

Testimony of Jillian Wood  
*Executive Director, CT Chapter of the American Academy of Pediatrics*  
*Executive Director, CT Council of Child and Adolescent Psychiatry*

Before the Public Health Committee

March 20, 2013

**SB1136 An Act Concerning Mental Health Services**

Senator Gerratana, Representative Johnson, and distinguished members of the Public Health Committee:

On behalf of AAP and CCCAP, I am pleased to provide you with this information related to the Massachusetts Child Psychiatry Access Project (MCPAP) for you in consideration of SB1136.

MCPAP is a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with psychiatric problems.

Implementation of a similar program was recently included in the consensus items of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety's Mental Health Services Working Group, and is included in Section 2 of the bill before you.

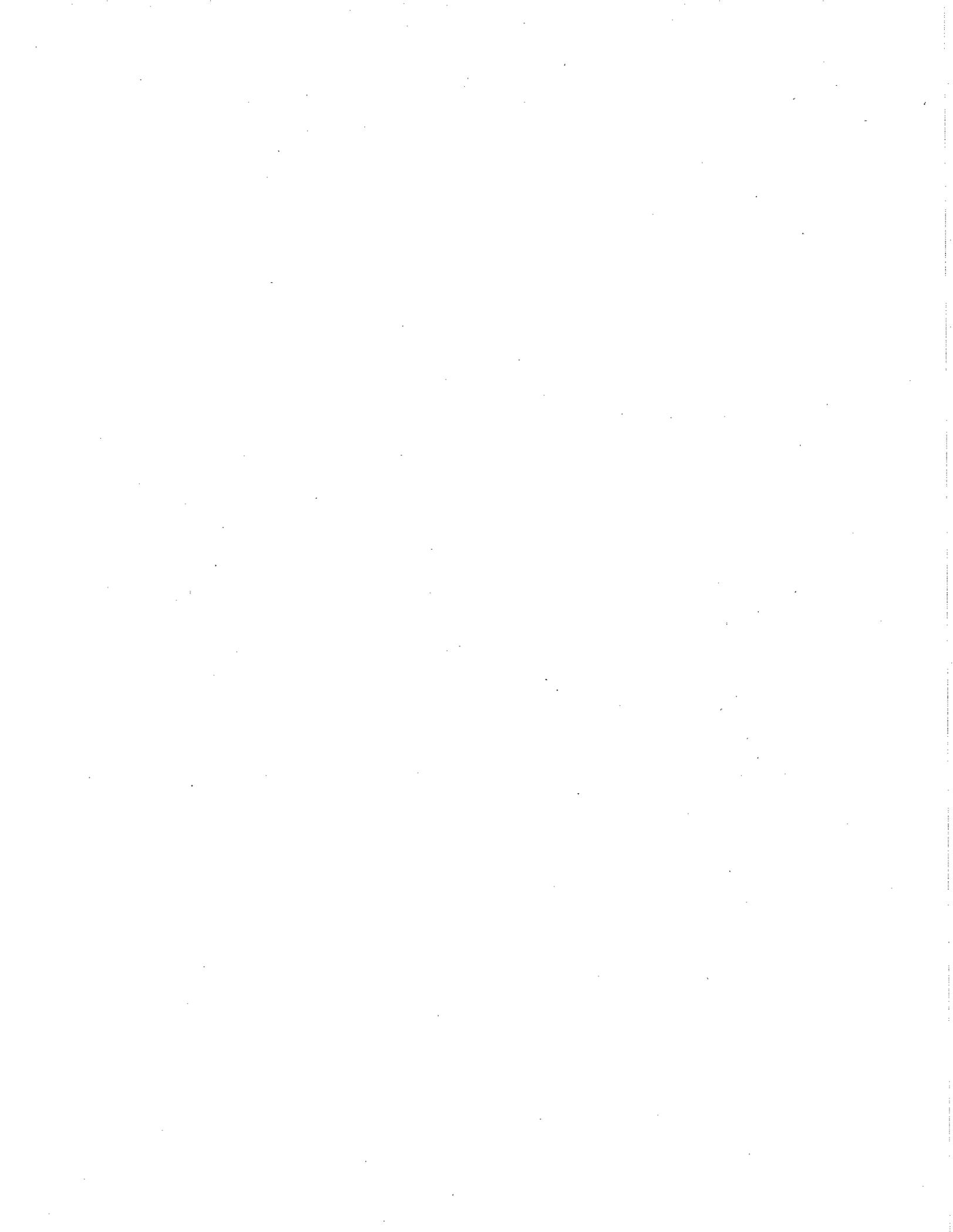
The information in this submitted testimony includes a PowerPoint overview as well as a draft project design for Connecticut ACCESS-MH.

Please contact me with any questions about MCPAP. Thank you for the opportunity to share information about this important program with you.

Respectfully submitted,

Jillian Wood

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Connecting Primary Care with Child Psychiatry

## Massachusetts Child Psychiatry Access Project

John H. Straus, MD

Massachusetts Behavioral Health Partnership

Barry Sarvet, MD

Baystate Health, Tufts School of Medicine



## What is MCPAP?

- MCPAP is a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with psychiatric problems.



## NATIONAL NETWORK OF CHILD PSYCHIATRY ACCESS PROGRAMS

An idea that has caught on....

- Alaska
- Arkansas
- California
- Colorado
- Delaware
- Florida
- Illinois
- Louisiana
- Maine
- Michigan
- Massachusetts
- Missouri
- New Hampshire
- Illinois
- Iowa
- Louisiana
- Maine
- Michigan
- Massachusetts
- Missouri
- New Hampshire
- New Jersey
- New York
- North Carolina
- Ohio
- Pennsylvania
- Texas
- Vermont
- Virginia
- Washington
- Wyoming
- Wisconsin

NNCPAP.org

### WHY?



Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda

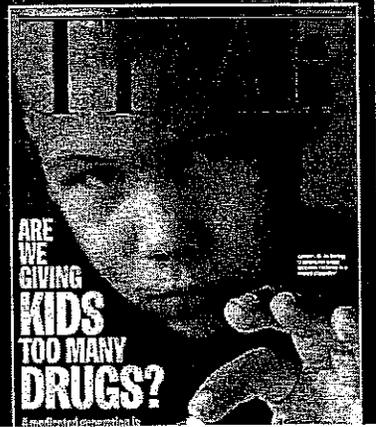


The Experiences of Massachusetts Families in Obtaining Mental Health Care for their Children

Health, Free For All and Parent/Professional Advocacy League

Written by: Janet Frank, JAM Consulting and Lisa Lamert

October 2007



ARE WE GIVING KIDS TOO MANY DRUGS?

LEXSEE 418 F SUPP2D 18

ROSIE D. ET AL., Plaintiffs, v. MITT ROMNEY ET AL., Defendants.

CIVIL ACTION NO. 01-30159-MAP

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

418 F. Supp. 2d 18; 2006 U.S. Dist. LEXIS 3026

### Special Bulletin



The Experiences of Massachusetts Families  
in Obtaining Mental Health Care for their Children

Health Care For All and Parent/Professional Advocacy League

Written by:  
Arië Frank, Josh Greenberg and Lisa Lashlett

October 2002

- 33% of parent respondents waited more than 1 year for an appt with a child mental health provider
- 50% reported that pediatrician never asked about child's mental health
- 77% reported that pediatrician was not helpful in connecting them to resources

## Child Psychiatry Workforce Issues

- Estimated 1.6 child and adolescent psychiatrists per 1,000 children and youth with DSM IV rated severe
- Overall rate of 8.6 child psychiatrists per 100,000 children and youth (range Alaska 3.1 to MA 21.3)
- Poorly distributed throughout country
- Inverse relationship between # of child psychiatrists and percentage of youth in poverty
- No increase in number of child psychiatrists trained per year between 1995 and 2006 (census ~700)

Thomas and Holzer, JAACAP,  
2006

## Suitability of Primary Care Providers for Mental Health

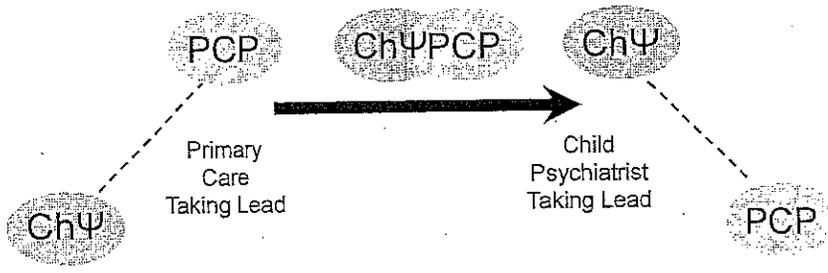
- Patients and families often feel more comfortable and trusting of primary care providers
- Primary care providers have the opportunity for prevention and screening
- Primary care providers know the developmental context of symptoms
- Addressing psychiatric issues in primary care setting can reduce stigma

## Pediatrics and Mental Health

- Costello E et al: Psychopathology in pediatric primary care: the new hidden morbidity, Pediatrics, 1988
  - routine care, pediatricians sensitivity=17%
- Pediatricians prescribing 84.8% of the psychotropic meds in large national office-based practice survey (Goodwin et al, 2001)
- Organized medicine gets behind mental health in mid-90's to present
  - Bright Futures in Mental Health
  - AAP Mental Health Task Force
  - AACAP Initiatives 2005 through 2008

# Continuum of Collaborative Care

Less Complex  $\longrightarrow$  More Complex



## Targeted Child Psychiatric Services: A New Model of Pediatric Primary Clinician—Child Psychiatry Collaborative Care

David P. Connor, MD  
 Thomas J. McGee, PhD  
 Mary Adkins-Lory, RN CS  
 William H. D'Onofrio, MD  
 Christopher S. Grier, MD, MPH  
 Lydia M. Young, MS  
 Richard E. Atkinson, MD, MS

### PILOT

**SUMMARY:** Between 16% and 25% of children and adolescents seen in pediatric primary care have a behavioral health disorder with significant psychopathology, high functional impairment, and frequent psychiatric diagnostic comorbidity. Because child psychiatric services are frequently unavailable, primary care clinicians are frequently left managing these children without access to child psychiatry consultation. We describe Targeted Child Psychiatric Services (TCPS), a new model of pediatric primary clinician-child psychiatry collaborative care, and describe program utilization and characteristics of children referred over the first 18 months of the program using a retrospective chart review. The TCPS model can serve a large number of pediatric primary care practices and provide collaborative help with the evaluation and treatment of complex attention deficit hyperactivity disorder, depression, anxiety disorders, and pediatric psychopharmacology. *Child Welfare*, 2010, 90(4):423-434

#### Introduction

Between 16% and 25% of children and adolescents in the United States experience significant mental health disorders.<sup>1</sup> The average prevalence

of children and adolescents with a behavioral health disorder in primary care practices is estimated to range between 15% and 25%,<sup>2,3</sup> and the number appears to be growing.<sup>4</sup> Increasingly effective treatments for many common

mental health disorders may drive growing demand for services.<sup>5,6</sup> Access to child psychiatric care is problematic for these children. While the small number of child psychiatrists in a historical sense was only about 6700 child and adolescent psychiatrists practicing in the United States compared to approximately 50,000 pediatricians and 78,000 family physicians (FCPs), the distribution of child psychiatry care is geographic region with certain rural areas having virtually no access. However, even urban areas with substantial access appear to

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DOI: 10.1177/0898010110382812  
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 10.1177/0898010110382812

## MCPAP Goals

- Improve access to treatment for children with psychiatric illness
- Promote the inclusion of child psychiatry within the scope of primary care practice
- Create functional primary care/specialist relationship between pcp's and child and adolescent psychiatrists
- Promote the rational utilization of scarce specialty resources for the most complex and high-risk children

## MCPAP Leadership

- John Straus, MD, Administrator/Designer, Massachusetts Behavioral Health Partnership
- Barry Sarvet, MD, Medical Director, Baystate Health
- Irene Tanzman, Program Director, Massachusetts Behavioral Health Partnership
- Hub Medical Directors:
  - Joseph Gold, MD, McLean Hospital
  - Mary Jeffers-Terry, APRN, UMass Med Ctr
  - Jeff Q. Bostic, MD, EdD, Mass General Hospital
  - Jefferson Prince, MD, North Shore Children's Hospital
  - John Sargent, MD, Tufts Medical Center
  - Charles Moore, MD, McLean Hospital-Brockton
  - Barry Sarvet MD, Baystate Health

## Program Design

- Dedicated teams deployed regionally across state
- A state governmental program, through the Massachusetts Department of Mental Health, administered by the Medicaid managed care organization.
- Serves all children and families in Massachusetts regardless of insurance status.
- Serves all types of PCPs (MDs, PNs, PAs)
- Teams hosted by prominent children's healthcare institutions with existing relationships with pediatricians and family physicians.
- Operating budgets of teams are fully funded, subject to reconciliation of third party reimbursement .

## 6 MCPAP "HUBS"

UMass Memorial Med Ctr  
 Kelly Chabot  
 Deanna Pedro, LICSW  
 Danette Mucaria, LICSW  
 Mary Jeffers-Terry, CNS  
 Mathieu Bermingham, MD  
 William O'Brien, MSW

\*

Northshore Children's Hospital  
 Brianna Roy  
 Tracey Terrazzano, LICSW  
 Jennifer McAdoo, LMHC  
 Jefferson Prince, MD  
 Lisa D'Silva, MD  
 Michele Reardon, MD \*  
 Joseph DiPietro, PsyD

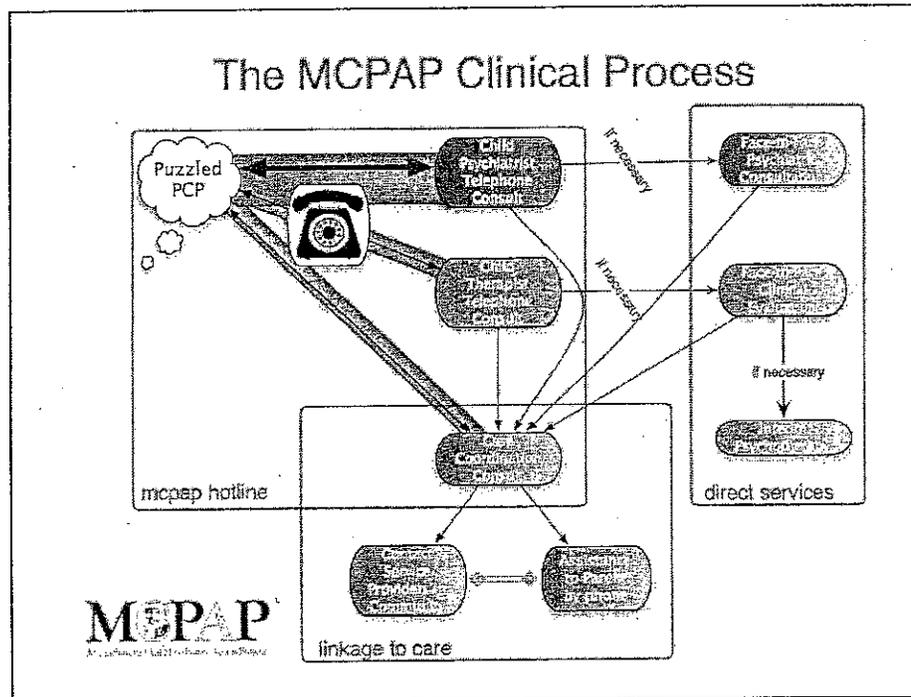
Mass General Hospital  
 Lauren Hart, MPH  
 Leah Grant, MSW LICSW  
 Jeff Bostic, MD EdD  
 Betty Wang, MD  
 Elizabeth Pinsky, MD \*  
 Paul Hammerness, MD

Tufts Med Ctr  
 Children's Hospital Boston  
 Rachael Roy Gorton  
 Alexis Hinchey Davis, LICSW  
 Sigalit Hoffman, MD  
 Neha Sharma, DO  
 Eric Goepfert MD  
 Mimi Thein, MD  
 Lauren Mckenna \*

Baystate Med Ctr  
 Arlyn Perez \*  
 Jodi Devine, LICSW  
 Barry Sarvet, MD  
 Bruce Waslick, MD  
 Shadi Zaghoul, MD  
 Sara Brewer, MD  
 John Fanton, MD  
 Marjorie Williams-Kohl, CNS

McLean Hospital/Brockton  
 Amanda Carveiro  
 Caria Fink, MSSA  
 LICSW  
 Charles Moore, MD  
 Tracy Mullare MD \*  
 Mark Picciotto, PhD

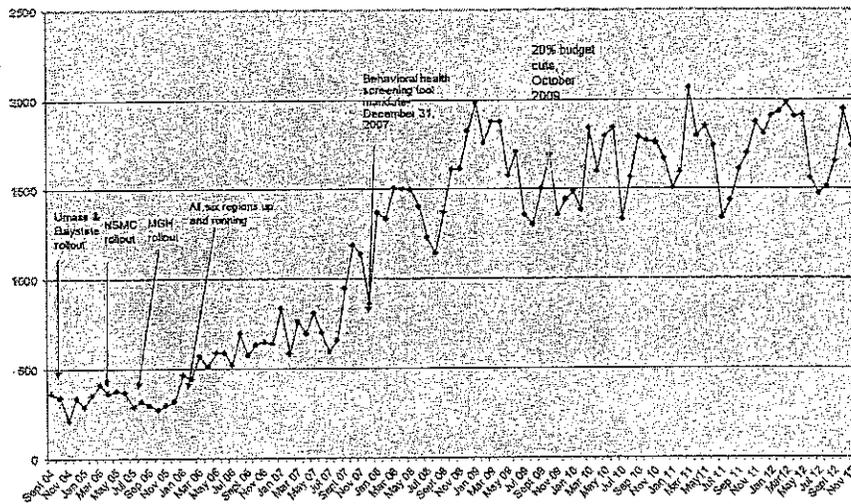
MCPAP  
 Massachusetts Child Psychiatry Access Program



## Overview

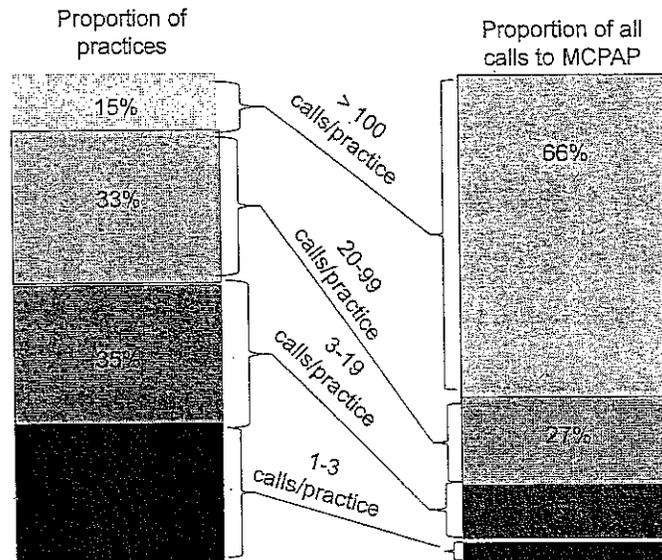
- 6 teams
- 423 practices with 1534 FTEs of primary care providers
- 92% of pediatric practices with panel size of 2000 or more in MA used MCPAP at least once in 2011
- 20,958 encounters in FY 2012
- Over 1,460,000 children now covered
- Over 98% of Commonwealth
- Cost = \$2.20 per child per year

## Utilization – Encounters by Month



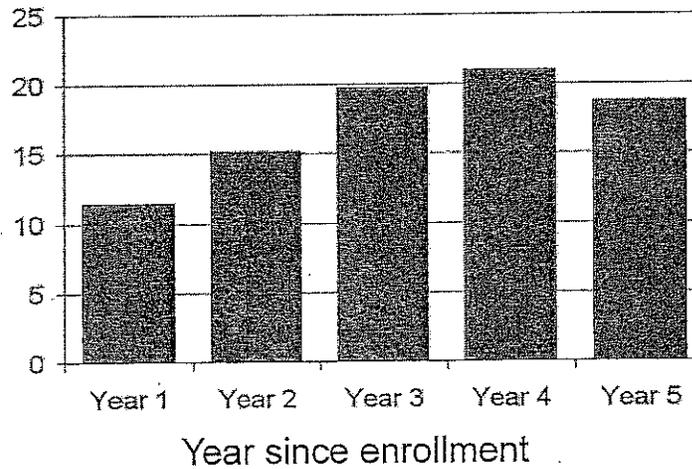
60% Commercially Insured – 40% Publicly Insured

## Variability in practices' patterns of use of MCPAP



Van Cleave, J et al, AACAP Poster 1.37, 2012

### Volume of Calls per Practice (n=248)



Van Cleave, J et al, AACAP Poster 1.37, 2012

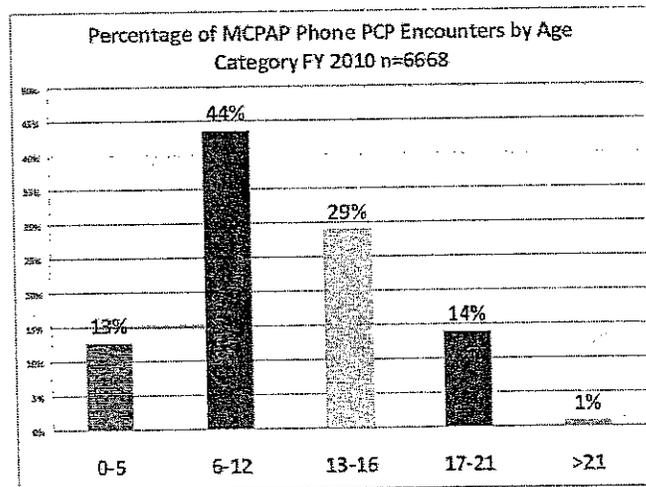
## Engagement Strategies

- Be helpful on every call
- Be in practice
- Personalized, localized
- Care coordination
- Outreach/CME

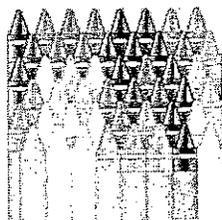
### MCPAP Encounter Types

Activity	FY2012 N = 20,958	Cumulative FY05 - FY 12 N = 106,827
•Phone Consultation with PCP	42%	40%
•Care Coordination	31%	29%
•Face to Face Evaluation	10%	11%
•Phone with Member/Family	10%	10%
•Follow Up Visit	2%	3%
•Other	5%	6%

### Percentage of Encounters by Age



## Types of Consultation Questions



Help!	Screening Support	Therapy Questions:
Diagnostic question	Medication Questions:	-Selection
Treatment planning	-Selection	-Monitoring
Unable to access MH resources	-Side Effects	-Linkages
Need second opinion	-Interim management	

## Reason for contact (% of total calls)

Reason for Contact	FY 2011 N = 7,823	Cumulative April 2008 – June 2012* N = 33,694
Resources –Community Access	36%	36%
Diagnostic	36%	35%
Medication Question	23%	22%
Medication Evaluation	25%	23%
Parent Guidance	4%	6%
Second Opinion	1%	3%
Follow Up	7%	3%
School Issues	2%	4%
Crisis	1%	2%
Other	0%	2%

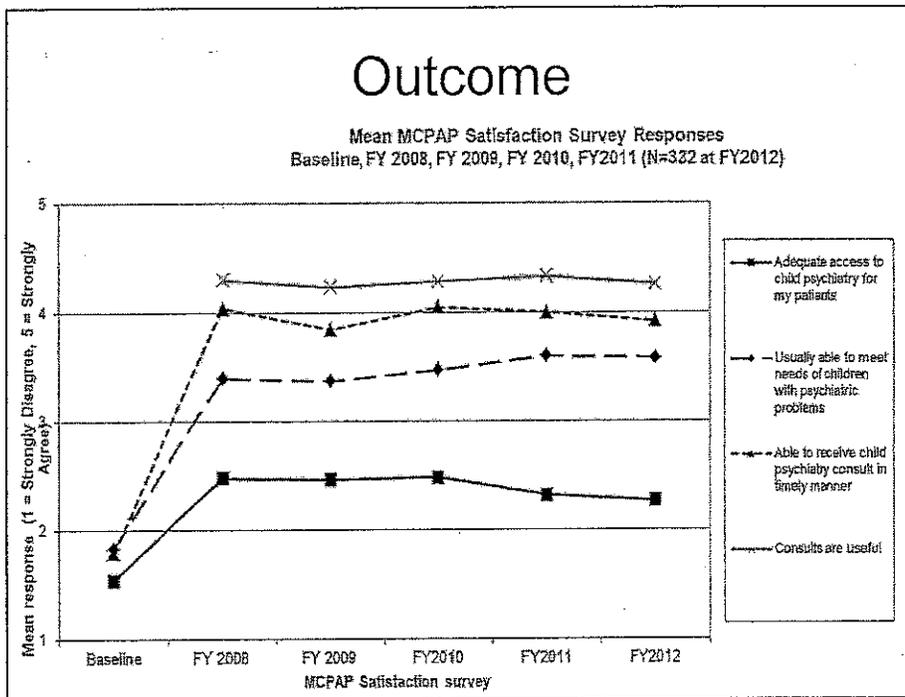
\* Reason for contact field added in April of 2008

## Diagnoses (% of total calls)

Diagnoses	FY 2012 (N=8,706)	Cumulative FY05-FY12 (N=43,131)
ADHD	33%	33%
Anxiety	30%	26%
Depression	24%	24%
Deferred Diagnosis	14%	12%
Oppositional Defiance Disorder/CD	8%	10%
Other	5%	10%
Autism Spectrum Disorder	6%	6%
Adjustment Disorder	4%	4%
Mood Disorder NOS	6%	4%
Bipolar	2%	4%
Post Traumatic Stress Disorder	2%	3%
Obsessive Compulsive Disorder	2%	3%
Substance Abuse	1%	2%
Eating Disorder	1%	2%
Developmental Delay	1%	1%
Psychosis	0%	1%

## Medications (% of total calls)

Medications	FY 2011 N = 7,823	Cumulative FY05-FY11 N = 32,372
None	59%	51%
Stimulant	21%	21%
SSRI	15%	16%
Atypical Antipsychotic	4%	4%
Alpha Agonist	5%	4%
Other	3%	4%
Benzodiazepine	2%	2%
Other Mood Stabilizer	1%	1%
Atomoxetine	1%	1%
Other Antidepressant	1%	1%
Wellbutrin	1%	1%
Depakote	0%	1%
SNRI	0%	0%



### Pediatricians' Perceptions of an Off-Site Collaboration With Child Psychiatry

CITATION INFORMATION  
 10.1093/psp/psp022  
 © The Author(s) 2012  
 Published by Oxford University Press  
 DOI: 10.1093/psp/psp022  
 www.oxfordjournals.org/doi/abs/10.1093/psp/psp022

R. Christopher Sheldrick, PhD<sup>1</sup>, Kathryn Mattern, BA<sup>1</sup>,  
and Ellen C. Perrin, MD<sup>1</sup>

	Mental Health Resource				
	MCPAP (%)	Community MHD Clinicians (%)	Assessment Center (%)	OT/SRL (%)	EI/School (%)
<b>A. Frequency with which each resource was used for:</b>					
Advice or informal consultation					
For children 0-5 years	26	26	31	31	59 <sup>b</sup>
For children 6+ years	47	39	27 <sup>b</sup>	19 <sup>b</sup>	32 <sup>b</sup>
Developmental or mental health evaluations					
For children 0-5 years	24	34 <sup>b</sup>	48 <sup>b</sup>	38 <sup>b</sup>	78 <sup>b</sup>
For children 6+ years	42	58 <sup>b</sup>	42	27 <sup>b</sup>	43
Medication consult					
For children 0-5 years	36	28 <sup>b</sup>	37	—	—
For children 6+ years	50	48	27 <sup>b</sup>	—	—
Behavioral treatment or therapy					
For children 0-5 years	22	51 <sup>b</sup>	38 <sup>b</sup>	28	49 <sup>b</sup>
For children 6+ years	30	68 <sup>b</sup>	29	26	25
<b>B. Satisfaction with mental health resources</b>					
How often [resource] provides feedback					
For children 0-5 years	66	38 <sup>b</sup>	68	61	66
For children 6+ years	65	35 <sup>b</sup>	56 <sup>b</sup>	51 <sup>b</sup>	22 <sup>b</sup>
How often [resource] provides services in a reasonable time period					
For children 0-5 years	67	20 <sup>b</sup>	11 <sup>b</sup>	52 <sup>b</sup>	67
For children 6+ years	66	24 <sup>b</sup>	12 <sup>b</sup>	45 <sup>b</sup>	32 <sup>b</sup>
How often services are satisfactory to PCPs and parents					
For children 0-5 years	73	57 <sup>b</sup>	69	72	72
For children 6+ years	73	62 <sup>b</sup>	69	66 <sup>b</sup>	48 <sup>b</sup>
How often respondents' has ongoing conversations about patients					
For children 0-5 years	30	14 <sup>b</sup>	09 <sup>b</sup>	11 <sup>b</sup>	14 <sup>b</sup>
For children 6+ years	31	18 <sup>b</sup>	12 <sup>b</sup>	12 <sup>b</sup>	12 <sup>b</sup>



## An assessment of satisfaction with ambulatory child psychiatry consultation services to primary care providers by parents of children with emotional and behavioral needs: the Massachusetts Child Psychiatry Access Project University of Massachusetts Parent Satisfaction Study

Yael Dvir\*, Melodie Wenz-Gross, Mary Jeffers-Terry and W. Peter Metz

Psychiatry/Child and Adolescent Psychiatry, University of Massachusetts Medical School, Worcester, MA, USA

**Edited by:**

Anne Glowinski, Washington University School of Medicine, USA

**Reviewed by:**

Natasha Madan, St. Louis Children's Hospital, USA  
Elise M. Finkelstein, Hepatobiliary Children's Clinic, USA

**\*Correspondence:**

Yael Dvir, Psychiatry/Child and Adolescent Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655, USA.  
e-mail: yael.dvir@umassmed.edu

This study evaluated parents' experience with University of Massachusetts (UMass) Child Psychiatry Access Project (MCPAP), a consultation service to primary care providers (PCP), aimed at improving access to child psychiatry. Parent satisfaction questionnaire was sent to families referred to UMass MCPAP by their PCP, asking about their concerns leading to the referral, the satisfaction from the service provided, adequacy of the follow up plan, and outcome. Seventy-nine percent of parents agreed or strongly agreed that the services provided were offered in a timely manner. Fifty percent agreed or strongly agreed that their child's situation improved following their contact with the services. Sixty-nine percent agreed or strongly agreed that the service met their family's need. The results suggest moderate to high parental satisfaction with MCPAP model, but highlight ongoing challenges in making successful referrals for children's mental health services in the community, following MCPAP recommendations.

**Keywords:** child psychiatry, primary care, consultation liaison, parent satisfaction

## Dvir et al. study

368 surveys sent out, 158 returned (44% response rate)

25% phone consult, 75% face-to-face visit

**GENERAL OUTCOME**

Services helped deal with issues more effectively (n = 128)

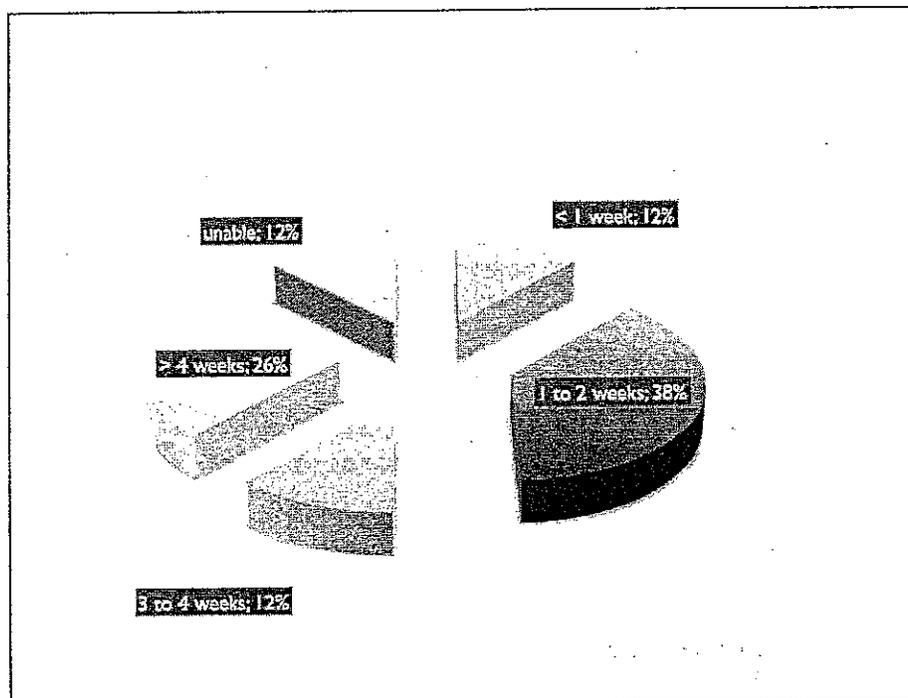
% Strongly agree	24.2
% Agree	34.4
% Undecided	22.7
% Disagree	10.2
% Strongly disagree	8.5

Service met family need (n = 123)

% Strongly agree	31.8
% Agree	37.2
% Undecided	14
% Disagree	6.2
% Strongly disagree	10.9

Situation improved following contact with service (n = 124)

% Strongly agree	25
% Agree	25
% Undecided	24.2
% Disagree	17.7
% Strongly disagree	6.1



### MCPAP as Statewide Vehicle for Quality Improvement

- Use of Standardized BH screening tools
- Screening of children of military families
- Use of national guidelines (GLAD-PC)
- Promotion of court ordered services (Rosie D.)
- Improving management of teen substance use as part of recently received state CMS SIM grant.
- Research

# Screening

Outcomes of MCPAP PCC Screening Tool Implementation  
 Number of surveys mailed = 828  
 Number of respondents who did not use MCPAP = 15  
 Number of responses analyzed = 288  
 FY 2009

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
I have increased my ability to use behavioral health screening tools	4%	14%	25%	48%	9%

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Massachusetts Child Psychiatry Access Project



Connecting Primary Care with Child Psychiatry

**WELCOME**

Order a free supply of "How's Your Child's Mental Health?" brochures in English and/or in Spanish. PCC Plan providers, click here to order. All others click here to order.

**MCPAP SPOTLIGHT**

The National Network of Child Psychiatry Access Programs (NNCPAP)  
 MCPAP has launched a new national network of child psychiatry access programs. This organization's current administrative home is at the Johns Hopkins Center for Mental Health Services in Pediatric Primary Care. To find out more about this dynamic and innovative organization, please click here.

MCPAP Improves Access to Child Behavioral Health  
 Click here to view our 2011 primary care clinician satisfaction survey.

**FEATURES**

Clarification of the August 2011 FDA Orange Alert  
 Click here.

Identifying Post-Traumatic Stress Disorder (PTSD) in Children and Adolescents  
 Identifying Post-Traumatic Stress Disorder (PTSD) in children and adolescents is challenging given its variable presentation in this age group. Adding to the difficulty is the fact that the child is often reluctant or unable to discuss traumatic exposures. However, early detection and initiation of treatment is key to recovery. Pediatricians are in a unique position, in treating children and their families, to recognize the presence of PTSD. Click here to learn more about PTSD in the pediatric population.

**TOOLKIT SPOTLIGHT**



A Toolkit for the Well Child Screening of Military Children  
 The Red Sox Foundation and Massachusetts General Hospital Home Base Program in partnership with The

**RESOURCES FOR THE MEDICAL HOME**

Massachusetts Child Psychiatry Access Project (MCPAP) enrolled practices may call MCPAP for questions pertaining to behavioral health issues.

Don't know which MCPAP number to call??  
 -click here to find out which MCPAP region to call.

Practice not enrolled with MCPAP? Click here to begin the process of MCPAP enrollment.

Click here for a quick reference guide to Children's Behavioral Health Initiative (CBHI) services from the Children's Low Center of Massachusetts.

Click here to find directories of behavioral health providers.

Click here for help on navigating the special education system in Massachusetts.

The statewide number for Emergency Service Programs/Abuse Crisis is 1-877-562-1909.

[www.mcpap.org](http://www.mcpap.org)



*4th Annual Child Psychiatry in Primary Care*  
**After the Screen... Assessment and Treatment Planning  
 for Kids Identified at Risk for Psychiatric Problems  
 in the Primary Care Setting**

By participating in this program, you should be able to:

1. Explain how to interpret mental health screening instruments.
2. Discuss the mental health reform initiatives currently underway through the MA Department of Mental Health.
3. Discuss assessment and treatment planning for children with anxiety disorders.
4. Discuss assessment and treatment planning for children with depressive disorders.
5. Discuss assessment and treatment planning for children with ADHD, oppositional defiant disorder.
6. Discuss assessment and treatment planning for children with substance abuse disorders.
7. Discuss assessment and treatment planning for children with autism spectrum disorders.
8. Discuss mental status examination procedures to rule out high risk mental health problems including juvenile mania, psychosis, and suicidal ideation.

### Program

8:00 Registration & Refreshments

8:30 Welcome and Introduction  
Barry Sarvet, MD

8:45 The Massachusetts Children's Behavioral Health Initiative  
John Swanson, MD

9:45 Coffee Break

10:00 Workshops  
(each will be offered twice)

A. Advanced Mental Status Exam  
Barry Sarvet, MD

B. Substance Abuse  
Ranna Parakh, MD, MPH

C. Depression  
Bruce Waslick, MD

D. Anxiety Disorders  
Lisa Namerow, MD

12:30 Workshops

E. Depression  
Bruce Waslick, MD

F. Anxiety Disorders  
Lisa Namerow, MD

G. Disruptive Behavior Disorders  
John Fenton, MD

H. Autism Spectrum Disorders  
Joseph Gold, MD

2:00 Refreshment Break

2:15 Workshops

I. Autism Spectrum Disorders  
Joseph Gold, MD

J. Advanced Mental Status Exam  
Barry Sarvet, MD

K. Substance Abuse  
Ranna Parakh, MD, MPH

L. Disruptive Behavior Disorders  
John Fenton, MD

## References

- Sarvet B, Wegner L. Developing Effective Child Psychiatry Collaboration with Primary Care: Leadership and Management Strategies. *Child Adolesc Psychiatr Clin N Am*. 2010 Jan;19(1):139-48
- Sarvet B, Gold J, Straus J. Bridging the Divide between Child Psychiatry and Primary Care: The Use of Telephone Consultation within a Population-Based Collaborative System. *Child Adolesc Psychiatr Clin N Am*. 2011 Jan;20(1):41-53.
- Sarvet B, Gold J, Bostic JQ et al. Improving Access to Mental Health Care for Children: the Massachusetts Child Psychiatry Access Project. *Pediatrics*. 2010 Dec; 126: 1191-1200.
- Rosie D. and Mental Health Screening: A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit, TeenScreen National Center for Mental Health Checkups at Columbia University, Fall 2010
- The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment In Primary Care, Wendy Holt, Commonwealth Fund, Publication 1378, Volume 41, March 2010

# **DRAFT - Project Design for Connecticut ACCESS-MH**

(March 12, 2013)

## **Overview**

The goal of ACCESS-MH is to ensure that all youth in Connecticut have child psychiatry and behavioral health services that are accessible through their primary care providers (PCPs). ACCESS-MH is an acronym for Access to all of Connecticut's Children of Every Socioeconomic Status – Mental Health. ACCESS-MH will provide PCPs with timely access to child psychiatry consultation and, when indicated, care coordination and transitional services into ongoing behavioral health care. ACCESS-MH will be available to all children and families, regardless of insurance status, as long as the point of entry is through their PCP. ACCESS-MH will operate from 9 a.m. to 5 p.m., Monday thru Friday, and is not meant to replace necessary emergency services. Through ACCESS-MH, 3 hubs, each with a child psychiatrist, social worker and care coordinator will provide assistance to PCPs in accessing psychiatric services. ACCESS-MH will be regionalized to facilitate an ongoing relationship between the ACCESS-MH hub and the PCP. The regional ACCESS-MH hub will provide training and continuing education to maximize the appropriate division of activities between PCP, the ACCESS-MH hub, and routine behavioral health services. The Connecticut Behavioral Health Partnership will provide program oversight, data analytic services, measurement of outcome, and reports to the state and stakeholders.

ACCESS-MH is modeled after the success of the Massachusetts Child Psychiatry Access Project (MCPAP). This model recognizes that increasing PCP ability to manage behavioral health issues requires a close mentoring, educational relationship between consultant and PCP in which the consultant always has the PCP's back. The motto to the PCP is "call as often as you need". The consultant can walk the PCP through situations they should be able to manage but also provide help with referral when the situation is more complex than reasonable for the primary care setting.

## **Regional Hub Design and Activities**

The state will be divided into three regional hubs. The need for three hubs was based on the experience in Massachusetts that each hub can manage a population of children of between 250,000 and 300,000. Based on 2010 census data, Connecticut has 819,210 children under the age of 19. With 3 teams the average population covered per team would be 273,070.

Each regional hub will consist of one FTE of child psychiatrist, one FTE of a licensed social worker, 1.2 FTEs of a care coordinator, and appropriate administrative support. Each hub will build relationships with the PCPs in their region to provide psychiatric telephone consultation, often immediately, but at least within 30 minutes Monday through Friday from 9 a.m. to 5 p.m. The consultation will result in one of the following outcomes depending upon the needs of the youth and family:

1. An answer to the PCP's question;
2. Referral to the hub care coordinator to assist the family in accessing routine, local behavioral health services;
3. Referral to the hub social worker to provide transitional face-to-face care or telephonic support to the Member and family until the family can access routine, local behavioral health services;

4. Referral to hub child psychiatrist for an acute psychopharmacologic or diagnostic consultation.

The regional ACCESS-MH hub will also provide PCPs with training and behavioral health continuing education. Although much of this education will occur during telephone consultations around specific members, the hub will be available for “brown bag” or other types learning sessions at the PCP office, regional grand rounds, or CME sessions and conferences. ACCESS-MH recognizes that individual PCPs are able to manage behavioral health cases of varying complexity. The relationship of the PCP – ACCESS-MH hub will accommodate that variability.

The geographic arrangement of regional hubs will seek to maximize existing PCP – child psychiatry relationships, particularly those within integrated health systems. Additionally, some PCPs with onsite behavioral health services may not need the assistance of ACCESS-MH. In order to facilitate transition into routine care, each hub will develop knowledge of local behavioral health capacity and expertise. .2 FTE of the care coordinator (suggest using a family member with lived experience) will work in the evening to call families referred for behavioral health services to monitor follow up with keeping of appointments.

PCPs will be expected to understand the ACCESS-MH program rules and limits. This includes continuing to manage appropriate cases in the primary care setting, participating in training and continuing education, and completing annual evaluation surveys.

Each hub will maintain an appropriate clinical setting for the social worker and psychiatrist to see youth needing face-to-face consultative or transitional services with the care coordinator as the receptionist.

Although it is expected that a hub will probably have its one FTE of child psychiatry split between several child psychiatrists or registered nurse clinical specialists (RNCS) who are each part-time with the program, each hub will appoint one psychiatrist as a regional medical director. Additionally, each hub will designate an individual to be administratively accountable. Medical directors and administrators will meet at least monthly (telephone or face-to-face) to guide the program.

Experience from Massachusetts has shown that all face-to-face visits must be only consultative in order to keep the system from backing up. Consultants will not write prescriptions but if medication is necessary, the consultant will decide if the PCP or a specialist should manage the medication. Each hub will use insurer-based network management resources to assist in maintaining appropriate access to routine behavioral health services.

Hub consultants will be aware of standard behavioral health screening instruments and support their use in all primary care practices. Each hub will reinforce any statewide effort to implement universal behavioral health screening.

See Attachment 1 for summary of hub contractual requirements.

### **Administrative Structure**

The Connecticut Behavioral Health Partnership (CT-BHP) will administer ACCESS-MH. CT-BHP will employ a .5 FTE program director and a .5FTE data analyst; CT-BHP will also employ

or contract through one of the hubs a .2FTE child psychiatrist medical director. CT-BHP will negotiate contracts with each hub and hold each hub accountable to deliver agreed upon services.

CT-BHP will set up an advisory committee for ACCESS-MH with participation from all stakeholders including pediatricians, family physicians, child and adolescent psychiatrists, family/behavioral health advocates, public and commercial insurers, the local chapters of the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry, other appropriate associations, and state government. The advisory committee will communicate initially to discuss program specifications and then periodically but not less than twice per year to review program evaluations and recommend any modifications.

CT-BHP will use a secure electronic medical record system developed in Massachusetts to collect data from the regional hubs. CT-BHP will then aggregate de-identified data into a central database for both financial and program analysis and evaluation.

CT-BHP will administer an annual survey to assess program quality and outcome beginning with a pre-start survey to create a baseline to measure improvement.

CT-BHP will perform at least quarterly site visits to each hub.

CT-BHP will provide a quarterly report to each hub listing practices that have not used the service in the past quarter. This list is used by the hub to reach out to those practices to ensure that they are meeting all the behavioral health needs of their patients and encourage them to use program.

CT-BHP will provide a public website and a newsletter to all PCPs and interested parties.

CT-BHP will meet hold a statewide meeting of all hub staff at least annually to review program, develop cohesiveness and consistency between hubs, and brainstorm around future improvements.

CT-BHP will provide a brochure for PCPs to use in their office to encourage youth and families to raise behavioral health issues because of having the support of ACCESS-MH.

CT-BHP will join the National Network of Child Psychiatry Access Programs (NNCPAP) to share experiences with other states doing similar work and take advantage of national best practices.

### **Finance**

Each ACCESS-MH hub will be paid monthly by CT-BHP, based on an annually negotiated rate between CT-BHP and the regional hub's parent organization depending on specific staffing and administrative overhead. As an off-set to the CT-BHP payments, face-to-face visits will be billed to applicable third-party insurers, and payments received will be reconciled on a quarterly basis. From these collections, 75% will offset CT-BHP funding, and 25% will remain with the regional hub.

CT-BHP administrative and regional hub contracted expenses will be negotiated annually with DCF.

A sample budget for each hub and the overall program is Attachment 2.

## Expected Outcomes and Evaluation

The goal of ACCESS-MH is to efficiently and effectively eliminate perceived and real difficulties with timely access to child psychiatry services. This project will assume that improving access will lead to better behavioral health outcomes. Therefore, the expected outcomes for ACCESS-MH are as follows:

<b>Expected Outcome</b>	<b>Type</b>	<b>Measure</b>
Full utilization of hub resources.	Process	Analysis of Encounters
All PCPs will have ACCESS-MH coverage.	Process	PCP Initial Agreement
PCP satisfaction with program and access to BH services.	Outcome	PCP Survey
Member/family satisfaction with program and access to BH services.	Outcome	Member/Family Survey

Additionally, working with NNCPAP, ACCESS-MH will explore measuring change in PCP knowledge, skills, and attitudes towards managing behavioral health problems.

Attachment 3 is a sample encounter form that allows analysis of productivity. To maintain HIPAA compliance, all personal identifiable information will be encrypted and only available to the regional hub. Attachment 4 is to be completed by each PCP when they agree to participate in the program. This form will allow calculation of costs per youth and penetration rates.

## Implementation

CT-BHP will work with stakeholders and providers to obtain three regionally-based teams that can assure statewide coverage. All interested parties will have an opportunity to discuss participation in ACCESS-MH. Medical centers with ongoing relationships with PCPs and with academic experience running programs and providing education are preferred both programmatically and also to not remove the limited availability of community based child psychiatrists. CT-BHP will decide final participation based on geographic coverage, ability to fulfill program specifications, and acceptance of financial terms.

Each regional hub will sequentially engage PCPs in order to allow time for initial on-site orientation and training. This orientation visit is best done during a practice staff meeting so that everyone in the office is oriented to the program. All PCPs will sign a PCP Initial Agreement (Attachment 4). High volume PCPs will have priority. School based health centers and other places of care can enroll as long as they have a PCP who is able to diagnose and prescribe for behavioral health problems.

## **DRAFT - Specifications for Hub Contracts – Attachment 1**

### **Child Psychiatrist**

- All child psychiatrists must be board certified or eligible and skilled in psychopharmacology.
- One child psychiatrist will be designated as medical director for each hub.
- RNCSs may participate provided at least one child psychiatrist
- One individual will be on call from 9 a.m. to 5 p.m. Monday thru Friday.
- Hub member on call will at all times carry beeper/cell phone and be accessible within 30 minutes.
- Hub member on call will not be engaged in uninterruptible activities such as psychotherapy.
- The child psychiatrist will make an on-site visit to each PCP practice at least annually.

### **Social Worker**

- Must be licensed.
- Supports the care coordinator in understanding different referral resources
- Must engage only in consultative or short-term transitional care.
- Must be knowledgeable of local behavioral health resources.
- May be psychologist.

### **Care Coordinator**

- Works with hub to coordinate and maintain schedules.
- Manages registration and billing of patients requiring face-to-face visits.
- Arranges appointments with local behavioral health providers.
- Insures collection of encounter data.
- Follows up with family to make sure referral is successful.

### **Hub**

- Each hub will provide appropriate, accessible space for seeing Members.
- All hubs will be able to bill major third-party insurers.
- All hub employees will have the skills necessary to work as a hub so that responses to the PCP community are consistent.
- Hub will be supportive to all local behavioral health organizations without preference to any organization associated with that hub.
- Hub will be knowledgeable about cultural competencies of local behavioral health providers.
- Hub will keep track of waiting times for access to local behavioral health services.
- Each hub will provide and maintain appropriate computers to have secure VPN connection with CT-BHP.
- Each hub will designate an administratively accountable individual.
- Each hub will cooperate with monthly meetings of medical directors and administrative leaders.
- Each hub will have a single number to access the on-call consultant.
- Each hub will be knowledgeable of requirements of local school systems for behavioral health information.
- Each hub will have a standard orientation curriculum for PCPs, to include at a minimum: how to use the hub; orientation to community behavioral health services; and prescribing information and side effects for common psychotropic medications.

**ACCESS-MH Financial Model – Attachment 2**  
**Draft 3/11/13**

**Hub Expense**

FTE	Position	Base Salary	Total
		\$	
1.0	Child Psychiatrist	190,000	\$ 190,000
1.0	Social Worker	\$ 68,000	\$ 68,000
1.2	Care Coordinator	\$ 40,000	\$ 48,000
		\$	
0.1	Administrator	110,000	\$ 11,000
	Salary without Benefits		\$ 317,000
	Benefits (%)	28%	
	Salary with Benefits		\$ 405,760
	Office Expense		\$ 50,000
	Direct Hub Expense		\$ 455,760
	Indirect Percent	12%	
	<b>Total Team Expense</b>		<b>\$ 510,451</b>
	Number of Teams	3	
	<b>Total Hub Expenses</b>		<b>\$ 1,531,354</b>

**CT-BHP Expense**

0.5	Program Manager	\$ 75,000	\$ 37,500
0.5	Data Analyst	\$ 60,000	\$ 30,000
	Total Salary		\$ 67,500
	Benefits	22%	\$ 14,850
	CT-BHP Salary		\$ 82,350
	CT-BHP Newsletter/Web		\$ 20,000
	Meetings/Travel		\$ 5,000
	Miscellaneous expenses		\$ 10,000
	<b>Total CT-BHP Expense</b>		<b>\$ 117,350</b>

**Program Medical Director**

		\$	
0.2	Child Psychiatrist	210,000	\$ 42,000
	With Benefits		\$ 53,760

Program Direct Expense		\$ 1,702,464
Program Indirect Expense (CT-BHP)	6%	\$ 102,148

**Total Program Costs** **\$ 1,804,611**

Number of CT youth	819,210	
Cost per Youth per Year		\$ 2.20

**DRAFT ACCESS-MH Encounter Form – Attachment 3**

Date of Service	(MM/DD/YY)		Time of Service	(HH/MM)	
Patient Name			No Name	Male	Female
Patient Age	Patient DOB		Patient/Family Phone		
Provider			Provider ID		
Provider Type	MD	RNCS	Licensed Therapist	Care Coordinator	
Practice Name			Practice ID		
PCP					
<b>Insurance (circle)</b>	<b>Add Specific Connecticut Plans/ None/ Unknown</b>				
<b>Activity</b> (Choose only one activity per encounter.)	Phone PCC	Phone Other	Phone Member/Family		
BH Network Mgmt	Face-to-Face Visit		Care Coordination		
ER Follow Up	Ind Follow Up Visit	Family Visit	Crisis Visit		
Care Coordination	Case Conference	Case Supervision	Non Pt Specific Consultation		
	Hallway PCC	Hallway Other	CME	E-Mail	
<b>Medication Change</b>	Yes	No	Not Applicable		
<b>Length of Service</b> (minutes)	5	10	15	20	
	30	45	60	90	120
<b>Outcome</b>	<i>Medication Outcomes – For Phone PCC activity, you must choose at least one Medical Outcome</i>			<i>Other Outcomes- You may choose an additional Other Outcome</i>	
<i>You may choose more than one outcome.</i>	PCP	Psychopharm Eval	Therapist Appt - MCPAP		
	Refer to an Existing Psychiatrist	Refer to a New Psychiatrist	Therapist Appt- Outpt		
	Avoid Crisis Visit	Care Coordination	Bridge Treatment with PCP		
	MD Appt.	Inpatient	ESP	None	
<b>Diagnosis</b>	ADHD	Depression	OCD	SA	
	ODD	Bipolar	PTSD/trauma	PDD/ASD	
	CD	Anxiety	Psychosis	DD	
	Adjustment Disorder	Eating Disorder	Deferred Diagnosis	Mood Disorder NOS	
	Aspergers	Ages and Stages	Diagnosis Comorbidity	Other _____	
<b>Medication</b>	Stimulants	Other Antiidepressant	Atomoxetine	Depakote	
	SSRI	Other Mood Stabilizer	Wellbutrin	Benzodiazepine	
	SNRI	Other Antipsychotic	TCA	Atypical Antipsychotic	
	Lithium	Alpha -Agonist	No meds after encounter		
<b>Medication Options</b>	Increase meds	Decrease meds	Refer med treatment	Start first meds	
	Change meds	No meds before encounter	Taper off meds	Add meds	
	Med Other	Non --patient specific			



**DRAFT - ACCESS-MH PCP Initial Agreement – Attachment 4**

Practice Name: \_\_\_\_\_  
Practice Address: \_\_\_\_\_  
Practice Type: Pediatrics\_\_ Family Practice\_\_ Peds/Family\_\_ School Based HC\_\_  
Practice Telephone Number: \_\_\_\_\_  
Practice Medical Director: \_\_\_\_\_  
Practice Office Manager: \_\_\_\_\_

Professional FTEs:  
Pediatrician: \_\_\_\_\_  
Family Practitioner \_\_\_\_\_  
Mid-Level Practitioner: \_\_\_\_\_  
Behavioral Health Provider: \_\_\_\_\_

Approximate Child Covered Lives: \_\_\_\_\_

Insurances Accepted ( please check):  
Plan A \_\_\_\_\_ % of Practice \_\_\_\_\_  
Plan B \_\_\_\_\_ % of Practice \_\_\_\_\_  
Plan C \_\_\_\_\_ % of Practice \_\_\_\_\_  
Plan D \_\_\_\_\_ % of Practice \_\_\_\_\_  
Plan E \_\_\_\_\_ % of Practice \_\_\_\_\_

Site #1: Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Provider Names: \_\_\_\_\_

Site #2: Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Provider Names: \_\_\_\_\_

*List additional sites on the back of this sheet.*

We agree to participate in ACCESS-MH with the following regional team:

\_\_\_\_\_

We agree to participate in training at the beginning of the project and continuing education as needed during the project.

We agree to complete periodic satisfaction surveys.

We agree to continue to manage behavioral health care of appropriate cases for the primary care setting following case based education with the team.

We understand that the ACCESS-MH psychiatrist/clinical nurse specialist will not be prescribing medications.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



