TeenScreen Primary Care
Preparing Your Office Guide

TeenScreen® Primary Care
TeenScreen® National Center for Mental Health Checkups at Columbia University
Prepping Your Office to Implement Mental Health Checkups

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Introduction

Introducing Mental Health Checkups to Office Staff

When preparing to implement mental health screening in your office it is important to educate staff members about the new procedure and have a discussion about their involvement. The following are some general tips and recommendations for introducing mental health checkups to your office staff:

- Educate staff about the problems of mental illness and suicide in adolescents; TeenScreen has a library of materials and information on their web site that can assist with this step of the process. ([www.teenscreen.org](http://www.teenscreen.org))
- Discuss how mental health checkups can help to identify patients who may be suffering from mental illness.
- Review the logistics of screening, focusing on how the process will work in your setting.
- Talk about the mental health resources that are available to patients who are identified through the screening process; review our Guide to Referral for additional information.
- Determine how staff members will be involved in the process and discuss the individual responsibilities they will have (see Screening Implementation Staffing Roles on page 5).
- Complete the Screening Implementation Worksheet on page 6; this will help to outline the entire process from start to finish and can be distributed to staff once completed as a reminder.
Tips on Logistics of Screening

TeenScreen’s mental health checkup involves a simple screening procedure in the form of a brief, evidence-based, screening questionnaire that can be administered by a nurse or medical technician in the exam room or waiting room. The PCP discusses the screening results with the patient and further assesses any problem areas the patient endorsed on the questionnaire. This evaluation is typically incorporated into well-child exams, EPSDT exams, sports physicals or other routine office visits.

Parents of adolescents found to be at risk are informed of the screening results and, when indicated, are provided assistance with obtaining further evaluation and/or treatment for their children. In some cases, identified youth can be served by their PCP and, in other cases they are referred to local mental health professionals. It is recommended that mental health checkups be conducted annually.

When and to Whom will Mental Health Checkups be Offered?

Mental health checkups can be offered to patients between the ages of 11-18 during the following visits:

- Annual well-child exams
- Mental health related visits
- Sports physicals

Timing of Mental Health Checkups

- The screening questionnaire takes less than 5 minutes to complete and score.
- The amount of time it will take to discuss the screening results with the patient and then his/her parent will vary, depending on the patient’s responses on the questionnaire and the level of difficulty they are having with the problems they endorsed.

Frequency of Mental Health Checkups

- It is recommended that mental health checkups are conducted annually for adolescent patients.

Administering and Scoring the Questionnaire

- Arrange for a private area for patients to complete the questionnaire before their appointment with the PCP.
- Inform patients of their rights regarding confidentiality before the questionnaire is administered.
- Questionnaire can be scored by a nurse, medical technician or other office staff.
- Privately score the questionnaire.
- Hand the scored questionnaire directly to the PCP or insert it in the medical chart prior to the exam.
## Sample Screening Roles

<table>
<thead>
<tr>
<th>Activity</th>
<th>Primary Care Provider (PCP)</th>
<th>Nurses</th>
<th>Office Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreeing on screening protocol and ensuring that all staff members are on board with the procedures</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Leading staff through the rationale for implementing mental health screening in your practice and inspiring them about the value and importance of screening for mental illness &amp; suicide risk</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Ensuring that copies of the screen are available each day for patients to complete, identifying where copies of screening materials will be kept and who will maintain the stock of supplies</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Identifying patients that are eligible to participate (age) and activating the process for them</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Helping patients that need assistance or have questions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Collecting, administering and scoring the screening questionnaire</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Attaching completed screens to the patient’s chart or otherwise making sure they are available to the PCP</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Evaluating the results of the screening questionnaire with the patient and determining follow-up for patients who score positive</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Providing feedback to parents by explaining the screening results</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Activating the referral/ follow-up process and ensuring patients gain access to appropriate referrals</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Identifying referral resources within and outside of the practice – develop a resource list to share with parents who receive a referral for their child</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Locating &amp; distributing educational materials to parents and patients when needed or requested</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Update medical records, documenting and maintaining completed screening related materials and outcomes in the patient’s record</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Establishing billing and coding procedures for screening and submitting claims</td>
<td></td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Establishing a timeframe for full integration of screening and ensuring a smooth screening process</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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</tbody>
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## Screening Implementation Worksheet

<table>
<thead>
<tr>
<th>Task</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will lead staff through the rationale for screening and educate staff members about the process?</td>
<td></td>
</tr>
<tr>
<td>Who will identify patients that are eligible for screening prior to their appointment each day?</td>
<td></td>
</tr>
<tr>
<td>What screening questionnaire will you use?</td>
<td></td>
</tr>
<tr>
<td>Who will distribute the questionnaire to the patient and explain the screening process to patients AND parents if they have questions?</td>
<td></td>
</tr>
<tr>
<td>Who will ensure that copies of questionnaires are available each day for patients to complete?</td>
<td></td>
</tr>
<tr>
<td>Where will you keep supplies of questionnaires and educational materials?</td>
<td></td>
</tr>
<tr>
<td>Who will help patients in need of assistance as they are completing the questionnaire?</td>
<td></td>
</tr>
<tr>
<td>Where will the patient complete the questionnaire? Is this location private? How will they arrive at this location?</td>
<td></td>
</tr>
<tr>
<td>Who will collect the questionnaire from the patient?</td>
<td></td>
</tr>
<tr>
<td>Who will score the questionnaire?</td>
<td></td>
</tr>
<tr>
<td>If the PCP is not the one to score the questionnaire, who will ensure that the results are attached to the chart or otherwise shared with the PCP before they meet with the patient?</td>
<td></td>
</tr>
<tr>
<td>Who will discuss the screening results with the patients (note, in almost all cases, this will be the PCP)? Where will this discussion take place? Will it be done in private and not in the presence of the patient’s parent(s)?</td>
<td></td>
</tr>
<tr>
<td>Who will explain the screening results to the patient’s parents and assist them with the next step in the process if a recommendation for referral or additional follow-up is being made?</td>
<td></td>
</tr>
<tr>
<td>How will you handle situations where patients are concerned with or refuse to share screening related information with their parents?</td>
<td></td>
</tr>
<tr>
<td>Will you provide assistance in accessing a referral for patients that are identified through the screening process? If so, what type of assistance will be provided and who will be responsible for this?</td>
<td></td>
</tr>
<tr>
<td>Who will ensure that a release of information is signed by parents to allow for the transfer of information between the PCP and the professional that accepts the referral?</td>
<td></td>
</tr>
<tr>
<td>Will you compile a list of referral resources to share with parents? If so, who will locate the resources that are available in your community and be responsible for this list?</td>
<td></td>
</tr>
<tr>
<td>Who will follow up with patients if necessary? How will this person know when to follow up?</td>
<td></td>
</tr>
<tr>
<td>What will you do with the completed screening questionnaires and screening results after the process is complete? How will you document the outcome and who will be responsible for this?</td>
<td></td>
</tr>
<tr>
<td>Who will bill/code for completion of a screening questionnaire during a routine office visit? What procedure and codes will be used?</td>
<td></td>
</tr>
<tr>
<td>Are you going to locate patient/parent educational materials about mental health issues and, if so, who will locate, collect and maintain these resources?</td>
<td></td>
</tr>
<tr>
<td>What is your timeframe for accomplishing a smooth screening process?</td>
<td></td>
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</tbody>
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Working with Parents

It is important to consider how parents will be informed about the mental health checkup process, what information will be shared with parents and how any information concerning their children will be communicated to them. Below are some general recommendations for engaging and informing parents about screening and screening results.

Prior to Screening

• Share general information with parents about the screening questionnaire, process, importance, etc, as they accompany their child into the office.

• Use the sample script (see Appendix) provided by TeenScreen if needed; ensure that appropriate office staff have a copy of the script, are informed about the screening process, and can answer questions from parents.

• Consider providing parents a copy of the questionnaire as their children complete it.

Post-Screening

As a result of screening, there will be some patients who require additional follow-up, either through a mental health referral or follow-up with the primary care provider. The following are suggested practices for notifying parents of the screening results and facilitating follow-up and/or referral:

• Inform parents of positive screening results, recent suicidal thinking and past suicide attempts.

• Notify parents of the results regardless of the outcome of screening (positive or negative).

• Inform parents of the PCP’s decisions regarding follow-up and/or referral.

• PCP activates the follow-up/ referral process and provides the parents with information about the next steps.

• Designate an office staff member who can assist the patient and their family with accessing a referral/connecting to local resources.

• If requested, provide parent and patient with relevant educational materials about depression, anxiety, substance abuse, mental illness or suicide.

Parent and Patient Educational Materials:


• If parents agree to the referral, or to schedule follow-up with the PCP to address the mental health concern, discuss expectations, timelines, what their next steps should be and how you will work with them.

• If a referral is recommended for a patient who is already receiving treatment, confirm with the parents that the patient is indeed receiving treatment and that the services are adequate.

• It is recommended that a plan is in place to follow-up with patients and families identified during the screening process to ensure that the patient has access to the help that they need.

• It is recommended for the primary care office to obtain a signed release of information form from the parent to allow for the transfer of information between the PCP and the mental health provider that accepts the referral (see Appendix for sample release of information form).

Please refer to TeenScreen’s Guide to Referral for additional information about the referral process and for a comprehensive list of organizations where you can obtain additional information and educational materials.
Appendix A  **Sample Script**  
**Introduce Screening to Parents**

Doctor ________________ is offering a mental health checkup for patients ages X and up to check on your teens’ mental health as part of their regular medical care. This checkup consists of your child completing a brief, 5-minute questionnaire designed to help the doctor address common issues in your teen’s life. For most parents, these checkups will be reassurance that a teen is just experiencing typical adolescent “growing pains.” For others, a mental health checkup can help identify and address problems like teen depression early on. The doctor will review the answers and discuss any areas that seem to be concerning your teen. If necessary, he or she can provide you and your family with additional resources and referrals.

- Ask the parent to leave child in private so they can complete the questionnaire, directing them and the child where to go to complete it.

- Briefly explain confidentiality rights for the patient.
Appendix B Release of Information Form
Sample Referrals to Agencies Outside Your Organization

Member Name (please print) ___________________________ Date of Birth ___________________________

Member Consent to Exchange Information (to be completed by member) Health Plan:

I, ___________________________ , authorize/do not authorize ___________________________.

Please print

CIRCLE ONE

Please Providers Name ___________________________.

My behavioral health provider, and ___________________________.

Primary Care Physician Name ___________________________.

PCP Address and Phone Number ___________________________.

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of

care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged

may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan.

I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of

this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above

behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose

to change my Primary Care Physician.

I Authorize Communication between My PCP and Behavioral Health Provider (Member’s Signature )

Date ___________________________.

I DO NOT Authorize Communication between My PCP and Behavioral Health Provider (Member’s Signature )

Date ___________________________.

Signature of parent or guardian (if member is a minor)

Date ___________________________.

Witness

Date ___________________________.

Provider Information (to be completed by the Behavioral Health Provider) — Please Print

Practitioner Name(s) (Therapist and Psychiatrist if applicable ) ___________________________.

Facility Name ___________________________.

Address ___________________________.

City/State ___________________________.

Telephone Number ___________________________.

DSM IV Diagnosis Code & Name ___________________________.

Treatment Plan: Type ___________________________.

Frequency ___________________________.

Est length of Tx ___________________________.

Medication(s) Prescribed:

____________________________________________________

____________________________________________________
Comments:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

For urgent or emergency situation, please call the primary care physician in addition to sending form.

☐ Conclusion of mental health/substance treatment Date of last session _______________________

Treatment completed? ☐ Yes ☐ No

Notification of prescription or change in medications (see comments)

Other: ______________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

A copy of this form must be sent to the primary care physician, retaining the original in the member’s chart. If the form is sent by fax, attach confirmation that fax was sent.

Please Check Method

☐ Fax ☐ Mail DATE SENT ________________________ BY (CLINICIAN PLEASE INITIAL) ________________________

Print Clinician Name __________________ Signature/Credentials __________________ Telephone Number __________________
Please complete the following information regarding the person listed on the reverse and forward to the behavioral health provider.

Provider Information (to be completed by Primary Care Physician) — Please Print

__________________________ ___________________________ __________________________

__________________________ ___________________________ __________________________

__________________________ ___________________________ __________________________

Physician Name(s)

Address

City/State

Telephone Number

Medical History

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Medication(s) Prescribed:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Comments:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Send a copy of this form to the behavioral health provider, retaining the original in the patient’s chart. If the form is sent by fax, attach confirmation that fax was sent.

☐ Fax  ☐ Mail DATE SENT ___________________________ BY (CLINICIAN PLEASE INITIAL) ___________________________.