Pedi Behavioral Health Integration Design Group Meeting 3

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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, 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

1. Pediatric BH integration along with entire PCM initiative must be applied to all if not most of population
    a. FHC Expert: If 25-30% is covered by this modernization plan, this won't work in practice.
    b. What is this adding?
        i. Within advanced networks, to include commercial payers, this model will only work if it incorporates all patients.
        ii. Workforce development-bundled payment?
            1. There are new CPT codes that do cover bundled payments; not all insurers will honor these codes, but they do cover a team-based approach. They also cover time devoted to a patient by a team. The question is: how do you make this universal?
            2. FHC: We will take this to the Payment Reform Council.
            3. Provider: These codes are not widely adopted because there is a copay.
            4. Provider: Requirements for psychologists→ recommend you use licensed psychologists to highlight areas of expertise this workforce should have
            5. Provider: Say child psychologist to find those who have at least worked with children.
            6. Provider: Workforce development-not enough care coordinators. What is a care coordinator within a PCP? It's not a case manager.
2. Work force development will be critical to availability of key functions, including but limited to:
    a. Care coordinators
    b. Marriage and Family Therapists
    c. Psychologists
    d. Psychiatrists
    e. NPs
    f. Social workers
    g. Community Health Workers
        i. Include infant and young child psychologists
3. Focus on developmental and socioemotional health promotion prevention and early identification:
    a. Routine screening and assessments by pediatric providers and embedded BH practitioners

    b. Co-location of BH practitioners whenever possible for BH practitioners located in practice "neighborhood"
4. This language could sound just like developmental screenings.
5. Data quality and data improvement-will everyone be disconnected?
    a. FHC Expert: We are trying to gather information on this.
    b. State: The design group for the task force is looking at this. Data will be entered into structured fields and available for research.
    c. No mention of parent as part of the screening
        i. FHC Expert: Many of the screenings and diagrams include the parents. We will show this.
    d. Can we use co-management instead of co-location?
        i. State: The idea is a dedicated behavioral health professional that supports this, where this individual is physically co-located, the idea is that they are a dedicated resource. Nothing more than a referral relationship.
            1. Integrated or embedded would be better. You want beyond physical location being the same.
            2. State: Add a third bullet that says integration can be achieved by having the on-site capabilities (virtual, etc.)
            3. Consumer: The issue becomes whether there is going to be staging on this. The goal is we have an embedded or co-located behavioral health practitioner, but this may not be possible. There may be an issue on this child side.
            4. FHC Expert: It would be great if we can have the BHP embedded or co-located, just by practice-size and resource availability, it may not happen.
            5. State: We can have a payment reform option that stages the process; I think it should be a dedicated behavioral health resource and then we can have a conversation as to how it should be organized.
            6. If the BHP is integrated into the practice (virtually), it will work.
6. FHC Expert: Circle that says "Brief Intervention" would be provided in the practice
7. Recommendations Page 2
    a. Brief interventions by pediatric care team and/embedded BH practitioners
    b. Extended therapy/counseling/extensive evaluations by psychologists/NPs/Social workers and other
        i. Includes interventions in health behaviors
        ii. Medication management by psychiatrists/NPs
    c. Care coordination across all aspects of care and community resource knowledge and linkages
        i. Concern with care coordination, we must be careful about what we are saying care coordination looks like. It's more case management within the practice.
            1. FHC Expert: We will have very clear roles and responsibilities
            2. Provider: The integration of physical and mental health is key
            3. There is overlap between the physical and mental health role
                a. BHP needs to have some expertise in chronic disease

4. In PC, there are a lot of kids who are prescribed and on medication with no psychiatric intervention whatsoever
    a. FHC Expert: Not meant to include what pediatrician prescribes
5. We envision the BHC to know all the community resources and maintain those connections
    a. It's a lot to have them also know the subspecialists in care
    b. State: BHCC -how will this get paid for?
        i. Talk about what we think a well-equipped practice looks like. Is it preferable to have a dedicated BHC separate from someone who is more medically-oriented? And, is this a preference or a requirement?
            1. Provider: Cross-training is very important.
            2. Provider: Agrees.
            3. Look at it from the family's perspective-to make it as simple as possible to have one person they deal with. One person to be a point-person for a family and knows all aspects.
            4. Consumer: This issue of care coordination generally in primary care
                a. State: I would propose that FHC come back with a statement on this that provides a little clarity
                b. Better to have a single care coordinator and then add on a case manager for the medical conditions. Acknowledgement that there is a lot of case management outside of behavioral health.
        ii. There are some special skills required of BHS as well.
    d. Medication management by psychiatrists/NPs
        i. A lot of over medication going on already, but be sensitive to this and be able to capture data on this
    e. Issue about the care coordinator
        i. Issue of advocacy
        ii. FHC: one of the care team managers might be a CHW to help identify needs
        iii. If we are talking about the entire state: the availability of resources is minimal
        iv. Partnerships should be formed between care coordinators and CBOs
8. Screening recommendations
    a. Ad hoc committee of screening experts approved the required:
        i. Universal Screening recommendations for screening tools
        ii. Second stage/indicated recommendations for screening tools

Questions for discussion

- Are we missing any elements of the model?
- Which elements should be implemented first?

- Which elements of the model have a longer lead time?
- Is there anything else that would enhance implementation which should be noted?
    - Let FHC know by email or phone