Primary Care Modernization Pediatric Behavioral Health Integration Design Group Meeting 2
09/05/2018

Participants: Linda Green, Alyssa Harrington, Vinayak Sinha, Ellen Bloom, Jeff Lasker, Sandi Carbonari, Deborah Ferholt, Barbara Ward-Zimmerman, Susan Kelley, Erin Warnick, Linda Mayes, Elsa Stone, Jerry Calnen, David Grodberg, Mark Schaefer, Karen Siegel, Michele Goyette-Ewing, Joseph Woolston, Megan Smith, Katherine Klem, Jean Adnopoz, Laine Taylor, Colleen Vadala, Ian Solomon, Mary Katherine Montgomery, Susan Busch, Madison Bunderson, Kathryn Lally, Lisa Honigfeld, Madison Bunderson, Erin Rice, Arlene Murphy, Tekisha Everette, Kevin Galvin

PCM Overview

- Consumer Comments, Questions, Feedback from Meeting 1
    - Better screening for early identification of behavioral health issues
    - Need for increased training of pediatricians in mental health evaluation and treatment for child and family ("whole family") approach.
    - Concern about rate of psychotropic medications
    - Having a mental health clinician in the office as part of the team can improve appropriate treatment options
    - High deductibles/out of network providers and insufficient capacity in the community to treat positive screenings are barriers to integration and bundling of services
    - Pediatricians should not be at risk for performance due to inefficiencies in behavioral health systems. Need greater accountability in behavioral health services delivery system.
    - Need to involve parents of children with behavioral health needs in conversation for "boots on the ground" perspective
- There is a need for increased training→ mental health education and coordinator of tasks
    - Evaluation isn't quite right. It's more than just screening. It's about connecting with a behavioral health specialist.
- Provider: Important for pediatricians to understand what a full evaluation is. Understanding what you're screening makes you a better provider.
- The high deductible bullet point-Accountability aspect is important.
- Consumer: The mechanisms for/measuring accountability really matters and is critical to understanding whether the quality is meeting our standards.

DRAFT Concept Map for Pediatric Behavioral Health Integration

- Is this a model that should be required for every pediatric practice?
- Does the Design Group have specific recommendations about staffing and resource intensity?
- Should every practice be required to have the same level of resources?
    - ATRN at the medication level would be a good idea.
    - Does this mean the primary care practitioner has no say in the monitoring of medication?
        - FHC Expert: No. A child psychologist or nurse practitioner would be doing the prescribing, but it wouldn't rule out a primary care practitioner from taking part.
    - What's the range of medications used under that model?

        - Varies: Access Mental Health Model; Model where the pediatric practice has a very close relationship w/ the ATRN
- State: The diagram should not create an impression that prescribing is moving outside.
    - Would propose a graphic change.
    - FHC: Not included to preclude the role of the pediatrician.
- Provider: What are you defining as an evaluation? What's the definition of brief treatment?
    - FHC Expert: This is not meant to be a fully detailed model.
    - Pediatricians must be able to refer to what the office can offer.
    - Some output from that-either testing or some other evaluation.
    - It's really a preliminary diagnosis.
- It's important to get the family on board.
    - FHC Expert: That is why we put child/family & pediatrician at the center of the model.
- There could be another step between Brief Treatment and Extended therapy/counseling.
- Management of psychiatrist therapy within the domain of Therapy and Medication
    - In terms of follow up- having a team approach is good.
    - Responsibility lies with the pediatrician and psychiatrist
    - Needs to be a back-and-forth relationship
    - BHW communicating with physicians should be a thing.
    - A patient's relationship with their pediatrician is likely to be a lot longer.
    - The same w/ any referral- the role of the pediatrician is to engage the family
        - FHC Expert: The behavioral health provider might not work out for a family, so the pediatrician must stay involved.
- What do you mean by extended therapy by psychologist/nurse practitioners?
- Provider: The real role in pediatrics is really health promotion and prevention.
    - Early intervention, screen, and prevent an anxiety disorder from becoming a true anxiety disorder
- Provider: Instead of using the term "therapy"→ early brief intervention
- State: It's ambiguous who's doing the roles inside the blue box
    - FHC Expert: Pediatrician or a behavioral health coordinator
- Integrated behavioral health and pediatric primary care would allow for an on-site trained clinician
    - FHC Expert: Yes; graphic does not preclude that.
- Have an arrow pointing within the care team
    - Ideally onsite or telemedicine vehicle
    - What category of licensed profession per arrow

Model Component: Screening

- Provider: EPSDT screening required by Medicaid
- Any class of screening falls broadly under this
    - Does not specify "this is what you should see as a developmental infant/young child and this is what you should do"
- Provider: Follow what EPSDT is recommending
    - Annual screenings
- FHC Expert: Chatted with providers about screenings
        - There should be required screenings with a choice of what tests practices use

        - Making resources available will be important to figure out how to get things implemented
        - Other screening tools available to these folks to administer under certain circumstances
        - A certain set of required screening is necessary but the training and how to use the assessments would be worked into the individual practices
        - Provider: Broad-band screenings:
            - Wise to do an annual screening→ allows focus on problem area
    - Screening should include children under 4 years of age
        - There's really no developmental screening
        - What's the practice for screening for children under the age of 4?
        - 18 & 24-month visit is recommended in CT
        - Survey of Well-Being of Young Children (SWYC)
            - Has developmental and behavioral health questions
            - Conducts all screening in one visit
        - You can do developmental screening more but that's not the bottom line
        - 2nd stage screening can be done by a range of providers before a full evaluation
        - Provider: Family questionnaire is important→ parents who have depression often have children at risk for mental health problems
            - SWYC has standard family questions that reflect parental depression and relationships
        - Part C and Part B guidelines-worthwhile to know what you're able to catch in the screening
    - FHC Expert: We will do some more work on this and will circle back with specific recommendations.

Care Coordination

- Provider: Absolutely needs to be minimum training qualifications
    - Depends on social identity of the provider
    - Needs to have a basic understanding of child health diagnoses
    - Set of skills working with families and engaging families
- Consumer: Any consideration of using community health workers to help navigate systems and not necessarily having clinical training
    - Community health ambassadors→ a clear curriculum we could look at
    - There are some good models to refer to
- FHC Expert: we were envisioning the doctor has a close relationship w/ a patient's care team
    - Need to establish a structured relationship
    - Would want the CHW to have more training in mental health
    - Solve for health literacy and cultural issues
    - Telemedicine on the one hand and on the other care coordination with levels
- FHC Expert: Is anyone aware of benchmarks of resources?
    - Where are we going to find these people? Are there CHWs available throughout the state?

    - Someone should be training mental health workers inside and outside the practice
    - Care navigation and training of cultural differences
    - A community health worker doing the job of traditional care coordination and then there can be a short-term person doing the screening
    - ACCESS mental health model
        - There are mental health workers and there are also some statewide services that provide that as well
- FHC: Needs to be a more structured linkage within the practice and will come up with a specific model.

Case Consultations

- ACCESS Mental Health poised to do this
    - Don't want to develop a parallel system
- Payment issues need to be addressed
- State: Telemedicine and bonding payments upfront is good and unencumbered
    - Include a basic level of behavioral health support in the bundle
    - Need to be thoughtful of how we train people
- Consult and supervise by a psychiatrist- what does that mean? Supervise not the best word here.
    - With ACCESS there is no direct contact between psychiatrist and patient
        - If there is, it's very brief; one-time visit
        - We are really talking about consultation
        - ACCESS Mental Health→ patients telephone or email psychiatrist
- Might want to change the green in the model to make it unambiguous
- ACCESS-funding for this every year is an issue
    - Funding issue is relevant
- State: To engage with integrated behavioral health clinician→ separates out community psychiatrist and is not a part of the bundle

Performance Monitoring

- Provider: Whether patients really follow recommendations made with treatment makes follow-up important
    - Pediatrician responsible?
    - Follow-up with linkage
        - What type of linkage to the level of service provided
- State: Important to measure performance for accountability
    - Both at the macro and micro level

Next Steps:

- FHC will come back with:
    - Revised diagram
    - More information on screenings
    - Specifics about care team roles
    - Clarify role of ACCESS Health
    - Performance monitoring