



The Integration of Behavioral Health into Pediatric Primary Care Settings

KEY FINDINGS:

Project LAUNCH grantee evaluations demonstrated that a range of strategies can lead to greater integration of behavioral health services in pediatric primary care settings, including training primary care providers in developmental and social-emotional screenings; establishing enhanced referral and care coordination systems; providing parenting education and support groups; and embedding infant and early childhood mental health consultants in primary care settings. These strategies are associated with positive outcomes in Project LAUNCH sites, including increased screening and early referrals from primary care providers; increased patient, family and provider satisfaction; and improved social-emotional functioning among children.

In implementing these various strategies, the Project LAUNCH grantees revealed the following lessons that are key to successful behavioral health integration efforts:

- Providers must be met “where they are” to establish long-lasting changes.
- Behavioral health resources and enhanced referral systems facilitate provider buy-in for transitioning to an integrated model.
- Embedding mental health consultants supports higher screening rates, increased provider and patient satisfaction, and improved children’s social-emotional functioning.
- Leveraging existing infrastructure is key to ensuring integration efforts lead to sustained change.

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I. INTRODUCTION

The integration of behavioral health services into pediatric primary care settings is a key strategy for advancing health promotion and prevention among children and families. Behavioral health integration refers to a model of care through which a practice team of primary care and behavioral health clinicians work in concert to provide a systematic, cost-effective, and patient- and family-centered approach. While behavioral health integration can take a variety of forms, it ultimately aims to change how care is delivered by equipping providers with the skills and training needed to support social-emotional and behavioral health, reinforcing the importance of the whole care continuum, and promoting care coordination. This model of care supports the identification of family risk factors and the early onset of behavioral health issues, and ensures that linkages to additional services and supports are in place to address any identified needs.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), an initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA), provides grants to states, tribes, and local communities to support behavioral health integration into primary care settings, among other activities. This issue brief highlights selected promising behavioral health integration strategies that the Project LAUNCH grantees used to improve the delivery and quality of care for children and families. This issue brief also examines common lessons from the grantees that can promote the successful integration of behavioral health services, in addition to mechanisms for sustaining and spreading these efforts.

II. OVERVIEW OF PROJECT LAUNCH

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is an initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) that is promoting the wellness of young children from birth to eight years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. Project LAUNCH ultimately aims to ensure that all children are thriving in safe, supportive environments, and are entering school ready to learn and able to succeed.

States, territories, and tribes receive grants to pilot initiatives in local communities that are designed to promote health social-emotional and brain development, reducing the likelihood that children will develop mental health and substance use disorders later in life. Grantees implement five core prevention and promotion strategies: (1) screening and assessment in a variety of child-serving settings, (2) enhanced home visiting through increased focus on social and emotional well-being,

(3) mental health consultation in early care and education programs, (4) family strengthening and parent skills training, and (5) integration of behavioral health into primary care settings.

This issue brief examines the Project LAUNCH grantees' efforts to promote the integration of behavioral health into primary care settings (strategy 5). The issue brief describes integration strategies, lessons learned, outcomes, and opportunities to advance this work based on information contained in the Final Cumulative Reports and Final Evaluation Reports developed by the 17 states that participated in Cohort 1 and Cohort 2 of Project LAUNCH.¹ The Project LAUNCH evaluations were conducted by independent researchers on an annual basis using qualitative and quantitative data gathered through provider and family surveys, stakeholder interviews, and direct service data.

III. DEFINING BEHAVIORAL HEALTH INTEGRATION AND ITS ROLE IN HEALTHY CHILDHOOD DEVELOPMENT

A well-established body of evidence documents the impact of early life experiences on infant and child brain development, underscoring the critical role that the early years of a child's life play in setting the foundation for positive social-emotional and cognitive capabilities. Negative early experiences and exposure to toxic stress, such as abuse or neglect, maternal depression, parental substance abuse, or family violence can have disruptive effects on a young child's brain, leading to the potential for lifelong physical and mental health issues.^{i, ii} However, early identification and intervention can help mitigate the negative effects and promote better developmental and health outcomes.ⁱⁱⁱ

The integration of behavioral health into primary care settings is a key strategy for promoting children's health and well-being, especially in the early years of life. An estimated one in five children will experience a mental health disorder at some point in their life.^{iv} Of those children diagnosed with mental health disorders, 75 percent of children are currently seen in primary care settings, demonstrating the growing role primary care settings have in addressing behavioral health issues.^v At the same time, it is estimated that 75-80 percent of children in need of mental health services do not receive them.^{vi} Research has shown that unaddressed mental health problems among children can lead to lower educational achievement, greater involvement with the criminal justice system, and poor health and social outcomes overall.^{vii}

¹ Project LAUNCH Cohort 1(2008-2012) state grantees were Arizona, Maine, New Mexico, Rhode Island, and Washington. Cohort 1 also included one tribal grantee - the Red Cliff Band of Lake Superior

Chippewa. Project LAUNCH Cohort 2 (2009-2013) state grantees were California, District of Columbia, Illinois, Iowa, Kansas, Massachusetts, Michigan, New York, North Carolina, Ohio, Oregon, and Wisconsin.

Primary care providers are well-positioned to proactively support children's social-emotional development and detect the early onset of behavioral health issues. Based on the American Academy of Pediatrics (AAP) schedule for well-child visits, children should have 15 preventive care visits in the first five years of life, which should in turn facilitate primary care providers having regular contact with children and their families throughout childhood.^{viii} They also tend to have established relationships and a measure of the family's trust.^{ix} However, in traditional pediatric primary care settings, there are numerous barriers to the early detection of and intervention for behavioral health issues. Many primary care providers lack sufficient training in the use of standardized screening tools, they have too little time during appointments to implement screenings, and they are not always able to bill for the behavioral health services they provide.^x Additionally, the physical and behavioral health systems in the U.S. are historically highly fragmented. Thus, if a primary care provider detects a behavioral health concern, the family may have to navigate multiple systems to receive care, with little or no coordination between providers.^{xi}

Behavioral health integration in pediatric primary care settings is intended to address these challenges and promote a model of care that addresses the whole child, supporting their social-emotional, cognitive, and physical development, and the needs of their family. Behavioral health integration emphasizes health promotion and prevention, including systematic surveillance and screening to monitor the well-being of all children, not just those with an identified need, and supporting and educating parents. Having integrated services also allows for early identification and response to behavioral health issues through assessments, short-term interventions, and referrals to more intensive supports, thereby mitigating the long-term, adverse effects of unaddressed behavioral health needs.^{xii}

Defining Behavioral Health Integration

Behavioral health integration refers to "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."^{xiii} Strategies or models for achieving such comprehensive, coordinated, and patient-/family-centered care can take a variety of forms, and there are a growing number of integration frameworks designed to help practices or systems conceptualize the pathway to integration.

One approach to understanding integration is to examine discrete components that make up integrated services. The Agency for Healthcare Research and Quality (AHRQ) has developed a framework based on a series of functional domains or essential components of behavioral health integration that are designed to be observable and measurable in order to allow for a more accurate assessment of integrated services. The domains include: 1) care team expertise tailored to patient population; 2) shared clinical

workflow; 3) systematic patient identification; 4) patient and family engagement; 5) treatment monitoring; 6) leadership alignment; 7) operational reliability; 8) business model sustainability; 9) data collection and use; and 10) patient experience.^{xiv} While the current models of behavioral health integration continue to evolve, the underlying aim remains constant – to fundamentally change how care is delivered by increasing provider knowledge, reinforcing the importance of the whole-care continuum, providing coordinated care, identifying behavioral health conditions sooner, promoting collaboration among providers, and improving patient education and satisfaction.^{xv}

IV. INTEGRATION STRATEGIES AMONG PROJECT LAUNCH GRANTEES

Given children's unique health needs and the opportunity for early identification and intervention presented by pediatric care, it is important to develop and implement models of integration that are tailored to children and their families. To date, many state behavioral health integration efforts have focused on adult populations. Thus, Project LAUNCH, with its emphasis on behavioral health integration as a core strategy for improving children's well-being, has begun to lay the foundation for a new standard model of care for pediatric populations. Through a review of the early experiences of a subset of the LAUNCH grantees, Oppenheim, et al. identified ten common elements of behavioral integration for pediatric populations: 1) embedded mental health consultants; 2) inclusion of a family partner/navigator; 3) cross-training of primary care and behavioral health providers; 4) use of standardized behavioral health screening tools; 5) wellness promotion and prevention as part of the well-child visit; 6) warm hand-offs; 7) assessment and brief intervention; 8) parenting groups and health promotion; 9) shared record-keeping; and 10) care coordination.^{xvi}

This research represented an important step in beginning to define a model of pediatric primary care that will prevent social-emotional and behavioral problems. However, the specific strategies underlying these core elements varied by Project LAUNCH site, and these strategies offer important lessons in how to operationalize behavioral health integration for pediatric populations. To further understand how the grantees were able to achieve fuller integration and to identify potential strategies for other states to leverage, the following sections explore further the successful strategies utilized by the Project LAUNCH grantees.

Project LAUNCH Grantees Advanced Holistic Models of Care for Children

The Project LAUNCH grantees advance holistic models for pediatric primary care through a variety of strategies, offering important lessons for other states and communities in how to operationalize behavioral integration for pediatric populations.

Training in and Implementation of Developmental and Social-Emotional Screenings in Primary Care Settings

One foundational strategy for integration that many Project LAUNCH grantees have pursued is training providers in the use of developmental and social-emotional screening tools, and promoting their routine use. For many grantees, this represented the first step in getting primary care providers to shift to a more holistic approach to health care. Not only did such trainings equip providers with the knowledge and skills to detect and screen for behavioral health issues, but it also served as a tool for raising awareness of the interconnections between children’s environments and their social-emotional and cognitive development.

Training Providers to Conduct Screenings is a Critical Step for Behavioral Health Integration

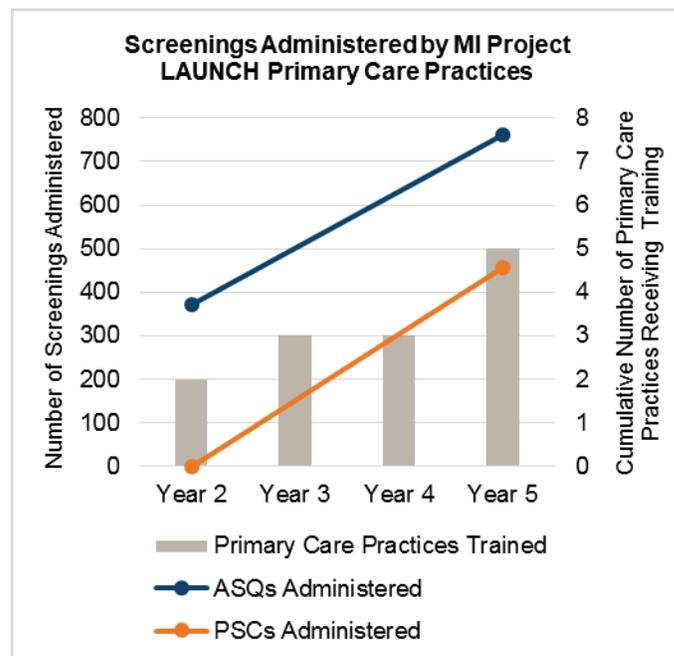
Training primary care providers in the routine use of screenings was a critical first step for Project LAUNCH grantees in moving providers toward a more holistic approach to care – it increased providers’ capacity to detect and screen for behavioral health issues and their awareness of the connections between children’s environments and their healthy development.

Illinois Project LAUNCH partnered with the Enhancing Developmentally Orientated Primary Care (EDOPC) program to support behavioral health integration in primary care settings. EDOPC, which was developed by the Advocate Health Care Healthy Steps Program and the Illinois Chapter of the American Academy of Pediatrics (ICAAP), was designed to improve the delivery and financing of preventive and developmental services for children. In leveraging EDOPC, Illinois LAUNCH was able to conduct trainings in 32 primary care sites in the Chicago area to help primary care providers integrate routine psychosocial and developmental screening into well-child visits for children from birth to age three. EDOPC used a range of strategies to support primary care providers in the effective implementation of the screening tools, including onsite training, online courses, accessible training materials, and technical assistance.

Between 2010 and 2014, over 1,000 physicians, nurses, physician assistants, medical assistants, consultants, case managers, and referral coordinators were trained in at least one of the nine EDOPC training modules. The topics of the training modules included social-emotional screening, perinatal

maternal depression screening and referral, and psychosocial development screening and referral. Illinois LAUNCH used pre/post knowledge tests at the trainings to assess whether the trainings had enhanced the participating providers’ ability to identify developmental delays and mental health issues, and contributed to an overall change in knowledge. Survey data from across all of the modules suggest the majority of respondents (ranging from 87 to 98 percent across the modules) gained an increased knowledge of the training topic as well as referral resources available to them. The pre-/post-tests also indicated the impact that the trainings can have on current practices, with the vast majority of providers (ranging from 90 to 100 percent across the modules) reporting that they would use the information and resources provided by the EDOPC program in their practices.

Michigan Project LAUNCH used a multi-faceted approach to increasing the integration of developmental screening tools in primary care settings. In Years 1 and 2, it funded the Michigan Chapter of the AAP to provide onsite training and virtual technical assistance for a Federally Qualified Health Center (FQHC) and a private medical practice in the use standardized developmental screening tools, including Ages and Stages Questionnaire (ASQ) and Pediatric Symptoms Checklist (PSC). It also used a mental health consultant to provide in-person trainings for primary care providers in the use of these tools. The mental health consultant expanded the work from one pediatric practice at the start of the grant, to five primary care practices by Year 4. From the time that Michigan LAUNCH introduced screening trainings in April 2011 through September 2014, the total number of ASQs administered at LAUNCH-involved primary care practices increased by 105 percent. Three primary care practices also began implementing the PSC, which they had not used prior to LAUNCH, and by the end of the project period, over 456 PSCs had been administered.



To build on the success of this work, Michigan Project LAUNCH worked with the Michigan Primary Care Association to expand the developmental screening trainings to additional FQHCs throughout Michigan in Years 4 and 5. Through this partnership, Michigan Project LAUNCH established a curriculum on “Integration of Developmental Screening” and provided a group training for 26 participants from 11 FQHCs throughout the state. They also created an online training on the use of the ASQ, for which providers can receive continuing education credits.

On-site Trainings and Technical Assistance Dramatically Increased Screening Rates among Primary Care Providers

By offering on-site trainings and technical assistance to providers, Michigan LAUNCH increased primary care providers’ use of ASQ by 105 percent, and successfully promoted the uptake of PSC, a screening tool that had not been previously used by participating providers.

Enhanced Referral and Care Coordination Systems

To further support primary care providers in the use of developmental and social-emotional screening tools, the Project LAUNCH grantees also sought to establish enhanced referral and care coordination systems. Historically, when a child is diagnosed with a behavioral health issue, he/she will be referred to a specialty care provider in a separate system from that of the child’s pediatrician, and there tends to be little follow-up to ensure the child receives the care he/she needed and little information-sharing between providers. Enhanced referral and care coordination systems help to institutionalize the linkages between primary and specialty care systems, ensuring that the child and family are successful in accessing the care they need and that care is coordinated across various settings.

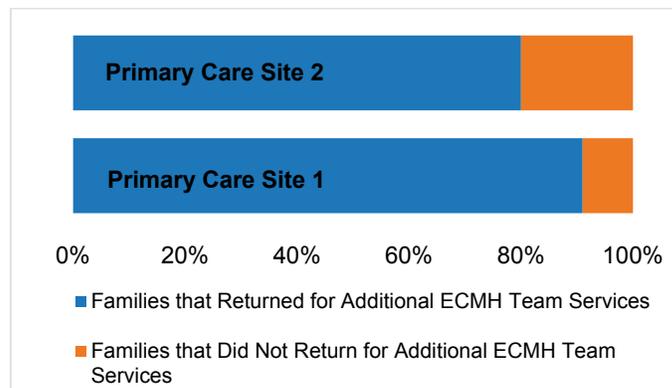
Iowa Project LAUNCH took a collaborative approach to integrating behavioral services into primary care setting, partnering with an existing program, 1st Five Healthy Mental Development Initiative (1st Five). 1st Five aims to support providers in earlier detection and intervention for social-emotional and developmental delays and family-related risk factors (e.g., caregiver stress and depression) in children from birth to age five. Through this partnership, 1st Five trained providers in the use of standardized surveillance and screening tools for children and parents during well-child visits. 1st Five also established a process for referrals. If a primary care provider detected a behavioral health issue, they referred the family to 1st Five, which provided care coordination, serving as the link between the primary care and behavioral health systems, assisting families with navigating both systems, and following up to ensure families’ needs were met. As a result of the success of this collaboration with Project LAUNCH, 1st Five received funding from the Iowa legislature, which allowed them to expand their provider trainings and care coordination services to significantly more counties in FY 2014.

North Carolina Project LAUNCH’s approach to enhanced referral and care coordination systems paired a Family-Centered Health Navigator (FCHN) with an early childhood mental health specialist (ECMHS), forming two-person early childhood mental health (ECMH) teams within two primary care practices. The FCHN was a parent from the local community with experience navigating the various service delivery systems. When a behavioral health issue or unmet need was identified by the primary care provider or raised by the family, the FCHN would offer peer support, link families to community resources to assist with practical issues (e.g., housing, transportation, and food), and provide care coordination. The FCHN, in collaboration with the ECMHS, would then “close the loop” with the primary care provider, informing them of all activities/services provided to the child and family. North Carolina documented the roles of the ECMH team and how others can implement this model in its [“Family-Centered Medical Home Training Manual.”](#)

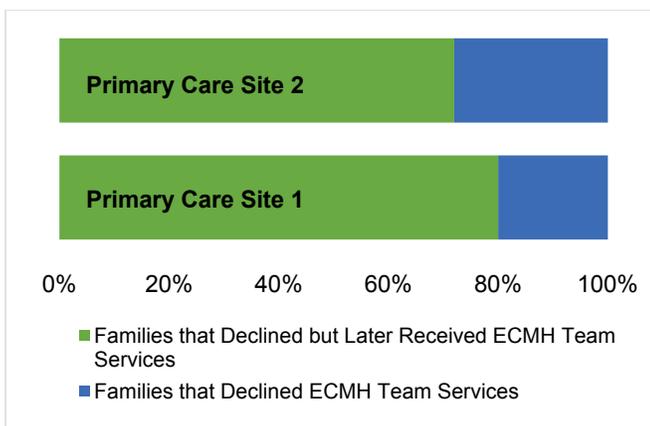
To coordinate the activities of the ECMH teams, North Carolina LAUNCH developed a database in which the teams could track their clients and services provided. The ECMH teams used the database to document their clients’ demographic information, screenings, Triple P services (more details below), outcomes, and referrals. Other providers in the primary care practice were also able to access the database to allow for improved coordination of services. Additionally, the database was designed to be flexible; new fields could be added to accommodate the changing roles of the ECMH team, as well as support both project and federal reporting requirements.

From 2012-2015, the ECMH teams in the two pediatric practices received 1,567 unique referrals. In one practice, 91 percent of families that received initial services from the ECMH team returned for additional services when issues persisted or new concerns arose, and 80 percent of the families returned to the other clinic. Similarly, among families that initially declined the referral to the ECMH team, 80 percent of families within the first practice and 72 percent at the other clinic eventually returned and received behavioral health services. These data suggest that not only were families highly satisfied with the care coordination supports but they will also use behavioral health services when they are easily accessible and family-centered.

Percentage of Families that Returned for Additional ECMH Team Services, by Primary Care Practice



Percentage of Families that Initially Declined But Later Opted to Receive ECMH Team Services, by Primary Care Practice



Parenting Education and Support Groups within Primary Care Settings

In order to effectively promote a child’s well-being and prevent the onset of social-emotional and behavioral issues, providers also need to support parents’ well-being. A child’s family environment can present a range of risk factors that may contribute to the onset of behavioral health issues, such as parental depression, substance use, family violence, and socioeconomic stressors (e.g., poverty and lack of community resources). Lack of parental involvement or poor caregiver practices can instigate or reinforce challenging behaviors in a child.^{xvii} Supporting parents in fostering healthy and nurturing environments can help prevent or mitigate the effects of such adverse experiences.^{xviii} Thus, Project LAUNCH grantees are also working to integrate parenting supports and education into primary care settings.

To support healthy parenting practices, **California Project LAUNCH** implemented two evidence-based programs – Centering Pregnancy and Centering Parenting – at a primary care clinic in East Oakland. These programs provided an innovative group model for prenatal care and well-child visits for new and expectant parents. Through these programs, parents and their babies receive routine health screenings and assessments, followed by a class that provides information on healthy childhood development and facilitated peer-to-peer support. As a result of the pilot program’s success, the East Oakland primary care clinic continues to sustain the program after Project LAUNCH funding ended. California Project LAUNCH also began to train other health care providers and clinics in how to establish Centering Pregnancy and Centering Parenting programs.

Both External and Embedded Supports Improved Care Coordination and Increased Referrals

Iowa and North Carolina successfully implemented enhanced referral and care coordination systems using different approaches.

- Iowa LAUNCH partnered with an existing program, 1st Five, to which providers could refer patients in order to assist families in accessing additional behavioral health services.
- North Carolina embedded a Family-Centered Health Navigator and early childhood mental health specialist into primary care practices to coordinate additional services and supports for families.

North Carolina Project LAUNCH implemented Positive Parenting Program (Triple P) as part of its efforts to integrate behavioral services into primary care settings. Triple P is an evidence-based family strengthening program designed to prevent behavioral, emotional and developmental problems in children by enhancing parents’ knowledge, skills and confidence. Triple P has five levels tailored for different parents’ needs. Triple P Level 1 is the least intensive, providing information to parents who are interested in learning more about effective parenting strategies and healthy childhood development. Triple P Level 5 – the most intensive – is used for parents who are experiencing high levels of stress or substantial relationship difficulties. North Carolina LAUNCH incorporated Triple P into the two participating primary care practices.

Both the medical providers and ECMH teams were trained and accredited in Triple P Level 3, which is intended for parents with specific concerns and typically involves brief consultation or skills training through four 20-minute sessions. ECMH teams were also trained in Triple P Level 4, which involves up to ten parenting support sessions. Nine doctors and nurses were trained and accredited at the first practice, accounting for 24 percent of their staff, and five doctors and nurses were trained at the other clinic, (56 percent of all staff). North Carolina LAUNCH found that many primary care providers were not able to provide full Triple P Level 3 sessions during visits due to insufficient time during the appointments. Thus, many parents in need of Level 3 services were typically referred to ECMH teams. However, many providers provided “light touch” Triple P within 15- to 30-minute appointments, which involved giving positive parenting advice and tip sheets.

Parenting Education in Primary Care Positively Impacts Providers and Families

In implementing Triple P, a parent strengthening program, in primary care settings, North Carolina LAUNCH saw increases in parents' confidence in their parenting abilities and decreases in children's challenging behaviors. Additionally, providers reported that they had a better understanding of behavioral health needs, and it helped make parenting support a routine part of care.

Between October 2012 and June 2015, medical staff in the first practice provided 309 Triple P-informed visits (including "light touch" through Level 3), and medical staff in the other clinic provided 1,627 Triple P-informed visits. North Carolina LAUNCH also found that training medical staff in Triple P gave the staff a better understanding of behavioral health needs, and helped to normalize parenting support as part of healthy childhood development. Additionally, parents who received Triple P Level 3 or 4 services were given pre/post surveys to assess changes in parenting and parenting confidence. Based on surveys completed by 158 parents from both clinics, the parents reported decreases in their child's challenging behaviors and parenting stress, and an increase in their confidence to undertake their responsibilities as a parent.

Embedding an Infant/Early Childhood Mental Health Consultant in Primary Care Settings

Many states embedded an early childhood mental health consultant in primary care settings. Mental health consultants perform a variety of functions – they can train providers in detecting and screening for developmental issues, conduct screenings and assessments, provide brief interventions, make referrals to more intensive services, and assist in coordinating care. With their dynamic roles, mental health consultants can serve as the backbone for other behavioral integration strategies, including those previously discussed.

Washington Project LAUNCH supported the integration of behavioral health and primary care through a medical home model, referred to as the Behavioral Health Integration Program (BHIP). Two part-time master's level therapists, called Behavioral Health Consultants (BHCs), were co-located in the primary care practice with the goal of supporting whole-person care for children and families by addressing their medical, mental, and social health all together. As part of this program, BHCs provided consultations and conducted behavioral health assessments for children and their families. As behavioral health or developmental needs were identified, the child, family, and the care staff at the medical home (Primary Care Physician, Nurse, BHC) worked together to develop care plans, which led to better communication, coordination of care, and improvement in outcomes. Washington Project LAUNCH also convened a Behavioral Health Integration Workgroup to help support its integration efforts. Medical providers, agency administrators, clinic managers, BHCs, and other stakeholder involved in child systems participated in the workgroup, which

met on a quarterly basis. The Workgroup reviewed the progress of BHIP, worked through any gaps or needs related to the integration of services, discussed the direction of the program, and developed strategies for sustaining and expanding it. These approaches reinforced the role of behavioral health integration as a population-based strategy to promote healthy development and prevent or mitigate the onset of behavioral health issues

A systematic evaluation of the pilot behavioral health program to measure outcomes and impact was not conducted. However, utilization data demonstrated that, during the two years that BHIP was in place, the BHCs saw an average of 68 children each month, with approximately 112 visits each, suggesting that the program was well-utilized. Additionally, through qualitative stakeholder interviews, service providers, and other organizations involved in Project LAUNCH noted that BHIP benefited physician practices, and facilitated increased coordination of family supports and improved access to care.

Embedded Mental Health Consultants Increased Access to Care and Improved Children's Social-Emotional Functioning

- Providers participating in Washington LAUNCH reported that the embedded behavioral health consultant led to increased access to and coordination of additional services and supports for families.
- In Massachusetts, the use of an embedded mental health consultant and family partner resulted in higher social-emotional screening rates, and decreased Total Problems Scores on the Child Behavior Checklist among the children participating in Project LAUNCH.t.

Massachusetts Project LAUNCH integrated a service delivery team consisting of a family partner who has lived experience with caring for a child with social, emotional, or behavioral needs, and an early childhood mental health consultant, into three pediatric medical homes. These teams served as consultants to primary care providers if a behavioral health or developmental issue was detected, and worked directly with families of young children to provide prevention and intervention services, including the implementation of comprehensive child and family screenings, assessments, and care coordination. As a result of the embedded mental health consultant and the provider trainings conducted as part of this new model of care, 63 percent of the participating primary care providers reported a substantial increase in their use of screenings, and 64 percent reported a substantial increase in their use of assessments for children.

Massachusetts Project LAUNCH further evaluated the impact of this approach on the health of children up to 5 years old by comparing Project LAUNCH sites to a comparison site (i.e., a pediatric clinic not participating in the program). The results indicated that more children in the Project LAUNCH sites were at significant social-emotional risk compared to the children at the comparison site at baseline (56 percent and 19 percent,

respectively). The Project LAUNCH children had on average a 15-point higher ASQ-SE score than the children at the comparison site (99.7 compared to 84.98), with higher ASQ-SE scores indicating increased social-emotional risk. Based on a 6-month follow-up assessment of the children deemed to be at significant social-emotional risk at both sites (a total of 136 children), the Project LAUNCH children experienced a 15.9-point decline in their ASQ-SE, while the comparison group experienced an 18.5-point increase in their risk level over the same period.

Additionally, the impact of Project LAUNCH on older children (ages 6-8 years) was assessed using the Total Problems Score (TPS) from the Child Behavioral Checklist (CBCL), an assessment tool consisting of three subdomains – Executive Function, Self-Regulation, and Behavior Problems – that is used to identify behavioral and emotional problems among children. In comparing children participating in Project LAUNCH, evaluators found that the TPSs of children at lower social-emotional risk at baseline were stable over time. However, the TPSs of children at higher social-emotional risk at baseline decreased by over 31 points, representing a 43 percent decline over the same time period. The lower scores indicate decreased problem behaviors in one or more of the three subdomains. These results, all of which were statistically significant, suggest that the Project LAUNCH program had positive impacts on children’s social-emotional functioning, particularly for those at higher risk.

As a result of the demonstrated impact that it had on child social emotional risk and behavior, the service delivery team model has been replicated with in Family Resource Centers, which are a statewide network of community-based providers managed by the Massachusetts Department of Children and Families, in all 14 counties across the state. Massachusetts LAUNCH also developed an [“Early Childhood Mental Health Toolkit”](#) to provide tools and guidance for others interested in implementing a similar pediatric medical home model.

V. LESSONS LEARNED FROM THE STATES INTEGRATING BEHAVIORAL HEALTH SERVICES INTO PRIMARY CARE SETTINGS

The Project LAUNCH grantees took on the challenging task of integrating behavioral services into primary care practices. While the degree of integration varied across LAUNCH sites, the grantees demonstrated that even making small, incremental changes, such as ensuring the providers were trained in developmental screening tools, can have an impact on the health and well-being of children and families. Despite differences in approaches and strategies for integration, some common lessons across grantees emerged that can inform other states’ efforts to integrate behavioral health services.

Key Takeaways for Successful Behavioral Health Integration

The LAUNCH grantees implemented a variety of strategies, which offer key takeaways for promoting successful integration of behavioral health services, including the following.

- Providers must be met “where they are” to establish long-lasting changes.
- Behavioral health resources and enhanced referral systems facilitate providers’ buy-in for transitioning to an integrated model.
- Embedding mental health consultants supports higher screening rates, increased provider and patient satisfaction, and improved social-emotional functioning among children.
- Building on existing state infrastructure is key to sustaining behavioral health integration efforts.

Primary care providers must be met “where they are” and supported in the practice transformation process in order to establish long-lasting changes in delivery systems.

Many Project LAUNCH grantees acknowledged that behavioral health integration requires a new way of thinking and operating in primary care practices. Primary care providers need to develop new skills, establish new workflows, adapt their administrative processes, and build relationships with new care team members when integration efforts involve an embedded mental health consultant. They will have varying levels of openness and capacity to support the necessary practice changes. Thus, it is important for teams supporting integration efforts to be flexible and adapt to the needs of the practices and providers, in addition to having realistic expectations for the time it can take to get primary care providers’ support and for the changes to take hold.

Resources and referral systems between behavioral health and primary care are needed to secure primary care providers’ buy-in and comfort with moving toward a more integrated model of care.

One challenge related to increasing primary care providers’ use of social-emotional and developmental screenings in their practices was the uncertainty of the mental health services and supports available if a need was identified. The primary care providers did not want to diagnose an issue if the appropriate services and supports were not in place to help the child and family. In LAUNCH sites with an embedded mental health consultant, the consultant was able to serve as the link between the primary care provider and additional resources. LAUNCH sites without an embedded mental health consultant had to take extra steps to educate primary care providers about the available behavioral health resources and supports, such as care coordination programs and community referrals. Additionally, some LAUNCH sites, such as Rhode Island, found they needed to conduct trainings to increase the capacity of the behavioral health workforce to address early

childhood mental health issues. This helped ensure that primary care providers had someone to whom they could refer their patients. Once providers knew supports and services were readily accessible for their patients, they were much more likely to conduct screenings.

Embedding a mental health consultant in primary care settings results in high screening rates, increased provider and patient satisfaction, and improved social-emotional functioning among children.

Among the Project LAUNCH sites, embedding a mental health consultant in primary care settings resulted in some of the most significant impacts, as compared to the other integration strategies. Grantees noted the stigma of behavioral health issues was an ongoing challenge in their work, as it led to some reluctance among providers to implement screenings for all patients, as well as reluctance among families to utilize the embedded mental health consultant. However, having an embedded mental health consultant helped normalize behavioral health services as a routine part of care.

Embedding a mental health consultant boosted providers' confidence and their comfort with implementing screenings and assessments, which led to increased rates of screenings and early referrals. When parents opted to receive services from a mental health consultant, they consistently reported being highly satisfied with the services and found them useful to their family. The culminating effect of embedded mental health consultants was improved social-emotional functioning among children as they supported the early identification of risk factors, and helped to ensure children accessed the care they needed when issues were identified.

Identifying opportunities to build on existing infrastructure can help ensure that states' behavioral health integration efforts lead to sustained change.

Behavioral integration requires significant investments in time, infrastructure, and workforce development, and even implementing the most basic component, such as training providers in screening tools, can be a significant undertaking. Some of the more successful Project LAUNCH grantees were able to leverage existing systems and programs to support their efforts. For example, Rhode Island LAUNCH was able to use KIDSNET, an existing state database, to track developmental screenings, which reduced duplicative screenings, improved families' experiences, and promoted the more efficient use of resources. Rhode Island continued to use KIDSNET to track developmental screenings after the Project LAUNCH project period ended. Iowa Project LAUNCH was another grantee that partnered with an existing, well-established program in the state (1st Five) to provide care coordination services, a relationship that was a key component of its integration efforts. This successful strategy has continued to be funded beyond the Iowa LAUNCH project period.

VI. SUPPORTING THE SPREAD OF BEHAVIORAL HEALTH INTEGRATION FOR PEDIATRIC POPULATIONS

Project LAUNCH's implementation has come at a time of rapid transformation of the U.S. health care system, as policymakers and health system leaders strive to improve quality of and experience with care, and reduce health care costs. Many states have made behavioral health integration a top priority as part of their transformation efforts due to the prevalence of mental issues, high comorbidity and mortality rates among those with mental health issues, and the resultant high health care costs for this population.^{xix} However, many of the current integration efforts have focused on adult health care systems, and specifically target adults with serious mental health illness. It is critical that states include children and their families in their integration efforts and tailor integration models to meet the needs of children in order to effectively support health promotion and prevention and mitigate the impact of social-emotional and behavioral health issues, should they arise.

The Project LAUNCH grantees have made significant progress in identifying and implementing effective strategies for facilitating fuller integration of services in pediatric primary care settings. As states continue to develop and refine their approaches to payment and delivery system reform, there is a great opportunity to align and build on the work of Project LAUNCH to ensure that all populations receive integrated and whole-person care. Several Project LAUNCH states are exploring or have already been successful in leveraging other statewide health system transformation initiatives to expand and sustain their integration efforts for children and families.

States Seek to Expand Behavioral Health Integration through SIM and Medical Home Initiatives

- Maine LAUNCH is exploring opportunities to use its State Innovation Model grant as platform for expanding its pediatric behavioral health integration work.
- Rhode Island LAUNCH is expanding behavioral health integration for children statewide through PCMH-Kids, the state's pediatric patient-centered medical homes initiative.
- New York LAUNCH is building on integration strategies developed and tested through LAUNCH as part of the state's Patient-Centered Medical Home initiative and Health Home Services for Children program.

Maine Project LAUNCH: In 2013, Maine received a State Innovation Model (SIM) Test Award from the Centers for Medicare & Medicaid Services (CMS) through which the state aims to: 1) strengthen primary care; 2) integrate physical and behavioral health care; 3) develop new workforce models; 4) develop new payment models; 5) centralize data and analysis; and 6) engage people and communities.^{xx} LAUNCH has been exploring opportunities to use the SIM grant as a platform for replicating and expanding its integration work based on its positive outcomes, including increased screening rates by

primary care providers, increased rates of early referrals, and parents reporting being better able to support their child's social-emotional health.

Rhode Island LAUNCH's experience with the integration of behavioral health with primary care will be expanded statewide through its pediatric patient-centered medical homes initiative, PCMH-Kids. PCMH-Kids is being supported by Rhode Island's SIM grant, and is intended to standardize, and improve the patient and family-centered care delivered by pediatric practices, which includes integrated behavioral health services.

New York Project LAUNCH: From the outset, New York used Project LAUNCH as an opportunity to test local strategies for promoting children's social-emotional health, while working to build state-level capacity to address young children's social-emotional development. As a result, New York State has implemented a number of projects and initiatives that continue to advance Project LAUNCH's behavioral health integration efforts, which include the New York State Department of Health's (DOH) Patient-Centered Medical Home initiative, which aims to improve health outcomes through better coordination and integration of patient care for individuals enrolled in New York Medicaid; and Health Home Services for Children, which is a model for providing enhanced care coordination for Medicaid enrollees with qualifying chronic medical and/or behavioral health diagnoses. Additionally, New York is exploring how the Project LAUNCH behavioral health integration activities could be built into its Delivery System Reform Incentive Payment (DSRIP) Program, through which the state receives funding to redesign payment and delivery systems for Medicaid beneficiaries.

VII. OPPORTUNITIES FOR SUSTAINABILITY OF BEHAVIORAL HEALTH INTEGRATION ACTIVITIES POST-PROJECT LAUNCH

As a result of the positive impact of behavioral health integration on providers, children, and their families, the Project LAUNCH grantees have been making a concerted effort to sustain their related efforts beyond the Project LAUNCH project period. While several states were successful in incorporating Project LAUNCH strategies and activities into other statewide health system transformation efforts, the sustainability of behavioral health integration efforts has remained an ongoing challenge among the Project LAUNCH sites. Many states noted that receiving Medicaid reimbursement is a promising pathway toward the sustainability of integrated care; however, they have made limited progress in working with state Medicaid agencies to expand billing systems to cover integrated services and the providers who deliver them. While Medicaid programs are

driving health care reform, they face competing demands on their resources and capacity. Many are implementing numerous health system transformation initiatives as they strive to improve program performance and accommodate enrollment growth. In 2016, 31 state Medicaid agencies reported experiencing budgetary constraints that impede reform efforts.^{xxi}

To ensure the long-term spread and sustainability of integration, states have looked to leverage multiple funding streams in order to support the infrastructure development necessary for integrated services, such as workforce training, and to provide more robust services such as employing a family navigator for care coordination services. With a growing recognition of the interconnectivity of mental health, physical health, and early childhood development, there are numerous funding opportunities at the federal, state and local levels to support behavioral health integration efforts.

The following chart details the funding streams that the Project LAUNCH Cohort 1 and 2 states are considering or have pursued to continue to support behavioral health integration activities.

VIII. CONCLUSION

Behavioral health integration has represented a significant undertaking by the Project LAUNCH grantees to establish of a new model of care that supports the whole child and family. The Project LAUNCH grantees have had to overcome numerous challenges in order to move toward more integrated services, including securing provider buy-in, supporting practice transformation, establishing new pathways for services, and ensuring that the necessary infrastructure is in place to facilitate success. At the same time, their efforts have demonstrated the positive impact that integrated services can have on children, their families, and providers. Evaluations of the Project LAUNCH sites to date have shown that their efforts can lead to increased screenings and early referrals by primary care providers; increased patient, family, and provider satisfaction; and improved social-emotional functioning among children. While these programs have been successful, continued financing and sustainability remain an ongoing challenge. Some Project LAUNCH grantees have secured funding to build on and expand their integrated behavioral health activities through other grants, such as RTT-ELC and ECCS, and several states have partnered with private funders to sustain integrated activities. Other states are exploring opportunities to promote long-term sustainability through more flexible payment arrangements with Medicaid and aligning these efforts with other state-based health system transformation efforts.

Sustainability Opportunity	Description of Grant/Program	Activities Supported	State Example(s)
Federal Funding Opportunities			
<p><i>Early Child Comprehensive Systems (ECCS) grant</i></p>	<p>The purpose of this grant program is to enhance early childhood systems to build and demonstrate improved outcomes in population-based children’s developmental health and family well-being indicators.</p>	<p>Through a Collaborative Innovation and Improvement Network (CoIIN) approach, grantees are testing innovative early childhood systems-change ideas, developing spread strategies, and adopting policies for sustaining the systems that increase children’s age-appropriate developmental skills and reduce developmental disparities.</p>	<p>Washington: The state has secured an ECCS grant through which it will continue to support trainings for providers in the use of developmental screenings and assessments in their practices.</p>
<p><i>Race to the Top – Early Learning Challenge (RTT ELC) grant</i></p>	<p>This program is focused on improving the quality of early learning and development programs and closing the achievement gap for children with high needs.</p>	<p>RTT-ELC supports states’ activities to: 1) increase the number and percentage of low-income and disadvantaged children who are enrolled in high-quality early learning programs; 2) design and implement an integrated system of high-quality early learning programs and services; and 3) ensure the use of standardized early childhood assessments.</p>	<p>California: Supporting providers in utilizing developmental screenings and conducting related follow-up has been a key strategy in California’s Race-to-the-Top Early Learning Challenge grant.</p> <p>Rhode Island: Based on Project LAUNCH’s demonstration of the importance of early screening, Rhode Island secured funding through RTT-ELC to expand the use of developmental screenings to 74 additional primary care practices.</p>
State Funding Opportunities			
<p><i>Medicaid</i></p>	<p>As a federal-state health care program for families and individuals with low incomes and limited resources, Medicaid is the single largest payer for mental health services, providing health coverage to more than 30 million children.</p>	<p>Several states indicated that their current inability to bill Medicaid for behavioral health services in primary care settings has served as a barrier to sustaining activities after the grant’s conclusion.</p>	<p>Massachusetts LAUNCH was able to demonstrate the value of screening for parents’ stress and depression in pediatric primary care; as a result, Massachusetts Medicaid will begin reimbursing for postpartum depression screening in pediatric primary care in July 2017.</p> <p>Michigan LAUNCH has been working with the Michigan Medical Services Administration (Medicaid) to establish billing codes for utilizing Medicaid funding for mental health consultation in primary care settings.</p> <p>Wisconsin LAUNCH staff were successful in working with Wisconsin Medicaid to expand the list of providers who could bill for developmental screening to include family physicians.</p>
<p><i>Establishing and/or Leveraging Existing State Funding</i></p>	<p>State governments have the flexibility to support activities related to child and family mental health as well as child care.</p>	<p>States have the opportunity to fund and support innovative, evidence-based programs that help children and families thrive.</p>	<p>Iowa: Based on Iowa LAUNCH’s work with 1st Five, a program dedicated to supporting earlier detection and interventions for social-emotional issues, the Iowa Legislature allocated funding to support the expansion of 1st Five’s services.</p> <p>Michigan: The LAUNCH model for mental health consultation in primary care practices has been supported by the Michigan Department of Department of Health and Human Services as an integration strategy and has been replicated in several communities.</p>

Sustainability Opportunity	Description of Grant/Program	Activities Supported	State Example(s)
<i>Implementing New Law/Regulation</i>		States have the ability to enact laws, policies, and regulations that will establish infrastructure to support statewide or expanded implementation of integrated behavioral health services.	<p>Massachusetts LAUNCH's mental health clinician and family partner service delivery team has been replicated within the Family Resource Centers managed by the Massachusetts Department of Children and Families in each of the 14 counties across the state.</p> <p>Wisconsin passed legislation to fund the child psychiatry consultation line, which was created by Wisconsin LAUNCH to support primary care clinicians who work with children.</p>
Private Funding Opportunities			
<i>Private Foundation Support</i>	Private foundations are legal entities set up by an individual, family or a group of individuals for philanthropic purposes. These entities may choose to support any number of activities.	Private foundations may choose to support a wide variety of activities, often influenced by the mission or goal of the entity.	<p>Michigan: Based on the work of Project LAUNCH, the Michigan Primary Care Association, in partnership with the Michigan chapter of AAP, secured private foundation funding to continue trainings on the integration of developmental screening into primary care. They also received private foundation funding to integrate a mental health consultant into two additional practices using the LAUNCH model.</p> <p>North Carolina LAUNCH received private funding to expand their family-centered medical home model for integration into an additional pediatric primary care site.</p>

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