SYSTEMS-BASED PRACTICE
THE PRIMARY HEALTH CARE SYSTEM

SYSTEMS-BASED PRACTICE: PRIMARY HEALTH CARE SYSTEM OBJECTIVES*

Knowledge
The resident will demonstrate an adequate knowledge of:
1) The definition of medical home and its implication for working with youth, families, and their primary care providers. (1-4,6,7,9-11)
2) Potential cultural disparities in accessing a medical home and how this may affect patient care. (1-4,6,7,9-11)
3) Federal legislation and mandates that impact primary care services for physical health, mental health, developmental delays, and anticipatory guidance for youth. (1-4,7-11)
4) Reasons why primary care has been considered the “de facto mental health system.” (1-6)
5) The traditional child and adolescent psychiatrist consultation-liaison inpatient service versus working with an outpatient primary care physician. (1-4,6,7,9-11)
6) The process of primary care consultation. (1-12)
7) The different rules regarding confidentiality and how they impact patient care. (4,7-12)
8) New models for improving mental health treatment in primary care. (1-4,6,7,9-11)

Skills
The resident will demonstrate the ability to:
1) Successfully use verbal and written communication skills when working with primary care clinicians. (1-6,8-11)
2) Achieve an appropriate transfer of care between primary care physician and child and adolescent psychiatrist. (1-6,8-11)
3) Share target goals, treatment plans, and implications of these interventions with primary care physicians. (1-6,8-11)
4) Share knowledge about mental health-related services, indications, and the role of components of the continuum of care with primary care physicians. (1-6,8-11)
5) Educate the primary care physician about psychiatric diagnoses, indications for treatments, and risks/benefits of treatment. (1-6,8-11)
6) Encourage patients to access and utilize the medical home appropriately. (2,4,5,9)

Attitudes
The resident will demonstrate a commitment to gain knowledge to the following principles:
1) The impact of child psychiatry specialty training and cultures and how it may affect patient care. (4,5,7,9,10)
2) The unique relationship between a primary care physician and a family and the role that primary care providers serve in their health and wellbeing. (5,7,10)

* The parentheses refer to the core competencies for systems-based practice as outlined in the RRC Program Requirements. Please refer to Appendix 1 for the complete list of these competencies.
3) The importance of using resources that exist within the system to provide excellent patient care and promote patient safety. (7,10)

4) The role that communication between the child and adolescent psychiatrist and primary care provider can serve in promoting high quality, safe, and efficacious care. (1-12)

5) The medical home concept can help assure that the youth and family’s medical, developmental, and mental health concerns are managed in a safe and appropriate fashion. (1-12)
OVERVIEW
This module should help the trainee begin to develop an appreciation of the values, mandates, and culture of primary care physician and their treatment of mental illness and psychosocial issues. Primary care providers are often the first professionals in a position to identify developmental, behavioral, and mental health problems. They see children frequently in the first years of life and ideally develop a continuous relationship with a youth and family over the lifespan. However, for multiple reasons, repeated changes in primary care providers may occur especially in high risk populations. A primary care physician can be an invaluable partner with the child and adolescent psychiatrist in the evaluation and treatment process with youth and families. At the completion of this module, a trainee should have a better understanding of the primary care system and also be able to identify the difference between interacting with a primary care physician in an outpatient setting and the traditional inpatient consultation-liaison experience, so that they can apply these principles in their ongoing management of youth in whatever setting they may treat patients.

I. DEFINING PRIMARY CARE
Primary care is typically the “point of entry” for a patient into the health care system. Primary care physicians are trained to provide comprehensive first contact and continuing care for patients with any undiagnosed health concern, regardless of the organ system involved, the diagnosis, or the origin of the problem (biological, psychological, or social). Utilization of appropriate referrals and consultation with other healthcare professionals is the mainstay of ongoing continuous care. Primary care also includes health promotion, disease prevention, health maintenance, and patient and family education. This may occur in a wide variety of health care settings, including outpatient practice, inpatient hospitals, critical care, long-term care facilities, in-home care, etc. Primary care also provides patient advocacy in the health care system and strives to attain effective and efficient care by coordination of services. Primary care physicians may work with physician extenders, such as nurse practitioners and physician assistants, in providing care. This section will highlight some of the roles of primary care physicians who provide care for children and adolescents, namely pediatricians and family physicians. It will also review some considerations of medical decision-making and confidentiality in primary care practice.

Pediatricians
• Trained in evaluation and treatment of children and adolescents.
Patients under three years old account for up to two-thirds of visits due to frequent appointments during the first few years of life.

Patients from ages 5-12 years old are recommended to receive annual well-child visits.

Adolescents are recommended to receive annual well-child visits, but frequently adolescents are seen much less frequently due to a combination of factors including: fewer acute illness episodes, diversification of goals/roles of adolescents, and increased adolescent independence.

- Office visits are short, often 10-20 minutes, and problem-focused. An exception is well-child visits, where there are multiple expectations including physical, developmental, and behavioral screening and needs, anticipatory guidance for parents, and immunizations.
- Variability in whether adolescents are seen alone or with parents, depending on the chief complaint.
- May continue to see patients throughout college, although may be less prepared to address system needs of this population.

Family Physicians

- May evaluate and treat family members of all ages.
- Office visits tend to be short and problem-focused.

Benefits

- Aware of all strengths and weaknesses within the family, including psychosocial, psychiatric, medical, genetic, etc.
- May be able to bolster supports within the family (e.g., helping a parent access services or being able to recognize and treat problems with parents).
- May continue to see patients across the lifespan.

Drawbacks

- Child may not trust physician to maintain his or her confidentiality if the physician is also the physician for their parent or other family member.
- Parent problems may interfere with child appointments.
- Receive less training in childhood disorders than pediatricians.

Decision-Making and Confidentiality in Primary Care

- Age of majority is the age at which youth are able to assume control over their own medical and legal decisions. This varies from state-to-state, ranging from 18-21.
- Rules of confidentiality and ability to consent to medical care vary by state, procedure, and condition.
- Rules regarding medical decision-making vary by condition even within physical health. Specifically, services related to sexual disorders, gynecologic treatment, and obstetric treatment are often separated from other conditions. Pregnancy termination is also a divisive issue, which varies from rules regarding other OB/GYN treatment in different states.
- Mental health and substance abuse also have different rules regarding confidentiality and consent that vary from state to state. Primary care physicians
may understand some of the variation, but may be uninformed or misinformed about others.

- In youth with significant physical, mental health, or developmental disability, medical power of attorney may need to be pursued prior to reaching age of majority in order to assure that parents can maintain continuity of care.
- Primary care providers prioritize patient needs over confidentiality on a more regular basis than mental health professionals.
- Primary care offices are not necessarily confidential spaces.

II. PRIMARY CARE/MENTAL HEALTH INTERFACE

Primary care was first described as the “de facto mental health system” by Regier and colleagues in 1978. The reasons for this are numerous and are outlined in the following section. In order to provide better collaboration with colleagues in primary care, it is essential for the child and adolescent psychiatrist (CAP) to understand the multiple referral sources into the mental health system, the inherent cultural and role differences between the primary care and mental health systems, and the potential gaps between the systems. The medical home model strives to increase communication and collaboration, and bridge the gaps that exist in the interface between primary care and mental health.

Primary care as a first point of entry into the mental health system:

- Primary care is often the first place that behavioral/emotional/psychosocial problems present. Primary care physicians are in a natural position to develop a rapport with families beginning in the child’s infancy and lasting throughout childhood and adolescence during routine well-child visits, which provide multiple opportunities to screen for mental health concerns.
- Schools may suggest a need for treatment, and parents often take these referrals to the primary care physician, with whom they are most familiar and whose role is to give anticipatory guidance on developmental and behavioral concerns.
- Although primary care physicians identify and treat common and less complex problems, they often identify more complex problems that need management beyond their expertise.
- While the mortality from acute medical conditions has declined in the past 50 years, the morbidity from chronic health care problems has increased. The sequelae of premature births as well as federal mandates to screen and identify disabilities through the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) (Title V) have increased the identification and treatment of psychosocial issues in primary care.

Barriers in accessing mental health through the primary care office:

- Insufficient coverage for mental health problems in many commercial behavioral health plans that cover youth.
- Stigma and embarrassment or resentment impact referral to and acceptance of treatment in formal behavioral health programs.
• Rural and underserved areas often have no child and adolescent psychiatrists, resulting in the need for primary care physicians to treat illnesses they might not otherwise treat.
• Low show rates for patients who are referred for specialty care results from the burden of extra specialty care appointments, familial struggles secondary to family members with mental illness (e.g., housing, employment, legal, or other health problems), and the burden of navigating the mental health system.

Cultural differences between primary care and mental health:
• “Watchful waiting” and anticipatory guidance are key parts of the philosophy of the primary care provider, but are not a key element in psychiatric or mental health training.
• Primary care physicians tend to see patients as having a medical home at their practice, and many feel that all information including mental health should pass through them so they can track all health care issues and understand their patients holistically. Even if they don’t know how to evaluate the appropriateness of certain mental health treatments, most still desire information about the treatments that are occurring, especially regarding medication.
• Primary care physicians tend to like referring to specialists that they know so that they can be confident they are sending “their patients” to good providers.
• Primary care physicians have many brief, often 10 or 15 minute, appointments and are accustomed to diagnosing and treating focused medical problems during that time frame. Some may be concerned that addressing mental health problems or psychosocial problems will reduce productivity, especially if they feel a pressure to “diagnose and treat” the mental health or psychosocial problem in one session.
• Primary care physicians desire timely feedback from specialists for acute concerns that they referred the patient. A mechanism for timely feedback is not built into most mental health systems, and CAPs are not currently reimbursed for this activity, often leading to a “disconnect” in communication.
• Confidentiality is traditionally a higher level of concern in the mental health field, and may hamper communication verbally and with regard to accessing patient records.
• Pediatricians get very little required training in the diagnosis and treatment of mental health concerns. Their only specific requirement in residency is 4 weeks of developmental and behavioral pediatrics.

Bridging the Gaps - A history of barriers preventing the development of strong relationships between primary care and mental health systems:
• Lack of reimbursement for either primary care providers or CAPs to communicate with each other.
• Lack of interoperability of electronic medical records between primary care and CAPs.
• Differing levels of training and expertise between CAPs and primary care physicians regarding the medications they are willing to prescribe.
• The tendency of mental health systems to have initial contact with an ancillary provider, such as a therapist, prior to a visit with a prescribing clinician may interfere with the primary care physician’s traditional expectations for specialist consultation.
• Psychiatrists may be concerned that if they open themselves up to a primary care physician they will be overwhelmed with referrals they cannot respond to adequately.

III. THE MEDICAL HOME
A medical home is defined as “a community-based primary care setting that provides and coordinates planned, family/youth-centered, high quality health promotion and chronic-condition management.”9 A medical home is not a physical structure or building, but rather an approach to providing comprehensive primary care. The concept was developed by the American Academy of Pediatrics (AAP) to deliver primary care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including youth with special health care needs.”10 The AAP has adopted the definition of youth with special health care needs as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally”.11 The medical home is also referred to by some organizations for those with chronic health conditions as a health home.

Scope of the Medical Home
• A medical home provides patients with enhanced access to providers and timely, organized care.
• Having a medical home is meant to improve quality and safety by assuring that one physician/practice has access to all up-to-date information regarding the health and development of the patient across multiple systems.
• The primary care office helps the patient as they navigate specialty systems and has records related to all care services that are provided regardless of specialty.
• The medical home model places emphasis on reminding patients of preventive care services, including screenings and immunizations.
• The medical home concept encourages the primary care physician to look beyond the patient’s medical needs and help the family coordinate services between systems such as schools, child welfare, out-of-home placement, mental health, etc. This aids in the development of a comprehensive, multidisciplinary treatment plan.

Socioeconomic Disparities in Identifying the Medical Home
• Patients with medical homes are better prepared to manage chronic conditions and have better outcomes overall than those without access to a medical home.12
• In general, the presence of insurance, more education, and higher income are associated with the identification of a medical home.12
• The impact of ethnic, racial, and income factors is mitigated by the presence of insurance.13-15
Importance of Medical Home for CAPs

- Supporting the medical home concept should encourage safe, high quality care.
- CAPs can support the medical home concept by communicating with primary care physicians about all interventions that are implemented with the child and family.
- A primary care physician who is informed about medications prescribed, dosages, and indications can help ensure that there are no unrecognized adverse interactions with other prescribed medications.
- Good communication between the CAP and primary care physician can facilitate the evaluation, diagnosis, and treatment of medical issues that may cause or exacerbate psychiatric symptoms.
- Primary care physicians can help support the multidisciplinary treatment plan, which ultimately helps the child, family, and all care providers.
- The medical home has been endorsed by federal healthcare reform in the accountable care organization model and CAPs need to be an integrated part of these models.\textsuperscript{16}

Medical Home and Case Management

- Complete implementation of the medical home concept requires primary care physicians or offices to perform significant case management services, many of which are not reimbursed. This is especially true for youth with complex physical or mental health needs.
- There are many strategies that primary care offices can utilize, especially by utilizing the skills of physician-extenders and non-professional staff, in order to improve implementation of the medical home concept.\textsuperscript{9}

IV. WORKING WITH A PRIMARY CARE CLINICIAN IN OUTPATIENT CONSULTATION VERSUS TRADITIONAL CAP INPATIENT CONSULTATION-LIAISON RELATIONSHIP

As a pediatric and psychiatric subspecialist, a CAP is often called upon by primary care physicians in a consultative role in both the inpatient and outpatient settings. This provides the CAP with the opportunity to work with youth with chronic illness, as well as considering physical origins as the source or perpetuating factor for mental health issues in medically ill youth. This section will outline the consultation process, as well as important differences and considerations in consultation among these settings. For more information about types of formal consultation relationships, please refer to the Consultation Module.

Process of Consultation

- Identify role – Are you answering a specific question once? Will you be assuming long-term management? Will you have long-term availability for follow-up consultation? Will you be stabilizing the patient and then returning the patient to their primary care provider for ongoing management? How will you share oversight with the primary care physician?\textsuperscript{7}
- Clarify the consultation question, including calling the primary care physician if needed.
• Communicate in a clear and timely manner.
  o Respond to the consult question asked.
  o Provide formulation and diagnosis, as well as rule-out possibilities if pertinent.
  o Provide clear rationale for any medication and plan for monitoring.
  o Clearly delineate roles of primary care physician, CAP, and other care providers that may be involved (especially mental health and developmental professionals).
  o Provide information about medication changes.
  o Communicate with primary care physician verbally when planning to transfer patient back to them, or if you do a consult and ascertain that intervention is not needed at that point.
  o Provide a discharge summary to the primary care physician when ending treatment relationship.
  o Consider socio-cultural milieu of primary care.
  o Assess strength of relationship of patient’s parents to primary care physician.
• Build relationships with the treating clinicians.
  o Timely and clear communication between clinicians is essential for optimal patient care.
  o Provide education activities about common behavioral problems in primary care (e.g., ADHD, ODD, depression, anxiety, somatization, developmentally appropriate stages of grief, or reaction to divorce).

Outpatient Consultations
• In the outpatient mental health setting, patients are most likely to be seen by a mental health provider other than an M.D. (such as a therapist) prior to psychiatric evaluation.
• Less clarity about the role of the psychiatrist (i.e., evaluation and making treatment recommendations to the primary care clinician to follow through vs. assuming long-term management of the patient).
• The level of involvement of an outpatient psychiatrist may vary depending on the clinical need of the patient, availability of providers in the area, or other factors the primary care physician may not understand unless they are actively involved in the process of determining the ongoing needs of the family.

Inpatient Consultations
• Generally, procedures about consultation vs. ongoing care of the patient have been developed and roles are more clearly defined.
• Members of the primary team are generally aware of services available for ongoing management in the hospital setting, including social work and case management, and have a more established relationship with these providers.
V. COLLABORATION WITH PRIMARY CARE AND MODELS FOR IMPROVING MENTAL HEALTH TREATMENT IN PRIMARY CARE

As discussed in the sections above, collaboration with primary care is important in the care of youth with mental health problems. There is a lack of mental health care access because of an inadequate workforce. As there are increasing psychosocial problems in primary care settings and increased use of medication for common behavioral problems, primary care physicians often act as the gatekeepers to other systems of health care and are in a prime position to partner with CAPs in the diagnosis and management of youth with mental health problems. Although not inclusive, the following section discusses several ways in which mental health has been integrated with primary care practice.

Residency Training Programs
- Since 2000, the AAP has renewed its commitment to the treatment of mental health problems and the Pediatric RRC of the ACGME has increased the mental health training requirements in residency. Individual residency programs have incorporated mental health training opportunities in addition to the required one month rotation in developmental pediatrics in a variety of ways.
- Family practice programs have a history of including a mental health faculty member, who is often a psychologist.
- “Triple Board Programs” produce physicians who are board-eligible in Pediatrics, Adult Psychiatry, and Child and Adolescent Psychiatry. This 5-year combined training has the potential to produce leaders in the field who understand and overcome the traditional boundaries between physical and mental health treatment providers.
- “Post Pediatric Portal Programs” were approved by the ACGME in 2009. These 3-year post-residency programs are designed to “fast track” pediatricians to a Child and Adolescent Psychiatry certification to increase the youth mental health workforce.

Opportunities for Educating Practicing Primary Care Providers
- CAPs have the opportunity to educate primary care providers (PCPs) regarding child mental health issues and treatments that allow PCPs to extend their involvement in mental health care beyond their usual scope of practice. They also have the opportunity to guide PCPs in the education of their patients and their families. This can occur in a variety of forums:
  - The implicit case-based teaching that occurs with consultation and psychiatric services provided to patients.
  - “Lunch and learn” in primary care practices to discuss cases, diagnosis, treatment, best practices, therapies, and community resources.
  - CME training events, case conferences, and collaborative office rounds, in which CAPs and PCPs discuss cases of selected patients.
- Goodfriend et al. tested a model meant to improve capacity of pediatricians to work with mental health complaints by having them see their own patients and families with a CAP. Participating pediatricians and CAPs provided positive feedback about the model, but there have been no other formal outcomes reported and the model may not be financially feasible for many settings.
Telepsychiatry

- Telepsychiatry has potential for bringing CAP services to underserved and/or remote areas and improving the problems that result from uneven distribution of child and adolescent psychiatrists.
- AACAP has published a set of guidelines for successful implementation of telepsychiatry services.19
- Telepsychiatrists predominantly provide direct care services such as ongoing treatment and consultative evaluations.

Collaborative and Co-Located Models

- AACAP and AAP joined forces to recognize promising models for improving access to mental health services for children, and published a position paper recognizing promising models and needed system changes for implementation.20
- AACAP published two papers to help providers and payers build collaborative and integrated programs.6,7
- Co-located models bring the mental health system physically to the primary care site. Patients are seen by therapists of CAPs in their PCP’s office, but interaction between the mental health and primary care providers is not formally incorporated.21
- Reverse co-located models bring primary care practitioners physically into the mental health setting. For example, an RN may perform screening for metabolic syndrome in a psychiatrist’s office for patients on atypical antipsychotic medications.
- Collaborative models have formal mechanisms in place for encouraging collaboration between providers. Collaborative models have been shown to improve short-term outcomes and be cost-effective in the treatment of adult mental health disorders.22-24 Less is known about the efficacy and cost-effectiveness of collaborative models for youth mental health treatment with the most evidence available for treatment of adolescent depression25 and ADHD.26

Examples of Collaborative and Co-Located Models

- Massachusetts Child Psychiatry Access Project (MCPAP) – A primary care physician within a region calls that region’s MCPAP hotline to find community services such as therapy, referral to a child psychiatrist, crisis services. The telephone consultation may be provided while the patient is still in the primary care physician’s office for efficient communication and implementation of the recommendation.27
- Nurse practitioner with mental health training provides ongoing chronic care for youth with mental health needs and works in an onsite team of a pediatrician, a CAP, and a therapist. The CAP and therapists were originally available to provide ongoing care in concert with the pediatric nurse practitioner and the pediatrician, and the role of the CAP later shifted to that of a consultant available for complex cases as the model matured.28
VI. FEDERAL LEGISLATION AND YOUTH MENTAL HEALTH SERVICES

The following timeline is a brief historical summary of federal legislation contributing to current funding of youth mental health services, with more specific focus on Title V, Medicaid, EPSDT, SCHIP/CHIP, and the Patient Protection and Affordable Care Act of 2010. This overview is intended to provide a snapshot of notable historical legislation that has bridged medical and mental health care availability to youth in the United States, as well as an introduction to future planned initiatives under the current administration. The following information is in part obtained from the Health Resources and Services Administration through the U.S. Department of Health and Human Services, as well as the Commonwealth Fund.  

1912 – Children’s Bureau created by Congress in Department of Commerce and Labor
1935 – Title V of Social Security Act of 1935

- Maternal Child Health Program established the only federal legislation devoted to promoting and improving the health of our nation’s mothers and children.
- Original legislation specifically did not provide health insurance in response to concerns from the American Medical Association and insurance industry.
- Administered by Health Resources and Services Agency (HRSA).
- Between 1967 and 1989 amendments included working with Medicaid, coordinating EPSDT, providing toll-free numbers to youth or families requesting Title V or EPSDT, providing outreach to women and youth who qualify for Medicaid, and others.  

1965 – Social Security Amendments establish Medicaid

- Medicaid is a publicly funded health insurance program designed to provide increased access to health care for the poor.
- It is a Federal-State entitlement fund – a right granted by the government that is paid for by both the state and the federal government.
  - “Sponsored” by federal government and administered by states.
  - The federal Centers for Medicare and Medicaid Services (CMS) monitors the state-run programs and oversees requirements for service funding, delivery, quality, and eligibility.
  - Federal government provides matching funds to states.
  - It is not required for states to participate, but all states have participated since 1982.
  - Some states subcontract Medicaid to private health insurance companies, other states pay health care providers directly.
- Eligibility: U.S. citizens or legal permanent residents, low-income parents and children, elderly, some disabled individuals.
  - Children make up >54% of beneficiaries.
  - Most disabled individuals are eligible because they receive assistance through social security disability insurance through Medicaid.
- It is the largest purchaser of health insurance in the U.S.
- It was not designed to control (or even consider) the price of health care.
  - Problem with escalating prices of health care from the 1970s to present, and no original built-in mechanism to control costs, resulted in growth that outpaced expectations.
• Large program, with many components, susceptible to fraud.

1967 – EPSDT

• The child health component of Medicaid.
• EPSDT includes a comprehensive package of benefits to provide early detection of physical, mental health, and developmental problems; periodic assessment of those with these issues and those at risk; screening for potential medical, mental health, or dental conditions; diagnosis of conditions; all medically necessary treatment services; includes assistance in scheduling and getting transportation to appointments; and intensive home and community based services.
• It is a Federal-State entitlement fund.
• Eligibility: all youth under 21 years of age enrolled in Medicaid.

1981 – Omnibus Budget Reconciliation Act

• Combined five programs related to maternal and child mental health (including Title V) and administered block grants to states. A block grant is a sum of money provided by the federal government to a regional government with only general provisions about how it is to be spent (as opposed to a categorical grant, which is has more strict and specific provisions).
• Gave states more discretion with where to direct funds for children and families.
• This discretion resulted in larger variation from state to state. Therefore, although Medicaid and EPSDT are “federal laws”, the politics and rules are very local in nature.

1989 – Amendments to increase reporting and tighten rules about use of funds.

1990 – Maternal Child Health Bureau (MCH) established to administer Title V programs.

1991 – Healthy Start enacted

• Increase access to learning and family supports in schools and the community to close the achievement gap.
• Centers might help with finding academic support, family support (child protection, parenting education, case management, ESL), assistance with basic needs, medical and mental health care, employment assistance (career counseling, job placement) on an as-needed basis for the child or family.

1995 – Deficit Reduction Act

• Created Medicaid waiver program so states could modify how they administered EPSDT.

1997 – Title XXI of Social Security Act results in State Children’s Health Insurance Program (SCHIP), now known as CHIP (Children’s Health Insurance Program)

• CHIP gives states federal funding to fund public insurance for “targeted low income” children who are not eligible for Medicaid or other “creditable coverage.”
• It is NOT considered a Federal entitlement. Each state receives a capped allotment of funds, so there is no individual entitlement.
• Provides funds to states at enhanced matching rate compared to Medicaid.
  o States have significant discretion in how they administer funds, including program design and eligibility.
o States can use funds for separate program for “targeted low income children” or can expand youth who qualify for Medicaid.

- Eligibility: 1 in 3 children under age 6 is eligible; serves 1/5 of children in U.S.

2005 – House Budget Reconciliation Bill
- Allowed states to shift children from EPSDT to CHIP, effectively reducing the amount of mental health coverage available to some children.

2009 – Children’s Health Insurance Reauthorization Act of 2009 (CHIPRA)\textsuperscript{31,32}
- SCHIP became more simply known as CHIP.
- Expanded CHIP to more children and to include legal immigrants without a waiting period.
- Expanded coverage to pregnant women. Prior to this, states could cover pregnant women under CHIP by covering “unborn children.”
- Requires mental health parity for states that chose to include mental health or substance abuse services in their CHIP plans.

2010 – Patient Protection and Affordable Care Act (aka ACA or ObamaCare)\textsuperscript{33}
- Extended authorization of federal CHIP program through September 2015.
- Required states to maintain current income eligibility levels for CHIP through September 30, 2019, and states cannot implement eligibility requirements that are more restrictive than those in place as of March 23, 2010, with exception of waiting lists for enrolling children in CHIP.
- Prohibits insurance plans from denying coverage to children with pre-existing conditions. Applied to all persons in 2014.
- Required new private health plans to cover preventive services with no copayments, and for preventive services to be exempt from deductibles. Will apply to all plans in 2018.
- Extends coverage of young people through age 26 under their parents’ insurance, at the choice of the parents, regardless of the youth’s marital status.
- Created state health exchanges to provide individual coverage to those currently without health insurance.
- Created Accountable Care Organizations to manage care based on quality, including coordination of care through health and medical homes.

2015 – Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Extended authorization of federal CHIP program through September 2017.

CONCLUSION
Because of their frequent and long-term interactions with youth and families, primary care clinicians are in a prime position to identify and treat mental health and psychosocial issues. However, effective identification and treatment is often limited by factors such as provider comfort in diagnosis and management, and availability and/or knowledge of mental health resources. The medical home model facilitates collaboration between the primary care and mental health systems in the comprehensive, multidisciplinary care of the patient. CAPs can interact with PCPs in multiple ways, including formal consultation, curbside consultation and education, co-location of practice, and collaboration of care between providers. Issues such as child and adolescent psychiatry workforce limitations, and funding of collaboration between primary care and mental health systems continue to pose challenges to optimal delivery of
mental health care in the primary care setting.
*APPENDIX 1

Systems-Based Practice Competencies

RRC Program Requirements, Section IV.A.5.f

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

1. Work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2. Coordinate patient care within the health care system relevant to their clinical specialty;
3. Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4. Advocate for quality patient care and optimal patient care systems;
5. Work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6. Participate in identifying system errors and implementing potential systems solutions.
7. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8. Practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9. Advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10. Work with health care managers and health care providers to assess, coordinate, and improve health care;
11. Know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12. Instruct in the practice of utilization review, quality assurance and performance improvement.
REFERENCES


33. National Conference of State Legislatures. NCSL Health Reform Fact Sheet: Key Provisions that Take Effect Immediately under Senate Bill (HR 3590) as Amended by Reconciliation Bill (HR 4872).  
Primary Health Care System – Discussion Vignette I – Trainee Version

Annie, a three-year-old child with insulin dependent diabetes, is brought to the pediatrician by her mother, Ms. Knock, because of increased irritability, mood swings and difficulty sleeping through the night. She has become increasingly irritable when receiving her shots over the past months, and in the last week the only people with the ability to administer her shots are her mother and father. Her other caretakers at daycare were previously quite adept at giving the shots, but now feel uncomfortable because of her thrashing and screaming. They still are trying, but admit that they have missed a few shots over the last two weeks. Both the pediatrician and parents are in distress over this situation. The child’s labs currently reveal that the diabetes is not controlled as well as it was 6 months ago, although it doesn’t quite reach the need for inpatient hospitalization or a trip to the ER yet. Nevertheless the pediatrician fears that this child could be headed for complications if intervention is not taken soon.

To complicate matters more, the father has just lost his job and the family is now without insurance coverage. The mother is distraught and asks for help because they cannot afford Annie’s medicine or the office visits. The pediatrician is feeling overwhelmed and calls you for a curbside consultation saying, “what medication can I give in order to sedate this child so that her diabetes can be properly monitored and controlled?” There is a family history of psychiatric disorder, specifically generalized anxiety disorder and obsessive compulsive disorder.

What are some possible suggestions you could give to the pediatrician?
Primary Health Care System – Discussion Vignette II – Trainee Version

You are talking to a colleague who is a pediatrician and is interested in treating mental health problems. She has heard that behavioral health treatment provided by a primary care provider is a federal entitlement (right granted by law or government) but doesn’t understand the specifics. She states, “The entitlement means that I can provide childhood immunizations and well-child care checks.”

Please describe the relationship of EPSDT, Medicaid, and CHIP for your colleague as it relates to mental health treatment.

Which children are eligible for SCHIP in your state?
Primary Health Care System – Discussion Vignette III – Trainee version

You are a CAP in a mental health clinic in a small town in the Midwest and have a patient referred to you by a primary care doctor because they have begun to have panic attacks. The youth’s mother also has panic attacks and sees a psychiatrist for treatment of an anxiety disorder. When you complete the evaluation you recognize that the youth’s “panic attacks” began soon after a drastic increase in the use of his albuterol inhaler in conjunction with a worsening of his asthma. Many, though not every, panic attack has been precipitated by the use of his inhaler. The child has never been diagnosed with a psychiatric disorder. You receive this referral sheet a week before the patient’s appointment.

Discuss your approach with the pediatrician.

You have discussed the patient’s presentation and clarified your role with the pediatrician. The pediatrician wants you to complete a consultation and send the patient back to them with recommendations. You perform a complete psychiatric evaluation and believe that the panic attacks are entirely precipitated by the inhaler. Discuss how you would manage this situation.

Once you have met with the child and family you contact the pediatrician. What would you discuss?