

Best Principles for Integration of Child Psychiatry into the Pediatric Health Home

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EXECUTIVE SUMMARY

Child and adolescent psychiatric disorders are common, but inadequately addressed by the existing health care system. The pediatric health home* represents an opportunity to increase access to mental health services through the integration of child psychiatry into the primary care setting. Despite the potential for integrated care to enhance the quality of mental health services while controlling costs, the existing health insurance system has so far been unable to adequately support this initiative.

This document is intended to assist health insurance payers and purchasers by providing a framework for integrating and sustaining mental health in the pediatric health home. The principles underlying this framework include mechanisms to support:

- 1) Family-focused care,
- 2) Professional collaboration between primary care providers (PCPs) and child and adolescent psychiatrists,
- 3) Care plan development for children and adolescents with complex mental health needs, and
- 4) Care coordination.

The framework for integrated care is based on levels of severity and complexity of a child's mental health needs and identifies essential care components necessary to support optimal service delivery. These care components should be inherent in high quality pediatric health homes and, when properly implemented, promote the availability and effectiveness of child psychiatric services to children and adolescents with mental illnesses while reducing unnecessary healthcare expenditures.

These care components of integration include:

- 1) screening for and early detection of behavioral health problems;
- 2) triage/referral to appropriate behavioral health treatment;
- 3) ready access to child and adolescent psychiatric consultations, including:
 - a) on-demand, indirect ('curbside') psychiatric consultation to the primary care provider,
 - b) timely, face-to-face consultations with the patient and/or family by the child and adolescent psychiatrist;
- 4) care coordination that facilitates the delivery of mental health services and enhances collaboration with the health care team parents, family, and child-serving agencies;
- 5) access to child psychiatric specialty treatment services for children and adolescents with moderate to severe psychiatric disorders; and
- 6) a mechanism to monitor outcomes at both the individual case and delivery system level.

Significant barriers to collaborative practice exist because current reimbursement practices do not support the necessary consultative care activities and cross-system coordination of care. The current fee-for-service reimbursement system does not allow for payment for child and adolescent psychiatric consultative services, such as visits with parents without the identified

* Throughout the document "pediatric health home" is meant to be interchangeable with "pediatric medical home."

patient, nor does it support consultations between primary care clinicians and child and adolescent psychiatrists. Sustainable funding strategies need to be addressed for optimal effectiveness. Consultative and coordination services should be incentivized and reimbursed as covered benefits in health plans. AACAP encourages health insurance payors and purchasers to evaluate their ability to support the integration of child psychiatric services into the pediatric health home.

INTRODUCTION

Improved access to mental health services for children, adolescents, and their families is a priority for the American Academy of Child and Adolescent Psychiatry (AACAP). With the changes in healthcare delivery and the movement towards coordinated care through a health home, it is important to consider the unique needs of children and adolescents with mental illnesses. This document outlines the best principles for integrating child and adolescent psychiatry into the pediatric health home to provide access to high quality mental health care.

The Need for Mental Health Services in the Pediatric Health Home

- Almost 20% of children in the United States suffer from some form of a mental illness¹ - only 20% of these children receive treatment.²
- Thirteen percent of youth ages 8-15 live with mental illness severe enough to cause significant impairment in their day-to-day lives,³ and this figure jumps to 21% for teenage youth ages 13-18.⁴
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.⁵
- Five percent of children and adolescents suffer from complex illnesses requiring long term treatment.
- The average delay between onset of symptoms and biopsychosocial intervention for children is between 8 and 10 years - critical developmental years in the life of a child.⁶

Opportunities to Improve Access and Care

Recognizing that the role of primary care providers (PCPs) in identifying and treating children with emotional, behavioral and developmental disorders will continue to increase, the American Academy of Pediatrics (AAP) has advocated the integration of many elements of mental health care into the health home. Twenty five percent of children and adolescents seen in the primary care setting and about half of all pediatric office visits involve behavioral, emotional, developmental, psychosocial, and/or educational concerns. Approximately 75% of children and adolescents with psychiatric disorders are seen in the pediatrician's office. As a result, primary care providers are on the front line in the effort to identify, diagnose, and treat psychiatric disorders in children and adolescents. However, there are a number of barriers that impede pediatricians' capability to deliver mental health services, including insufficient time, training, knowledge of local resources, and access to specialists.

¹ National Research Council and Institute of Medicine (2009).

² Mental Health: A Report of the Surgeon General (1999).

³ National Health and Nutrition Examination Survey (2010).

⁴ National Comorbidity Survey Replication—Adolescent Supplement (2010).

⁵ NIMH, Mental Illness Exacts Heavy Toll: Beginning in Youth (2005).

⁶ NIMH (2005).

Early identification of psychiatric, developmental, and substance abuse problems coupled with ready access to mental health services offers the promise of decreasing the utilization of high intensity services. This will also reduce the impact of such disorders on a child or adolescent's ability to function in his or her developmentally appropriate role, and decrease the future cost burden on the child or adolescent's family, such as lost productivity at work. As a result, the cost burden to society as a whole will be lessened.

Child and Adolescent Psychiatrists in the Pediatric Health Home

The AACAP strongly promotes the establishment of collaborative mental health partnerships between child and adolescent psychiatrists and PCPs in the pediatric health home.⁷ Child and adolescent psychiatrists are physicians who specialize in the diagnosis of disorders of thinking, feeling, behavior, and/or development affecting children, adolescents, and their families. Child and adolescent psychiatrists have specific expertise in developing comprehensive biological, psychological, and social treatment plans that may include evidence-based pharmacotherapy and psychotherapy. To support the PCP's efforts in mental health screening, assessing, treatment, and referrals, the child and adolescent psychiatrist should act in a dual role as both the medical specialist and as a bridge to community-based mental health and child-serving services.

Screening, triage, diagnosis, and initiation of treatment in the primary care setting should be done in active collaboration with a child and adolescent psychiatrist and/or allied mental health providers, as needed, to improve service outcomes for children with mental illnesses. There should be active communication and coordination between the pediatric health home and mental health providers in other child systems including schools, child welfare, and the juvenile justice system. Effective treatment also requires ready access to intensive specialty services (e.g., psychiatric inpatient units, crisis stabilization units, residential treatment centers, partial hospitalization programs, wraparound services) for youth with severe and complex mental illness.

PRINCIPLES FOR INTEGRATING CHILD AND ADOLESCENT PSYCHIATRY INTO THE HEALTH HOME

- 1) **Family Focused Care:** Patients and families are essential partners with healthcare providers in identifying strengths and needs, developing comprehensive treatment plans, implementing and evaluating mental health services, and ensuring that services are culturally appropriate. Time spent collaborating with children and parents or legal guardians in developing the care plan should constitute a covered service. In like manner, time spent with families without the child patient present to provide parent education and address parental concerns should also be a covered service.
- 2) **Professional Collaboration:** Effective collaboration between child and adolescent psychiatrists and PCPs must include support for child and adolescent psychiatrists to serve as consultants to PCPs through both direct and indirect service activities.
 - a. **Direct Service Collaboration:** Existing healthcare systems generally allow for some degree of joint direct treatment of affected children. However, there are numerous barriers to this form of collaboration that need to be reformed. Some examples of

⁷ American Academy Child Adolescent Psychiatry (2010). A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care
http://www.aacap.org/galleries/PracticeInformation/Collaboration_Guide_FINAL_approved_6-10.pdf Assessed 2/26/2012

- improved service capacity that should be addressed in healthcare reform standards include:
- i. A reduction of insurance panel barriers. Often a mental health provider is not on the same panel as the primary care physician, creating many barriers to collaboration.
 - ii. Consultative discussion and review of joint cases should be a reimbursable activity for both the specialist child and adolescent psychiatrist and the PCP.
 - iii. Both the child and adolescent psychiatrist and the PCP should be reimbursed for joint time spent with the child and family.
- b. Indirect Service Collaboration: Most existing healthcare systems do not reimburse the broad range of indirect collaborative processes and services that would materially enhance the capacity and effectiveness of primary care mental efforts. Examples of recommended service enhancements include:
- i. Seamless access to medical records across providers, including access to health assessments, laboratory results, diagnostic formulation, treatment plans, consultation communications, and reports.
 - ii. Incentivizing PCPs to advance their skills, knowledge, and attitudes regarding mental health assessment and treatment, as well as child and adolescent psychiatrist as core participants in such educational and skill building activities.
- 3) **Care Plan Development**: Primary health homes face challenges in their ability and capacity to coordinate mental health interventions with other core elements of their child patients' lives, such as schools and other public and private sector organizations (including allied behavioral health providers). Because of their special expertise, child and adolescent psychiatrists should be incentivized to support families and youth in the development of coordinated care plans that include linkages with schools, child welfare agencies, juvenile courts, and other child-serving agencies.
- 4) **Care coordination**: Care coordination is essential for the successful integration of child psychiatric services within the health home because a) mental health services are often administered and reimbursed through a different mechanism than medical services, b) the specialized mental health system is often very complicated and difficult for families to navigate, c) communication between specialty mental health providers and PCPs has historically been poor, and unlikely to improve without structural assistance, and d) for children with complex psychiatric needs, care coordination ensures that all involved parties coordinate their individual efforts for the benefit of the child.

FRAMEWORK FOR THE INTEGRATION OF CHILD PSYCHIATRY INTO THE HEALTH HOME

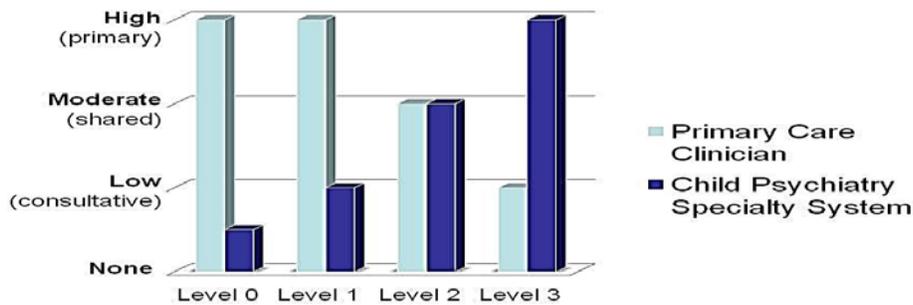
The mental health care components within the pediatric health home include: prevention and screening, early intervention, routine assessment and treatment, specialty consultation, specialized treatment, coordination of services, and monitoring. The allocation of these components across providers varies according to the severity, chronicity, and complexity of mental health problems for individual patients. To meet these responsibilities, the PCP, the consulting child and adolescent psychiatrist, the care coordinator, and the availability of child

psychiatric specialty treatment services will play key roles. Within all levels of service, patients and families are essential partners in care, who will identify strengths and needs, collaborate on developing the plans of care, assist with care implementation, and evaluate the outcome and cultural appropriateness of services.

LEVELS OF COMPLEXITY OF PATIENT’S MENTAL HEALTH NEEDS:

- 0. PREVENTIVE SERVICES & SCREENING:** Applicable to all patients being seen in a primary care practice, to prevent and detect mental health problems.
- 1. EARLY INTERVENTION & ROUTINE CARE PROVISION:** Applicable for patients and families with identified but relatively uncomplicated, high prevalence behavioral health clinical problems. Assessment and management is typically performed by the PCP, with support available from a consulting psychiatrist.
- 2. SPECIALTY CONSULTATION, TREATMENT & COORDINATION:** Applicable for patients with defined behavioral health disorder/problem at intermediate level of risk, complexity or severity, requiring enhanced specialist consultation or intervention. Involves a negotiated management role between PCPs and child and adolescent psychiatrists.
- 3. INTENSIVE MENTAL HEALTH SERVICES FOR COMPLEX CLINICAL PROBLEMS:** Applicable for patients with a defined behavioral health disorder/problem at high level of risk, complexity or severity, requiring specialist consultation or intervention that may include multisystem service teams.

Degree of Provider Responsibility for Mental Health Treatment and Planning



LEVELS DESCRIBED:

0. PREVENTATIVE SERVICES & SCREENING

Example: 13 year old being seen for a well-child check, who has no major presenting concerns

- **ROLE OF PRIMARY CARE PROVIDER**
 - Screen with a regular frequency for mental health, substance abuse, developmental and family psychosocial problems, including difficulties at home, at school, and with peers.
 - Promote parent/youth self-management skills to enhance self-sufficiency to help prevent the onset of illness, and/or to prevent relapse for those in recovery.
 - Provide anticipatory guidance regarding developmental and behavioral health concerns.
 - If necessary, consult with a mental health professional regarding further screening or need for a mental health referral.
 - Refer for further clinical assessment when indicated for diagnostic or treatment services
- **ROLE OF CONSULTING CHILD AND ADOLESCENT PSYCHIATRIST**
 - Educate PCP regarding the use and interpretation of screening tools. Assist in defining decision of when to enhance level of intervention and resource choice.
 - Enhance PCP's knowledge of at-risk vulnerabilities and educational and community mental health resources.
- **ROLE OF CARE COORDINATOR**
 - Assist PCP with administration and tracking of screening assessments.
 - Provide PCP with anticipatory guidance and self-management materials that can be easily distributed to parents, as appropriate.
 - Provide PCP with information about community resources that might be used by parents for common problems; for example, a list of local parenting classes.
- **ROLE OF CHILD PSYCHIATRIC SPECIALTY TREATMENT SERVICES**
 - Maintain an accessible collegial relationship with pediatricians, with capacity to consult and support in care delivery processes as needed.

1. EARLY INTERVENTION & ROUTINE CARE PROVISION

Example: 13 year old being seen for well child check, who has parent-identified problems of impulsivity and poor peer relationships that could be signs of ADHD.

- **ROLE OF PRIMARY CARE PROVIDER**
 - Provide all level 0 PCP activities
 - Provide focused assessment of mental health, substance abuse, developmental and family psychosocial problems, utilizing clinical interview, relevant rating scales and/or other resources.

- Screen for common co-morbid concerns and conditions with the identified problem (e.g., learning disabilities, depression and anxiety, etc.)
- Provide anticipatory guidance and self-management advice regarding the identified problem.
- Provide behavioral recommendations and psychopharmacological treatments, as appropriate.
- Review evaluation/treatment questions via a brief consult discussion with a child and adolescent psychiatrist, as needed.
- Refer for specialty clinical assessment when indicated for diagnostic or acute treatment needs.
- Plan for ongoing monitoring of the child's condition and the efficacy of the interventions made.
- **ROLE OF CONSULTING CHILD AND ADOLESCENT PSYCHIATRIST**
 - Provide all level 0 consulting child and adolescent activities
 - Provide on-demand verbal consultations to the PCP regarding appropriate diagnostic evaluation, behavioral recommendations, consideration of the role of psychopharmacology, and treatment monitoring.
 - Be available for consultation appointments with parent and child, at the request of the PCP that include diagnostic and treatment recommendations.
- **ROLE OF CARE COORDINATOR**
 - Develop a care plan for the identified problem with full participation of the patient and family.
 - Assist the family with the implementation of the care plan
 - Communicate and coordinate with other child serving agencies (e.g., schools, child welfare, juvenile justice, substance abuse).
 - Monitor the implementation and effectiveness of the care plan.
- **ROLE OF CHILD PSYCHIATRIC SPECIALTY TREATMENT SERVICES**
 - Ensure that a child and adolescent psychiatrist is available to perform consultations at the request of the primary care team.

2. SPECIALTY CONSULTATION, TREATMENT & COORDINATION

Example: 13 year old receiving psychotherapy and a medication for depression, being seen by the PCP for follow-up.

- **ROLE OF PRIMARY CARE PROVIDER**
 - Provide all appropriate level 0 and 1 PCP activities.
 - Collaborate with the child and adolescent psychiatrist, who should have primary responsibility for diagnostic and treatment services.
 - The decision regarding primary responsibility for the case will be based both on the child's clinical severity/complexity and the PCP's level of experience and/or expertise.
 - Instead of making case-by-case decisions regarding responsibility, the Pediatric Health Home can choose to establish guidelines regarding whether the PCP or the child and adolescent psychiatrist have primary responsibility.

- Even if a child and adolescent psychiatrist is assigned primary responsibility, this may change back to the PCP over time with improvement in the child's clinical presentation.
 - Collaborate with child and adolescent psychiatrist regarding health maintenance and treatment of medical illnesses.
- **ROLE OF CONSULTING CHILD AND ADOLESCENT PSYCHIATRIST**
 - Provide all appropriate level 0 and 1 consulting child and adolescent psychiatrist activities.
 - Discuss with the collaborating PCP if they will be maintaining primary responsibility for the provision of mental health evaluation and treatment services, or if this role will be assigned to a child and adolescent psychiatrist.
 - In collaboration with the PCP, develop a care plan that care coordinator can assist the team to follow.
 - Even if a child and adolescent psychiatrist is assigned primary management responsibility, this may change back to the PCP over time with improvement in the child's acuity and/or complexity of clinical needs.
 - The child and adolescent psychiatrist who assumes primary evaluation and management of mental health care delivery and coordination of the multidisciplinary team will perform the duties listed in Child Psychiatric Evaluation and Management Services section below.
- **ROLE OF CARE COORDINATOR**
 - Receive and assemble information about the child's diagnosis, clinical formulation and treatment plan.
 - Assist the family with the implementation of the care plan
 - Regularly communicate with the family regarding treatment progress.
 - Provide referral to and coordination with community agencies and other service care providers when indicated, such as the school, community mental health or substance abuse, juvenile justice, and child welfare systems.
 - Provide community collaborators with updates on diagnosis, clinical formulation, care plans and treatment progress.
 - Coordinate the patient's need for ongoing health maintenance and medical treatment (when relevant).
- **ROLE OF CHILD PSYCHIATRIC SPECIALTY TREATMENT SERVICES**
 - Conduct a thorough diagnostic evaluation for mental health, substance abuse, developmental, and family psychosocial problems.
 - Assess for common co-morbid concerns and conditions (e.g., learning disabilities and ADHD, depression and anxiety, etc.).
 - Provide behavioral recommendations, psychotherapy, and psychopharmacology treatments, as appropriate to the clinical scenario.
 - Provide primary care team with updates on diagnosis, clinical formulation and treatment progress.
 - Ask primary care team to assist with medical monitoring, if appropriate for the child's circumstance.
 - Plan for ongoing monitoring and intervention, including scheduling follow-ups.

- Provide PCP and/or care coordinator with regular treatment status updates to enhance service coordination

3. INTENSIVE MENTAL HEALTH SERVICES FOR COMPLEX CLINICAL PROBLEMS:

Example: 13 year old with bipolar disorder, with a history of out-of-home mental health placements, who was recently hospitalized for mania treatment and now needs to be seen post-discharge.

- **ROLE OF PRIMARY CARE PROVIDER**
 - Provide all appropriate level 0, 1 and 2 PCP activities
 - In most circumstances, the PCP will refer mental health management of these children to a child and adolescent psychiatrist.
 - Collaboration with child and adolescent psychiatrist regarding health maintenance and treatment of medical illnesses.
- **ROLE OF CONSULTING CHILD AND ADOLESCENT PSYCHIATRIST**
 - Provide all appropriate level 0, 1, and 2 child and adolescent psychiatrist activities.
 - Be available to conduct a thorough diagnostic assessment of mental health, substance abuse, developmental and psychosocial treatment needs should an ongoing care community psychiatrist be unable to provide that service in a timely fashion.
 - Help the primary care team identify the child's clinical care needs, including the need for intensive specialty services.
 - Advise the PCP on interim management measures (medications, referrals, crisis management, etc.) if there is a delay in initiating treatment with a child and adolescent psychiatrist or other child mental health specialist.
 - Collaborate with the PCP regarding when primary management responsibility for treatment would appropriately move back into the hands of the primary care team, after symptom severity improves.
- **ROLE OF CARE COORDINATOR**
 - Receive and assemble information about the child's diagnosis, clinical formulation, and care plan.
 - After a discharge from a hospital or other intensive specialty service, ensure the PCP and child and adolescent psychiatrist receive a brief summary of the patient's interim history, diagnosis, and response to treatment. Help ensure that appropriate follow up care occurs with PCP and child and adolescent psychiatrist.
 - Assist with referring to a child and adolescent psychiatrist and/or mental health care provider to provide ongoing management of mental health issues
 - Refer to and coordinate with community agencies and other service care providers when indicated, such as the child welfare system, school, juvenile justice, community mental health or substance abuse agencies.
 - Share updates on clinical care with the PCP, including current psychotropic medications, and implementation of and response to psychotherapeutic interventions.

- Coordinate the patient's ongoing health maintenance and medical treatments.
- **ROLE OF CHILD PSYCHIATRIC SPECIALTY TREATMENT SERVICES**
 - Provide all level 2 psychiatric evaluation and management service activities.
 - Collaboratively develop post-discharge care plans with intensive services team, patient and family during a psychiatric hospitalization or other intensive service referral.
 - Provide PCP and/or care coordinator with regular treatment status updates to enhance service coordination.
 - Provide behavioral recommendations, psychotherapy, and psychopharmacology treatments, as appropriate to the clinical scenario.
 - If chronic, severe psychiatric illness:
 - Consult to and help supervise the mental health team coordinating the patient's multi-system care.
 - Consult to the various programs and agencies involved in the child's care plan and help coordinate the interventions provided by various care providers.
 - Within multidisciplinary team discussions about high clinical need children, assume primary responsibility for guiding the development of the child's care delivery and management plan with full participation of the child and family.
 - Recommend and help initiate a child and family ongoing care team, as indicated.
 - Help design and implement a wrap-around service plan, as indicated.

SUSTAINABILITY

The AACAP recommends that sustainable funding strategies be developed for integrating child psychiatry into the pediatric health home. The current fee-for-service financing model does not reimburse non-face to face consultations, care coordination, or the integration of child psychiatry within the health home and community-based systems of care. Furthermore, the health home is not expected nor incentivized to develop coordinated linkages with community partners, including allied mental health providers and other involved agencies, particularly the schools. Alternative mechanisms for integrating care at all levels of service to include capitation, case-rate payments, service contracts, pay-for-performance mechanisms and braided funding across public sector child serving agencies should be considered.

Until new business models for integrating child psychiatric practice into the pediatric health home are available, enhancements to the fee-for-service system should occur. These involve the development of CPT codes for non-face to face services that promote family-focused collaborative care, and changing regulations to allow PCPs to bill for their services in treating primary psychiatric diagnoses.

In order to implement the service levels described in this document, it is essential that the following elements be reimbursed in any financing model:

Primary care provider

- Administration and scoring of screening instruments and protocols for early identification

- Provision of focused mental health assessments and treatment, assistance with parent-youth self-management skills, and anticipatory guidance
- Meetings with family members of the identified patient without the patient present, and provider-to-family communication for care coordination
- No requirement for prior authorization for initial mental health clinical evaluation regardless of whether referred by PCP or by patient directly (i.e., no prior authorization for entry level services)
- Joint evaluations and meetings involving the child and/or family by the child and adolescent psychiatrist with the PCP that are billable by both professionals
- Reimbursement for integrating child psychiatric services into the health home, such as provider to provider collaborative care communication and consultation, provider to family for care coordination, etc.
- Incentivizing PCPs to advance their skills, knowledge, and attitudes regarding mental health care beyond their usual scope of practice
- Reimbursement of mental health diagnostic codes for PCPs with appropriate training and collaborative relationships

Consulting child and adolescent psychiatrist

- Psychiatric consultations with primary care providers without the patient present
- Mental health communication with primary care as an expected and reimbursable activity with appropriate consent/authorization
- Timely, face-to-face consultations with the patient and family by the child and adolescent psychiatrist (or via telepsychiatry)
- Meetings with family members of the identified patient without the patient present
- Joint evaluations and meetings involving the child and/or family by the child and adolescent psychiatrist with the PCP that are billable by both professionals
- Services provided by licensed mental health providers employed in medical and psychiatric group practice will meet “incident to” standards
- Evaluation and management codes to child and adolescent psychiatrists
- Incentivizing child and adolescent psychiatrists to educate PCPs beyond their usual scope of practice regarding their involvement in mental health care

Care coordinator

The care coordinator’s time to perform all functions is an administrative expense, and as such should be accounted for in the financial models for an integrated pediatric health home. Given the complexity of the nation’s health care system, case management is essential to helping patients and their families navigate the care plan and access the appropriate level of psychiatric services (e.g., outpatient, urgent, emergency, inpatient).

Child Psychiatric Specialty Treatment Services

- Access and utilization of intensive, high-end specialty mental health services and levels of care (e.g., hospital, day treatment, residential and intensive community-based wrap around) for children and adolescents with moderate to severe behavioral health problems
- No requirement for prior authorization for initial mental health clinical evaluation regardless of whether referred by primary care or by patient directly (no prior authorization for entry level services)

- Psychoeducational and support groups
- Services provided by licensed mental health providers employed in medical and psychiatric group practice will meet “incident to” standards
- E/M codes usable by child and adolescent psychiatrists

Outcomes Assessment

The AACAP recommends developing and implementing strategies to evaluate the effectiveness of collaborative care services in order to determine that the health home is meeting its established goals. Performance can be measured through the analysis of collaborative care process variables (such as the number and characteristics of consultations and collaborative work), patient follow-up studies to examine specific clinical outcomes, child and family satisfaction, and cost analysis.

CONCLUSION

Integration of child psychiatry into the health home is essential to ensuring access to appropriate, high quality care for children with mental and behavioral health needs. A mechanism to finance this integration of child and adolescent psychiatrists within the health home is needed for this to occur. As the process of developing and funding models for a comprehensive, collaborative health home moves forward, it is important that the process be inclusive and take into account the unique characteristics of the community and its stakeholders.