

AMERICAN ACADEMY OF  
CHILD & ADOLESCENT  
PSYCHIATRY

W W W . A A C A P . O R G

ACOs & CAPs:  
PREPARING FOR THE IMPACT OF  
HEALTHCARE REFORM  
ON CHILD AND ADOLESCENT  
PSYCHIATRY PRACTICE

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## **INTRODUCTION**

The passage of the *Patient Protection and Affordable Care Act* of 2010 (ACA)<sup>1</sup> brought with it the potential to radically alter the delivery of healthcare within the United States. The ACA was signed into law within two years of the passage of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* of 2008.<sup>2</sup> Together, these Acts lay the groundwork for dramatic improvements in the historically inadequate delivery of mental health services to children and adolescents.

The purpose of this document is to provide the child and adolescent psychiatrist (CAP) with a brief overview of the changes in the healthcare delivery system that are expected to occur as a result of the ACA, and how these changes are anticipated to affect the practice of child and adolescent psychiatry.

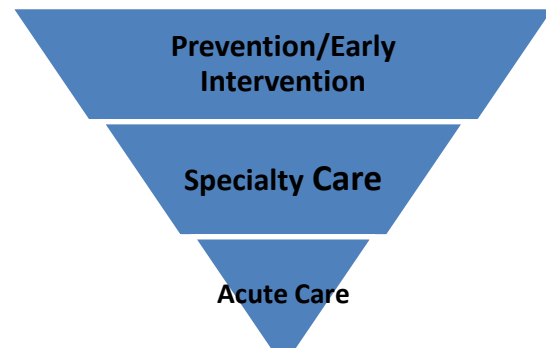
## **THE KEY COMPONENTS OF THE AFFORDABLE CARE ACT**

The following key components of the ACA are intended to expand healthcare coverage to all individuals while improving the quality and efficiency of the healthcare system and controlling the rise in healthcare costs.

*Increased Access:* A major component of the ACA is the requirement for universal healthcare insurance coverage (the individual mandate). Over 8 million children and adolescents were uninsured prior to the implementation of the ACA. When the ACA is fully implemented, not only will all children and adolescents have some form of health insurance coverage, but also all transition-age young adults (ages 18-25). The scarcity of child and adolescent psychiatry resources will persist as a critical issue in the context of the expanded demand for youth mental health services.

*Shift to a Public Health Orientation:* Universal coverage under the ACA will likely adopt a broad public health orientation, which emphasizes health promotion, disease prevention, early identification and intervention, and a greater reliance on community supports. These public health efforts will be driven by population-based approaches (e.g., screening for mental health problems within the primary care setting) to maximize the early identification of children at risk.

*Heightened Attention to Quality and Cost:* Attention to quality and cost will significantly increase under the ACA. Outcomes of care, both at individual and population levels, will be routinely monitored and measured by state and private healthcare entities. In some models, increased reimbursement to providers will be dependent upon the achievement of specific quality indicators.



*Enhanced Information Technology (IT):* The ACA heavily incentivizes the use of healthcare IT, and in some cases provides financial support for its adoption (e.g., the “meaningful use” incentive). In 2015, for providers accepting Medicare reimbursement there will be penalties in the form of reduction in reimbursement for those medical practices that have not implemented electronic medical records. The implementation of HIPAA-compliant electronic communications between providers and families and the use of telepsychiatry for psychiatric assessment, treatment, and provider collaboration are other expected examples of expanded healthcare IT.

*Promotion of Patient and Family-Centered Care:* The ACA supports the delivery of patient and family-centered care through the expectation of greater collaboration between the primary and specialty care providers and greater access to supportive resources, as well as an emphasis on “one-stop” shopping for patients and their families. Patient and family satisfaction surveys will become a routine component of quality measures.

*Emphasis on Healthcare Innovations:* Healthcare innovations that improve access to and quality of care while constraining costs will be rewarded. Practices that support the integration of healthcare services across the spectrum of primary and specialty care and to other service delivery systems (e.g., education, child welfare) are promoted under the ACA. There is expected to be an increased use of evidence-based treatments, a reliance on disease management technologies, and a focus on early identification and treatment. However, all of these changes will ultimately have to prove their worth in the form of a measurable increase in the quality of care delivered within a context of cost containment and reduction.

### **ACCOUNTABLE CARE ORGANIZATIONS – A MANDATE OF THE ACA**

In order to implement the key components of the ACA, the Act mandates the development of Accountable Care Organizations (ACOs). ACOs are well-defined legal entities consisting of a network of individual physicians, physician groups, hospitals, and other entities that provide healthcare to patients, enrolled within a specific insurance plan. The healthcare must be coordinated within the network with the goal of containing costs through the provision of preventive services, reduction in the duplication of services and tests, avoidance of hospital readmission, value-based purchasing, the adoption of integrated electronic medical record systems, and other targeted cost containment provisions as determined by the Centers for Medicare and Medicaid Services. The ACO concept was developed collaboratively by several medical organizations, including the American College of Physicians, the American Association of Family Practice, and the American Medical Association. In 2011, the U.S. Department of Health and Human Services released rules for physicians and hospitals to aid in the establishment of ACOs.<sup>3</sup> Initially, these rules apply only to patients enrolled in Medicare and only for ACOs that can ensure the enrollment of a minimum of 5,000 Medicare patients. The ACA also calls for the initiation of a Pediatric Demonstration Project between 2012 and 2016 that would allow for the development of Pediatric ACOs to provide care for children enrolled in Medicaid and state Children’s Health Insurance Programs. Based on the success of these programs, it is anticipated that fundamental aspects of the ACO model, including payment reform initiatives, will be widely adopted by private insurers.

ACOs must meet National Committee for Quality Assurance (NCQA) standards, which have the overall goal of connecting each patient with “the right provider at the right time”. These standards include:

- Timely access to a sufficient network of healthcare providers (including number and types) to cover primary care, specialty care, urgent/emergent/inpatient care, community and home based services, and long term care;
- Primary care practices that are responsible for patient and family-centered care within a healthcare home;
- Coordinated care across multiple providers with a timely exchange of information during transitions;
- Attention to patient and family rights and responsibilities with a grievance process, as well as a means to protect access to health-related data; and
- Performance reporting that includes data on quality of care, preventive health, patient experience, care coordination and cost, and efforts to improve performance.

### **THE PEDIATRIC HEALTH HOME IN ACOS**

Most ACO models of care delivery promote the concept of a health or medical “home”. Health homes are designed to promote patient and family-centered healthcare through the development of collaborative relationships between primary care, specialists, subspecialists, and hospitals. NCQA requirements state that one of the primary responsibilities of the health home is the provision of mental health services. Mental health interventions in the health home may include patient/parent education, identifying and tracking clinical symptoms with the use of standardized rating scales, monitoring adherence with treatment regimens, and providing brief therapeutic interventions including supportive and behavioral therapies.

The American Academy of Child and Adolescent Psychiatry, in its *Best Principles for the Integration of Child Psychiatry into the Pediatric Health Home*,<sup>4</sup> provides a framework for integrating mental health care into the pediatric health home. The principles upon which this framework is grounded include family-focused care, professional collaboration, care plan development, and care coordination.

The tiered role of CAPs in the context of the pediatric health home can include the following (see full document for details):

1. Preventive Services and Screening
  - a. Educate primary care practitioners (PCPs) regarding the use and interpretation of screening tools
  - b. Enhance PCPs’ knowledge of mental health vulnerabilities and mental health and educational resources
2. Early Intervention and Routine Care Provision
  - a. Provide on-demand verbal consultations to PCPs regarding appropriate evaluation and management of mental health problems
  - b. Provide in-person consultation for mental health problems at the request of the PCP and family

3. Specialty Consultation, Treatment, and Coordination
  - a. Collaboratively with the PCP, develop a patient/family mental health care plan that will be implemented by the PCP with the assistance of a mental health care coordinator
4. Intensive Mental Health Services for Complex Clinical Problems
  - a. Provide psychiatric assessment, clinical formulation, and treatment recommendations for patients referred by PCPs for mental health care
  - b. Collaboratively with the PCP, plan for the return of care to the primary care sector when appropriate

### **NEW OPPORTUNITIES AND CHALLENGES FOR CHILD & ADOLESCENT PSYCHIATRY**

Healthcare reform will entail changes in how CAPs connect with other system stakeholders, patients and families, other providers, insurers, institutions, and government agencies at all levels. No one can predict the extent and magnitude of these changes on the variety of CAP practice settings, though it is anticipated that change will occur sooner and more quickly within large institutions that are seeking to be designated as ACOs. This would include institutions already aligned with managed care organizations, such as public and private clinics that work with Medicare and Medicaid populations, and many academic medical centers. Later, it is anticipated that changes will filter down through private insurers and smaller group practices.

While the ACA ultimately aims to reduce costs within the ‘fee for service’ delivery model, it is not clear what the magnitude or timing of the impact will be on the individual CAP in private practice. In any case, most CAPs are likely to face a number of opportunities and challenges in the context of the anticipated changes.

#### **Opportunities**

- 1) ***Broader public health impact:*** Under the ACA, patient quality and outcomes are likely to be favorably affected by: increased access to mental health services; greater emphasis on prevention and early intervention; improved adherence to evidence-based assessment and treatment; greater use of medical technology to share information, reduce errors, guide treatment, and assess outcomes; and, lower cost of services through a broad range of cost control measures. In the context of the Pediatric Health Home model and its prominent inclusion of behavioral health, CAPs will have an opportunity to work as a team with primary care clinicians and professionals from other child-serving systems to enhance the health and well-being of youth through a broad range of prevention, early intervention, and shared care initiatives. As such, CAPs could broaden their focus from an individual to a public health perspective, and as such, enable a substantially greater impact of CAPs’ practices on children’s mental health.
- 2) ***Enhanced role satisfaction:*** With the ascendance of the integrated care model, CAPs will have an important opportunity to become physician leaders in an evolving health care system. CAPs that are familiar with AACAP’s *Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care* and *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*<sup>5</sup> would be well-positioned to participate at the planning and policy level in the creation of ACOs, Pediatric Health

Homes, and other new healthcare delivery systems. Within an integrated care model, CAPs would have the opportunity to advance their consultation skills, particularly at the interface between physical and emotional health, in the service of closer working relationships with primary care practitioners. CAPs could advance their teaching skills as they educate professionals from other disciplines about mental health issues, and as they oversee other mental health clinicians. By reducing the professional isolation of a non-integrated practice, CAPs are likely to enjoy both increased professional stature by virtue of their unique contributions to the care of the child, and increased work satisfaction by working closely with other professionals in pursuit of shared goals.

- 3) ***Greater family-focused care:*** In accordance with Child and Adolescent Service System Program principles,<sup>6</sup> because family factors play a major role in treatment outcomes, the practice of CAPs will increasingly emphasize family-focused care. In family-focused care, the strengths and needs of the entire family are systematically assessed and subsequently addressed through dyadic and family therapies, parent management training, referral of family members for their own mental health assessment and treatment as indicated, and referral of the family to supportive social services. CAPs' experience with family development and dynamics and their training working within and among various systems of care will reinforce these key aspects of treatment planning and oversight.
- 4) ***Enhanced health information technology:*** Quality control protocols will assume an increasingly important role in the practice of child and adolescent psychiatry. Quality control will likely take a number of forms, from technological advances to an emphasis on evidence-based assessment and treatment, and treatment outcomes. Technological advances will include the ascendance of electronic medical records over paper charts and the attendant possibility of embedded treatment algorithms derived from practice guidelines that will guide practitioners to the safest and most effective care. Embedded medication formularies can automatically raise "red flags" pertaining to dosage, contraindications, or cross-reactivity to reduce medication errors, and can be linked electronically to pharmacies to improve adherence. Technological advances also could include the direct computer entry of historical data and symptom ratings by patients, their parents, and their teachers to reduce the time spent by the practitioner in gathering this information, as well as the electronic sharing of diagnostic impressions and treatment recommendations with other members of the care team and external providers to enhance care coordination. Since many electronic medical record/practice management systems now offer "a patient portal and share medical and psychiatric records with non-psychiatric medical professionals, including patients and families, they will require the implementation of protocols and procedures that protect sensitive patient/family information.

## Challenges

1. ***Change from autonomous practice to team based approaches:*** One of the biggest challenges for CAPs will be a shift from relative professional autonomy as solo practitioners to a team-based approach to care. As the demand for mental health care increases and as cost control measures are implemented, mental health care (and health care generally) will likely shift to a more tiered delivery system in which non-complex care would be delivered by less specialized (and less costly) professionals and paraprofessionals, while more specialized professionals would focus on more complex tasks. Thus in mental health care, social workers and mental health counselors may preferentially provide crisis management, screening, case management and supportive therapy services; advanced practice nurses or nurse practitioners may preferentially provide non-complex psychopharmacology services; psychologists and other licensed clinicians may preferentially provide manualized psychotherapy services; and, child and adolescent psychiatrists may preferentially provide diagnostic, treatment planning, and psychopharmacologic services. Under this tiered model, CAPs would have less control over the type of patients that they attend to and the type of services they provide. Moreover, their practice would likely shift towards the care of the most complex patients.
2. ***Less family and patient interaction, more consultative role:*** In the context of a Pediatric Health Home, the primary care physician (PCP) will likely serve as leader of a multidisciplinary team that attends to the medical and mental health needs of the patients through the collaborative development and implementation of comprehensive care plans. The CAP may play a more consultative role on the team, focusing on the triaging of patients' mental health needs to the most appropriate mental health service provider/level of care. In some situations, the CAP may not be a regular member of the care team; rather a lower-cost professional (likely a social worker) may instead represent mental health. In that situation, the CAP might episodically join the team when children with more complex mental health needs are identified, and participate as an educator and quality reviewer. The CAP would likely assume a leadership role when the care team addresses the needs of children and adolescents with severe and persistent mental illness. For CAPs who have enjoyed the broad range of services that can be provided in an individual practice, this narrowing of roles may feel constraining, and shifting to a more consultative role may limit the opportunity to develop close relationships with patients and their families.
3. ***Loss of autonomy in clinical diagnosis and treatment:*** A shift toward evidence-based assessment and treatment by payers and institutions may require the practitioner to become more adept at integrating the use of structured diagnostic interviews and symptom rating scales to ensure accuracy of diagnoses and to assess response to treatment. The practitioner also will need to become familiar with the recognized standard of treatment as articulated in clinical practice guidelines, which should inform that his/her practice is in conformance with the community standard of care. Moreover, the practitioner will need to become adept at medical literature searches, especially the outcomes of meta-analyses and systematic reviews, to assess the evidence supporting

various treatment options and convey this information to the patient and family, as well as the treatment team.

The outcomes of clinical practice will likely be exposed to closer scrutiny as hospitals, clinics, and other entities begin to systematically collect data on mortality, prevention of re-hospitalization, symptom remission, functional improvement, patient satisfaction, access to and coordination of care, and completion of referrals. Practitioners will likely be required to both report patient and systems outcome data from their practices and hold responsibility for outcomes by creating “plan, do, check, act” remediation protocols when their data fall short of institutional or payer targets.

### **TAKING STEPS TO PREPARE**

The American Academy of Child and Adolescent Psychiatry, in its *Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care*,<sup>7</sup> presents guidelines for understanding, building, and implementing collaborative mental health care partnerships in the primary care setting. The core components of the collaborative process include the following (see document for details):

1. Advocating collaboratively with PCPs to build a strong foundation of awareness and concern among the widest array of stakeholders about the problem of access to children’s mental health services;
2. Partnering with PCPs to develop a collaborative care model;
3. Partnering with families through systematic outreach;
4. Engaging community partners in the development of collaborative relationships;
5. Consideration of the professional characteristics CAPs will need to develop to effectively participate in collaborative care models;
6. Effectively managing the workflow of collaborative partnerships;
7. Program evaluation to demonstrate effectiveness; and
8. Sustainability of collaborative partnerships

By educating, consulting to, and collaborating with the primary care system, CAPs can positively impact the care of many more patients than would be possible through the traditional individual treatment model. CAPs interested in working more directly with primary care can follow many different paths to creating this experience. One preliminary step is building upon (and in some cases repairing) collegial relationships with PCPs. CAPs in private practice often have limited personal connections with PCPs in their communities. This separation may have been protective if the CAP did not have time available to accept the potentially large volume of referrals that may come from the relationship. However, PCPs need to see child psychiatrists as helpful resources if we wish to join with them in care system relationships.

CAPs interested in collaborative care programs, but without access to a fully formed program to simply join, might actively work with their local PCPs to develop a desired collaborative care service. This can start with informal visits and discussions about the primary care medical home (PCMH) with PCP leaders in your community, with community health programs, or with directors from the pediatric and mental health divisions of academic hospitals or medical centers.



Making yourself known to community PCPs engaged in PCMH efforts and informing them of your interest in joining with them may lead to collaboration opportunities. If you are not aware of any PCPs who have this as their special interest, you could contact a local primary care organization such as the state chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) to see if they can connect you with local leaders on the PCMH.

It is also possible to develop experience in collaborative work with small practices on a small scale without incurring any significant financial commitments or the risk of becoming overwhelmed with referrals. Strategies for this include protecting a small block of time to do consultations for a specific pediatric practice to which the CAP grants unique access, offering to provide periodic in-office topic discussions or case conferences to a pediatric practice, or offering “curbside” phone consults during an agreeable time to a small number of PCPs regarding patients for whom they are managing the psychiatric treatment. PCPs understand that CAPs’ practices are very busy due to the workforce shortage and are generally appreciative of any effort to help them and/or to accept even a small percentage of their referrals. CAPs who find they enjoy this way of working can bring their experiences to the larger agencies and to ACOs building out the medical home organization and reimbursement systems, and look to become one of their local mental health partners.

CAPs can also use AACAP as a resource for developing child mental health advocacy efforts<sup>8</sup> and for advice on developing a relationship with the PCMH.<sup>9</sup> Sections of the AACAP website are designed to assist members with advocacy and developing collaborative care programs.<sup>10,11</sup> The AAP Task Force on Mental Health’s *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit*<sup>12</sup> provides CAPs pragmatic information useful in understanding, engaging, and partnering with PCPs

Because the PCPs in the PCMH often have the need for rapid input from a CAP, a system or group of CAPs may be more successful at meeting the needs of primary care practices or an overall ACO system than a solo practitioner who has other clinical commitments could reasonably be. Consulting teams might be multidisciplinary and include psychologists, social workers, and paraprofessional health educators. CAPs well suited for working in collaborative mental health systems include those who enjoy teaching, have good communication skills, are able to tolerate ambiguity and less direct control, are efficient in creating concise and practical consultation notes, and have an interest in prevention and population-based medicine. The types of business arrangements defining these alliances may vary to include informal affiliations, practice organizations made up of individual practitioners with shared overhead, group practices, and employment models. Working with a group of other CAPs will also offer the advantage of allowing for the expenses associated with managing risk contracts and implementing health information technology to be spread out.

For a formal PCMH collaborative treatment relationship to work well, there should be a clear agreement between the CAPs and PCPs regarding the mental health service structure. Formal agreements would include procedures and access standards within the PCMH for: 1) informally accessing CAPs for helping with brief questions arising in pediatric practice; 2) direct CAP

patient consultation (evaluation) for patients managed within the PCMH; 3) triage of patients/families regarding the level of service they need in the PCMH and/or the CAP specialty care system; and 4) assistance with referral and care coordination.

Even with well coordinated patient-centered care supported by both a PCP and a CAP, there will continue to be many patients (i.e., those with more severe disorders) who should be under the principal care of a CAP. CAPs and PCPs will need to work together to identify the patients in need of specialized ongoing child mental health services. Ideally, the PCMH will be able to utilize a care coordinator who can assist the CAPs and PCPs in securing needed ongoing specialist services, beyond what a PCP (with advice from a CAP) should be expected to manage. Linkage with community mental health and other child-serving agencies would be needed and appropriate in caring for the more severely challenged children and their families.

Robust and clear systems for clinical information sharing and communication are essential for collaboration with other healthcare providers. Within the communication system, the confidentiality of mental health information must be ensured and clinical communication among collaborating healthcare providers must comply with relevant state and federal regulations. Ideally, mental health electronic record systems should be a part of, compatible with, and integrate with general electronic health records, allowing CAPs to easily access essential medical information from PCMHs and vice versa. In addition, CAPs should have access to a secure messaging platform allowing them to correspond easily with their pediatric colleagues.

## **CONCLUSION**

It is important that child and adolescent psychiatrists, regardless of the nature of their primary interests and work settings, become familiar with the ACA and its implementation. The ACA builds on priorities shared by CAPs and by AACAP, including the need to increase access to mental health services for children, adolescents, and families, improve the quality of care and clinical outcomes, and contain healthcare costs. In addition, the ACA supports specific values embraced by CAPs and AACAP, particularly care that is child-centered and family-focused, and care that makes use of an array of services and supports to build on child and family strengths and address existing needs. The ACA also offers an opportunity to address such previously elusive public health practices as prevention, early intervention, and mental health promotion.

The implementation of the ACA will change the way mental health care is structured, delivered, evaluated, and reimbursed. It is in the best interests of CAPs to learn about this process and be proactive. Child and adolescent psychiatry training programs must begin to look at their current training methods and curriculum and update them to reflect future practice settings. Establishing collaborative training with pediatric and family residency programs within training programs is one way to begin to mirror future practice. The primary care medical home builds on accumulating evidence that coordinated, integrated care – including primary care that addresses many mental health needs – results in both positive outcomes and consumer satisfaction. The more generic “health home” concept within the ACA also allows for the use of behavioral health homes for those children and adolescents with the most challenging mental health and psychosocial needs, and CAPs need to become familiar with and advocate for these emerging

structures as well. The bottom line is that change is taking place and CAPs need to be informed, prepared, and “at the table.”

As the different elements of the ACA are implemented and the refinement of the nation’s healthcare delivery system continues, AACAP will keep members up to date on how these changes will affect you in your practices. If you have any questions, please contact our Department of Government Affairs and Clinical Practice at 202-966-7300 or visit us on the web at <http://www.aacap.org>.

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<sup>1</sup> [Pub.L. 111-148](#), 124 [Stat.](#) 119, to be codified as amended at scattered sections of the [Internal Revenue Code](#) and in [42 U.S.C.](#)

<sup>2</sup> <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html> for a fact sheet that summarizes MHPAEA.

<sup>3</sup> <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>

<sup>4</sup> [http://www.aacap.org/galleries/default-file/best\\_principles\\_for\\_integration\\_of\\_child\\_psychiatry\\_into\\_the\\_pediatic\\_health\\_home\\_2012.pdf](http://www.aacap.org/galleries/default-file/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf)

<sup>5</sup> [http://www.aacap.org/galleries/default-file/best\\_principles\\_for\\_integration\\_of\\_child\\_psychiatry\\_into\\_the\\_pediatic\\_health\\_home\\_2012.pdf](http://www.aacap.org/galleries/default-file/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf)

<sup>6</sup> [http://www.aacap.org/galleries/PracticeInformation/CASSP\\_Principles.pdf](http://www.aacap.org/galleries/PracticeInformation/CASSP_Principles.pdf)

<sup>7</sup> [http://www.aacap.org/galleries/PracticeInformation/Collaboration\\_Guide\\_FINAL\\_approved\\_6-10.pdf](http://www.aacap.org/galleries/PracticeInformation/Collaboration_Guide_FINAL_approved_6-10.pdf)

<sup>8</sup> For more information on AACAP advocacy, go to: <http://www.aacap.org/cs/advocacy>

<sup>9</sup> [http://www.aacap.org/cs/systems\\_of\\_care\\_and\\_collaborative\\_models/collaboration\\_with\\_primary\\_care](http://www.aacap.org/cs/systems_of_care_and_collaborative_models/collaboration_with_primary_care)

<sup>10</sup> <http://www.aacap.org/cs/advocacy>

<sup>11</sup> [http://www.aacap.org/cs/systems\\_of\\_care\\_and\\_collaborative\\_models/collaboration\\_with\\_primary\\_care](http://www.aacap.org/cs/systems_of_care_and_collaborative_models/collaboration_with_primary_care)

<sup>12</sup> <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Addressing-Mental-Health-Concerns-in-Primary-Care-A-Clinicians-Toolkit.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token>