

## Pediatrics Behavioral Health Integration Design Group

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### PCM Overview

- Directed at pediatric groups participating in shared savings models
- Feedback to be incorporated in a revised skeleton to be submitted to the Practice Transformation Task Force

### Skeleton Review

- Consumer need additions:
  - Consumer: Early identification of behavioral health issues
  - Consumer: Whole family approach to address the needs of the whole family
    - Consumer: Behavioral health education for parents/families
      - Provider: This could fall under reducing stigma
    - Consumer: Inclusion in treatment plan development
    - Consumer: Consideration of the avoidance of payment for out of network providers
      - Provider: Access mental health does not provide treatment, but rather consultations to pediatricians for medication management and mental health evaluation
- Provider: If a parent is already getting care through their primary care provider, there needs to be coordination to ensure the child and parent's care is aligned
- State: Consumer out of pocket expense as a barrier should be addressed.
  - Example is a large CT employer that has eliminated all cost sharing in primary care, including behavioral health
    - BH not subject to co-pay or coinsurance
  - FHC Expert: Pediatric preventive services do not require cost share under the ACA
- Important to talk about screening services, including first line coaching for parents, guardians, older children
  - Pediatrician – child behavioral health consultation
  - Pediatrician – clinician warm hand off
  - Provider: CHDI provides screenings for Medicaid patients, commercial patient parents are still exposed to cost sharing, etc.
    - Provider: Mental health screenings are different from behavioral health screening, which can incorporate a developmental screening
    - Provider: Younger children require developmental screenings, maternal health screenings (particularly depression) – there are whole packages of screenings that need to be considered
    - Noticed interest in pediatric sites for uptake of screening

- Provider: AAP has information on adolescents need depression screenings and other developmental tools for school-aged children
  - Provider: Family screenings should include those who are not in the household
    - There are many behaviors that reflect not just developmental problems, but mental health problems – a screening tool needs to be sophisticated and the clinician should be aware of these components
  - State: What are the current recommended practices for screenings? Are there any screenings we should include as we look ahead prior to USPFTF inclusion – example universal trauma screening?
    - Provider: USPFTF screenings start at age 11, this should be lowered to about age 4 to catch issues early.
      - Maternal depression screening uptake has been slow because of provider liability issues
    - Provider: Pediatricians seem to be able to pick and choose which screenings are conducted, thus if just focusing on depression may miss a large number of children who have anxiety issues, which have similar symptoms as depression
      - Must also consider screenings for young children, under the age of 4 because the standard developmental screening used is not sufficient
      - Adverse Childhood Experiences (ACEs) screening for infants and young children
        - Provider: ACEs screening is resource intensive and therefore should be studied prior to consideration
        - Provider: Tennessee is working to make ACEs screening a statewide effort
  - **Provider and FHC Expert** to reach out to Provider (AAP) and Provider (CHDI) to receive their screening toolkit for further discussion
  - Provider: Important to highlight that there needs to an ability to follow-up
  - Provider: Important to take AAP and CHDI screenings and compare for overlap and gaps
  - Consumer: There is a tension of trying to innovative for screenings, but we are not ready to implement all of these screenings. Many services are limited by region and practice because there is a large variation of services across facilities
  - Researcher: Need to consider the bridges to build to make primary care linked to pediatrics behavioral health, including care coordination, short-term treatment interventions, as these are person-centered bridges
- Provider: Colocation should rely on team-based integrated care with a care coordinator and maybe a behavioral health provider
  - Colocation is a model that requires a separate person who comes into the pediatric facility, they serve as a resource, but aren't coordinated into the practice working alongside the care team. They tend to provide some treatment for the family
  - Behavioral health coordinator is not often well trained enough to do consults with school, etc. They can offer resources to connect the patient appropriately
  - Provider: Need to be clear on the definition of colocation
    - It is possible to provide care coordinators with the education needed to undertake school consultation and other important consultant responsibilities

- Need to make use of knowledge that exists with child psychiatrists and therefore create a system that takes advantage of all resources
- FHC Expert: There is flexibility within the skeleton document to allow for variance in practice and provide guidelines
  - It will be important to clearly define the guidelines
  - What types of roles should be included/what professionals?
    - Provider: The cost of psychiatry is much higher, therefore utility should be considered
      - Need to avoid just medication management
    - Provider: Pediatric psychologists, APRNs, and social workers currently deliver care
- Consumer: Payment has a large influence on the models chosen, particularly on measuring quality and outcomes.
- Provider: All of these aspects of pediatric behavioral health needs to be done within around twenty minutes and there are a host of other activities that need to be conducted in this time
  - Provider: Payment reform to double the spend on primary care should allow for more time to allow to conduct appropriate services
  - Consumer: Care coordination can reduce the burden of time taken for well visits for physicians down
    - Care coordination should include diet and fitness as part of the whole family work
    - Skeleton was heavy on medication management rather than diet, fitness, alternative therapies (music or sports)
      - Don't want to fall into over-medication or a slanted system
  - Provider: Need to nod to the fact that there is a high rate of burn out due to a lack of time to form relationships for the families they care for
    - This should be considered

### Next Steps

- Summary:
  - Screenings are important and should be integrated into the primary care pediatrics practices
  - Need for care coordination to connect the child and family to support services
    - Treatment resources need to support the recommendations, including community resources for the child and family
  - Consultative resources are important for the pediatrician and behavioral health coordinators to receive support and advice
- FHC Expert: We didn't get to discussing training – particularly for pediatricians on screening tools
  - Provider: Training on screening tools and how to build a relationship with families, how to work with families till they're ready for a referral
  - Practicing excellence is a program that helps with provider satisfaction
  - **FHC Expert** to reach out to Provider on training programs for pediatricians

- Provider: There needs to be a connection to training in residency, particularly for mental health care
- Consumer: Part of the summary barriers to overcome – high deductible and insurance issue