Linking and Integrating With Primary Care:
The Medical Home Model for Children’s Mental Health

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Objectives

Participants will be able to…

- Describe the concept of the medical home, particularly as it applies to the care of children with special health care needs;
- List challenges commonly encountered in providing a medical home to children with mental health problems; and
- Identify strategies and tools for linking medical homes and systems of care for children with mental health problems, highlighting opportunities presented by the Affordable Care Act.
What is a medical home?
A medical home is NOT a...

- Building
- House
- Hospital
A medical home IS.....

- A family-centered, interdisciplinary partnership in the primary care setting
- A source of accessible preventive, acute, and chronic care services that are
  - Coordinated
  - Compassionate
  - Continuous
  - Comprehensive
  - Culturally effective
- An entry point to community medical and non-medical services for all children and youth, especially those with special health care needs
Children and Youth With Special Health Care Needs (CYSHCN):

Definition:

Children and youth with special health care needs are 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.

Maternal and Child Health Bureau, 1995
CYSHCN: examples

- Premature infants
- Children with growth failure
- Children with chronic medical conditions (eg, asthma, diabetes, sickle cell anemia, cancer)
- Children with developmental delays
- Children / youth with mental health (MH) or substance abuse (SA) problems
- Children / youth whose caregivers have psychosocial problems (eg, parental MH problems, developmental disabilities, SA)
Medical home characteristics

- Family-centered
- Coordinated
- Continuous
- Accessible
- Comprehensive
- Compassionate
- Culturally Effective
Family-centered

- The family is recognized as the principal caregiver and center of strength and support for the child, as well as the expert.
- The medical home physician and practice team is knowledgeable about the family, its culture, and needs including health literacy.
- Mutual responsibility and trust exist among the CYSHCN, family, and the medical home physician and practice team.
- Clear, unbiased, and complete information and options are shared on an ongoing basis with the family.
- Families and youth are supported to play a central role in care coordination and share responsibility in decision making.
Coordinated

- A plan of care is developed by the physician, CYSHCN, and family and is shared with other providers involved with the care of the patient.

- Care among multiple providers is coordinated through the medical home.

- A central record or database containing all pertinent medical information, including hospitalizations and specialty care, is maintained at the practice. The record is accessible, but confidentiality is preserved.
The medical home physician and practice team shares information among the CYSHCN, family, and consultant; provides specific reason for referral; and assists the family and CYSHCN in communicating clinical issues.

Families are linked to support and advocacy groups, parent-to-parent groups, and other family resources.

The medical home physician evaluates and interprets consultant’s recommendations for the CYSHCN and family and, in consultation with them and sub-specialists, implements recommendations that are indicated and appropriate.
Continuous

- The same primary pediatric health care professionals are available from infancy through adolescence and young adulthood.

- Assistance with transitions, in the form of developmentally appropriate health assessments and counseling, is available to the CYSHCN and family.

- The medical home physician participates to the fullest extent allowed in care and discharge planning when the child is hospitalized or care is provided at another facility or by another provider.
Medical home team members

- Primary care clinician
- Family
- Child/youth
- Allied health care professionals
- Family’s community
- Pediatric office staff
- Representatives of agencies serving the child
- If necessary, pediatric subspecialists and mental health/substance abuse professionals
Outcomes of a medical home

- Optimal health and functioning of children and families
- Monitoring and coordination of care within/outside the primary care setting
- Patient and family satisfaction
- Professional satisfaction
- Cost-effective use of limited resources
- Forum for problem solving and quality improvement
How does the medical home concept apply to children with MH / SA problems?
Children with MH /SA problems are CYSHCN: primary care clinicians can / should provide them with a medical home.
Prevalence of MH / SA disorders, problems, & concerns

- **21%** of children and adolescents in the US meet diagnostic criteria for MH disorder with impaired functioning
- **16%** of children and adolescents in the US have impaired MH functioning and do not meet criteria for a disorder
- **13%** of school-aged, **10%** of preschool children with normal functioning have parents with “concerns”
- **50%** of adults in US with MH disorders had symptoms by the age of 14 years
- Children with chronic medical conditions have more than **2X** the likelihood of having a MH disorder
The “Primary Care Advantage” in providing mental health care

- Longitudinal, trusting relationship
- Family centeredness
- Unique opportunities for prevention & anticipatory guidance
- Understanding of common social-emotional & learning issues in context of development
- Experience in coordinating with specialists in the care of CYSHCN
- Familiarity with chronic care principles & practice improvement
Front line role of primary care in mental health

- Fit mental health care into pace of primary care practice
- Promote mental health (per *Bright Futures* guidance)
- Identify risks, intervene to prevent MH problems (acknowledging strengths)
- Elicit concerns (screening, acute care, chronic care)
- Overcome resistance, stigma, conflict, other barriers to help-seeking
- Address emerging problems, problems not rising to level of diagnosis
- Assess / manage MH problems
- Refer / co-manage / coordinate
- Monitor
The Four Quadrant Clinical Integration Model

**Quadrant I**
- Primary care provider has standard screens and guidelines
- Primary care provider-based MH

**Quadrant II**
- MH case mgr coordinates with primary care provider
- Primary care provider has standard screens and guidelines
- Specialty MH
- MH inpatient
- Crisis/ER

**Quadrant III**
- Primary care provider has standard screens and guidelines
- Primary care provider-based MH
- Care/Disease mgr
- Specialty medical
- Med/surg inpatient

**Quadrant IV**
- MH case mgr coordinates with primary care provider and disease mgr
- Primary care provider has standard screens and guidelines
- Specialty medical & MH
- MH and med/surg inpatient
- Crisis/ER

Source: Mauer BJ. Behavioral health/Primary Care Integration. The Four Quadrant Model and Evidence-Based Practices. Rockville, MD: National Council for Community Behavioral Healthcare; 2006
What are the challenges to providing a medical home for children with MH problems?
Current realities

- Many conditions are unidentified or identified late
- Most are untreated, especially minority children
- Current mental health system lacks workforce sufficient to meet the needs of children and youth
- Responsibility for care has shifted to schools and primary care, especially in rural areas
- Primary care system operates in parallel with other systems serving children with MH needs
Families’ perspective

- Stigma
- Reliance on other sources (e.g., faith community, mental health specialists)
- Distraction by demands of child’s condition
- Unawareness of the medical home as a source of mental health care (and other services)
- Lack of guidance in choosing a medical home: what questions to ask
System challenges

- Lack of support for preventive MH services and services to children without diagnosable conditions
- Administrative barriers within health care plans
- Barriers / lack of relationships with community providers ("silos")
- Paucity of mental health services, especially for children younger than age 6
- Lack of payment for the uninsured and underinsured
Primary care challenges

- Treating the “whole” child in the context of the family, its culture, the school, the community (especially with limited information exchange)

- Operationalizing family centeredness as part of the practice system

- Enhancing processes for children with MH/SA needs: engagement strategies, registries, longer visits, linkages to community resources, assistance with referrals, monitoring response to care, self-management strategies, health literacy
Primary care challenges (cont.)

- Considering family needs as well as office needs for scheduling and logistics (rapid pace of primary care)

- “Knowing the system” of public and private MH/SA providers locally

- Maintaining continuity and communication with specialists, child care, school, juvenile justice, departments of social services, Early Intervention…

- Adolescent-specific issues: denial, confidentiality, self-management strategies, health literacy…..
Primary care challenges (cont.)

- General shortage of mental health professionals
- Absence of mechanism for coordination with mental health providers
- Procedural requirements of public and private mental health programs (impact on professional relationships)
- Non-parity of MH benefits in insurance plans (still)
- Role of schools, departments of social services, juvenile justice
What are strategies and tools to link medical homes and systems of care?
Expand partnerships

- Consumers (e.g., National Alliance on Mental Illness, Federation of Families)
- Professional associations of MH providers
- Academic pediatricians and psychiatrists
- Area Health Education Center
- Primary care clinicians (pediatricians, family medicine, nurse practitioners, physician assistants)
- Juvenile justice / departments of social services
- State department of education / local school systems
- Early Intervention system
- Medicaid / SCHIP agencies
- Insurers
Foster collaborative models

- Off-site collaboration
- Co-location / integration of MH professional in primary care setting
- Expedited psychiatry consultation for PC clinicians (eg, MCPAP)
- Tele-psychiatry
- Primary care involvement in System of Care
Enhance communication between primary care clinicians (PCCs) and mental health / Early Intervention community

- Include PCCs in System of Care planning
- Develop relationships through collaborative projects (e.g., community protocols for psychiatric emergencies and for assessment of children with academic problems, MH resource directory, “mixers”…)
- Routinely request family’s authorization for exchange of information with PCC
- Use mutually-approved forms for exchange of information and care planning
Raise awareness of new consumer protections in the Affordable Care Act

- All *Bright Futures* services covered with no co-pays
- Elimination of pre-existing condition exclusions for children (including mental health and substance use disorder)
- Extension of dependent coverage to young adults up to age 26, regardless of marital status.
- Elimination of lifetime limits and restricted annual limits ("caps") on benefits
- New temporary insurance option called the *Pre-Existing Condition Insurance Plan* until 2014 (must have been denied insurance due to pre-ex condition, 6 months uninsured prior to enrollment)
Pursue opportunities in the Affordable Care Act: the Medicaid “health” home

- State option to provide health homes for Medicaid enrollees with a chronic condition or one serious and persistent mental health condition
- Increased federal share of payment for enrollees in program
- Health homes based on AAP medical home model and payments made to each provider or to the team of health home professionals
- Effective January 1, 2011, Centers of Medicare & Medicaid Services (CMS) beginning to award planning grants to states
Pursue opportunities in the Affordable Care Act: Essential Health Benefits Pkg

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

42 USC 18022.
Pursue other opportunities in the Affordable Care Act…

- Monitor process whereby Secretary of HHS / IOM define list of services in the essential benefit package
- Protect current and future state benefit mandates for insurance coverage
- Maintain the Prevention and Public Health Trust Fund ($750 million in FY11 and includes funding for mental health services)
- Seek opportunities within Accountable Care Organizations to enhance the medical home
- Advocate to fund new or existing programs such as the new loan repayment program for pediatric subspecialists and pediatric surgical specialists (up to $35,000 per year for at least two years of full-time pediatric subspecialty work in a shortage area)
Advocate for resources & system changes

Examples:

- Fully implement insurance parity
- Subsidize child psychiatrists (e.g., consultation network)
- Incorporate MH care coordination into ECCS (Early Childhood Comprehensive Services) early childhood health plan
- Optimize Medicaid / SCHIP benefits and program design
Advocate for Medicaid policies that foster collaboration between primary care and mental health

- Generally enhanced reimbursement for MH/SA services
- Payment for visits not resulting in a diagnostic code (ie, screening, testing, multi-visit assessment)
- “Incident to” rule changes (supervision requirements, site restrictions, limitations on certain disciplines)
Advocate for Medicaid policies that foster collaboration between primary care and mental health (continued)

- Direct enrollment of MH providers
- Payment for new categories of MH professionals
- Addressing systems issues in state MH system (patient access, referrals, collaborative practice)
- Enhancements in locations of service (eg, school-based services)
Advocate for Medicaid policies that foster collaboration between primary care and mental health (continued)

- Enhancements in care coordination system
- Enhanced payment for physicians with advanced credentials (eg, developmental-behavioral pediatricians)
- Payment for non-face-to-face services
Engage public health community in providing the population perspective

- Publicize mental health trends
- Identify and address risk factors for childhood mental illness
- Identify and enhance protective factors
Champion community-level preventive programs

Examples:

- Nurse-family Partnership (Olds model)
- Evidence-based parenting programs
- Environmental health (lead, mercury…)
- Healthy lifestyles (nutrition, physical activity, stress management, sleep…)
Improve early identification

Examples:

- MH screening at all ages
- Warning signs (child and family)
- Training of school / public health personnel
- Child care training / consultation
- Transition from Early Intervention system to schools
Incorporate mental health services/perspective into public health programs

- Mental Health
- Child service coordination
- Maternity care coordination
- High risk obstetric clinics
- School Health (!!!)
- Child care consultation
- Disaster preparedness
Educate public

Examples:

- Parent education (anticipatory guidance, building resilience, early signs of distress)
- Public campaign addressing stigma
Access AAP resources

- Strategies for System Change in Children’s Mental Health: A Chapter Action Kit
- Web site: [www.aap.org/mentalhealth](http://www.aap.org/mentalhealth)
- Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration (joint white paper with AACAP), *Pediatrics*, April 2009
- The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care (policy statement), *Pediatrics*, July 2009
- Supplement to *Pediatrics*, June, 2010
ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN’S TOOLKIT
Sample tools for collaboration

- Glossary of MH / SA terms
- Matrix of evidence-based psychosocial interventions
- Listing of evidence-based parenting programs
- Guidelines for developing a community-specific MH directory
- Referral assistance and resources for families
- Forms to facilitate exchange of information with MH / SA / Early Intervention (EI) specialists and schools
- Sample care plans
Monitor impact of changes at the community level

- Participating MH providers
- Claims data / Medicaid & SCHIP
- Youth Risk Behavior Survey
- Persons receiving MH services by race / ethnicity
- Abuse / neglect rates; out-of-home placements
- Educational outcomes (drop-out, suspension, graduation rate)
- Juvenile crime rate
- Injuries
- Consumer / provider opinion
WELCOME to the National Center for Medical Home Implementation. This resource is for health professionals, families, and anyone interested in creating a medical home for all children and youth.

WHAT IS A FAMILY-CENTERED MEDICAL HOME?

A family-centered medical home is not a building, house, hospital, or home healthcare service, but rather an approach to providing comprehensive primary care.

In a family-centered medical home the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met.

Through this partnership the pediatric care team can help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family.

The American Academy of Pediatrics (AAP) developed the medical home model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including those with special health care needs.

FIND US ON FACEBOOK!

National Center for Medical Home Implementation

QUICK LINKS

Building Your Medical Home Toolkit
Child Health Issues & Medical Home
Children & Youth With Special Health Needs
Family-Centered Medical Home Overview
Medical Homes@Work e-Newsletter
Upcoming Conferences

FOR FAMILIES

Building Your Care Notebook
Family-to-Family Health Information Centers
HealthyChildren.org
How to Partner With Your Physician
Title V Overview
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EVERY CHILD DESERVES A MEDICAL HOME