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April 7, 2017

Ms. Amy Bassano
Acting Director
Centers for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: HealthyChildrenandYouth@cms.hhs.gov RFI

Dear Ms. Bassano:

The American Academy of Child and Adolescent Psychiatry (AACAP) very much appreciates the opportunity to provide comments pursuant to your Request for Information (RFI) on Pediatric Alternative Payment Model Concepts that would include children with behavioral health or emotional challenges. AACAP represents the interests of 9,200 child and adolescent psychiatrists (CAPs). Improved access to mental health services for children, adolescents, and their families is a priority for AACAP, and we believe it is critically important to address the unique needs of children and adolescents with mental illnesses. We applaud the agency's initiative on this topic and would like to share AACAP's work, and resources, to help inform the development of alternative payment models that consider the whole child, including social service and behavioral health supports.

AACAP has developed Workforce Maps¹, available on AACAP's website, illustrating the magnitude of the national CAP shortage. Nationally, 13% of youth 8-15 years of age have a mental illness, yet 79% of children 6-17

¹ American Academy of Child and Adolescent Psychiatry.

[http://www.aacap.org/aacap/Advocacy/Federal and State Initiatives/Workforce Maps/Home.aspx](http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx)

years old, with mental illness, don't receive treatment. This shortage is significant given the individual and societal impact of children and adolescents failing to receive needed services. Nearly 50% of students with mental illness who are 14, or older, won't complete high school, illustrating the critical need to improve these trends.

This crisis points to the urgent need to develop and utilize new treatment approaches such as collaborative mental health models. AACAP recognizes the benefit in integrating behavioral health care into pediatric care, and in 2015 launched an initiative called the *Pediatric Integrated Care Resource Center* (PIC-RC). The Presidential Initiative of AACAP's current president, Dr. Gregory Fritz, has supported this endeavor which has resulted in a website resource entitled IntegratedCareforKids.org¹. This living resource represents the collective wisdom of medical, behavioral, and mental health experts, and supports and encourages collaborative partnerships with pediatric medical homes. Summaries of several innovative programs and projects taking place around the country are available at the website, and more are being added on a continuous basis. The programs highlighted on the website provide useful examples of how to address the service needs of children and adolescents through innovative approaches that make the most of collaborative clinical relationships. The programs also demonstrate the significant interest among the states to develop team-based approaches that can improve health outcomes, while being mindful of workforce issues and limited funding. AACAP has long supported, and actively promotes, the establishment of collaborative mental health partnerships to help address ongoing workforce shortages, while meeting the needs of children and adolescents.²

Some examples of PIC-RC projects are provided here to demonstrate how organizations across the country are meeting the needs of children and adolescents who require social service and behavioral health supports.

ACCESS Mental Health Connecticut

The objective of ACCESS Mental Health Connecticut is to ensure that all youth under 19 years of age, irrespective of insurance coverage, have access to psychiatric and behavioral health services through contact with their PCPs. The program provides telephonic psychiatric consultation to support and educate PCPs about how to identify and treat children with behavioral health issues. Through contracts with behavioral health organizations, Hub teams have been created to provide support across the state. Each Hub team has a board-certified CAP, a behavioral health clinician, a program coordinator, and a half-time family peer specialist. Funding for the program comes from the state.

¹ American Academy of Child and Adolescent Psychiatry. <http://integratedcareforkids.org/>

² American Academy of Child and Adolescent Psychiatry (2010). A Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf

The model provides real-time psychiatric consultation and individualized case-based education to pediatricians and PCPs over the phone. Topics addressed during these conversations include diagnostic clarification, psychopharmacology, counseling recommendations, and how to access existing community resources.

During the first two years of the program, ending on June 20, 2016, 83% of pediatric and family care practices had enrolled, with more than 1,500 prescribing physicians enrolling statewide. During this time, more than 11,000 consults were provided, supporting the needs of 2,300 youth and their families. The program is noteworthy for its associated pediatrician and PCP satisfaction.

Integrated Pediatric Services, University of Louisville Department of Pediatrics, Divisions of General Pediatrics and Pediatric Psychiatry and Psychology – Kentucky

Located in a primary care clinic, this program provides PCP education and consultation, co-located psychopharmacology and therapy services, care coordination, telepsychiatry, patient and family education, and self-management training. These services are provided to pediatricians and adolescent PCPs, physician assistants, children, adolescents, parents, and families. The care team includes pediatricians and adolescent PCPs, advanced practice nurses, physician assistants, CAPs, psychologists, social workers, and medical students.

Program features include integration of a child psychologist into two large pediatric general clinics, with a child psychiatry fellow and a child psychiatry faculty member present on-site, primarily for education and consultation for a limited number of days per week. Additional clinicians co-located at the clinic include social workers and psychologists. A telephone consultation service for all members of the Department of Pediatrics is available, with first line calls directed to a senior child psychiatry fellow, with a faculty member as backup.

The Division of Pediatric Psychiatry and Psychology is part of the Department of Pediatrics at the University of Louisville School of Medicine. The program has been well-received, with psychiatric fellows enjoying the interface with pediatric residents and faculty that allows them to educate and support them, and promote the value of integration.

Michigan Child Collaborative Care Program (MC3)

The MC3 program provides psychiatric support to primary care providers in Michigan who are managing patients with behavioral health problems, including children and adolescents. The care team includes CAPs, adult psychiatrists, social workers, and mental health counselors. CAPs and adult psychiatrists are available to offer guidance on diagnoses, prescribing, and psychotherapy interventions, enabling pediatricians and PCPs to successfully manage patients in their practices who require behavioral health support. The program utilizes same day telephone consultations to referring providers, and remote psychiatric evaluation to patients and families through video telepsychiatry.

MC3 relies on a combination of funding streams from the federal government, state government, and the Medicaid program. This program has contracted with local community mental health organizations for behavioral health consultations to provide collaborative care services in 40 Michigan counties, with more than 1,000 pediatricians and PCPs from 297 practices participating in the program. The patient populations served include urban, inner city, suburban, rural, migrant, and tribal. The program reports very high satisfaction with the services provided, and part of its mission is to work with payors to ensure a sustainable payment model.

Psych TLC, Arkansas

Through a partnership with the Arkansas Department of Human Services, Arkansas Children's Hospital, and the Psychiatric Research Institute of the University of Arkansas for Medical Sciences, the Psych TLC offers timely support to pediatricians and other PCPs, much like the other programs mentioned here. In addition, Psych TLC also offers hands-on coaching and training, free of charge, utilizing a training program that was originally developed by the non-profit REACH Institute³, which seeks to improve the emotional and behavioral health of children, through evidence-based therapies. Psych TLC has also provided this training to more than 2,200 pediatricians and PCPs across the United States.

Psych TLC is funded by the Arkansas Department of Human Services, with support from the Psychiatric Research Institute of Medical Sciences. The patient populations served include urban, inner city, suburban, rural, and migrant.

Many other fine examples of programs that are providing high-quality and cost-effective services to meet the behavioral and mental health needs of children and adolescents, while helping to build capacity to treat these needs in primary care settings, are available at the IntegratedCareforKids.org website.

MCPAP

Another effective state initiative that has served as a model nationally is the Massachusetts Child Psychiatry Access Program⁴ (MCPAP). The MCPAP is a system of regional children's behavioral health consultation teams designed to assist pediatricians and other PCPs in their management of the behavioral health needs of their patients. Each care team is staffed with two full-time CAPs, independently licensed behavioral health clinicians, resource and referral specialists, and program coordinators. Through consultation and education, MCPAP improves the pediatric team's skills and comfort with screening, identification, and assessment; treating mild to moderate cases of behavioral health disorders in accordance with current evidence-based

³ The Reach Institute. <http://thereachinstitute.org/>

⁴ Massachusetts Child Psychiatry Access Program.

http://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

practices; making effective referrals, and coordinating care for patients who can benefit from community-based specialty behavioral health services.

Most MCPAP services are of a consultative nature, but can include face-to-face assessments conducted by a behavioral health clinician, or **referral to a team child psychiatrist for an acute psychopharmacological face-to-face assessment**, when needed.

MCPAP is made available through primary care practices for all children and families, regardless of insurance coverage, and is funded through the Massachusetts Department of Mental Health with a portion coming from large commercial insurers in the state.

Many of these programs utilize telepsychiatry services to help them meet the needs of the patients they serve. AACAP strongly supports the use of telepsychiatry and believes that expanding the availability of and reimbursement for these services would be beneficial.

Adapting the Health Home Model for Pediatrics

The RFI also asks how the Health Home model, which targets adult beneficiaries who have chronic health conditions or serious mental illnesses, could be adapted to better meet the needs of a pediatric population. AACAP's *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*⁵ addresses this topic, and identifies the following elements in a framework for the integration of child psychiatry into the Health Home: prevention and screening, early intervention, routine assessment and treatment, specialty consultation, specialized treatment, coordination of services, and monitoring. Within this framework, the allocation of these service elements between healthcare providers would vary according to the severity, chronicity, and complexity of the mental health problems for individual patients. The model envisions a primary care provider, a consulting CAP (as in the collaborative models described above), a care coordinator, the availability of a CAP for specialty psychiatric services, and the patient and family, all playing key roles. In this model, the levels of complexity of patient's mental health needs are as follows:

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.

⁵ American Academy of Child and Adolescent Psychiatry (June 2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*, Retrieved March 17, 2017 from https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf

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 CAPs.

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.

Within this framework, the respective levels of involvement for each member of the care team would be variable, according to patient need, with children who have more complex behavioral health needs receiving higher levels of psychiatric intervention.

The models discussed here represent AACAP's ongoing work to foster and promote sustainable integrated delivery models for behavioral health care. We would also like to acknowledge the excellent comments in response to this RFI being submitted by several other entities, especially at The National Technical Assistance Network for Children's Behavioral Health, the National Alliance on Mental Illness, Mental Health America, the National Alliance to Advance Adolescent Health, among many other organizations that have a keen interest in ensuring that the behavioral and emotional health care needs of America's children and adolescents are better met.

Please don't hesitate to reach out to Karen Ferguson, Deputy Director of Clinical Practice at kferguson@aacap.org should you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Gregory K. Fritz".

Gregory K. Fritz, MD
President