

CT Primary Care Payment Reform

Design Group Capabilities Skeleton:

Behavioral Health Integration in Pediatric Primary Care

This Draft: August 15, 2018

Scope and Purpose of the Design Group

Thank you for joining the conversation about Primary Care Modernization in Connecticut. The Practice Transformation Task Force is currently reviewing the capabilities that should be incorporated into a primary care payment model.

The purpose of the Design Group is to consider whether the capability should be included in a primary care payment bundle. During the Design Group meetings, we will have an opportunity to confirm the group's understanding of the different options to improve behavioral health integration into pediatric practices and the option's overall impact in terms of better health, better care, patient experience, provider satisfaction and cost. With a shared understanding of the option, the group will also consider whether the option should be elective or required and, if so, how it should be delivered – by all practices, by some practices, or by the network. The Design Group's conclusions will be presented to the Practice Transformation Task Force, which is responsible for making a formal recommendation to the Payment Reform Council (PRC).

Some considerations to keep in mind:

- The CT SIM primary care payment initiative is directed at provider groups that participate in shared savings contracts and the pediatric practices within those groups.
- The payment model will include recommendations about risk adjustment (so that providers are fairly compensated for populations with higher needs) and attribution methodologies.

Questions for this Design Group's First Meeting

- Do we need to add anything to the list of Consumer Needs?
- What do we want to add to the types of services described?
- Should the Design Group recommend specific program models or services to include in the primary care bundle?
- Should this project's array of behavioral health services include education and coaching about health behaviors?
- What are the barriers for existing promising programs/models in CT to scale up to meet increased utilization needs?
- How should the model address coordination with school, community and family support resources?
- Can the Design Group frame some guidelines for services that should come into a primary care bundle and those that should remain as part of a separate behavioral health payment stream?

Understanding the Need

The Problem:

According to the American Academy of Pediatrics, "emotional, relationship, and behavioral problems affect nearly as many preschoolers as older children, with prevalence rates of 7% to 10%. Emotional,

behavioral, and relationship problems, including disorders of attachment, disruptive behavior disorders, attention deficit/hyperactivity disorder (ADHD), anxiety and mood disorders, and disorders of self-regulation of sleep and feeding in children younger than 6 years, interfere with development across multiple domains, including social interactions, parent–child relationships, physical safety, ability to participate in child care, and school readiness. Importantly, if untreated, these problems can persist and have long-lasting effects, including measurable abnormalities in brain functioning and persistent emotional and behavioral problems” (AAP, 2016). In 2005 to 2011, the most common disorders among children aged 3 through 17 years were ADHD, behavioral or conduct problems, anxiety, depression, autism spectrum disorder, and Tourette syndrome, all of which are amenable to behavior therapy approaches and other therapies. Timely and adequate treatment can promote lifelong health and development, whereas a lack of appropriate treatment could lead to worsening and compounding of the child’s difficulties in home, academic, and community settings. (Tyler, 2017)

Despite the high rates of pediatric behavioral health (BH) disorders, four of out five children ages 6 to 17 with a mental health problem do not receive any help ([Soni, 2009](#)). Some of the reasons for this scenario reflect limitations in treatment access, acceptability, and impact that cut across problems and disorders ([Kelleher & Stevens, 2009](#)). Common obstacles include the unavailability of appropriate providers, insurance restrictions, long delays for services, high drop-out or no-show rates, limited quality but high cost of care, stigma, and poor communication between the mental and physical health professions ([Kolko, 2009](#)). Thus, many children with BH problems receive suboptimal care and suffer significant long-term impairments (Kolko, 2014). There is also the opportunity to promote psycho-emotional development through supporting families in early childhood (AAP, 2016).

The pediatric office is recognized as a universally accessed, non-stigmatized setting, ideal for the assessment and treatment of early childhood behavioral health problems. However, barriers to this type of care include time limitations of pediatric providers, inadequate reimbursement structures, inadequate training of pediatricians and other pediatric providers, and insufficient integration between medical and behavioral health providers (Briggs, 2007). Pediatric providers are often overwhelmed by these barriers leading to avoidance of diagnosing behavioral health conditions and contributing to pediatrician burn-out.

Primary care presents an excellent opportunity to change the life health trajectory of at risk children to a healthy one over the life course. More than 90% of children use primary care services annually, providing a venue to deliver health messages, identify health concerns, and connect patients to services that can address health risks early before they lead to larger problems, which are costly to manage and become lifelong chronic conditions. The American Academy of Pediatrics (AAP) and federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) schedules outline an array of primary care services that, when fully implemented, contribute to long term health outcomes. (Honigfeld, 2018).

Proven Strategy:

Name: Integrated Behavioral Health for Primary Care Practices

Definition: Behavioral Health Integration (BHI) refers to a set of services aimed at unifying behavioral health and primary care to improve treatment and outcomes and reduce health disparities. Because

children have frequent well child visits, BHI offers an opportunity to improve care for children and families. Different models have emerged to improve care, including co-location and telehealth consultation, which can be implemented independently or in conjunction with one another. In addition, behavioral health care coordination can facilitate the needed services, connect families with community resources, improve communication between providers and outside facilities such as schools, and improve pediatric provider's ability to oversee the behavioral health needs of the large numbers of pediatric patients who need help.

- **Co-location** refers to BH clinicians onsite in the pediatric practice to improve access, facilitate care coordination and streamline billing (Tyler, 2017). BH clinicians located in a pediatric office can screen, triage/response to a positive screening, provide services ranging from brief interventions to short term or long-term therapy, offering self-management counseling for children and their families, facilitating referrals and communication with external behavioral health providers, facilitating transitions across settings and levels of care and communicating with teachers or other interested parties. (SAMHSA, 2013 in Tyler, 2017). In this arrangement, a behavioral health clinician can join the pediatric visit itself or the pediatric staff can accompany the patient to the BHC's office for a warm introduction. The BHC and pediatric staff can then coordinate care through face-to-face meetings, care management and other collaborative processes.
- For practices where co-location is not feasible, several practices may with a behavioral health counseling provider located nearby. This alignment allows pediatric practices to give referrals "in the neighborhood" and help patients make connections to services.
- **Telehealth Consultative services** provide timely access to child behavioral health specialists to aid in BH diagnosis and when developing or refining treatment plans for patients in the pediatric practice, often in acute or semi-acute circumstances. See the examples later in this document about [Access Mental Health CT](#) and [MCPAP](#). Pediatric providers who wish to manage certain behavioral health conditions on their own, especially when prescribing medications, can obtain enough advice for them to manage the patient. Often these patients will be co-managed with a behavioral health therapist. This can be particularly helpful in areas with shortages of child and adolescent psychiatrists and other mental health professionals.
- **Pediatric Provider Training:**
A resource of training materials and training programs to help pediatric providers improve their ability to screen, evaluate, and in certain circumstances initiate and maintain therapy for common pediatric behavioral health conditions.

Implementation: All pediatric practices, depending on practice characteristics such as size, nature of facilities, capabilities and on-site resources will have access to:

- A child psychologist or pediatric LICSW either co-located in the practice or located in the practices' community/neighborhood.
- A pediatric behavioral health care coordinator co-located or available by phone
- A pediatric telehealth behavioral health program such as Access Mental Health CT

- Access to a pediatric behavioral health training program providing resources and training sessions.

Intended Outcomes: List desired outcomes of the recommended capability

- Expand pediatric practices capability to manage child behavioral health conditions and to support socio-behavioral development of children and to support families
- Reduce health disparities
- Reduce time to treatment
- Improve child functional status
- Increase use of evidence-based medication algorithms and evidence-based psychotherapy

Consumer Needs:

- Reduce stigma for accessing pediatric behavioral health services
- Address child BH issues before needs become acute
- Reduce wait times between initial diagnosis and treatment plan, as well as for medication adjustments
- Help developing an overall “treatment plan” beyond medication, including School (academic, special needs), counseling/therapy,
- Help coordinating with schools and other social service agencies
- Finding BH clinicians who are accepting new patients and patient’s insurance plan

Health Equity Lens:

- Inconvenient locations and times create barriers to accessing care, such as the need for transportation to periodic counseling visits
- Cultural attitudes about accessing behavioral health services may need to be addressed
- Access to behavioral health clinicians who speak the patient’s preferred language
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Implementing the Strategy

Example Scenario 1:

During a well child visit, the pediatrician learns that the patient’s teachers are concerned that the adolescent patient has become disruptive and academic performance is affected. Parents are concerned that the child is withdrawn and angry.

Consultative Services: The pediatrician performs an initial screen and determines that behavioral health clinical intervention is indicated. The pediatrician calls a centralized telehealth consultative service to obtain advice on developing a treatment approach for the child, including an evidence-based medication plan. The pediatrician receives a call from a child psychiatrist within a few hours. The pediatrician then follows up with the family.

Co-located Services: The pediatrician provides a “warm hand-off” to a BH clinician who joins the discussion and assist in the development of the clinical intervention. The pediatric team may also include care coordinators and other professionals to assist in ensuring follow-up, assist with obtaining reports from schools and other social service agencies, assisting with transportation needs, answering

questions between follow up visits, and pro-actively assessing adherence with prescribed plans and reducing barriers to adherence.

Example Scenario 2:

A 3rd grader is brought into a small pediatric practice with a history of school difficulties, hyperactivity and poor attention span. No co-located services are available due to the size of the practice. However, the practice contacts their BH care coordinator by phone. He/she arranges to speak with the child's teacher, sends an ADHD screening tool to the school and identifies requests for educational testing. He/she also administers an ADHD screening tool to the child/family. The pediatric practitioner calls the consultation service and receives a call back later that day from a child psychiatrist and obtains recommendations on how to evaluate the child and, depending on the results of the evaluation, obtain medication treatment recommendations. The BH care coordinator follows up to ensure all evaluation materials are returned to the pediatric provider and that a follow up visit is scheduled and kept. He/she then informs the school of the plan and arranges a follow up call to get feedback once treatment is underway.

HIT Requirements:

- For telehealth consultative services regarding medication management, secure messaging is needed to exchange patient records.
- For co-located practices, BH clinicians need access to EMRs and clinical notes to ensure coordination with the primary care team.

Implementation Concerns: A bulleted list of any potential downsides of utilizing this strategy to acknowledge weaknesses and generate discussion around solutions.

- Co-located services:
 - Availability of appropriate physical space including concern for confidentiality
 - Availability of billing capabilities for billable services
 - Availability of qualified staff to meet different functional needs: medication management, evaluation, direct counseling for children and adolescents, community connections
 - Need to schedule BH staff in afternoon (afterschool) hours
- Telehealth Consultative model
 - Sufficient on-call child psychiatric resources to provide timely responses on medication and treatment planning
 - More acute patients may need on the spot interventions
- Pediatric Provider Training:
 - Time constraints of pediatric providers and pediatrician burn out
 - Effectiveness of training materials vs. training sessions

Impact

Aim	Summary of Evidence
<i>Health promotion/prevention</i>	<ul style="list-style-type: none"> • Findings suggest that using various technologies contributes to increased access to care, enhanced practitioner capacity, positive patient and family outcomes, and improved quality of life. (Boydell) • Primary care patients treated by tele-mental health showed improvement in terms of depression and subscales of the Child Behavioral Check List (Yellowlees, 2008) • Rural PCPs reported significantly more mental health services provided by themselves (35.8%-17.5%) than did suburban PCPs, and they sent more patients out of the community for outpatient (16.4%-0%) and inpatient (7.5%-0%) services than did suburban PCPs. (Hilty, 2013)
<i>Improved quality and outcomes</i>	<p>Meta-analysis of 31 studies with 35 intervention control comparison studies show a 66% probability that randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than one receiving usual care. The strongest effects were seen for treatment interventions that targeted mental health problems and those that used collaborative care models (Asarnow, 2015)</p>
<i>Patient experience</i>	<p>On a 5-point Likert scale (1 = very dissatisfied to 5 = extremely satisfied), patients rated their ability to talk freely (mean = 4.49) and having their needs met (mean = 4.28). Satisfaction was statistically higher for rural than for suburban patients overall (mean = 4.71 vs 4.13, P < .05); quality of consultation was rated higher by rural than by suburban PCPs (mean = 4.83 vs mean = 4.45, P < .05). (Hilty, 2013)</p>
<i>Provider satisfaction</i>	<ul style="list-style-type: none"> • PCP satisfaction scores show dramatic increases as a result of their access to and use of the service. PCPs are surveyed at the time their practice enrolls with MCPAP, and periodically thereafter, and their scores are compared. (Holt, 2010) • Results indicated significant satisfaction related to quality and continuity of care and improved access to services. Such models of care may increase access to care and reduce other service barriers encountered by individuals and their families with behavioral health concerns (i.e., those who otherwise would seek services through referrals to traditional tertiary care facilities). (Hine, 2017)
<i>Lower Cost</i>	<ul style="list-style-type: none"> • Literature cites trends to lower costs but is not definitive on ROI. • At one site, patients with behavior problems and ADHD in a BH pediatrics collaborative model had higher intervention costs, but the cost per patient treated for this group was lower than the group receiving enhanced usual care during the 6-month intervention period. In terms of costs of community mental health services, while the two groups had similar costs in the 6 months before the RCT intervention, the group in the collaborative care model had significantly lower costs in the 6-month intervention period, and in the 6 or 12 months after the

intervention, but not in the 18 or 24 months after the intervention. (Yu, 2017)

- The cost of specialist consultant visits... may contribute to the underuse of specialist involvement in the care of some patients, especially the underinsured. Even for patients with insurance coverage, avoidable in-person specialty care encounters contribute to higher health care costs and problems related to care transitions. It has been estimated that 30 percent of referrals could be avoided if other forms of communication between PCPs and specialists were available. (Electronic Consultations Between Primary and Specialty Care Clinicians, Horner)
- The quality of cost data in the literature is suboptimal and little information is collected in a systematic, controlled, prospective way (Hilty, Yellowlees, Sonik, Derlet, & Hendren, 2009). What literature exists suggests that total travel cost is less per patient using telepsychiatry than costs of travelling for psychiatry services (Elford et al., 2001). Cost savings to young people and their families are realized for travel time (Spaulding et al., 2010).

APPENDIX

Learning from Others

CHDI/Access Mental Health CT ACCESS Mental Health CT is a state funded program created to ensure that all youth under 19 years of age, irrespective of insurance coverage, have access to psychiatric and behavioral health services through contact with their primary care providers (PCP). The program is designed to increase PCPs' behavioral health knowledge base so they can identify and treat behavioral health disorders more effectively and expand their awareness of local resources. Beacon Health Options (Beacon) contracts with three behavioral health organizations to act as Hub teams and provide support across the state: Institute of Living at Hartford Hospital, Wheeler Clinic, and Yale Child Study Center. Each Hub team consists of board-certified child and adolescent psychiatrists, a behavioral health clinician, a program coordinator, and a half-time family peer specialist. The teams are charged with providing real-time psychiatric consultation and individualized, case-based education to PCPs over the phone. Phone conversations may entail diagnostic clarification, psychopharmacology recommendations, counseling recommendations and care coordination supporting youth and their family in connecting to community resources.

- Direct PCP Consultations: approximately 99% (730 out of 741) of initial PCP calls were answered by the Hub team's consulting psychiatrist within 30-minutes of the PCP's initial inquiry in Q1 and Q2 SFY'18; 74% (540 out of 730) of which were connected directly at the time of the call.
- collectively the Hub teams provided an average of 1,590 consultative activities per quarter from Q1 SFY'16 through Q2 SFY'18
- Of the 3,355 total consults provided in Q1 and Q2 SFY'18, approximately 56% (1,888) were for youth with an identified commercial insurance plan such as Aetna or Anthem BCBS of CT; 43% (1,441) were for youth with HUSKY coverage and approximately 1% (26) consultative activities were provided to youth without insurance during this reporting period.

(ACCESS Health Semi-Annual Report, 2017)

Massachusetts Child Psychiatry Access Project

When primary care pediatricians enroll in the program, they can access timely assistance for any patient with a behavioral health concern. After an initial phone consultation with a child psychiatrist, MCPAP might then provide an in-person clinical assessment, short-term therapy, or a facilitated connection to a community resource.²⁰ MCPAP has regional teams that each consist of child psychiatrists, licensed therapists, care coordinators, and appropriate administrative support.⁴⁰ Data from MCPAP indicate that 28% of initial consultations led to the child receiving a face-to-face consultation with a child psychiatrist or nurse. Pediatric primary care providers agreed to manage psychiatric follow-up care for 50% of patients involved in the MCPAP, which might indicate pediatric primary care provider confidence in managing behavioral health issues when supported by a specialty team. Provider surveys indicated that confidence in meeting the needs of children with behavioral health problems increased from 8% to 63% after implementation of MCPAP. Providers reporting that they successfully obtain consults in a timely manner grew from 8% to 80%. (Tyler, 2017).

New England Quality Care Alliance (NEQCA)

NEQCA is a network of over 1800 community and academic physicians affiliated with Tufts Medical Center in Boston. The network which extends throughout much of eastern MA includes almost 100 primary care pediatricians. The primary care pediatricians identified behavioral health problems in their patients as their number one concern in their practices. They estimated that 30% of their patients had some BH condition. To address this concern a program was developed to embed pediatric social workers focusing on pediatric BH integration in all the primary care pediatric practices. Their primary function was to coordinate the BH needs of the practice patients. They became highly effective at making community referrals and developed extensive referral networks. This had not been done effectively by the practices without this help. Early results of the program were a significant increase in pediatric provider satisfaction, improved coordination with schools and other community social service agencies and a reduction in emergency room visits for behavioral health diagnoses. The practices found that they engaged families around BH issues more because they knew they could hand the patients off to find community resources and ensure follow-up. (Source: *Personal communication*)

Additional Reading:

Access MentalHealth CT, Semi-Annual Progress Report, accessed at: <http://www.accessmhct.com/wp-content/uploads/2018/04/ACCESS-MH-Q1Q2-SFY18-Semi-Annual-Progress-Report-FINAL.pdf>

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