Chapter 7
Healthy Steps at Montefiore: Our Journey from Start Up to Scale

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Abstract With a decade of experience in integrated early childhood behavioral health programming, we present our lessons learned from Montefiore. We begin with our program model and chart the progression of the model as we expanded. We note why we made certain changes to the model, and how taking the model to scale throughout our system required modifications. We share our top three lessons learned: breaking down silos while respecting the medical hierarchy, navigating thorny issues of privacy related to documentation and communication, and the need to battle isolation as integrated behavioral health providers.

Keywords Healthy Steps • Montefiore • Integrated early childhood behavioral health • Pediatrics

Introduction

Montefiore Medicine has been a pioneer in early childhood integrated behavioral health. After a year of pilot programming, we formally became a Healthy Steps program in 2006, and have accumulated over a decade of experience in this arena. In this chapter, we will describe our program model, detail the mistakes we made (so that you can hopefully avoid them), and review lessons learned along the way, as we expanded our program from one initial primary care practice in 2005 to 19 in 2016.

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Program Model

Setting, Population, and Design

Montefiore Medical Group (MMG) is a division of Montefiore Health System, the University Hospital for Albert Einstein College of Medicine, and provides medical care to residents of the Bronx and lower Westchester County through a network of 19 pediatric primary care practices, community health centers, and urgent care sites. These sites currently serve more than 90,000 children, 1/3 of whom fall in the birth—5 age range ($N \approx 35{,}000$). Approximately 75 % of these children have Medicaid insurance, and almost 80 % identify as Hispanic and/or Black.

Although Healthy Steps (HS) has traditionally focused on developmental and procedural outcomes and HS Specialists (HSSs) are often early childhood educators or nurses, HS at Montefiore deviates from the usual model in two ways. First, we place significant emphasis on the social emotional development of young children *and* the mental health of their caregivers, and second, we do this by employing licensed clinical social workers and licensed psychologists. For more on the traditional Healthy Steps program, please see Chap. 5 in this volume.

Our program has two tracks: Development and Behavior (DB) Consults and Intensive Services (IS). In DB consults, ongoing universal behavioral health screenings and/or pediatricians' concerns result in referrals to Healthy Steps Specialists for assessment and short-term interventions on a range of topics, including (but not limited to) sleep, feeding, and discipline. In Intensive Services, we identify children at risk for a host of negative outcomes related to psychosocial stress as early as possible and enroll them and their caregivers to receive preemptive behavioral health services until the child turns 5 years old. As mentioned above, our staff are licensed clinical social workers or psychologists, each of whom have expertise in early childhood mental health, parent–child dyadic work, and adult mental health issues. Please see Chap. 6 on workforce development for more information.

Screenings

Our goal is to universally screen all the young children and their parents in the medical practice. We accomplish this through a team-based approach focused on obtaining screenings during well-child visits. Screenings are generally parent completed, scored by nursing staff, entered into our electronic medical record (EMR), and reviewed by pediatricians. We have configured our EMR to prompt medical staff when a certain screening is due and to automatically score those screening tools when possible (e.g., copyright protections allow).

To identify children at risk at the earliest possible moment, we administer the Adverse Childhood Experiences, or ACEs screening tool (Felitti et al., 1998). The ACEs study demonstrated the impact of traumatic childhood experiences (including abuse, neglect, and household dysfunction) on a range of health outcomes. In addition, these same traumatic experiences are known to impact parenting via a range of pathways (Murphy et al., 2013). It is our hypothesis, therefore, that parental ACEs scores may be the best way to identify newborn babies at risk for social emotional problems.

Between the prenatal period and age 4 months, ACEs screenings are completed by parents (or expectant parents) and returned to the primary care provider. We use a form that asks parents simply to endorse the number of ACEs they've experienced, rather than endorse the specific items. Once the child is born, we also ask parents to report on the child's ACEs, in the same manner (total score).

Lesson Learned: In our first site, we offered IS enrollment to *all* first time parents. We initially believed this was an effective way to provide the program to young parents who were most likely to have questions and be unsure or overwhelmed about parenting. Although that was indeed true, it was also the case that we were not able to enroll many high-risk families due to their already having a child. Moreover, we found our pediatric residents (who were also parents using the practice for medical care) enrolled in the program as well. While we appreciated endorsement of the program, it was not the best use of limited resources due to the residents' notably lower risk status.

In our second site, we developed a risk checklist, based on the literature on the impact of psychosocial stressors on child social–emotional development. We attempted to teach the pediatricians about the major risk factors for poor social emotional outcomes in children, such as having a parent with mental illness, homelessness, and teen pregnancy. That practice proceeded to generate fewer referrals than expected (and desired), which we attributed to the idea that a baby's risk status, measured in this manner, was too nebulous a concept for many pediatricians to reliably assess.

As a result of the above experiences, we began using the ACEs screening as a tool for enrollment at our third site in 2013. The screening is short, connected to health outcomes, and we find that parents are open to completing it. Our ACEs screening is introduced by a letter, and allows parents to simply report their total number, without endorsing specific ACEs (our data suggest that this encourages more honest responses, and also alleviates some provider concern re: events that would otherwise be reportable for abuse or neglect reasons). Please see the Appendix for a copy of our ACEs screening.

Any pregnant mother with an ACEs score of 4 or more is automatically referred to our program, introduced to the HSS, and offered enrollment in the Intensive Services track. If a mother did not visit a Montefiore OB/GYN practice with ACEs screenings, the same screening is conducted during the first few months of visits in Pediatrics (exact visit is determined by each site). During these visits, mothers, fathers, or other caregivers complete an ACEs screening both regarding their own childhood and the childhood of their newborn. Although it may seem unlikely for a newborn to have ACEs, this is, sadly, not an uncommon scenario in the Bronx. For example, an infant born to a single, depressed mother and whose father is in prison enters the world with an ACEs score of three. It is critical that we track babies' ACEs so that we can make all efforts to keep the number below the threshold of four that is associated with vastly increased risk of negative outcomes over time (see chapter by Dr. Murphy et al. in this volume for further detail). We believe that the ACEs screening is our best approach for early identification of families at risk. First, by screening the parents' ACEs we are not waiting for a child to screen positive on a risk assessment before intervening (in a previous study with a very at risk sample, only 8 % of infants in the practice screened positive on the Ages and Stages Questionnaire: Social Emotional at the 6 month visit (Briggs et al., 2012)). Second, we are not overextending enrollment slots due to offering it to an entire, preselected group (such as first time parents). In a world of limited resources, such overextension can doom a program. Instead, we are using this brief screening, with well-documented long-term implications, and identifying children at risk either prenatally or within the first 4 months of life.

If IS enrollment is declined when the program is first offered, there are additional universal screenings for maternal depression conducted by the pediatrician at children's 2-month and 24-month well-child pediatric visits. In addition, young children are universally screened for the presence of social emotional problems, autism, and general development at multiple pediatric visits during their first 3 years. These additional screens provide multiple opportunities for young children in need to be identified for treatment. Although a poor score on the screening tools suggests to primary care providers that the child should perhaps be referred to HS, pediatricians and nursing staff are encouraged to use their own clinical judgment to refer young children and/or their caregivers to our program for any relevant reason. Although we accept IS referrals only until the child's 18-month visit, behavior and development consultations are available through age 5.

Our screening schedule:

Newborn: Parental and child ACEs
2 months: Patient Health Questionnaire-2 (PHQ-2; parental depression)
12 months: Ages and Stages Questionnaire-3 (ASQ-3)
18 months: Modified Checklist of Autism in Toddlers, Revised (MCHAT-R)
24 months: Ages and Stages Questionnaire: Social Emotional (ASQ:SE), PHQ-2
36 months: ASQ:SE
48 months: Patient Symptom Checklist-17 (PSC-17) (Jellinek et al., 1988)
60 months: PSC-17

Lesson Learned: Screening tools must be short, written at an appropriate reading level, easy to score, and available in the languages your patients speak. Ideally, they are also normed on a population similar to that being screened. While some program designers exert a great deal of time and energy determining which screening tool to use, we believe a better approach is to simply determine the best fit for your practice, knowing that the most important part of the process is simply getting the conversation started. After all, a screening tool is merely that: a screening tool. A concerning score is not an end in and of itself; rather, it merely prompts both the pediatrician and/or the HSS to do a more comprehensive assessment.

Clinical Services and Interventions

Development and Behavior Consults

- Children are referred for DB consults by pediatricians, other practice staff (e.g., nurses), or parents generally due to a particular issue that presents itself during a pediatric visit (e.g., behavior, feeding problems, need for sleep training).
- Children 0–5 can be referred (5th birthday is the cutoff).
- Interventions with these children can be done in an exam room, in the HS office right after the visit, or by scheduling follow-up appointments for them to see the HSS on another day. Sessions range in length from 15 min (e.g., in an exam room following MD visit) to 60 min (e.g., separately scheduled session).
- If possible, a child ACEs is done in order to assess trauma history.
- Generally, this is short-term treatment and we schedule no more than 4–5 visits at a given time for a particular issue (e.g., once a week for a month). Children/families who need more intensive services should be referred out for additional help.
    - However, a new issue a few months later can result in a new referral.
- Children who are seen for a DB consult and are under 18 months may be enrolled in the Intensive Services program if deemed appropriate.
- It is very important to close the loop with the referring medical provider with regard to final action/outcome. Elsewhere in this volume, our pediatrician colleagues (Brown, Bloomfield, and Warman) detail the common lament of pediatricians that they "never hear back after a mental health referral." We advise our HSS to always route the medical provider the following:
    - Documentation of first outreach to the family (which acknowledges the referral),
    - The first clinical note,
    - Important disposition information (e.g., to outside services).

Intensive Services

- Babies whose caregivers have 4 or more ACEs, per universal screening, are automatically referred to the Intensive Services (IS) program and offered enrollment. Babies can also be referred by social work or medical providers based on other risk variables, be siblings of children already in IS, or be children whom a HSS saw for a DB consult. Any child referred before (or at) 18 months is eligible for Intensive Services, and HSS use their judgment as to when to enroll.

Lesson learned: We have worked hard to advise HSS not to "over enroll." As much as the Intensive Services program would likely benefit every family, it is also quite time- and labor intensive, and so patient slots need to be saved for those most in need.

- IS babies are seen at every possible well-child visit, either in a co-managed visit with both the pediatrician and HSS, or in a visit with the HSS before or after the pediatric visit. A child has 15 well-child visits during the first 5 years of life (American Academy of Pediatrics, 2008). Ongoing interventions concentrate on promoting secure attachment, developmental guidance, experiences of caregiver trauma and the impact on the child, and general behavioral intervention with a focus on positive parenting and nonphysical discipline. Interventions are generally offered as part of the well-child visit; if needed, however, families may return for separate follow-up visits with their HSS.
- HSS are informed that the patient's visit is scheduled with the pediatrician via a report that is generated by our EMR.

Lesson Learned: We have experimented in the past with asking parents to make two appointments, one for the PCP and one for the HSS, back to back, when they were scheduling, but parents found this laborious and thus it was not done consistently.

- Babies enrolled in IS receive the following *additional screenings*:
  - Follow-up child ACEs at 12-, 24-, 36-, 48-, and 60 months of age
- Children/families participate in IS until the child's 5th year well-child visit
- We advise HSS to remain in contact with the child's pediatrician and work as a team as needed. If a HSS knows he/she is going to miss a well-child visit for any reason, we ask them to inform the child's pediatrician, and provide outreach to family if deemed necessary.
- Children "graduate" early IF:

  - Two screenings in a row are not elevated,
  - AND they are doing very well in the clinical judgment of the HSS (this can be sufficient even if the screenings are high—for example, if the child has a developmental delay, but the family is highly intact and the child is receiving appropriate services).
  - Early graduates are informed that the HS specialist will not be preemptively seeing them at their well-child visits anymore, but are always available should questions/concerns arise. This is framed as an accomplishment, based on how well the child is doing, and how effectively caregivers are parenting. A standard letter is available to document early graduation if desired.

- *IS Dropouts*
  - Children under 2 years are considered to be dropouts if they have not been at the practice for 12 months.
  - Children over 2 years are considered dropouts if they have not been at the practice for 18 months.

Lesson Learned: keeping track of HS IS dropouts has been a challenge, for a few reasons. At several practices, hundreds of families are enrolled, and it is a difficult task for HSS to monitor who is due and/or overdue for a well-child visit. We have experimented with various systems for achieving this (e.g., spread sheets, alerts in our EMR), and, in the interest of full disclosure, are still honing the process. Part of the challenge in our particular medical system is that our patient population is quite transient. We serve a large immigrant population (i.e., families who are still in the process of finding where they will make their permanent home), as well as families whose phone numbers often change, and who move frequently. Most of our dropouts stem from these causes; that is, families leave the pediatric practice as a whole. It is only exceedingly rare that a family continues to receive medical care at one of our pediatric practices, but opts out of participating in the HS IS track.

It is important to establish criteria regarding early graduation and defining when a family has “dropped out,” to ensure that these coveted slots are occupied by the families most in need, and to ensure the program is designed to release slots that are not being used.

Parental Mental Health

One of the earliest lessons we learned when implementing our early childhood integrated behavioral health program was that the brief parenting interventions we offered did not appear to be effective when parents had their own significant mental health challenges. As discussed above, many of the caregivers with whom we work have severe trauma histories, and it is not uncommon that these mothers experienced Posttraumatic Stress Disorder (PTSD) symptoms—either for the first time or as a relapse—within the context of having and raising a baby. Other mothers experience postpartum depression and/or anxiety symptoms, and still others have prior psychiatric diagnoses (e.g., Bipolar Disorder) for which they are in need of treatment. Regardless of the particular symptoms or diagnosis at hand, we have found that offering psychoeducation and parenting strategies without addressing these parental mental health (PMH) issues is, at best, unsuccessful, and at worst, counterproductive or even harmful. Given this, we made a decision early on to invest substantial resources in our two-generation Healthy Steps Parental Mental Health program. For caregivers who present with mental health symptoms, specialized HS staff are available to provide ongoing individual psychotherapy and, if needed, psychotropic medication within the pediatric outpatient setting. We believe that integration of an adult mental health provider increases the likelihood that pediatricians will screen for maternal depression and ACEs, that caregivers will follow through on the referral, and that caregivers will attend counseling sessions.

A few notes on the concrete details of how the PMH aspect of our program works:

- Caregivers of children under the age of 5 may be eligible to participate in our Parental Mental Health Program (PMH), through which they are able to receive long-term, evidence-informed therapy. Ideally, the child of a parent receiving PMH services is enrolled in our HS Intensive Services track, although this is not always possible.
- Parents are encouraged to have a primary care provider in the network to ensure collaborative care, and this is a process with which our staff assists.
- Referrals for PMH are made to the Healthy Steps Specialists who coordinate outreach and refer to alternative agencies if a parent cannot be seen on site, due to insurance or scheduling limitations.
- PMH providers document in both the parent's and child's chart that patient is actively receiving mental health services through HS to alert pediatricians of treatment. However, PMH services are then documented in parent's chart in accordance with legal and privacy rules.

Education of Medical Colleagues

In addition to the clinical services provided to young children and their families, HS at Montefiore also engages in significant educational efforts. Although we believe that education will need to be an important part of the job for most (if not all) early childhood integrated behavioral health specialists, this is clearly more the case in primary care practices affiliated with medical schools and residency programs. Through both formal didactics and informal case consultation, HS staff members teach medical students, pediatric residents, and attending physicians. The medical students and residents participate in a 2-h introductory lecture, and then each spends an afternoon shadowing a HSS during patient visits. The lecture addresses early childhood brain development within a relationship context, attachment theory, toxic stress, and best practices for engaging with caregivers around issues of discipline and child development. In addition, the HS staff regularly present at staff meetings and engage in quality improvement projects designed to improve screening and referral rates of young children and their caregivers.

Lessons We Have Learned

Although we've done our best to highlight certain "lessons learned" in our program description, the ones discussed below are more global in nature, and merit a more detailed treatment given their nuances and complexities. It bears emphasis that integrated early childhood care brings unique challenges. Previously unforeseen questions emerge when thinking about, for example, how much of a parent's information to include in a baby's chart, and how to ensure that the pediatrician is appropriately informed about a parent's history. The three most challenging areas to consider are breaking down silos while respecting the medical home, documentation/communication/privacy, and isolation of behavioral health providers.

Lesson #1: Breaking Down Silos While Respecting the Hierarchy

In order to fully integrate an early childhood behavioral health program into a primary care setting, a system-wide paradigm shift had to occur. From security guards to the front desk staff, nursing, pediatricians, and our patients, we have needed to engage in ongoing education and discourse. For example, the security desk needed to be informed that "Healthy Steps" is a program within pediatrics, and that, even if an adult caregiver comes in alone for his or her PMH session, he/she will be registered in the pediatric clinic. The front desk staff have been critical to our ability to deliver screening tools to caregivers, and thus, have benefited from education about the purpose of these tools, how to answer caregivers' questions, and other issues relevant to that first point of entry. Nursing staff often help caregivers to complete the screening tools, alert HSS when their patients have arrived, and might even refer families to HS based on concerns observed. Finally pediatric providers, although commonly very supportive of HS, may find it unusual to share a well-child visit with another professional, and may be surprised to learn that their previous developmental assessments may have been insufficient, due to a lack of attention to social emotional issues.

Nevertheless, the primary care setting remains a medical practice first and foremost; thus, the HS program must exist in a way that is mindful of the flow of the practice, the demands on the providers, and the metrics upon which that practice is measured, from productivity to compliance. We had to learn to speak the language of the practice, with regard to scheduling, documenting, and billing, and the standards for patient care—while skillfully adding in our own voices in measured and strategic ways.

Lesson #2: Documentation, Privacy, and Communication with Providers

Psychologists coming from traditional mental health clinics approach issues of documentation and communication in specific ways, many of which differ from those conventionally used in pediatrics. Throughout our years in an integrated setting, we have addressed multiple challenges and miscommunications that have arisen as a result. One of the earliest and most critical questions that arose was the extent to which HSS should include caregivers' personal details within their children's medical charts. For example, when HSSs conduct an intake interview, they always assess caregiver trauma history. After all, we—as mental health professionals—know the large impact that a parent's past trauma can have on their parenting style, and, thus, on a child's development. That said, we have grappled with the extent to which knowledge of a caregiver's trauma history is helpful or even necessary for the child's pediatrician. Patient privacy concerns require us to consider whether the HSS needs to obtain consent before communicating this information to the pediatrician, and if the information is included in the child's chart, the level of detail must also be considered.

As pioneers of this model, we have confronted these—among many other—questions repeatedly. Questions of privacy, of which provider is entitled to what information, and of how best to document and communicate about sensitive issues are paramount to our practice. Not surprisingly, given the high level of complexity of these matters, we have not come to any sweeping conclusions. Rather, we have often opted to address these concerns on a case-by-case basis, seeking out consultation from each other and from experts in our field regarding regarding privacy and compliance. To date, our guiding principle has been to communicate to pediatricians only information deemed directly relevant to the child's care, and to do so with the minimal level of detail necessary (e.g., "mother has a long and severe trauma history," vs. details of said history). We inform caregivers that this is the manner in which we need to operate as a clinical team attempting to treat the whole family, including intergenerational dynamics and patterns. We have also attempted to provide ongoing education about these issues to clinic staff, so that we can continue to work together to serve our patients in the most respectful, legal, and ethical way possible.

This latter point is best illustrated by an example. During one well-child visit, a pediatrician unintentionally breached confidentiality by asking a mother about her experience with PMH therapy in front of her husband, who did not know that mother had been seeing a therapist through the HS program. In fact, this mother had sought therapy in order to process her discovery that her husband was having an affair, and she was worried he might find out that (a) she had this newfound knowledge, and (b) she had shared it with a professional. The therapist had not informed the pediatrician of the content of the therapy sessions, due to privacy regulations, as well as team consensus that the issues were not directly relevant to the child's care. However, she also had not let the pediatrician know that the mother's mere attendance was confidential; having been trained in multiple mental health settings, at which this is standard operating procedure, it did not occur to the PMH therapist that such a discussion was necessary. Following this incident, the HS staff made a point of educating the entire clinic staff about the importance of not mentioning a caregiver's therapy involvement unless he or she brings up the topic first; this is a very different approach for pediatricians, who are accustomed to following up with patient referrals as part of their job (e.g., "Have you been able to schedule an appointment with the cardiologist?").

Lesson #3: Isolation

The HS staff are often the only mental health providers within their pediatric clinics, and their feelings of isolation take many forms. On a purely practical level, there may not be a clear place within the administrative infrastructure to ensure that needs are met. Large medical practices function with clearly delineated roles, usually based on discipline (doctors, nurses, etc.), and HSSs do not neatly fall within one of those spheres. Thus, tasks from identifying someone to cancel HS patients if one of the specialists is out sick to ensuring that HSSs become trained on the new billing system may become needlessly difficult. On a more personal level, it may be challenging to be the only mental health provider within a system of physical health. This difficulty may rear its head following a particularly intense clinical session, when there is no like-minded colleague with whom to debrief, but there may also be frustrations in explaining the nature of one's work in order to meet the standards of best practice. As one PMH therapist was stationed in an exam room with the asthma treatment equipment, it required multiple explanations to convey that constant interruptions during her clinical sessions were more than minor inconveniences, and may have actually been damaging to the goals at hand. The demanding nature of the work requires opportunities for ongoing supervision and collaboration, and it is necessary to create these systems within the pediatric care structure.

Conclusion

We do not pretend to have all of these issues figured out; we have remained humble, and continue to tweak and refine our program even today. That said, we believe the lessons we have learned—and, frankly, mistakes we have made—may save those creating their own early childhood integrated care programs valuable time and energy, and it is in that spirit we have shared them here.

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