

# Is There a Psychiatrist in the House? Integrating Child Psychiatry Into the Pediatric Medical Home

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**T**he Patient-Centered Medical Home (PCMH) is a model of primary care practice incorporating core principles of accessibility, coordination, comprehensiveness, continuity, cultural competence, and respecting and valuing the preferences of families. As our nation struggles to reform our health care system, the PCMH model is widely acknowledged to be the foundation of a high-value, effective system of care that better meets the needs of patients and produces better health outcomes. Although most PCMH initiatives currently underway around the country focus on the management of chronic diseases of adults, the model has its roots in pediatric practice and the care of children with special health care needs. These features were codified in the Joint Statement on the Principles of the Medical Home,<sup>1</sup> establishing the modern definition of the medical home. The needs of children, however, are different than those of adults. A child-focused system requires attention to the “five Ds” that differentiate child from adult health care systems: development, dependence, dollars, demographics, and differential epidemiology. The needs of children change rapidly as they grow. They cannot be treated without attending to the needs of the family. In the United States, they are diverse in race/ethnicity and the poorest of our citizens. They comprise 25% of the population, yet account for less than 5% of health care spending.<sup>2</sup> Creating medical homes for this population will present unique challenges to policymakers.

Mental health problems collectively are the most prevalent and costly of all children's health care needs.<sup>3</sup> Despite this, access to mental

health services is challenging in most parts of the country. Mental health services are “carved out” of many insurance contracts, resulting in fragmented systems poorly coordinated with primary care. In formulating the Bright Futures standards for the care of children, the American Academy of Pediatrics recommended that pediatricians develop systems for the screening and treatment of common behavioral health problems, with robust systems for referral and shared care for children with more complicated problems. As the country moves toward transforming primary care practices into medical homes, child psychiatrists should join with other child advocates to ensure that comprehensive mental health services, including access to child psychiatry services, are part of the package.

To address the mental health needs of children and adolescents, PCMHs need the capacity to screen for and detect significant mental health symptoms at the earliest stages of expression, the ability to develop treatment plans with patients and families, and systems to monitor and guide treatment over time. Given the complex nature of children's mental health issues, primary care providers cannot be expected to perform these functions without the help of specialized child psychiatry resources offered in a collaborative fashion. PCMHs need access to consultation services and specialized care coordination.

## CONSULTATION SERVICES

Informal (“curbside”) and formal (direct patient evaluation) consultations can assist PCMHs in managing children with mental health problems. The consulting child



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psychiatrist can work with the pediatric primary care provider and PCMH staff to ensure best practices for assessment and treatment planning, facilitating the optimal use of specialty care, and acute treatment resources. Consultation services may be provided by multidisciplinary teams with child and adolescent psychiatrists (CAPs), psychologists, licensed clinical social workers, and other mental health professionals; however, the availability of a CAP is essential for addressing questions regarding the use of psychiatric medication and providing an integrated perspective on the biological, psychological, and social factors influencing the mental health presentation.

### SPECIALIZED CARE COORDINATION

The care coordination services required for implementing mental health treatment plans require a specialized body of knowledge and skill that often is beyond the capacity of usual PCMH care coordination staff. Mental health providers can provide this service directly or give ongoing technical assistance to PCMH care coordinators so that children and families do not become lost within the complex web of child mental health services.

Designing models for including CAPs in the health care team in PCMHs is challenging. The physical colocation of a CAP within a pediatric practice setting is the “gold standard” model of integration. Although this model does exist in some multispecialty group practices and academic programs, the scarcity and geographic maldistribution of the CAP workforce makes it unrealistic as a universal solution. Two types of models have been emerging in centers across the United States. Offsite consultation is exemplified by the Massachusetts Child Psychiatry Access Project,<sup>4</sup> a statewide system delivering collaborative child psychiatry resources through a system of six mental health teams, each supporting pediatric practices in its surrounding region with immediate telephone consultation, expedited clinical evaluation, and care coordination. The teams are supported by state funding and supplemented by fee-for-service billing for the expedited clinical evaluations. Although all the services are provided off site from the pediatric practice, the system is designed to create an experience of constant availability and collaboration from the child psychiatry resource that

has been shown to dramatically improve the self-reported ability of pediatricians to meet the mental health needs of children in the primary care setting. The model is being replicated in many states around the country. Onsite colocation is exemplified by the Lone Star Circle of Care Program in Texas,<sup>5</sup> in which colocated mental health professionals work within pediatric primary care sites to deliver these collaborative services and direct patient care in the pediatric clinic. With adequate availability of personnel and space, the immediacy and convenience of brief onsite clinical assessments and short-term psychotherapy services may help patients overcome practical and psychological barriers to accessing external mental health services. The Lone Star team includes CAPs on site or through telephone consultation. In general, colocation models are staffed by licensed clinical social workers or psychologists and therefore require additional strategies to deliver consultation with a CAP.

Change is never easy. Although interprofessional consultation and colocation of pediatric and child mental health services seem to be logical solutions to the problem of access to care for mental health problems, it has proved challenging to bring these programs to scale in a sustainable manner. Pediatricians and CAPs working collaboratively to treat patients find that many of their services are not billable under existing coding standards and insurance policies. Sustaining a pediatric practice or a child mental health practice in a fee-for-service environment leaves little time for collaboration. Families are often ashamed or stigmatized by mental health labels and may not want providers to share information with each other, much less with school officials or other youth workers. Efforts at practice transformation and team building within all PCMH projects will need to be directed specifically at creating a broad-based team that is comfortable transferring information between primary care and mental health systems. This will require funding that supports the transformation process and the ongoing needs of mental health and pediatric clinicians in their roles as vital members of the team.

Fortunately, there are many opportunities to foster change within the system transformation embodied in the Affordable Care Act and in the rapidly evolving world of practice. Payment reform is happening within public programs such as Medicaid and Medicare and throughout the

private sector. Those interested in driving change should look for ways to ensure that children's mental health is incorporated into the bundled payment schemes and shared savings plans currently being tested around the country. The Affordable Care Act focuses largely on transforming adult practice, highlighting the management of chronic diseases in the community. Children are different. Child mental health is the overt reason for up to 40% of visits in some practices. That needs to be factored into the construction of teams for the PCMHs that will care for these patients. Indeed, a focus on behavioral and mental health may prove beneficial to practices interested in decreasing the use of emergency rooms, increasing the shared savings, and providing some of the capital needed for practice transformation. Medicaid waiver opportunities such as the health home and grant programs funded by Children's Health Insurance Program Reauthorization Act, the Center for Medicare and Medicaid Innovation, and the Patient-Centered Outcomes Research Institute encourage innovation in practice design and payment. We need to be ready with models of care that integrate child mental health within a wide variety of practice circumstances and reach as many children and families as possible. We need to ensure stable financing for the care coordination function that allows primary care practices to work with the most

seriously emotionally disturbed patients. Ultimately, however, it will be the patients and their families who will reap the benefit of comprehensive specialty services being provided in a familiar locale. When they demand that child mental health services be integrated with pediatric care, we will have a sustainable model for improving the physical health and mental health of children and adolescents. &

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