:

https://cce.upmc.com/pediatric-behavioral-health

Provider is responsible for verifying CME eligibility. This activity is approved for *AMA PRA Category 1 Credit™* and ANCC. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

To receive credit, you will be required to log in, complete the course evaluation, and claim credit within 14 days of the activity. Please allow for 24 hours after the live event before trying to claim credit. If you are a new user, click **Register** to create a new account. The activity will be added to your **Pending Activities** and accessible on the first day of the activity. Upon completion, certificates will be available to download and stored for future reference in your **Completed Activities.**

Records are matched to users by email address.

To receive credit, log in and complete the course evaluation and/or claim credit on the CCEHS Learning Portal, cce.upmc.com. The activity is accessible in your **Pending Activities.** If you are a new user, click **Register** to create a new account.

For answers to common questions or step-by-step instructions please visit the FAQ available on the **CCEHS Learning Portal.**