

A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care

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Premise

“The walls between professions and institutions will crumble, so that your experiences will become seamless. You will never feel lost.”

“In its report on the Quality Chasm, the Institute of Medicine recognized the critical need for integration and coordination as a major barrier to optimal care. Today, it has become apparent that collaborative mental health care partnerships are the means to achieve the necessary integration of mental health into pediatric primary care. At this juncture, it is critical to the mental health care of our nation’s children and adolescents that we, as child and adolescent psychiatrists, remain at the forefront in the development and implementation of collaborative mental health care partnerships in the pediatric setting.”

Institute of Medicine, Crossing the Quality Chasm. The New Health System for the 21st Century. Washington, DC: National Academy Press; 2001

AACAP Policy Statement on Collaboration with Pediatric Medical Professionals

The American Academy of Child and Adolescent Psychiatry supports policies that promote mental health recovery as integral to overall health. Due to the shortage of child and adolescent mental health professionals, pediatric medical professionals are frequently called upon to assess and treat young patients with mental health disorders.

Safe and effective mental and physical health care requires collaboration and communication between child and adolescent psychiatrists and other medical professionals. Collaborative relationships must provide integrated care to maximize the pediatric and psychiatric caregivers’ knowledge and abilities, to facilitate alliances with families, and to work to overcome constraints within and beyond health care systems, such as reimbursement, time limitations and provider knowledge. Communication should occur following the initial evaluation, change in diagnosis or treatment, and throughout the treatment as indicated. The reasons for communication between professionals must be discussed with the family throughout the treatment. These services and appropriate payment for them must be included in any health insurance plan.

Adopted by AACAP Council in 2008

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). Recognizing that the lack of child and adolescent psychiatrists (CAPs) is a prominent problem throughout the country and that many primary care clinicians (PCCs) are struggling with children entering their practices with various mental health problems, AACAP is promoting collaborative mental health partnerships between child and adolescent psychiatrists and PCCs.

Collaborative mental health care partnerships are crucial to the integration of mental health into pediatric primary care.¹⁻³ Successful partnerships are characterized by effective collaboration, communication, and coordination between CAPs and PCCs, in consultation with the children and their families. These partnerships go beyond the traditional office-based practices of CAPs and PCCs to allow CAPs to have a much greater impact on children, families, medical professionals, and the community as a whole.

Given the significant national shortage of CAPs and the critical public health need for evidence-based mental health services,^{4,5} a working relationship between CAPs and PCCs can significantly enhance mental health services across populations. Through these partnerships, CAPs can significantly influence the psychiatric care of larger numbers of children and their families through the promotion of prevention, early intervention, and treatment of childhood psychiatric illness.¹⁻³

The goals in building collaborative mental health care partnerships in the pediatric primary care setting include:

- Integration of mental health services into the primary care setting.
- Promotion of optimal social and emotional development and emotional wellness.¹
- Early identification of mental health problems and interventions.¹
- Implementation of therapeutic and psychopharmacologic services.¹
- Improved care coordination among families, PCCs, and CAPs.
- Improved care coordination among community mental health clinicians, PCCs, and CAPs.
- Increased PCCs' comfort, knowledge, and abilities in diagnosing and responding to mental health problems.
- Increased CAPs' comfort, knowledge, and abilities in diagnosing and responding to physical health problems.
- Removal of constraints within and beyond health care systems, such as reimbursement, time limitations, and provider knowledge.⁶
- Development of a means for the collaborative measurement of treatment outcomes.
- Integration of culturally sensitive and evidence-based mental health services.

The *Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care* is designed to help CAPs in understanding, building, and implementing collaborative mental health care partnerships in the primary care setting. It draws from the experience of a number of national initiatives supporting the integration of mental health services into pediatric primary care.¹ This guide outlines: 1) the core components of these partnerships and 2) steps to consider in implementing an effective collaborative mental health care partnership.

Background for Integration of Mental Health into Primary Care

Pediatric primary care is conceptualized as being provided within a patient's *Medical Home*.⁷ The key characteristics of the *Medical Home*, as defined by the American Academy of Pediatrics (AAP), are that care is: accessible, continuous, comprehensive, collaborative, compassionate, culturally competent, and family-centered. Continuity provides the structure for a relationship over time with the child and family and is key component of promoting healthy physical, social, and emotional development. To care for the whole child, in the context of family, school, and community, the *Medical Home* needs to have effective and dynamic relationships among community agencies/services that may assist the child and family for a variety of needs.⁷

One in five U.S. children experience mental health problems, and up to one-half of all lifetime cases of mental illnesses begin by age fourteen.^{1,4,5} The fact that seventy-five percent of children diagnosed with mental disorders are seen in primary care makes this setting well positioned to detect problems.¹ Nationwide, about half of the treatment for common mental disorders is provided within a primary care practice and the majority of psychotropic prescriptions for children originate from PCCs.⁵ This expanded role of the PCCs in providing ongoing mental health treatment is the direct result of the shortage of child mental health clinicians, particularly CAPs. As a result, many PCCs act as *de facto* mental health care clinicians.

The critical national shortage of mental health clinicians combined with inadequate financing has pressured many PCCs to extend their medical home care into assessing and treating children with psychiatric disorders.^{5,6} To address this need, the AAP formed the Task Force on Mental Health, which has stated that PCCs can and should be able to provide mental health services to children and adolescents in the primary care setting.⁸ The AAP's Bright Futures practice guide outlines an approach to address developmental and mental health needs based upon age and stage of development.⁹ More recently, the AAP has spoken to the importance of mental health competencies in the primary care setting, emphasizing the importance of collaboration with mental health clinicians.¹⁰

Yet, PCCs typically report feeling uncomfortable with providing child mental health and substance abuse treatment. PCCs report lacking the skills needed to provide accurate diagnosis and effective evidence-based treatment. Barriers to successfully providing these services in the primary care setting include lack of mental health training, insufficient time,

lack of knowledge about community mental health care resources, and insufficient referral feedback from their community mental health clinicians.¹¹ Inadequate reimbursement for mental health care, as well as the carve out of mental health benefits from medical benefits, are cited as challenges to integrated health care.^{5,12}

Most private and public insurers do not provide reimbursement for collaborative or integrative care, although increasingly some health plans have begun to recognize the need to integrate physical and behavioral health.¹ Public sector funding is provided through a combination of public insurance programs, federal grants to states, community health and community mental health centers, school systems, public health departments, and juvenile justice. While Medicaid Early Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions require regular screening, state Medicaid programs vary and only sixty percent reimburse for screening and assessment.¹

In the face of these challenges, safe and effective child mental health care requires effective collaborative partnership between mental health clinicians and PCC's.⁸ As result, strategies to promote collaborative mental health care are rapidly emerging across the nation.¹ There are now innovative models of care that focus upon increasing the capacity of PCCs to more efficiently and effectively handle child mental health issues (see Appendix 1). While these care models vary in size, funding, and structure from state to state, they share important core features and implementation strategies.

Core Components to Collaborative Mental Health Care Partnerships

Collaborative mental health care partnerships represent integrated care approaches in which the PCCs and CAPs partner with children and their families to prevent, identify early, and manage mental health problems in the primary care setting. Successful partnerships begin with the development of systematic and regular communication between PCCs and CAPs.

In considering whether and how to integrate mental health, PCCs and CAPs must decide what roles they wish to play and what services they will provide directly. There are three broad categories of collaborative models that may be adopted in order to provide mental health services:¹

- **Consultation.** Allow providers to consult with CAPs via telepsychiatry and/or other means.
- **Co-location.** Mental health specialists work in the PCC practice to improve access to care, streamline billing, and enhance care coordination. Proximity allows more communication and facilitates “cross fertilization.”
- **Collaborative or Integrative.** Builds on the medical home by establishing treatment partnerships between PCCs and CAPs, including co-management and case coordination. Co-location with shared chart and scheduled case discussions.

Whichever integration approach or model is used, collaborative mental health care partnerships between PCCs and CAPs are characterized by the following core components: 1) timely access to consultation, 2) direct psychiatric service, 3) care coordination, and 4) PCC education.

1. Timely Access to Consultation

“Real time” communication is important to collaborative mental health care partnerships and requires CAPs to be available. Answers to clinical questions ideally are provided to PCCs within a time frame that allows them to respond in a timely way to patients and their families. Compared to CAPs and other mental health clinicians, PCCs see a higher volume of patients and as such, their workflow requires efficient use of their decision-making and time. Consequently, timely access to consultation with CAPs who provide practical and understandable advice is essential.¹³

- Timely access for communication is usually considered by PCCs as being in the context of minutes to the same day. Availability is generally weekdays or parts of weekdays, though some emergency availability is often a consideration.
- Timely access assures real time discussion of plans by CAPs and PCCs. It helps PCCs to support therapeutic goals from CAPs with the family and vice versa.
- Particularly in consultation and collaborative models, timely access can be managed through the development of a *communication protocol*. If the protocol works reliably and is used with adequate frequency, a growing sense of trust and confidence develops that encourages PCCs to extend their involvement in mental health care beyond their usual scope of practice. The *communication protocol* should include:
 - Days and hours available.
 - Who will be available (i.e., CAPs or other child mental health clinicians working with the CAPs).
 - Manner of availability (i.e., onsite, telephone, fax, email, shared electronic medical record, or telemedicine).
 - What the specific consultation will and will not include.
 - How the recommendations will be communicated (i.e., verbal and/or written).
 - How the PCCs will document the consultation in the patient record and what will be included in the documentation.
 - Procedures and criteria for routine, urgent, and emergency requests.
 - Process to communicate about interim medication follow-up by PCCs.
- CAPs can also help the PCCs identify their ability to handle psychiatric problems in their practices and when necessary, can help facilitate referrals to other mental health or community agencies.
- Consultation with CAPs can serve to triage primary care patients, based on acuity and complexity, to the appropriate level of service intensity (e.g., direct evaluation

and treatment by the CAP, or emergency care and inpatient hospitalization when indicated).

2. Direct Psychiatric Service

CAPs generally need to provide direct psychiatric assessments. In consultation with a PCC, a CAP may determine, based on the description of illness acuity and complexity, that the patient needs to be directly evaluated by the CAP or a child mental health clinician. Collaborative partnerships are significantly strengthened by the provision of (or at least facilitation of) urgent patient evaluations and treatment recommendations.

- CAPs must be able to provide or facilitate timely psychiatric evaluations. These evaluations ideally should occur within two to four weeks of the initial referral.
- Co-location models can most easily schedule these evaluations. Consultation or collaborative models will involve scheduling the evaluation in the offices of CAPs and/or affiliated child mental health clinicians.
- The use of telepsychiatry is an option, particularly in rural settings.
 - Telepsychiatry refers to the use of interactive video conferencing as a substitute for the actual presence of a CAP in a remote location.
 - With optimal connection speed, remote control camera, and high definition video and audio quality, the technology has been successful in the provision of remote interactive psychiatric evaluations of children, as well as allowing CAPs to remotely participate in case conferences and staff meetings.
 - When used in the context of a collaborative system in which both the CAP and PCC share responsibility for the success of the treatments, telepsychiatry can prove a valuable resource.
- The psychiatric evaluation or consultation should include biopsychosocial formulation, diagnostic impressions, and treatment/referral recommendations.^{13,14} Pragmatic and specific recommendations for the PCC are important to include in the consultation (i.e., medication management recommendations).
- Prompt communication of the findings and recommendations to the PCC is important.
 - Initial communication regarding urgent findings requiring immediate response by the PCC should be within the next business day; otherwise a written evaluation summary should be within one to two weeks.
 - Prompt written communication can be via shared EMR, secure fax, secure email, or letter.
 - All communication should be succinct and contain practical recommendations.

3. Care Coordination

Given the complexity of the nation's health care system, care coordination (or case management) is essential to helping patients and their families navigate access the

appropriate level of psychiatric services (e.g., outpatient, urgent, emergency, inpatient). Care coordination is an important component of effective collaborative partnerships.

- Care coordination needs to be part of the upfront consult partnership arrangements. CAPs and PCCs should consider the inclusion of a care coordinator well versed in utilizing the available community mental health resources
- Care coordination can range from the CAP providing advice to the PCC (i.e., provide critical information that allows the PCCs to advocate for and obtain necessary psychiatric services for their patients) to a designated case coordinator (i.e., BA-level resource specialist or social worker) who provides case management services (i.e., finding available mental health clinicians or intensive psychiatric resources). The latter is responsible for the care coordination needs of patients in their families, while sparing the CAP and PCC from case management services.
- The options for a designated care coordinator include: 1) PCCs and/or their office staff, 2) CAPs and/or their office staff, 3) parent advocates, parent partners, or a family member.
- Families and youth, as developmentally appropriate, must have a primary decision-making role in their treatment. They should: be involved in making decisions regarding providers and others involved in the treatment team; be encouraged to express preferences, needs, priorities, and disagreements; collaborate actively in treatment plan development and in identifying desired goals and outcomes; be given the best knowledge and information to make decisions; make joint decisions with their treatment team; and participate actively in monitoring treatment outcomes and modifying treatment.
- The federal government is encouraging physicians to computerize medical records by providing incentives ranging from \$44,000 to \$64,000 for individual practices and up to \$11 million to hospitals. Many of these technologies provide remote consultation for case management, continuing education, and virtual encounters, and can be used to further collaboration between CAPS and PCCs.

4. PCC Education

CAPs have the opportunity to educate PCCs regarding child mental health issues and treatments that allow PCCs to extend their involvement in mental health care beyond their usual scope of practice. They also have the opportunity to guide PCCs in the education of their patients and their families.

- Education opportunities are evident in the case-based teaching that occurs in the consultations and direct psychiatric services provided to the PCCs patients.
- CAPs can “lunch and learn” in primary care practices about cases, diagnosis, treatment, best practices, therapies, and community resources.
- CAPs can implement, facilitate, and/or participate in CME training events, case conferences, and collaborative office rounds¹⁵ where PCCs and CAPs share opinions on the care of selected patients.

- CAPs can help develop and implement routine mental health screening practices in the context of health maintenance visits. Rating scales can provide useful information to aid in the assessment and monitoring of mental health problems. CAPs can provide training in the selection, administration, and interpretation of psychiatric rating scales.
- CAPs can educate the PCCs on the availability of AACAP's *Facts for Families*, AACAP Resource Centers, and other educational handouts and website resources.
- CAPs can look for the opportunity to train both child and adolescent psychiatry residents and primary care clinicians by incorporating collaborative mental health care into their curriculum and/or clinical training whenever possible.

Implementation of Collaborative Mental Health Care Partnerships

1. Advocating Collaboratively

Advocating for collaborative mental health partnerships ranges from simple networking with community PCCs, to implementing a local community program, and all the way to recent successful efforts to build large-scale partnerships that impact at state levels.¹⁷ CAPs working with PCCs have proven to be a successful combination in building a strong foundation of awareness and concern among the widest array of stakeholders about the problems of access to children’s mental health services.^{1,6}

- CAPs should be aware that AACAP is an important resource for child mental health advocacy efforts (<http://www.aacap.org/cs/advocacy>). It provides government liaison and education in response to national concerns over health care and social-economic issues affecting children at the local, state, and national level. While AACAP has a commitment to educating policymakers, leaders, and the public about children’s mental health, most importantly it is a resource for CAPs to learn effective advocacy strategies.
- CAPs who want to advocate for the development, implementation, and/or maintenance of a collaborative mental health partnership should find PCCs interested in joining the effort. To begin your advocacy efforts, you should:
 - Establish a relationship with a community PCC who can join with you in championing collaboration in the primary setting.
 - Contact your local chapter of the American Academy of Pediatrics (AAP) and Academy of Family Physicians to garner their support.
 - Arrange a face-to-face meeting to gauge local needs and collect ideas and commitments for how each organization is willing to participate.
- It is important that CAPs wanting to understand the PCCs viewpoint should review the AAP’s Task Force on Mental Health’s *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit*.¹¹ This kit was developed by AAP to help address the mental health needs of children and adolescents that PCCs who provide *medical homes* face (see Appendix II).
- Together with PCCs, CAPs must work toward building and/or joining a coalition of partners who have a stake in the development of collaborative mental health care partnerships. This can start with informal visits and case discussions, as well as hosting “round tables.” These partners may include some or all of the following:
 - Individual families and their parent/family organizations (e.g., NAMI, CHADD, others).
 - Youth advocates.
 - Public health and/or mental health agencies.
 - Community mental health clinicians and/or programs.
 - Academic medical hospitals or centers.
 - Elected officials at local, state, and/or national levels.
 - Parent/teacher organizations.

- The coalition should collect local information regarding childhood psychiatric illnesses and their needs. ^{4,5,11,17} They should become knowledgeable of local community access challenges through previous needs assessments or work to define these needs. This data will assist in building the case/need for new models of care.
 - Given that budgetary challenges are the norm, it is important for CAPs to be prepared to estimate the impact of a partnership on health care costs (e.g., emergency room visits, repeated medical appointments for psychiatric problems, unnecessary medical admissions).
 - CAPs must understand local public concerns regarding children’s mental health.
 - For example, the community may be concerned about the overuse of psychiatric medications in young children. In this case, improving collaboration with PCCs could be proposed as a strategy to increase evidence-based care and advocate for the appropriate use of behavioral therapies.
- CAPs should work with a coalition of interested parties to devise a plan or strategy to implement a collaborative mental health care partnership. This may involve developing or obtaining educational materials as needed. It may involve networking with agencies that have the potential to provide funding, such as a state health and human service agency, a legislative champion or chair of a relevant legislative committee, a grant making agency, or a large regional insurance plan.

2. Partnering with PCCs

Experience with collaborative mental health partnerships has shown that a "*build it and they will come*" principle is not a winning strategy. In most communities, PCCs and CAPs are not accustomed to a collaborative working relationship. In successful partnerships, CAPs systematically reach out to PCCs to engage them in the specific consultative service model.

- The AAP’s Task Force on Mental Health’s *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit* provides CAPs pragmatic information useful in understanding, engaging, and partnering with PCCs (see Appendix II).¹¹
- For consultation or collaborative partnership models, establishing a formal enrollment process for PCC practices can be helpful in engaging PCCs. This involves arranging an in-person orientation meeting at the PCCs’ office in which CAPs can describe the program and give instructions on how to utilize it.
 - If face-to-face meetings at the PCCs’ offices are difficult to arrange, then other strategies, such as setting up free regional CME events, may help to spread the word about the program.
- There must be a well-outlined agreement between the CAPs and PCCs regarding the specific types of mental health services that are being provided in the collaborative partnership.

- For example, it might be emphasized that the CAP does not accept the patient as a "referral" in a consultation partnership; rather, the patient remains the responsibility of the PCC and the program helps the PCC in sorting out what to do for the patient. This might apply even in cases where the CAP assesses the patient and meets with the family.
- Collaborative mental health care partnerships should convey the clear recognition that many patients (i.e., those with more severe disorders) should be under the care of a CAP, that CAPs and PCCs will work together to identify the patients in need of specialized child mental health services, and that ideally the partnership will have a care coordinator who can assist the CAPs and PCCs in securing ongoing specialist services for them. For more information, see AACAP's guidelines on [When to Seek Referral of Consultation with a Child and Adolescent Psychiatrists](#) (2003).
- The most important predictor for program success is PCC satisfaction with initial encounters with CAPs. Key drivers of continued program utilization include quick response times, direct psychiatric service, timely communications, and available care coordination.
- CAPS should be aware of the increasing expectations of pediatricians around screening for emotional and behavioral health practices at all age levels.¹¹

3. Partnering with Families

Parents of children with psychiatric disorders are often on their own as they look for services and learn the financial and practical obligations associated with treatment. Little consistent information is typically available on these illnesses and parents can only guess at the best possible care available. They may fear the stigma that is associated with psychiatric diagnoses. The integration of mental health services through Medical Homes is the first step in overcoming these challenges.¹¹

- As the "default provider" of mental health services, PCCs are accustomed to having mental health issues brought to their attention in desperate situations. However, children and their families may not be accustomed to discussing mental health problems with their PCCs.
- CAPs may consider outreach endeavors (e.g., educational brochures) to families, which encourage them to talk with their PCCs about their children's emotional and behavioral problems as a useful way to engage families with collaborative partnerships.¹⁹
- In community outreach, CAPS must consider the diverse ethnic and religious backgrounds of the community, and keep in mind the financial limitations of the families that they serve.
- PCCs should be encouraged to inform their families of the availability of the collaborative mental health partnership program to ensure that utilizing the program is consistent with their preferences, and subsequently to share with them the results of the consultation.

4. Engaging Community Partners

CAPs should alert the community health care system regarding the existence of a collaborative care partnership, including its specific capabilities and its need for community involvement. CAPs should understand that PCCs may have standing working relationships with other types of child mental health clinicians that can and should be involved in a partnership.

- CAPs can help identify a network of culturally diverse community child mental health clinicians (e.g., psychologists, social workers, or advanced practice nurses) who are willing to participate in an integrative health care delivery model.
- CAPs can engage local psychotherapists regarding accepting some targeted referrals (e.g., specific types of therapy and preferred patient populations).
- CAPs can engage local advanced practice nurses regarding accepting some targeted referrals (e.g., psychopharmacologic services)
- CAPs can engage community non-partnership CAPs and encourage them to accept some targeted referrals.
- CAPs can explore allowing community child mental health clinicians to take advantage of educational and clinical resources offered through the collaborative care partnership in return for their participation.

5. Considerations in Recruiting CAPs

CAPs are particularly suited to work in a collaborative mental health partnership models. Not only are CAPs in position to recommend psychotherapy and psychopharmacology, they are also well-positioned to understand the complexity of integrating mental health assessment and treatment into primary care practice. Recruiting CAPs into collaborative mental health partnerships requires the identification of physicians who are interested in consultation service models and have the interest and flexibility to respond to the time demands of collaborative care models.

- Recruitment efforts should aim at selecting CAPs who enjoy seeing new patients, are able to tolerate ambiguity and less direct control, are efficient in dictating concise and practical consultation letters, enjoy teaching, have good written and verbal communication skills, have a strong interest in prevention, community mental health, and/or population-based medicine, have an interest in systems of mental health care, and understand the relationship between PCCs and mental health clinicians.
- CAPs need specific protocols regarding *“how to handle requests for ongoing services”* that grow out of the collaborative partnerships and the *“level of their clinical responsibility”* that follows assessment and treatment recommendations.
- CAP availability will need to be structured and time-limited. Strategies for managing time include:
 - In consultation or collaborative models, CAPs need to have scheduled breaks during their patient day or blocks of time available to provide the service.

While less pressured, CAPs in co-location models also need to allow for time to communicate with their onsite colleagues.

- Carefully informing patients and families of the time-limited consultative nature of the services provided.
- Medication recommendations are given to the PCC, rather than the CAP writing a prescription themselves. The CAP only provides recommendations for medications.
- If the child has a serious psychiatric disorder in need of specialty treatment, another party needs to provide care coordination to the PCC and/or family. As noted earlier, an individual employed to specialize in this function best delivers care coordination or case management.

6. Managing the Workflow

The workflow for CAPs depends on the nature of the collaborative care model. Participation could range from direct consultation on every identified case, to a role in a system defined by levels of care (divided among multiple mental health specialists that begin with the PCCs).

- Consultation begins at the moment PCCs would like assistance with a client. The PCC contacts the CAPs through the agreed upon communication protocol (e.g., direct call to CAP, call to an assistant, or other).
- CAPs and PCCs have a direct timely communication about the specific patient in one of the following modalities:
 - In person (e.g., co-located provider or at pre-arranged meeting times);
 - Via telephone;
 - Via telepsychiatry;
 - Via secure email (regular email must not contain HIPAA protected information); or
 - Via exchanged notes in EMR
- CAPs should focus on answering the PCCs question(s), which generally fall in one of the following types of consultation questions:²⁰
 - Diagnostic questions (i.e., how to assess complicated mood disorders, anxiety disorders, ADHD, and substance use disorders);
 - Management questions (i.e., how to implement behavioral and environmental interventions and/or manage psychotropic medications);
 - Disposition questions (i.e., when to refer to a therapist, when to refer for psychiatric evaluation and treatment, and how to coordinate services); or
 - Crisis and safety questions (i.e., how to assess and respond to a suicidal patient).
- Complicated patient scenarios that cannot be sufficiently addressed by an initial PCC and CAP consultation should be steered toward direct psychiatry evaluation with the CAP and/or another child mental health clinician.

- There are circumstances where PCCs request a “*second opinion*” for children already in the care of an existing child mental health specialist.
 - While indicated, the risk of undermining an existing treatment relationship must be weighed.
 - In these cases, CAPs may choose to offer general advice while facilitating communication between the PCCs and the existing child mental health clinicians.
 - Another alternative would be for CAPs to offer to review the PCCs questions with the current mental health clinician.
- CAPs should maintain medical records on all consultations they perform.
 - Liability issues are largely addressed by records that document the patient scenario from the PCC and the advice offered based on that scenario.
 - Consideration should be given to providing the PCC with a written summary of these recommendations.
 - Consultations should be securely maintained per HIPAA guidelines.
 - CAPs should have their malpractice insurer review their work to ensure that it is covered by their insurance.
- CAPs can encourage and support PCCs in initiating treatment for those mental health problems that can adequately be managed in their practice.
- CAPs can identify a plan whereby PCCs refer patients to CAPs who meet predetermined criteria for clinical severity and/or when local mental health services are unsuccessful.
- CAPs can serve not only as consultants but may also be supervisors for child mental health clinicians participating in the partnership. They provide administrative leadership for the program.
- CAPs can provide PCCs and their families with tools and materials that promote wellness and early identification (e.g., providing sample psychiatric rating scales and/or sample patient handouts).
- If there is not an identified care coordinator, CAPs need to reach an agreement with the PCCs as to who will have responsibility for coordinating needed psychiatric services.

7. Program Evaluation

While we know that early treatment for common children’s psychiatric illnesses is useful in preventing adverse outcomes (e.g., juvenile delinquency, disability, reductions in parental work productivity, and increased overall healthcare utilization),¹⁸ the long-term impact of collaborative mental health partnerships on the costs of these outcomes in children has not yet been systematically studied.

Strategies to evaluate the effectiveness of collaborative mental health care partnerships are essential in order to determine that the partnership is meeting its established goals. Many of the current larger consultation or collaborative partnerships began as small pilot projects.

In order to expand these pilots into larger, statewide programs, outcome data is critical in justifying their expansion.¹

- Considerations of what can be measured and evaluated may include:
 - Improved patient and family satisfaction;
 - Improved PCC satisfaction;
 - Improved CAP satisfaction;
 - Improved access to timely consultation for the PCC;
 - Improved access to timely direct evaluation of children and families by the CAP;
 - Improved quality of mental health and substance abuse disorder care delivered in the primary care setting;
 - Improved clinical outcomes per family reports;
 - Improved dissemination of evidenced-based treatment strategies;
 - Improved efficiency of mental health care delivery system;
 - Reduced unnecessary utilization of high service intensity levels (emergency room visits, inpatient hospitalizations, out of home placements); and
 - Adherence rates to consultant recommendations.
- Performance can be measured through the analysis of process variables:
 - Number of encounters;
 - Rates of psychiatric diagnosis;
 - Rates of psychiatric treatment in the primary care setting (following billing codes);
 - Number of CAP consultation requests;
 - Number of referrals to mental health professionals within the collaborative care network;
 - Response times for consultations; and
 - Wait times for direct consultations.
- Programs may conduct patient follow-up studies to examine specific clinical outcomes after recommendations are made.

8. Sustainability

Funding is a crucial issue to address in any of the collaborative mental health partnerships models. Collateral contacts between physicians or other important figures in a child's life (i.e., school) are generally not covered or, if so, at low reimbursement rates. Yet, collateral contacts and care coordination are critical elements to integrated health care. CAPs and PCCs must work together to insure adequate reimbursement for their collaborative mental health partnerships. The efforts have necessitated going beyond traditional fee-for-service models of care to advocate for new models of financial support whereby states, foundations, and/or even health insurance carriers *come to the table* to support collaborative partnerships.¹

- Reimbursement requirements for a large scale child mental health care partnership should include the following, at a minimum:
 - CAPs and/or affiliated child mental health clinicians
 - Collateral contacts related to PCC consultations, including telephone time and telepsychiatry
 - Billable face-to-face patient psychiatric care
 - PCCs' time
 - May be adequately reimbursed by including the time spent in collateral contacts with CAPs in the PCCs' visit level E&M code. The differential from one level visit to the next may not be equivalent to the time spent. Also if the consult takes place separated in time from the E&M this would be logistically difficult.
 - Payment for the PCC for time spent on phone or telemedicine.
 - Increase in per member per month (pmpm) to practices that engage in collaborative model.
 - Care coordinator
 - Communication costs
 - Communication costs (i.e., telephone, medical record, and transcriptions)
 - Telepsychiatry
 - Educational and/or consultant group meetings
- Besides direct billable patient services, CAPs, PCCs, and families should join together to advocate for the following funding from the following potential sources:¹
 - State Medicaid agency and/or state legislature.
 - Health insurance carrier.
 - State insurance commissioner and/or group of insurers could collaborate in collectively pooling together financial support for a shared consult program
 - Private/public foundation support for integrative health care models.
- CAPs can advocate with the above funding sources to support collateral contacts. These contacts are the process by which CAPs contact a primary care physician, foster care social worker, or teacher to coordinate and integrate a child's mental health care with other aspects of his or her life. This collaborative work is essential to the coordination of a child's overall health care.
 - For example, telephone time between CAPs and PCCs is not reimbursable in the standard insurance system. Yet, insurers or agencies could choose to activate and pay for current CPT billing codes, which pay for phone consultations.
 - Another example is to allow for standard billing procedures to be used for telepsychiatry evaluations.

9. Legal & Liability Issues

Consultation between physicians is a deeply established tradition within the medical profession. The activities of CAPs within collaborative systems require and depend on both

direct and indirect consultations regarding patients and their families. Despite the time-honored tradition of consultation, malpractice liability and privacy concerns regarding these activities can serve as a barrier to the development of collaborative relationships.

Consultations between physicians occur on the following different levels of interaction regarding patients:

- Psychoeducation activities
 - These educational activities include individual or group settings where formal and informal teaching occurs around children and their families.
 - In these activities, there are no specific identifiers for any specific patients discussed.
 - CAPs are at minimal risk for malpractice as a result of these activities.
- Indirect or informal or “curbside” consultations
 - In these consultations, CAPs have not personally evaluated the specific patient in question and there is not an established doctor-patient relationship.
 - These consultations regarding specific patients have long been considered to be protected from litigation. It is extremely rare for an informally consulted physician to be the subject of a malpractice suit.
 - Nonetheless, the following strategies may help to further minimize liability.
 - In keeping with their consultative role, CAPs should avoid using prescriptive language in their communications with PCCs.
 - CAPs should *inform* PCCs regarding best practices for assessment and management of various presenting problems
 - CAPs should *suggest* or *recommend that the PCC consider* follow-up plans and interventions.
 - CAPs may consider maintaining a log to record basic information about the consultation encounter including identifying information of the PCC and clinical information (but not identifying information about the patient), and a brief description of consultation question, and recommendation made. Such a log would be useful in the unlikely event of a subpoena.
 - Unless necessary for clinical purposes, identifying information about the patient should not be shared.
- Formal Collaboration Programs
 - PCCs and CAPs may develop more formal consultative relationships where the PCCs and the CAPs discuss a specific patient in more detail and the CAP provides more formal consultation, but does not see the patient for evaluation.
 - The PCC is responsible for making medical judgments, implementing treatment, and communicating with the patient and family.

- Both parties should document such a consultation. It is considered a legitimate professional service that can be billed and paid for by some health plans.
 - The CAP is responsible for the professional advice provided to the PCC but has not established a physician-patient relationship with the patient. This reduces professional liability exposure.
- Direct or formal consultations
 - In these consultations, CAPs personally evaluate a specific patient referred by a PCC and render recommendations to the family and the PCCs.
 - These consultations have the same legal risk as any other situation in which CAPs provide direct patient care.
 - As is customary, CAPs should obtain voluntary and knowledgeable informed consent from the patient and/or guardian before assessment or treatment.
 - Despite general information presented to the patient and family about the collaboration or consultation, a written release authorizing communication between professionals and specifying the nature of clinical data to be shared mitigates confidentiality and privacy concerns.
 - As was previously stated, documentation of clinically relevant material remains legally necessary. Since this is a customary service, standard professional liability policies should provide coverage and assure protection if there is an allegation that CAPs or PCCs have violated the standard of care, with resulting harm.

Concluding Comments

We end as we began: *Collaborative mental health care partnerships are crucial to the integration of mental health into pediatric primary care.*¹⁻³ Given that children with chronic mental illnesses are more prevalent than those with leukemia, diabetes and AIDS combined, the importance of integrated health care is critical. Part of the solution lies in the collaborative mental health partnerships whereby coordinated communication between all health care providers to coordinate systems of care for the child and family is essential.

We have seen the development and implementation of a number of successful collaborative mental health partnerships across our country (see Appendix III). These successes are truly encouraging. Yet, we also understand the new models of delivering care are daunting to most CAPS. The models present challenges, such as how to ensure that care coordination gets done and how to develop reimbursement models that go beyond current fee-for-service reimbursement models that are only medical and diagnosis driven. However, most ventures start small and build the advocacy through the months and years of positive outcomes and data reflecting improved access to mental health care. At this juncture, it is critical to the mental health care of our nation's children and adolescents that

CAPs remain at the forefront in the development and implementation of collaborative mental health care partnerships in the pediatric setting.

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Appendix I.

American Academy of Pediatrics' Chapter Action Kit & Clinician's Toolkit

Strategies for System Change in Children's Mental Health: A Chapter Action Kit

Strategies for System Change in Children's Mental Health: A Chapter Action Kit was developed out of a need to strategize how the American Academy of Pediatrics chapters can address the growing mental health needs of children and adolescents that pediatricians and other primary care clinicians who provide medical homes face. The strategies offered in this kit vary in time, effort, funding requirements, and collaboration with state, regional, and local partners. The Chapter Action Kit is a true collaborative effort, resulting in many hours of hard work, mainly by Jane Meschan Foy, MD, chair of the AAP Task Force on Mental Health (TFOMH); the TFOMH volunteers; our consultant, Karen J. VanLandeghem, MPH; Judith C. Dolins, MPH, director of the AAP Department of Community, Chapter, and State Affairs; and Aldina Hovde, MSW, manager, Mental Health Initiatives.

This kit includes chapters on strategies for partnering with families, assessing the service environment, collaborating with mental health professionals, educating AAP Chapter members, partnering with child service agencies, and improving children's mental health financing.

<http://www.aap.org/commpeds/doch/mentalhealth/cak/final%20cak.pdf>

(Accessed April 5, 2010)

Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit

Accessed through the American Academy of Pediatrics' Bookstore, *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit* brings together ready-to-use resources and tools on one instant-access CD-ROM. This clinician's toolkit includes screening and assessment instruments, quick-reference care management advice, step-by-step care plans, parent handouts, and community resource guides. Clinical tools provide step-by-step decision support for assessment and care of children with the most common mental health symptoms: anxiety, depression, disruptive behavior and aggression, inattention and impulsivity, substance use, learning difficulties, and social-emotional problems in young children.

https://www.nfaap.org/netforum/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=98c49253-ce05-465d-9b3e-3b9a4a48794d

(Accessed April 28, 2010)

Appendix II.

Collaborative Projects – Children’s Mental Health in Primary Care

The American Academy of Pediatrics (AAP) Task Force on Mental Health (TFOMH) has supported the development of collaborative projects of care among primary care clinicians and mental health professionals toward a goal of continually improving delivery of health care to children and their families. Collaborative models of care include rural and mental health care models. A number of primary care clinicians have had success with employing, co-locating with, and collaborating with social workers, psychologists, and nurse practitioners with specialized training to provide mental health services for children.

Please note that the list of projects that can be accessed online were compiled from a number of sources, including AAP Chapter Presidents, Vice Presidents, Executive Directors, Pediatrics for the 21st Century symposium presenters, AAP mental health listserv participants, AAP Task Force on Mental Health members, AAP Council on Community Pediatrics Rural Health Special Interest Group members, Bright Futures members, and others. The list is not exhaustive.

<http://www.aap.org/mentalhealth/mh3co.html>

(Accessed April 28, 2010)

Appendix III.

Selected AACAP Members Participating in Collaborative Mental Health Care Partnerships

Arkansas – Consultation model

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Colorado – Consultation model

Brian Stafford, M.D., MPH, FAAP
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Delaware – Consultation Model

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Massachusetts – Consultation model

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Minnesota – Collaborative model

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¹Earls M. Mental Health Integration through Co-Location: The North Carolina Collaborative Care Model.
Jul/Aug 2009

²Sood A. Roadway To A Regional Consultation Service for Primary Care Providers: The Virginia Experience.
Nov/Dec 2009

³Hilt R. The Partnership Access Line: State Telemedicine Consultation Service for Primary Care Providers.
AACAP News. May/Jun 2009