BHIPP
Maryland Behavioral Health Integration in Pediatric Primary Care

855-MD-BHIPP | mdbhipp.org

Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP)

History

BHIPP
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Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) was established in 2012 to support primary care providers in addressing the behavioral health needs of their patients.

Background and Significance

- Gap between the ***need for*** and ***availability*** of child and adolescent mental health services
- Lack of access to mental health care for children and adolescents is particularly evident in ***rural or remote communities*** where access to evidence-based mental health treatments is limited, with some areas having ***no access at all***

Partners & Funding

BHIPP
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- BHIPP is supported by funding from the **Maryland Department of Health, Behavioral Health Administration** and operates as a collaboration between the **University of Maryland School of Medicine**, the **Johns Hopkins University School of Medicine**, **Salisbury University,** and the **University of Maryland Eastern Shore.**
- *BHIPP is also supported by the **Health Resources and Services Administration (HRSA)** of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,019,327.00 with approximately 20% financed by non-governmental sources. The contents of this presentation are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government. For more information, visit www.hrsa.gov.*

University of Maryland School of Medicine
Johns Hopkins School of Medicine
Salisbury University
HBCU 1886 University of Maryland Eastern Shore

Who We Are

BHIPP
Maryland Behavioral Health Integration in Pediatric Primary Care

BHIPP is made up of a multidisciplinary team of:

- Child Psychiatrists
- Psychologists
- Social Workers
- Licensed Counselors
- Public Health Professionals

What We Do

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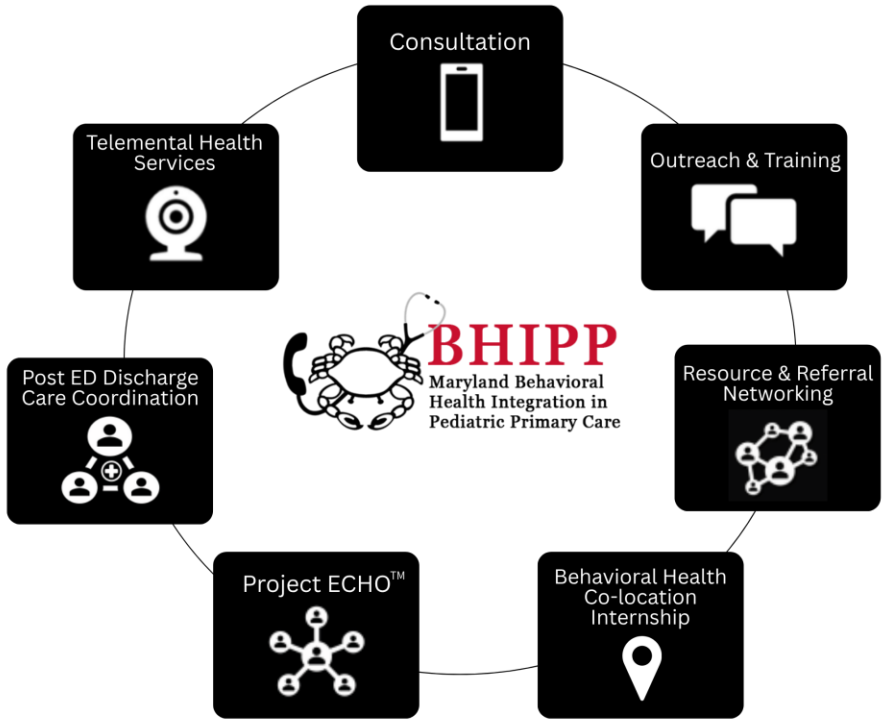

Support pediatric primary care providers, emergency medicine providers and PMHNPs in addressing child mental health through free:

- Telephone consultation (855-MD-BHIPP)
- Resource & referral support
- Training & continuing education
- Project ECHO® learning collaboratives
- Behavioral Health Co-location internship
- Telemental health services
- Care coordination following emergency department discharge

Telephone Consultation Warm-line

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- Child mental health specialists are available Monday - Friday, 9am-5pm (except major holidays)
- We provide consultation in many areas of behavioral health including medication management, diagnostic issues, developmental delays, school/learning issues, autism spectrum disorders, trauma, and early childhood mental health.
- Our Behavioral Health Consultants assist with identifying local resources, including information on wait times and accepted insurances.
    - We have built a robust, statewide resource and referral database since 2012 that includes over 1,600 referrals representing every county in Maryland
- Our consultants can be reached by:
    - Calling 855-MD-BHIPP (855-632-4477)
    - Submitting a consultation request via our website: https://mdbhipp.org/our-services/telephone-consultation/submit-a-consultation-request-2/

The BHIPP Consultation Warmline

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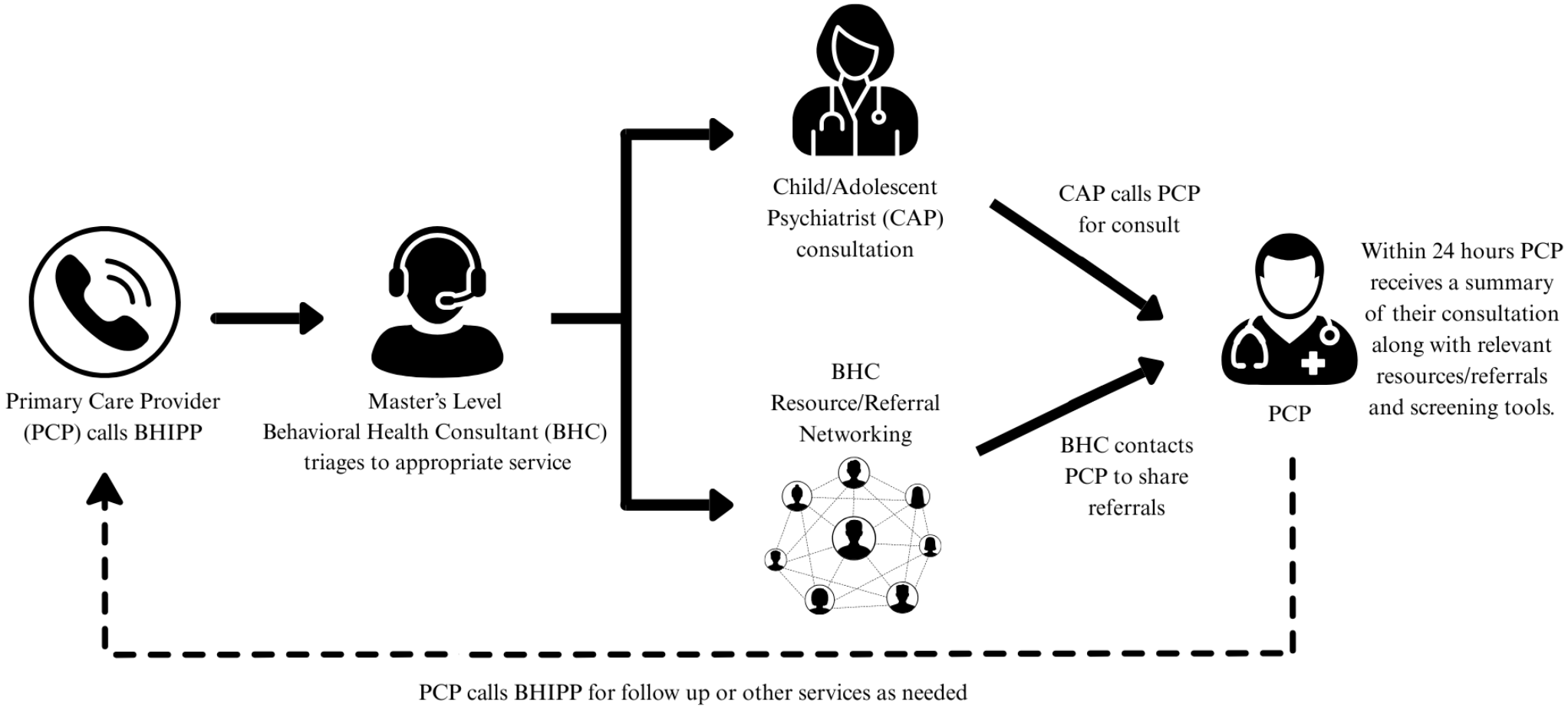

Provider Engagement with BHIPP by County
October 2012-June 2026

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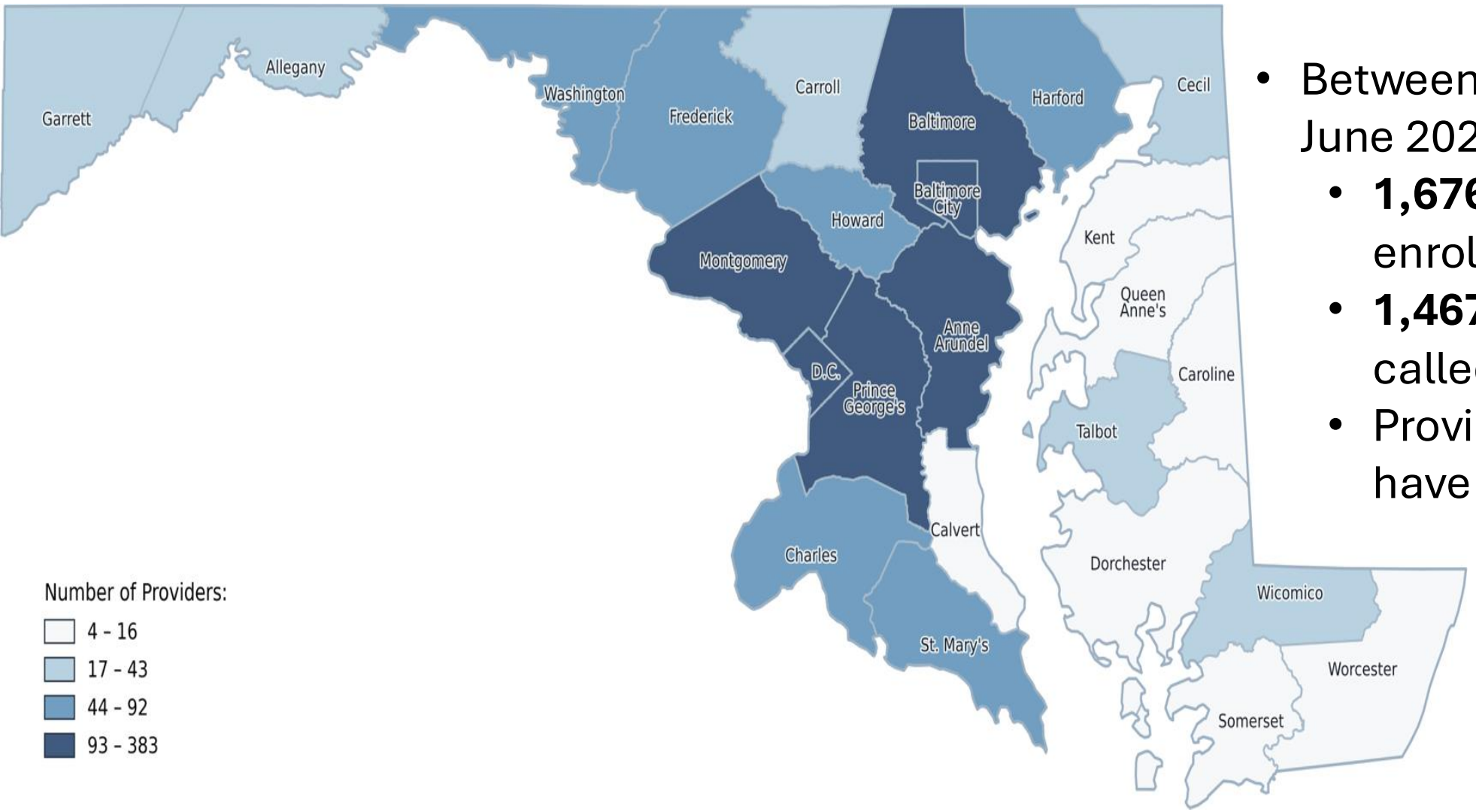

- Between October 2012 and June 2026:
  - **1,676** providers have enrolled in BHIPP
  - **1,467** providers have called BHIPP
  - Providers in every county have engaged with BHIPP

Data on Calls to the BHIPP Warmline
October 2012 – June 2026

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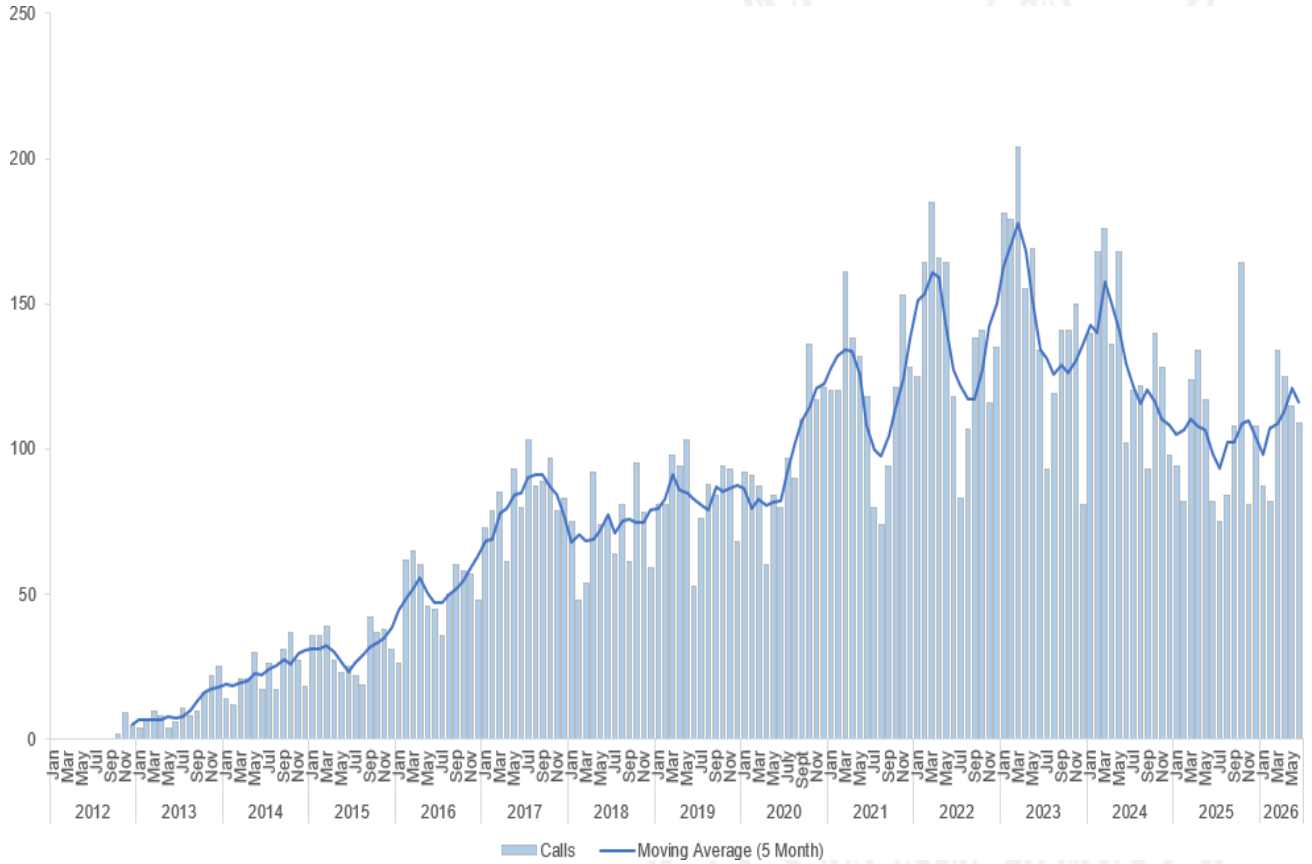
- Between October 2012 and June 2026, BHIPP has received **13,778** calls
  - Approximately 98% were case specific
  - Approximately 60% were for resource/referral calls
  - Approximately 39% were for clinical consultation with a child and adolescent psychiatrist
- During FY 26, among all patient-specific non-crisis calls to BHIPP:
  - Average age = 11.9 years
  - 49% were about female patients
  - 53% private insurance, 42% public insurance, ~1% both private and public insurance, ~1% with no insurance
  - 37% were taking psychotropic medication at time of call
  - 47% were already receiving some type of psychosocial service at the time of BHIPP call

Call volume by Month and Year



BHIPP Training

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Webinars

- 1-2 per month
- Typically held at noon

PROJECT ECHO

- Behavioral Health Training for PCPs
- Enhanced Behavioral Health Training for PMHNPs

Guest/Invited Lectures

- For our partners (e.g., UMES, Maryland AAP)
- Primary Care Practices
- Conferences

Self-Paced Online Curriculum

- Called BHIPP Child and Adolescent Provider Educational Support (BHIPP CAPES)
- To launch in late 2026!

- Visit https://mdbhipp.org/event-calendar/for more information and to sign up!
- All BHIPP-sponsored trainings offer free CMEs and CEUs; PCP ECHO series also offers MOC Part 2 credits

Upcoming BHIPP Webinars!

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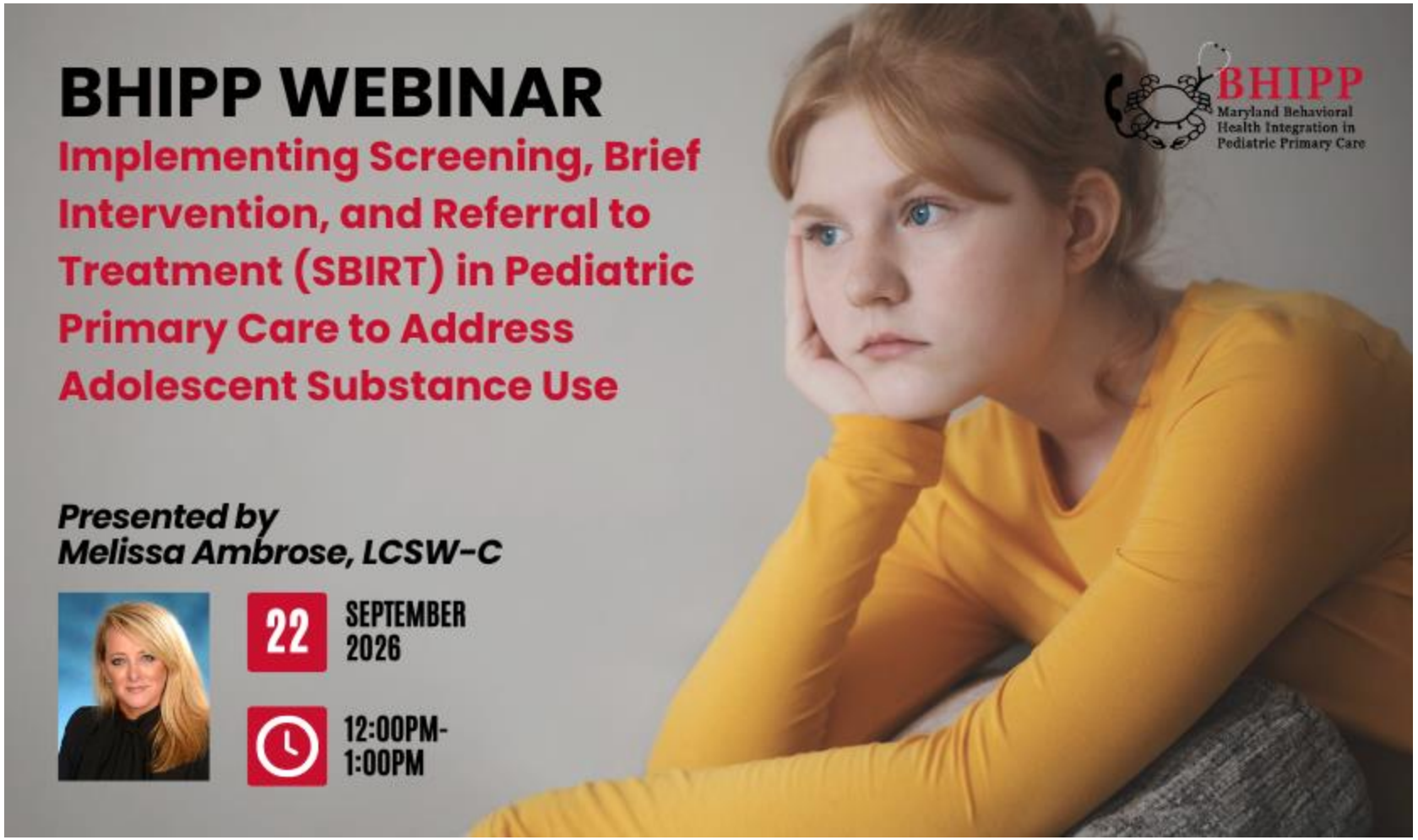

Register here:

Upcoming BHIPP Webinars!

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Register here:

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BHIPP CAPES

Child & Adolescent Provider Educational Support

- Coming Soon!
- Self-paced, online curriculum covering core areas in child and adolescent mental health
- Includes recorded lectures, case-based learning activities and curated list of screening tools and other provider resources (e.g., psychoeducational tip sheets)
- PCP learners will receive CMEs and MOC Part 2 for completing the curriculum

Behavioral Health Co-location Internship

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- Master's-level Behavioral Health students at Salisbury University, University of Maryland Eastern Shore, Frostburg State University and University of Maryland are placed in pediatric primary care offices in practices on the eastern shore and in western Maryland for their clinical internship
- During their internship, they receive training and supervision from BHIPP faculty and staff
- **3-Part Model:**
  - **Screening:** Use of standardized screening tools to help identify areas of concern
  - **Referral:** Connection to community resources and mental health care
  - **Brief Intervention:** Up to 6, 30-minute sessions for a presenting concern

Telemental Health Services

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BHIPP provides telemental health services including:

Psychological evaluations

- Limited slots for young children in need of diagnostic evaluations for developmental and autism spectrum disorders

Care Coordination

- The Care Coordinator will work with the family over the phone to remind them of telehealth appointments and to assist them in finding additional local resources.

Records Review

- The telemental health team will review existing assessments and clinical records to assist the PCP with treatment planning

Emergency Department Post-Discharge Care Coordination

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Model:

- Children and teens who visit the emergency department for a mental health crisis at partner hospitals will be referred to BHIPP for Care Coordination

- With permission, the BHIPP Care Coordinator will reach out to the family following discharge to provide services such as:
  - Ensure the family gets connected to mental health care
  - Connect the child/teen to a primary care provider, if needed
  - Facilitate the sharing of records
  - Make phone calls and help set up appointments, if needed
  - The Care Coordinator will follow up with the family after their appointment and at set intervals (1 week, 1 month) to check in on whether they are connected to services.

- All services are voluntary and at no cost to the family

Partner Hospitals

- University of Maryland Medical Center, Baltimore
- Meritus Health, Hagerstown
- UMD Shore Regional (4 locations)

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Post-Discharge Care Coordination Referral Form

Today's Date: _____ **Hospital:** _____

Referring Provider: _____ **Credentials:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Patient Name: _____ **Date of ~~Birth:~~** _____

Patient Address: _____

Parent/Guardian Name: _____ **Phone:** _____ **~~Email:~~** _____

Gender: Male Female Non-Binary Prefer not to disclose Prefer to self-describe _____

Race: African American Caucasian Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander Unknown Other _____ | Hispanic/Latino: Yes No

Insurance Type (circle): Private Public Both None

Insurance Carrier(s): _____

Is this the child's first ED visit for a mental health concern? (If no, indicate dates/reasons for previous visits): ~~Yes~~ ~~No~~

How many days has the child been in the ED? _____

Diagnostic Impressions:

Relevant History (current symptoms, prior evaluations, ongoing medical problems, social history):

Has the patient experienced any trauma or adverse events: ~~Yes~~ No Unknown If yes, please describe:

Prior to the ED visit, what services had the child been receiving (circle all that apply & add provider name if known)?
Individual Therapy: _____ Group Therapy: _____
Day Hospital: _____ School-based services: _____
Medication Management: _____ Other: _____

Will the child be returning to any of the above services following the ED visit? ~~Yes~~ No Unknown

Current Medications (include regimen and dose):

Prior Medications (include regimen and dose, if known):

Discharge Plan (include recommended services & names/contact info of providers that were given to the family):

Patient's Primary Care Provider: _____ ☐ **Check here if child does not have a ~~PCP~~**

Practice Name: _____

Address: _____

Phone: _____ **Fax:** _____ **Summary of the patient's ED visit was sent to the PCP:** Yes No

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Depression: In-office Approaches

Prevalence of Depression in Adolescents

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- According to data from the CDC in 2023, 36% of Maryland high school students reported feeling sad or hopeless during the past year
- According to the 2024 National Survey of Children's Health, 18.7% of adolescents in Maryland have depression or anxiety

https://www.childhealthdata.org/browse/survey/results?q=12692&r=22; https://datacenter.aecf.org/data/tables/11203-high-school-students-who-felt-sad-or-hopeless-during-the-past-year?loc=22&loct=2#detailed/2/22/false/2545,2048,1729,871,573,36,867,38/any/21588

Screening Recommendations

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	US Preventative Services Task Force (as of 2022)	American Academy of Pediatrics (as of 2022)
Depression: Ages 8-11	No	No
Depression: Ages 12-18	Yes, with no clear interval identified	Yes, at least at annual visits
Suicide: Ages 8-11	No	Yes, when presenting with mental health symptoms
Suicide: Ages 12-18	No	Yes, at all preventative visits

PHQ-9A

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- Recommended by the USPSTF and GLAD-PC
- PHQ9A - most thoroughly studied screening tool
- Available in multiple languages
- Guides clinical interview
- Includes suicide screening
- Sensitivity of 73% and specificity of 94%
- FREE!

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Johnson et al., 2002; Siu et al., 2016; http://www.gladpc.org/

Scoring the PHQ-9A

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- Scores ≥ 10 are associated with MDD
- A score ≥ 10 **or** a "yes" on either suicide-related question should be followed-up with an in-depth interview

PHQ-9A Total Score	Depression Severity
0-4	No or minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A Positive Screen, What's Next?

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- Be ready to interview parents and children separately
- Have a well-practiced "confidentiality spiel"
- Know the goals of the interview
  - Confirm the diagnosis
  - Determine severity – severe vs moderate vs mild
  - Check for comorbidities
  - Ensure immediate safety
- Let the PHQ-9 guide your questions about individual symptoms

A Reminder about MDD Diagnostic Criteria

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Five or more symptoms during a 2-week period with a change in functioning

Mood Symptoms (Core)	Somatic Symptoms	Cognitive Symptoms
• **Depressed or irritable most of the day** • **Diminished interest in activities**	• Appetite changes • Sleep changes • Psychomotor agitation or retardation • Fatigue or energy loss	• Feeling worthless or excessive guilt • Difficulty concentrating • Thoughts of suicide or death

American Psychiatric Association, 2022

Diagnosis Confirmed, What's Next?

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- GLAD-PC Treatment Guidelines
  - Guidelines and toolkit developed for PCPs with input from experts in adolescent depression, primary care, parent/family advocacy, quality improvement
- Mild depression:
  - Active support & monitoring first (6 – 8 weeks)
- Moderate - Severe depression OR presence of comorbidities:
  - Continue active support and monitoring and
  - Consultation w/mental health specialist recommended
- When mental health treatment needed, recommend evidence-based interventions:
  - CBT (Cognitive Behavioral Therapy)
  - IPT-A (Interpersonal Therapy for Adolescents)
  - Medication management

http://www.gladpc.org/

Mild Depression: Active Support and Monitoring

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- Provide psychoeducation to patient and family about the nature and course of depression; should follow assessment and occur in primary care even if referring out for treatment
- Increase frequency of visits w/ PCP
- PCP provides brief phone follow-up in between visits
- PCP prescribes:
  - Behavioral Activation - Pleasant activities (more on this later)
  - Peer support group (if appropriate)
- This approach is sufficient for many w/ mild depression

http://www.gladpc.org/

Moderate/Severe Depression

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Moderate Depression	Severe Depression

• Continue active support and monitoring through frequent visits and/or phone check-ins
 	
• Consult with a mental health specialist (e.g., call BHIPP) to discuss:
  • Treatment planning
  • Medication management
	• Continue active support and monitoring through frequent visits and/or phone check-ins
	
	• Consider referral to a mental health provider for therapy and potentially medication management
	  • Call BHIPP for support with referrals

http://www.gladpc.org/

CBT: Psychoeducation Key Points

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- It is a disorder that affects mood and feelings, behavior, thoughts, and bodies
- Differs from brief bad mood because associated w/other symptoms:
  - Negative emotions (e.g., sad, irritable, bored, guilty)
  - Negative thoughts and thinking difficulties (e.g., poor concentration, memory and decision-making, self-criticism, loss of interest, suicidal thoughts)
  - Behavior changes (e.g., crying, avoiding people, slow movement or agitation, self-harm)
  - Biological changes (e.g., sleep disturbance, appetite or weight disturbance, fatigue)
- May display as feeling unable to have fun or improve mood; youth may also display a loss of interest in things they usually enjoy; marked irritability

CBT: Psychoeducation Key Points (Cont.)

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- Has many contributing factors
  - Genetics: at greater risk if close relative has depression
  - Too much or too little neurotransmitters in brain (e.g., serotonin)
  - Social: bad experiences in current relationships with peers and parents, lack of support from friends/family
  - Life stressors/traumatic experiences
  - Negative thoughts about self, the world, the future and only focusing on negative experiences we have had
  - Past experiences have led to learning maladaptive ways of coping w/ stress and responding

CBT: Psychoeducation (Cont.)

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Depression can present as a change in any or all of the following:

- School performance (e.g., drop in grades, missed assignments, calls from the school)
- School behavior (e.g., truancy, fights at school, talking back to teachers)
- Hygiene (e.g., not showering, not brushing hair, wearing dirty clothes)
- Social engagement (e.g., quitting sports team or previously enjoyed after school activities, not wanting to hang out with friends, withdrawing from family activities)
- Sleep (e.g., too much sleep, not enough sleep, disrupted sleep)

Working with the Family

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- You can also encourage parents to support their child by:
  - Spending 1:1 time with their child, checking in on how child is feeling and validating emotions
  - Including the child in outings to help encourage/motivate leaving the house and socializing with others
  - Calling attention to the positive things the child is doing using praise
  - Keeping routines in place (e.g., don't let the child sleep all day)
  - Maintaining a healthy awareness of child's activities outside of school and home (e.g., who are they spending time with, what are they doing)
  - Being an active participant in their child's treatment – communicating with providers and helping to encourage practice of skills learned in therapy at home and in the community

https://childmind.org/article/how-to-help-your-depressed-teenager/

Working with the Family

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- If symptoms are causing impairments in school, parents need to be their child's advocate with the school
  - You can help support them in this area
- Parents may need help in accessing evidence-based treatment for their child
  - You can help them connect with a therapist to obtain this treatment (call BHIPP for referral support)
- Parents play a key role in decisions about medication and in promoting medication adherence
  - You can make recommendations, provide education about, and prescribe medications (call BHIPP for consultation)

https://childmind.org/article/how-to-help-your-depressed-teenager/

Working with the School

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- If depressive symptoms are getting in the way of learning, you can collaborate with parents to:
  - Submit a written request to the school for consideration for an IEP or 504 plan
  - Communicate regularly with the child's teacher and school to support the child's engagement in school and completion of classwork and homework
  - Inquire about school-based mental health services

CBT for Depression

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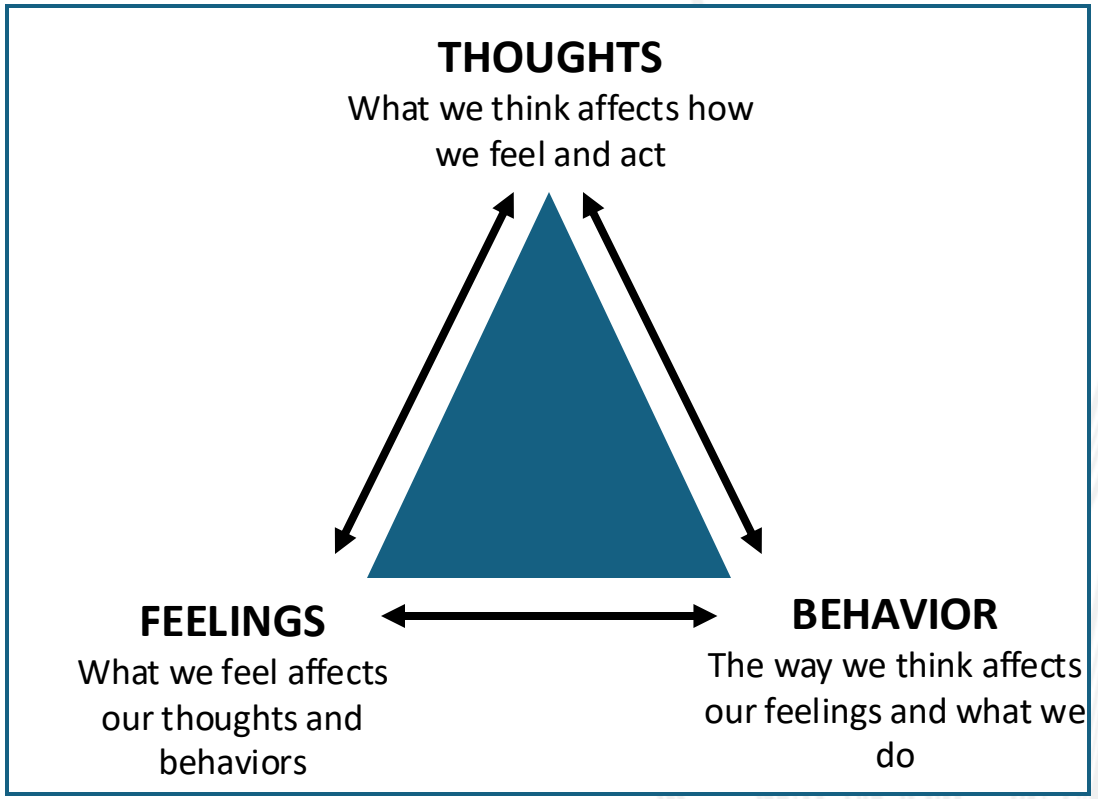
- CBT is the gold standard psychotherapy approach for youth with depression
- Involves:
  - Teaching coping skills
  - Identifying and changing unhelpful thoughts
  - Regular homework assignments to practice skills taught outside of sessions



Curry et al., 2005

CBT for Depression

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1) Psychoeducation
2) Mood monitoring
3) Behavioral activation
4) Problem-solving skills
5) Cognitive Restructuring
6) Relaxation ~ as appropriate
7) Social Skills training ~ as appropriate

Chorpita & Weisz, 2009; Curry et al., 2005

CBT: Mood Monitoring

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Mood monitoring involves:

- Paying attention to feelings
- Rating mood
- Identifying specific thoughts connected to those feelings

Teaching mood monitoring in primary care:

- Ask about specific examples when patients felt sad, irritable, angry, happy
- Practice mood ratings together on those examples, then encourage recording daily ratings
- Regularly review mood tracking when you meet with youth

Chorpita & Weisz, 2009; Curry et al., 2005

Use Feelings Thermometer to Monitor Mood Each Day

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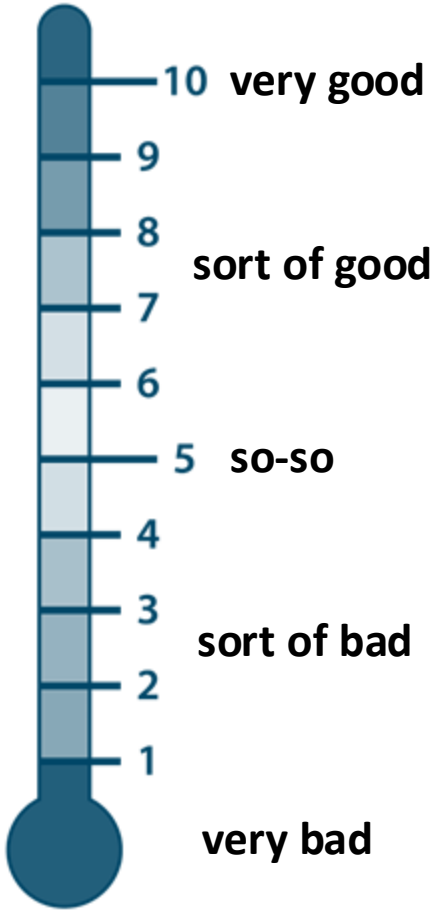

Date	Feelings Rating 0-10	What was happening that made you feel that way?	What were you thinking when that was happening?
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Chorpita & Weisz, 2009; Curry et al., 2005

CBT: Behavioral Activation

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- Involves engaging in activities to improve mood
- 5 types of activities that can improve mood:
  - Something the child has enjoyed before
  - Spending time with someone they enjoy
  - Something that keeps the child busy
  - Something that helps someone else
  - Any type of movement/exercise

Chorpita & Weisz, 2009; Curry et al., 2005

Behavioral Activation Daily Tracking

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When you meet with the patient, help them to:

- Generate a list of pleasant activities
- Schedule time for these activities during the week

Day and Plan	How I felt before (0-10)	Activity I did	How I felt after (0-10)
Sunday: Play a game with my sister	4	Played Uno with my sister	7
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

CBT: Problem-Solving Skills

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- Solving problems can improve mood while not solving them contributes to low mood
- Introduce how problem-solving skills can help with mood and what the **STEPS** to problem-solving are

S: Say what the problem is

T: Think of possible solutions

E: Examine each possible solution, looking at positive and negative aspects of each one

P: Pick one solution and give it a try

S: See if the solution worked. If it didn't work, go back to your list and pick another one

Chorpita & Weisz, 2009; Curry et al., 2005

Problem-solving Steps Application

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S	T	E	P	S
My sister borrowed my clothes without asking and we got into a fight about it	Request my sister asks me before she takes the clothes she wants to wear	**Positive**: She might agree to this and then I know what she wants to wear ahead of time **Negative**: She might refuse to talk to me	Let's try requesting that she ask before she borrows my clothes as the first solution fand see if it works	If it doesn't work will try talking with her about what is off limits
	Hide the clothes I don't want her to borrow	**Positive**: She won't be able to wear the clothes I don't want her to **Negative**: She might search through my room more		
	Talk with my sister about which clothes are and aren't ok for her to borrow	**Positive**: She knows what clothes are off limits **Negative**: She may disregard my wishes		

Examples of Application of CBT in the Primary Care Setting

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- Psychoeducation
  - Once you have made a diagnosis, provide education to the family about the nature and course of depression using the points in the first talk or in this talk
- Mood monitoring
  - After you provide education about depression, introduce the idea of mood monitoring (see earlier slides for examples) and provide a chart for tracking or suggest use of an app
  - When you see the youth again, review their mood ratings and observe & discuss any patterns

Examples of Application of CBT in the Primary Care Setting

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- Behavioral activation
  - After reviewing mood monitoring at follow-up appointment, introduce idea that engaging in pleasant activities can boost mood
  - Help youth generate list of pleasant activities and encourage their engagement in one activity each day
  - Tell parent about the plan so they can support youth with these activities
- Problem-solving
  - You can mention that not solving problems with others can contribute to low or depressed mood
  - You can introduce the STEPS to problem-solving and walk through an example from the child's life

Key Points

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- Both the AAP and USPSTF recommend regular screening for major depressive disorder beginning at age 12 with a well-validated instrument
- To meet criteria for MDD, adolescents must experience diminished interest in preferred activities, in addition to feelings of sadness or elevated irritability
- Glad-PC outlines guidelines for the treatment of mild, moderate, and severe depression, including a role for PCPs in providing active support and monitoring
- CBT for depression includes:
  - Psychoeducation
  - Mood monitoring,
  - Behavioral activation
  - Problem-solving skills
  - Cognitive restructuring
  - Relaxation
  - Social Skills
- Many components of CBT can be incorporated by PCPs into regular visits with patients with depression

Thank You!

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