

Strategic Planning Report

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I. INTRODUCTION

The Massachusetts Child Psychiatry Access Project (MCPAP) was established in 2004 to ensure the best use of limited child psychiatry resources by strengthening the ability of primary care providers (PCPs)¹ to manage the mild to moderate behavioral health² needs of their pediatric patients, freeing scarce child and adolescent psychiatrists (CAPs) to manage more serious and complex conditions. Child psychiatry continues to be in short supply across the country, as well as in Massachusetts. Massachusetts had 300 child and adolescent psychiatrists (CAPs) in 2009, more per child than in any other state but Hawaii³. However, this is far fewer than needed to provide appropriate access. Compounding this issue, it is common for CAPs not to accept insurance, making them unavailable to many families and resulting in long waits for services.⁴ In addition, the shortage of CAPs shows no signs of improving. A 2009 report by Blue Cross Blue Shield Foundation, “Accessing Children’s Mental Health Services in Massachusetts: Workforce Capacity Assessment,” found that 54 percent of CAPs planned to leave the field or the state by 2016.⁵ This survey has not been repeated, and current information is unavailable.

MCPAP offers pediatric PCPs same-day telephonic consultation with a CAP or a licensed behavioral health clinician; face-to-face psychiatric or behavioral health consultations for patients when needed, with a written summary provided to the PCP; and assistance with referral to community-based behavioral health services. MCPAP also offers training in the form of monthly webinars, practice-based education on screening, diagnostics, and medications, and a bi-monthly newsletter. MCPAP services are currently provided through six regional hubs located at academic teaching hospitals throughout the state. All services are available at no charge to Massachusetts PCPs serving any child, regardless of insurance. The Department of Mental Health (DMH) is the primary funder of MCPAP, with additional funding accruing to the state through a surcharge on commercial insurers.

After 11 years of operations, it was time to revisit the MCPAP model to ensure the program continues to effectively and efficiently meet the needs of primary care providers serving youth throughout the state. DMH and MCPAP selected DMA Health Strategies to conduct a strategic planning assessment. The goals of the assessment were to:

1. Determine whether MCPAP has opportunities for performance improvement
2. Determine whether MCPAP requires modifications in light of the changing health care environment, which is moving toward more closely integrated behavioral health and primary care and alternative payment methods

A. Strategic Assessment Questions

DMA Health Strategies collaborated with MCPAP and DMH to develop the following strategic questions that guided the assessment.

¹ In this report, the term primary care provider or PCP refers to pediatricians, family physicians, nurse practitioners, physician assistants, and their supporting practice staff such as behavioral health clinicians and care coordinators.

² The term behavioral health refers to mental health and substance use.

³ Substance Abuse and Mental Health Services Administration, Behavioral Health, United States, 2012, HHS Publication No. (SMA) 13-4797. Rockville, MD.

⁴ The Lewin Group and DMA Health Strategies, 2009, Accessing Children’s Mental Health Services in Massachusetts: Workforce Capacity Assessment, Blue Cross Blue Shield of Massachusetts Foundation.

⁵ Ibid.

1. **MCPAP Performance**
 - a. What does MCPAP administrative data tell us about the use of MCPAP resources over the past 11 years?
 - b. How efficiently and effectively is MCPAP performing its current functions?
 - c. What aspects of the MCPAP design are critical to its effectiveness?
 - d. Are there alternative ways to perform these functions?
2. **Management of Behavioral Health in Primary Care**
 - a. How are primary care practices serving youth managing patients' behavioral health care?
 - b. What additional supports do PCPs need, and where should these be provided? Are they best provided within the practice, by a health system or physician organization, by MCPAP, or in some other fashion?
3. **Changes in Pediatric Primary Care**
 - a. How are primary care practices serving youth changing, and how is this likely to affect what they need to manage mental health care?
 - i. What new MCPAP or other supports will be needed in five years to support their management of behavioral health care?
 - ii. What changes might make some MCPAP functions obsolete?
4. **Evolving Health Care System**
 - a. How will changing forms of payment and organization over the next five years affect what primary care practices serving youth need to manage behavioral health care?
 - b. How will new financing models change the role and/or viability of MCPAP?

B. Strategic Assessment Methodology

DMA conducted over 50 interviews with a broad range of stakeholders including representatives from the following groups:

- MCPAP Leadership: Central administration, hub leadership, and the MCPAP PCP Advisory Committee
- Primary Care Practitioners (PCPs): 12 PCPs who use MCPAP, some frequently and others less often. PCPs were selected from small, medium, and large practices and from regions across the state.
- Health systems and Physician Hospital Organizations (PHOs)/Accountable Care Organizations (ACOs): six health care systems and PHOs/ACOs of various sizes with differing care management, behavioral health/primary care integration, and financing structures
- Public and Commercial Payers: representatives of MassHealth, MassHealth managed care vendors, and two commercial health plans as well as the health plans' trade association
- Key state agency and advocacy stakeholders: representatives from the Executive Office of Health and Human Services (EOHHS), the Health Policy Commission, DMH, Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS), William James College INTERFACE Referral Service, the Children's Mental Health Campaign and the Parent/Professional Advocacy League

The DMA Health Strategies team also developed a survey and sent it to 47 hub staff via Survey Monkey in December 2015. Thirty-two staff completed the survey for a response

rate of 68 percent. Finally, DMA worked with MCPAP's health policy analyst to analyze MCPAP's data on PCP utilization, children served, services provided, and consultation outcomes.

Certain figures and tables presented in this report utilize data from varying time frames. This is due to the availability of various data sets at the time the strategic assessment was taking place.

The findings and recommendations for MCPAP performance improvements and modifications presented in this report are based solely on the interviews, survey, and data analysis conducted by DMA Health Strategies. This report is not meant to present a complete picture of the changes occurring in pediatric primary care and behavioral health integration. However, the report findings will inform DMH and MCPAP on potential modifications to MCPAP moving forward.

II. MCPAP PERFORMANCE FINDINGS

A. MCPAP Structure and Organization

MCPAP consists of a central administrative team housed at the Massachusetts Behavioral Health Partnership (MBHP) corporate office in Boston and six regional hubs. A teaching hospital is contracted to provide services in each of the five regions of the state, with two teams serving the MetroBoston region. Five of the host hospitals are tertiary care hospitals, and one is a psychiatric facility. The six regional hubs are:

- Western Region: Baystate Health
- Central Region: UMass Memorial Medical Center
- Northeast Region: North Shore Medical Center
- Southeast Region: McLean Southeast
- MetroBoston I: Massachusetts General Hospital
- MetroBoston II: Tufts Medical Center/Boston Children's Hospital (BCH) joint team

In most cases each hub has an administrator; a Medical Director; sufficient CAPs or Advanced Practice Registered Nurses (APRNs) to provide 40 hours per week of coverage for consultation and face-to-face assessments; sufficient licensed therapists to provide 40 hours per week of coverage; and a full-time care coordinator. Variation in staffing exists across the regional hubs. Hubs employ from three to six psychiatric consultants (including the Medical Director) to provide the 40 hours of coverage (i.e., 1 FTE). One hub employs two full-time therapists rather than a care coordinator as the therapists also perform the care coordination function; another hub employs two-part time therapists to fill the full-time therapist position; the remaining four hubs employ one individual as the full-time therapist. Funding for the hubs varies slightly as the salaries and benefit structures vary across the six host institutions. MCPAP team expenses are driven predominantly by the human resources.

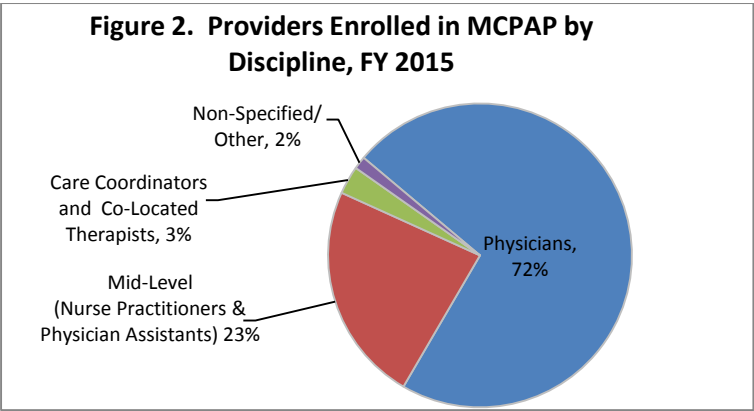
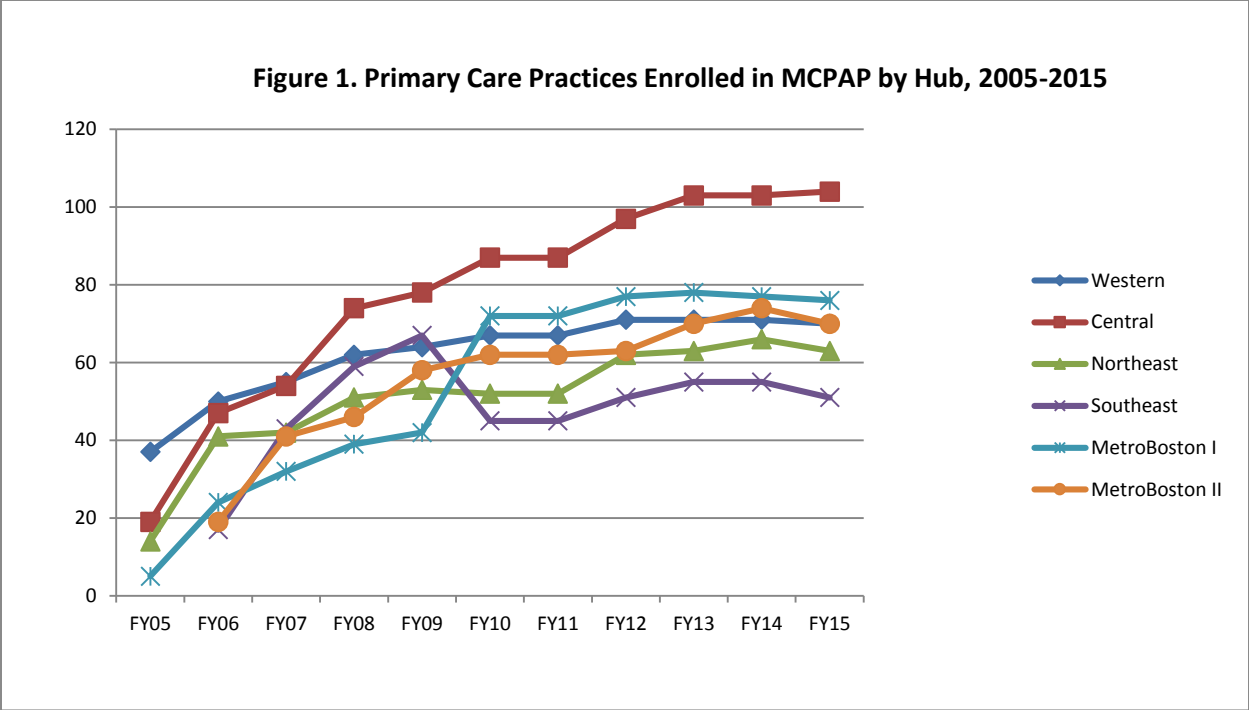
The original plan for MCPAP in 2004, which continues to the present time, divided the state into six teams based on the distribution of the number of children across the state. Each team covered a region with approximately 250,000 children; with twice that many children in the MetroBoston region, MCPAP contracted with two teams. In 2004 there were 1.5 million children in Massachusetts. Based on 2014 US Census estimates this number has decreased to 1,390,000 currently.

With additional funding in recent years from two federal grants, MCPAP's central administrative staff has been expanded to include a full-time Director, Health Policy Analyst, and Project Coordinator, in addition to the Founding Director. This staff increase has enabled a more active approach to oversight and quality management. MCPAP holds monthly meetings by phone, in one month bringing central administration together with hub staff, and in the alternate month including central administration and hub leadership. An annual in-person meeting including the all hub staff focuses on a salient clinical issue. MCPAP's Director makes a site visit to each hub at least once a year and more often when needed to review data on practice engagement, survey results, and progress on recent initiatives. Central administration staff work collaboratively with hub staff on quality improvement, such as developing care coordination and follow-up protocols and implementing peer review of consultation letters. Finally, the addition of a full-time health policy analyst has strengthened MCPAP's capacity to use its encounter data for performance management and quality improvement initiatives.

B. Practices and PCPs Served

From its beginning, MCPAP has actively reached out to primary care practices to introduce the program and build relationships with PCPs treating children and adolescents. As seen in Figure 1, this resulted in a rapid increase in enrollment in MCPAP. A primary care practice (pediatric or family practice) "enrolls" with the regional hub geographically closest to the practice; in the MetroBoston, area practices can choose which hub with which to enroll. To enroll with MCPAP, the practice participates in an orientation provided on-site by the regional hub and submits demographic information enabling MCPAP to identify PCPs calling for consultation and to track utilization. Once a practice enrolls with MCPAP, all of the PCPs in that practice are considered to be enrolled. As previously stated there are no fees associated with enrolling in or using MCPAP.

While there is no reliable way to determine the total number of primary care practices in the Commonwealth, MCPAP's outreach efforts have determined that there are relatively few known pediatric practices that are not enrolled. At the end of FY 2015, MCPAP had enrolled 445 primary care practices serving youth in the Commonwealth. Practice enrollment with the Central region hub has continued to grow rapidly, while enrollment in the other regional hubs has grown more slowly.

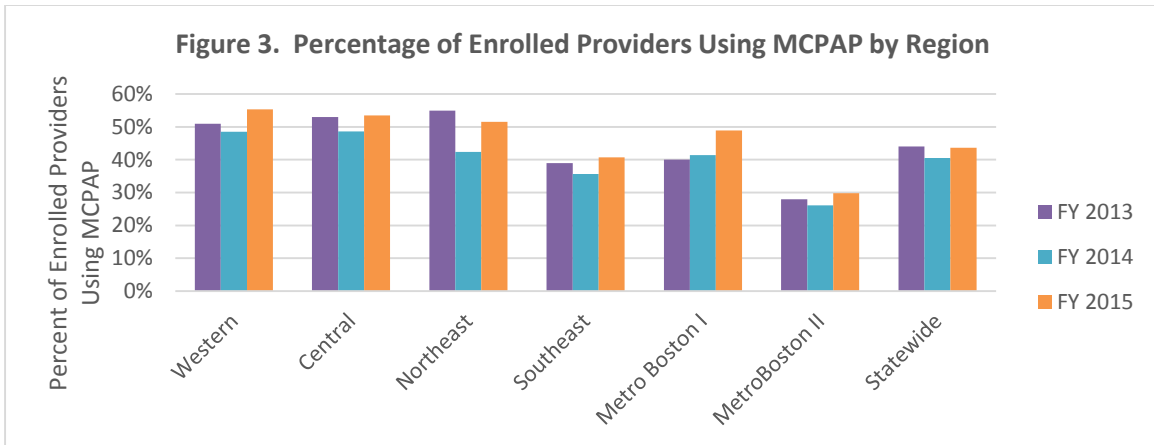


In FY 2015 MCPAP’s enrollment included 2,922 primary care providers serving youth. Physicians, primarily pediatricians, are the predominant type of provider enrolled in MCPAP, followed by nurse practitioners and physician assistants, but other types of practice personnel are also enrolled including care coordinators and co-located behavioral health therapists (Figure 2).

During FY15, 78 percent of enrolled practices used MCPAP at least once. At the individual provider level, a steadily growing number of unique PCPs are using MCPAP services. In FY15, MCPAP served a total of 1,248 individual PCPs, representing 44 percent of enrolled PCPs. Use by full-time pediatricians is even higher at 60 percent. This is a very high level of participation compared to psychiatric consultation services offered by health plans, which have found it difficult to generate substantial uptake.⁶

⁶ Interviews conducted by the author in 2010 in connection with work for the Department of Mental Health.

Considerable variation in PCP utilization of MCPAP exists across regions. The Western and Central regions consistently have the highest rate of PCP utilization. The MetroBoston Region II hub has consistently low utilization (Figure 3).



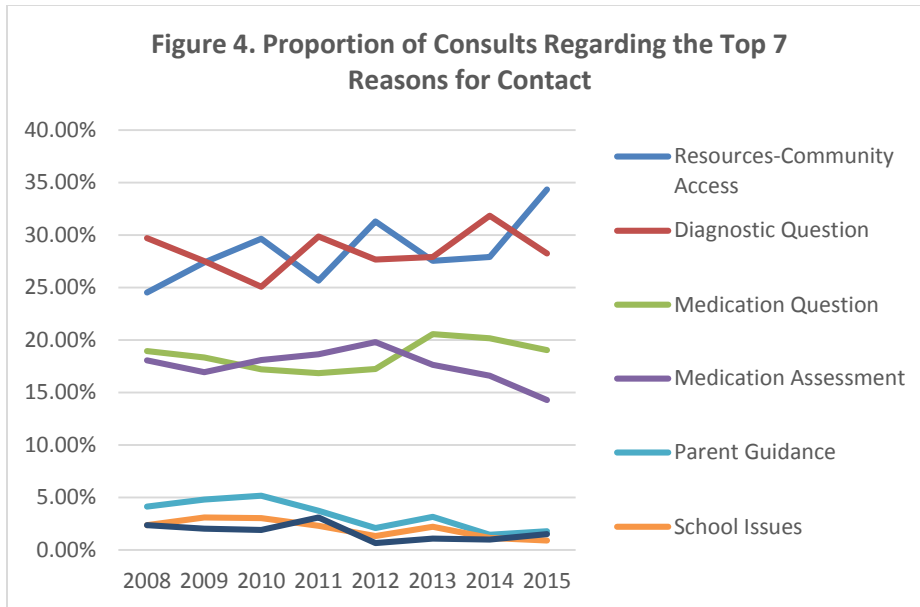
The 2015 PCP Experience Survey and MCPAP administrative data provide some indication of why almost half of enrolled PCPs don't use MCPAP in a year. Of those who reported not using MCPAP in the past year, 59 percent reported having access to onsite behavioral health resources. A MCPAP analysis of encounter and survey data also found that having on-site behavioral health resources (i.e., co-located or integrated behavioral health therapists or CAPs) was associated with a 39 percent decrease in the average number of consultations per PCP over a recent four year period.⁷ Smaller numbers of enrolled PCPs who did not use MCPAP indicated that they did not like the model or do not want to manage patients' behavioral health problems.

C. Children Served and Types of MCPAP Services Used

Over its 11-year history, MCPAP has steadily increased the number of children served from 2,369 in 2006 to 6,695 in 2015. The average number of children served for the past four years is 6,207. In FY15, 55 percent of children served by MCPAP were commercially insured, while 45 percent of children served by MCPAP were publicly insured, a greater proportion than the 36 percent of children statewide who are publicly insured. There is considerable difference in the racial and ethnic composition of the child population across the six regions, but MCPAP data does not currently assess the rate at which children from different racial and ethnic groups are being served.

PCPs most frequently contact MCPAP to receive assistance in determining a diagnosis and to request access to community resources (Figure 4). Both of these reasons for contact represented a quarter to a third of all contacts (more than one reason may be noted for a single contact). The next most frequent reasons – accounting for 15 percent to 20 percent of contacts – pertained to medications, either to discuss whether a patient needs medication or to discuss a medication that the patient is already taking. Guidance to parents, discussion of school issues, and provision of second opinions each accounted for less than 5 percent.

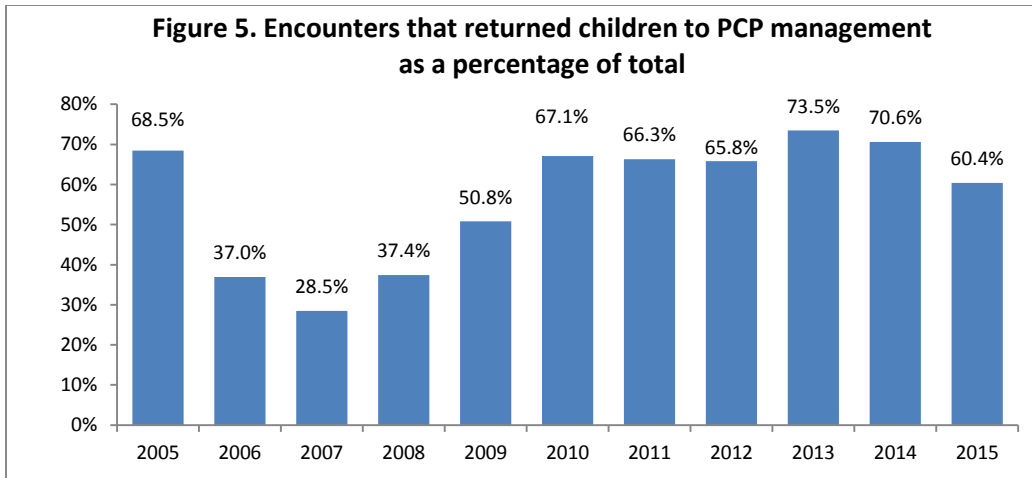
⁷ Scarce, Andrew, (2015) MCPAP FY15 Experience Survey – DMH Utilization Report.



An analysis of types of encounters showed that 40 percent of encounters are phone consultations with PCPs, 30 percent are care coordination requests, and 20 percent are face-to-face consultations with a MCPAP CAP or therapist. ADHD, anxiety, and depression are the most frequently discussed diagnoses, each discussed in 20 percent to 30 percent of contacts (more than one diagnosis may be discussed in a single contact). Most other diagnoses (e.g., bipolar disorder, adjustment disorder, psychoses, etc.) are discussed in 5 percent or less of encounters.

In FY15, most PCPs responding to the PCP Experience Survey indicated that they are comfortable treating ADHD, depression, and anxiety. However, it is notable that a fifth to a third of respondents are not comfortable treating these conditions, suggesting a need for continued consultation capacity. This survey also indicated that PCPs are considerably less comfortable addressing substance use issues than these three mental health conditions. MCPAP is currently disseminating and training on a Screening and Brief Intervention protocol for substance use. Re-measuring PCP confidence using these tools will determine whether progress has been made in this area.

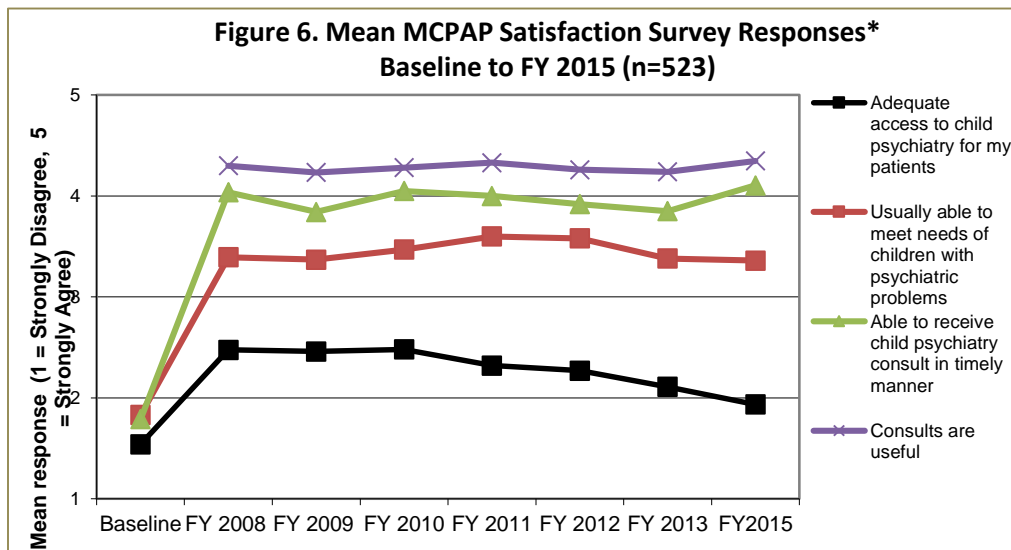
Resolution of the majority of MCPAP contacts (two thirds to three quarters in recent years) is that the PCP continues to manage the patient’s behavioral health care after the consultation, and, if any medications are involved, to serve as the prescriber (Figure 5).



A concern raised by stakeholders, and one recognized by MCPAP, is that some families do not follow up on referrals or encounter barriers that prevent them from initiating services. To address this problem, MCPAP recently added a part-time staff position to each hub, who is responsible for conducting follow-up on MCPAP referrals. In the fourth quarter of FY15, follow-up staff attempted contact with 80 percent of families, but it has proved difficult to reach many of them. Close to half did not respond to inquiries after three attempts. Of those who were reached, half had made appointments, and almost all of those who made appointments kept them and continued in treatment.

D. PCP Satisfaction

PCPs are consistently very satisfied with MCPAP's timeliness of response, usefulness of consultations, and ability to meet the needs of children with psychiatric problems (Figure 6).



*A survey was not administered in FY 2014.

However, their ratings of the adequacy of access to community-based child psychiatry for their patients has consistently eroded since FY 2010. Long waits for child psychiatry, often three to six months and sometimes longer, was a problem raised by multiple stakeholders, and most wished that MCPAP could address this gap.

E. MCPAP Relationships with Payers

Public health plans are considerably more familiar with MCPAP than commercial plans. Within commercial health plans there is varying knowledge about MCPAP. A couple of representatives who had some awareness of MCPAP perceived it as a program that has made an important place for itself with PCPs. Most were interested in additional information about the program. One plan would like data specific to its Members' utilization and the opportunity to discuss the findings and potential ways to collaborate. Representatives of the MassHealth Office of Behavioral Health are well aware of MCPAP services and the functions it fills in the behavioral health system. They are particularly appreciative of the role MCPAP played in helping PCPs adopt the behavioral health screening tools required as part of the Children's Behavioral Health Initiative (CBHI), the prompt response times, and quality of the MCPAP newsletter. They are concerned about treatment referrals that aren't completed and are hopeful that MCPAP can help PCPs consider the range of treatment options that CBHI has created. Both commercial and MassHealth plans are interested in information about MCPAP services used by their network PCPs for their Members.

MCPAP works closely with a number of state agencies including DMH and DPH BSAS. DMH is the primary funder of MCPAP. In the past few years, it has received federal grant resources that allow it to take a more active management role. DMH is particularly interested in what MCPAP's data can say about access and gaps in the system, using that information to contribute to an increased understanding of what is happening in the community-based children's behavioral health system, and analyzing the impact of MCPAP on PCP prescribing patterns. Finally, DMH sees the expertise of MCPAP as a potential source of clinical leadership, standard setting, and training which should be utilized to its full capacity.

F. Financing

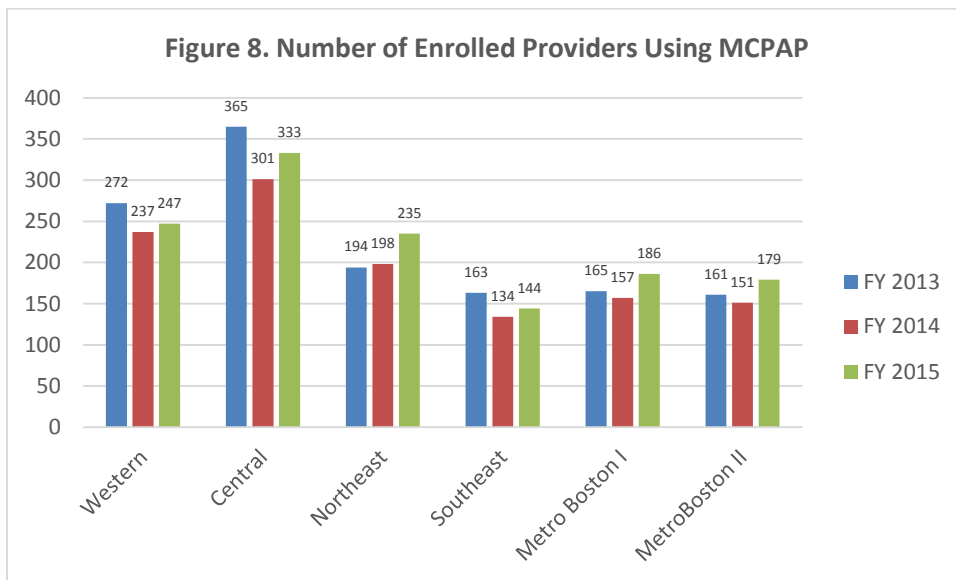
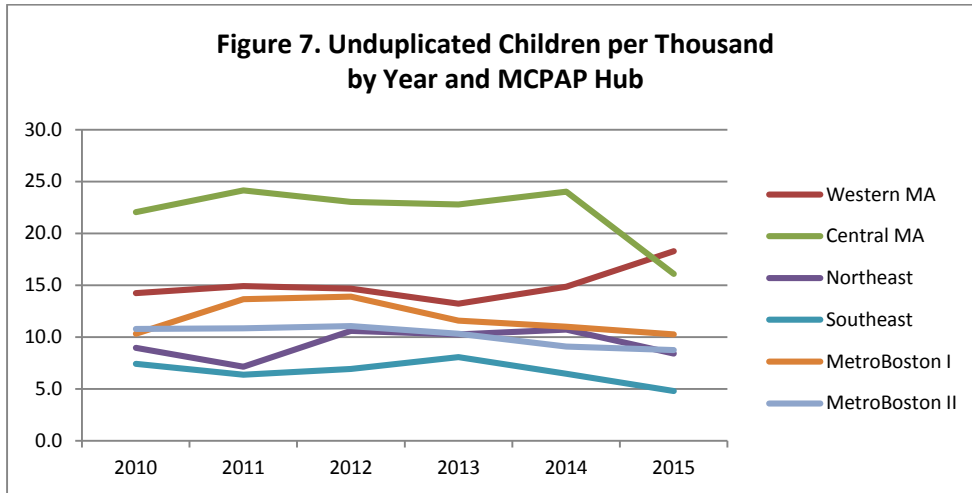
The Department of Mental Health (DMH) is the primary funder of MCPAP. In FY16, the state appropriation for MCPAP was \$3.1 million. Beginning in FY15, commercial insurers were assessed a surcharge⁸ to cover their Members' use of MCPAP consultation services. However, the surcharge revenue does not directly support MCPAP but goes back to the state's general fund.

G. Regional Variation

Across the regional hubs, considerable variation exists in number of children served per thousand (Figure 7) and PCPs using the service (Figure 8). Consistently, the Central and Western hubs serve more children per thousand population and more PCPs. The two Metro Boston hubs were somewhat below the state averages, and the Southeast numbers fall considerably below. These patterns are quite consistent over a number of years. In consequence, there is considerable range in the average cost per child

⁸ See MGL 104CMR 30.08 Massachusetts Child Psychiatry Access Program

served, per PCP, and per encounter between the hubs. In contrast, we found minimal variation in PCPs' ratings of the quality of consultation they received, suggesting that differences in participation between hubs are not due to differences in PCPs' perceptions of quality.



H. Discussion of MCPAP's Strengths and Weaknesses

1. Strengths of MCPAP

Overall, there was considerable agreement across respondents that MCPAP effectively performs its core mission of providing psychiatric consultation, meeting standards of responsiveness and quality of consultation. PCPs indicated that therapists and care coordinators are knowledgeable about regional resources, highly skilled, and responsive to family needs, taking time to work with families to understand their needs and to find well-matched community resources. Some PCPs mentioned the longevity of hub staff as providing desirable consistency.

In addition to exploring MCPAP strengths, we asked all respondents to identify the critical features of MCPAP. There was strong consensus on the features listed in Figure 9.

Policy makers and hub leaders highly value that MCPAP is payer blind and available to all Massachusetts children. This ensures that PCPs can use MCPAP services for all their patients and provides access to CAP consultation for every child in the Commonwealth.

MCPAP is perceived as a neutral party in the Massachusetts health care system. MCPAP CAPs are not associated with a health plan, so their recommendations are independent of the utilization management considerations that are a health plan function.

PCPs highly value MCPAP’s timely responses to their requests, high quality consultation advice, and accessible face-to-face psychiatric assessments for their patients. Continuing to provide the ability to respond to requests the same day, and offering knowledgeable and experienced CAPs who communicate well with primary care practitioners is a requirement. Finally, assistance with resource and referral continues to be a critical function, and great emphasis was placed on therapist and care coordinator familiarity with regional resources.

There was less certainty that it is necessary for hubs to be located in a teaching hospital. In addition, while regions are important, there was not a strong value put on specific regions as currently defined.

2. Weaknesses of MCPAP

While MCPAP has enrolled a high proportion of the state’s pediatric practices, use of MCPAP is uneven, with some PCPs using MCPAP only rarely, some regularly, and others not at all. This is not necessarily a weakness of MCPAP, since it stems primarily from PCPs having other resources to meet their needs for managing their patient’s behavioral health care or not wanting to take an active role in treating behavioral health problems. However, it is important that MCPAP ensure that PCPs are aware of MCPAP resources and how to use them, including through direct outreach and collaboration with health plans, PHOs, and ACOs.

There was concern among a few PCPs that medications are recommended too readily by MCPAP consultants without trying other approaches such as therapy first. However, statistics show that more than 50 percent of MCPAP contacts with PCPs do NOT result in a child being on medication. In fact, the percentage of children on medication after a MCPAP consult has decreased from 45 percent in 2013 to 41 percent in 2015. In addition, several hub CAPs emphasized in interviews that they often redirect PCPs from a medication approach to therapy.

Figure 9. Critical Features of MCPAP	
	Payer blind
	Neutrality
	Timely response
	High-quality consultation
	Accessible psychiatric assessments
	Resource and referral
	Knowledge of regional resources
Features Not Critical to MCPAP	
	Location in a teaching hospital
	Current regions

PCPs identified the following as areas for additional assistance and support from MCPAP:

- Assistance with children with autism spectrum disorders
- Infancy and early childhood social emotional development
- Managing adolescents with substance use issues
- Improved capacity to help families initiate and remain in community-based behavioral health treatment.

There are proven racial and ethnic differences in the prevalence of behavioral health conditions and disparities in the use of behavioral health care and the quality of care received.⁹ Lack of data on the race and ethnicity of children served by MCPAP prevents the program from determining whether there are similar disparities in accessing MCPAP services and in quality of care. It appears that MCPAP is working with practices in virtually all of the zip codes with low income and high rates of limited English speakers. However, better data would help to assess whether additional outreach is needed to reach these populations and to consider how to best assist PCPs in delivering culturally competent behavioral health care.

MCPAP central administration and some hub staff identified a weakness in the current program design. Because there is only one CAP “on duty” in each region at a time, the expectation that hub CAPS will provide orientations and trainings on-site at primary care practices reduces their availability to be responsive to requests for phone consults and for face-to-face assessments. They often use blocks of time set aside for face-to-face assessments for these visits to practices. This challenge was highlighted with the recent initiative to train enrolled practices in using a standardized adolescent substance use screening tool.

The significant variation between hubs in numbers of children served and PCPs using MCPAP suggests that there is unused capacity in those hubs where these numbers are lower. While available data makes it difficult to determine whether the variation between hubs represents a desirable customization to the region’s PCP network and their caseload, the longstanding and consistent differences in the level of activities between hubs suggests that the Central and Western hubs have a larger or more active set of users than those in the remaining four hubs. This is reflected not only in the number of service encounters and the children and PCPs served per thousand population, but also in the ratings of hub staff who said they could take on additional work.

Finally, all stakeholders reported deep concerns about the long waits to access community psychiatric treatment with some perceiving this to be a MCPAP weakness. However, MCPAP is designed as a psychiatric consultation program and not a treatment program. Nonetheless, many stakeholders wish that MCPAP could implement a strategy to address this problem. At the very least, MCPAP is in a position to inform discussion on this critical issue.

⁹ Alegria, Margarita, Cook, Benjamin, Loder, Stephen, and Doonan, Michael, 2014, *The Time is Now: Tackling Racial and Ethnic Disparities in Mental and Behavioral Health Services in Massachusetts*, Massachusetts Health Policy Forum.

III. STAKEHOLDER PERSPECTIVES ON CHANGES IN PEDIATRIC PRIMARY CARE

A. Status of Integration in Primary Care

MCPAP enrolled practices are in different stages of implementing behavioral health integration, with some not considering integration at all. The 2015 PCP Experience Survey found that 44 percent of survey respondents had access to a behavioral health provider on-site in their practice for at least some of the time. Most had access to a therapist, while 21 percent had access to a CAP. Among PCPs interviewed, approximately half had an on-site behavioral health clinician, many had on-site care coordinators, but only one had an on-site CAP. Two of the practices interviewed have developed medical home functions. Interviewed PCPs reported screening routinely for mental health problems using validated screening tools. No PCPs reported using a client registry for children and adolescents, though most reported having the capacity to do so.

B. Movement toward Increased Behavioral Health Integration

Interviews with stakeholders in leadership positions focused on how health plans and PHOs/ACOs are building pediatric integrated care in their networks; what supports they are providing or plan to provide to their primary care practices serving children and adolescents; and their view of how MCPAP's psychiatric consultation and additional services fit into their plans for integrated pediatric care.

1. Emerging models of behavioral health integration

There is a continuum of behavioral health integration, and different organizations and practices choose to integrate at different levels (i.e., practice, physician organization, health system) and use different models. Our stakeholder interviews identified a range of models of pediatric behavioral health integration being pursued in Massachusetts.

One model places care coordinators in practices to develop strong linkages with community behavioral health resources as well as other community organizations important in children's lives such as schools. Another places therapists and care coordinators in practices and offers psychiatric consultation to its affiliated practices. Yet another model pursues integration through partnering with community-based behavioral health providers that outpace therapists in primary care offices.

The Massachusetts Health Policy Commission (HPC), in collaboration with the National Committee for Quality Assurance (NCQA), has developed a PCMH PRIME program to further promote behavioral health integration across Massachusetts. In order to receive PRIME recognition, primary care practices who have met NCQA Level II or III certification must also meet seven of 13 criteria to demonstrate their capacity for effective integrated behavioral health care. PRIME recognition standards are likely to drive further development of practice-level behavioral health resources, since ACOs seeking certification may receive credit toward recognition by integrating or co-locating with behavioral health providers and training care managers to help track behavioral health needs. ACOs seeking state certification with the HPC must report on the number of practices with PRIME recognition in their networks.

2. Incentives and barriers for integrating care

Health systems and PHOs that carry financial risk or plan to become ACOs and CHCs have been moving toward integrating behavioral health into primary care, with some well along in the process. All parties expect that this movement will continue, though there is ongoing concern that pediatrics will continue to hold a lower priority for accountable care contracts and behavioral health funding than adult medicine, at least for commercial insurers. MassHealth, however, plans to develop alternative payment methods that include accountability for quality of children's behavioral health care and to include cost for behavioral health in calculating total medical expenses.

Additional forces will incentivize the movement toward integration. Several primary care leaders noted that pediatric primary care practice has been changing dramatically over the past several years. Demand for treating minor illnesses has been decreasing in primary care as urgent care centers have increasingly assumed this role and as immunization rates have increased. At the same time, an increasing number of children are presenting with behavioral health problems, which are also increasing in severity. Among MCPAP's advisory group, PCPs estimated that 30 percent to 50 percent of their visits are for behavioral health. To successfully negotiate these changes, pediatricians must be able to effectively treat behavioral health problems.

Some primary care practices do not see the need to move toward greater integration or are uninterested in doing so. Those that are interested face several barriers to increased integration. Not all practices are part of larger systems with the infrastructure to support integration. Some practices are affiliated with more than one health system or PHO, which may use different models for integration. Smaller practices worry they may not be able to support integration.

A critical barrier to integration is the lack of sustainable financing for integrated primary care. Behavioral health visits are relatively less well reimbursed than medical visits, and few payers reimburse for care coordination or many of the functions performed by therapists working in primary care settings. Eventually, the flexible financing methods being developed for ACOs may allow them to invest in such behavioral health resources, but ACOs must be convinced that the investment will pay off in a reasonable time period.

C. Implications for MCPAP

Changes in pediatric primary care and the increasing pressure to integrate primary and behavioral health care present opportunities for MCPAP. These same changes may potentially make some current MCPAP functions less essential.

Opportunities for MCPAP include:

- Most practices, including those participating in ACO arrangements, will continue to need psychiatric consultation. In fact, with a greater emphasis on case finding through increased screening, the potential exists for greater demand for consultation.

- Some PHOs/ACOs and Community Health Centers (CHCs)¹⁰ are interested in establishing their own consultation capacity. However, there are not enough child and adolescent psychiatrists in Massachusetts to support exclusive relationships by all the organizations or networks that may want them and also provide accessibility for youth outside of these organizations or networks. As a population-based service, MCPAP can provide statewide consultation for all children in Massachusetts with six FTE CAPs.
- There is a strong desire for MCPAP to take on a broader role in addressing service gaps, particularly for children with complex conditions who are in parts of the state where they experience waits as long as six to nine months to initiate specialty psychiatry.
- Primary care practice teams need support in implementing integrated care.
- MCPAP's credibility and respect in the field places it in a position to take a more assertive clinical leadership role. This could include developing and promoting best practice guidelines for treatment of behavioral health conditions in primary care settings.
- MCPAP could take a more active role as a key informant in focusing attention on systemic issues that challenge the effective provision of behavioral health care.

Some of the changes discussed above also present potential threats or new challenges for MCPAP:

- Some ACOs and CHCs currently employ their own child psychiatrists and consequently do not use MCPAP very often if at all. If this trend continues, the shortage of community-based child psychiatry will be exacerbated and demand for MCPAP will decrease.
- The differing integration models operating across different PCP practices may complicate the provision of MCPAP psychiatric consultation and support, especially if they employ a distinct clinical protocol or staffing model.
- The need for consultation by MCPAP therapists and resource and referral services may be reduced as primary care behavioral health resources (i.e., care coordinators, behavioral health therapists), are incorporated into primary care.
- The emergence of ACOs and integrated systems of care opens the possibility that one or more of these entities may seek to become a MCPAP team. All MCPAP teams would have to serve all practices in the defined region on an equal basis, whether part of an ACO network or not, and ensure full regional coverage.
- Like health plans, PHOs/ACOs may also want statistics on how their own populations use MCPAP requiring MCPAP to have a more robust database to respond to this need.

¹⁰ In this report the term Community Health Centers refers to Federally Qualified Community Health Centers (FQHCs) which are defined as all organizations receiving grants under Section 330 of the Public Health Service to enhance the provision of primary care in underserved urban and rural communities and hospital-owned community health centers that meet all requirements applicable to FQHCs.

IV. OPTIONS FOR REDESIGNING MCPAP

A. Recommendations for Improving MCPAP Performance

This section discusses opportunities to improve MCPAP performance. However, MCPAP cannot undertake all potential improvements within current funding, and will need to select carefully.

1. Increase PCP use of MCPAP psychiatric consultation services

Other avenues exist to increase PCPs appropriate use of MCPAP psychiatric consultation services. There are opportunities to reach out to health plans, physician networks, health systems, and ACOs to educate them about MCPAP services and identify opportunities for collaboration. In addition, MCPAP should reach out to families through organizations such as PPAL so that parents can encourage their PCPs to consult MCPAP.

2. Increase consistency in service provision and quality across hubs

Increase consistency in hub operations, practices, and quality of services through the following activities:

- a. Build consensus on performance standards for hub operations and service provision. Determine what standards should be set and monitored across hubs, and what areas may be left to the discretion of hub leadership to customize for most effective local implementation. Once standards have been developed, MCPAP should develop contracts with more specific performance requirements to ensure that hub resources are fully used.
- b. Further develop measures of MCPAP service quality and outcomes of care in order to target quality improvement initiatives.

3. Further develop consultation and training for PCPs and their practice teams

- a. Strengthen MCPAP's content expertise in autism spectrum disorders, infancy and early childhood social emotional development, intellectual disabilities, and dual diagnosis disorders, potentially identifying expertise that can be shared across teams.
- b. Consider streamlining the consultation process, developing standardized prescribing guidance, and using emerging forms of communication including HIT to facilitate communication with PCPs.
- c. Encourage and support practices to improve their capacity to address behavioral health by meeting relevant certification standards, such as the Health Policy Commission's PCMH PRIME certification for behavioral health integration.
- d. More closely coordinate with PCP practices' integration and medical home processes.

4. Develop a strong capacity for telepsychiatry videoconferencing

- a. MCPAP is beginning to use telepsychiatry videoconferencing for evaluations to increase accessibility of face-to-face assessments. As it expands implementation of videoconferencing it will be important that MCPAP carefully evaluate its costs, the best technical setups and visit protocols, and how it is working for staff and for the youth and families.

5. Expand proactive training and consultation

- a. To reach multiple PCPs at once, MCPAP can expand its efforts to more closely coordinate with PCPs' current clinical processes, such as conducting community

grand rounds or attending more clinical planning meetings held by larger practices.

6. Improve service to families

- a. Consider strengthening follow-up on MCPAP referrals by purchasing local family partner capacity to engage and assist families; developing other peer and family support options; and working collaboratively with staff in the PCP practice who know the families.
- b. Consider creating a web portal to collect information on a youth's treatment history and symptoms before a face-to-face appointment to allow more time for discussion of treatment options.
- c. Work with the Parent Professional Advocacy League to develop a video to help families understand the most common treatment approaches and the advantages and disadvantages that should be considered in selecting one for their child.

7. Communicate with payers and key stakeholders

- a. Provide regular information on MCPAP's performance to legislators, health plans, and PHOs/ACOs both through individualized reports and by meeting on at least an annual basis.

B. Recommendations for MCPAP Modifications

MCPAP has several strategic options for modifying its model to provide additional support to PCP practices as they pursue behavioral health integration. When evaluating these options, MCPAP will need to consider whether MCPAP is best positioned to meet these new PCP needs and how new financing models may change the role and/or viability of MCPAP.

1. Expand scope of behavioral health consultation

- a. MCPAP could expand the scope of its behavioral health consultation and assessment services for specific sub-populations by adding subspecialists to hub teams who could offer a full assessment for autism spectrum disorders; conduct neuropsychological evaluations; or consult on treatment of very young children, substance use issues, co-occurring disorders, or eating disorders. MCPAP needs to carefully assess the extent of need for such specialties, the feasibility of offering these services responsively, whether this is the best way to expand access to the state's limited subspecialists, and the amount of additional funding needed to do so.

2. Address the gap in access to community-based psychiatry

- a. While it is not MCPAP's mission to provide community-based psychiatric treatment, it is in a position to implement strategies to potentially help address some of the long waits for access. For example, MCPAP could:
 - i. Develop a coalition of regional CAPs willing to take children with complex needs after MCPAP has completed an assessment;
 - ii. Offer one or two additional MCPAP psychiatry visits for children with complex needs who can't immediately see a CAP; or
 - iii. Offer longer-term bridge treatment by hiring additional CAPs.
- b. An effective approach to implementing any of these options first requires that the problem be defined and quantified. It also requires collaboration with multiple system stakeholders, including payers, to work toward a balanced and feasible solution. All the options would require clear eligibility criteria so that MCPAP

hubs are not overwhelmed by demand. Finally, these options would likely require additional funding.

3. Support behavioral health staff in PCP practices

- a. MCPAP could take on a number of potential new functions to support the growing number of care coordinators and therapists working in PCP practices, including:
 - i. Coordinate with William James INTERFACE Referral Service¹¹ to provide its resource and referral database to practices;
 - ii. Train and consult with care coordinators on best practices for resource and referral; and/or
 - iii. Coach integrated therapists as they define their role and develop PCP team relationships.
- b. Health Plans and PHOs/ACOs may prefer to deliver these services themselves, using their own standards and practices. If so, MCPAP might continue to perform this function only for smaller and unaffiliated practices.

4. Restructure the MCPAP service regions

- a. The analysis of hub utilization patterns indicates that a restructuring of the hubs would ensure better use of resources. The volume of consultation calls does not require six CAPs to be on-call simultaneously across the state. One option is to redefine current regions into two or three regions. Restructuring should appropriately size new regions to fully utilize hub staff and maximize productivity across the program. Restructuring to have less than six teams would free up funding to have more than one FTE of child psychiatry per hub to take on one or more of the additional functions that have been identified in this report.

5. Serve school health centers

- a. Assisting schools in addressing behavioral health challenges is an important DMH priority and a potential new area of growth for MCPAP. One option for expanding the MCPAP model to schools is to engage the 33 school health centers operating in Massachusetts, some of which are already enrolled. However, schools are governed by their own regulations and funding sources and are not part of the health care system. Therefore, a program to meet the needs of children in the almost 2,000 schools in the state would need to be specific to the education system and designed with robust school involvement.

6. Promote standards for behavioral health care in primary care

- a. MCPAP could capitalize on the prestige and the trust of its consultants to take a leadership role in promoting standards for behavioral health practice in primary care. This could include setting standards, developing training related to population management, and offering co-located or integrated behavioral health clinicians training in evidence-based practices.

7. Increase advocacy for the children's behavioral health system

- a. MCPAP can use its prestige and expertise to take a lead in advocating for improvements to the children's behavioral health system. This would require

¹¹ William James College INTERFACE Referral Service collects and categorizes a wide range of valuable resources related to mental health and wellness for the benefit of children, adults and families. INTERFACE works in partnership with MCPAP and MCPAP for Moms providing access to an expanded statewide database of mental health and substance use providers, and providing technical assistance for care coordination.

additional financial resources, time and energy, as well as targeted relationship building. State agency leaders recognize that the data MCPAP collects could inform discussion of solutions to some of the most serious challenges faced by families and children with behavioral health issues. MCPAP could convene stakeholders to develop solutions to access problems or to drive improvement of inpatient discharge plans.

8. **Provide guidance on implementing other primary care consultation programs**
 - a. The lessons learned from implementing MCPAP could inform the development of new primary care consultation programs to manage other conditions where specialty care resources are severely limited such as: addiction treatment consultation for adult and family practitioners; pain management consultation for primary care and dental prescribers; and/or geriatrics care for adult practitioners. These programs cannot be built upon the current MCPAP infrastructure because they require their own set of specialty consultants. However, they can be designed upon similar principles and build off MCPAP's successful methods of outreach and engagement that resulted in the high level of PCP uptake and satisfaction.

V. CONCLUSION

The strategic assessment findings demonstrate that MCPAP has been a ground-breaking solution to improving access to behavioral health in pediatric primary care and is highly regarded for its clinical expertise and accessibility. Pediatric psychiatric consultation will continue to be needed as health care and payment reform advances. However, the demand for consultation from MCPAP therapists and for resource and referral support will likely decrease as these functions are increasingly performed within primary care practices or made available through affiliations. To continue to be responsive within this changing health care environment, there are several new opportunities for MCPAP to expand its capacities and modify its infrastructure and services.

MCPAP is at a critical crossroads. It must choose those options that allow it to maintain its core functions, while adapting to the changing health care environment. MCPAP must prioritize which new functions to implement so that it continues to fill critical gaps in the children's behavioral health system.

The full transition to accountable care and integrated behavioral health care is likely to take years, especially for pediatric populations. At the same time, child psychiatry will remain a scarce resource. Therefore, MCPAP needs to continue its strong population-based model of making psychiatric consultation available to all children through primary care, regardless of their insurance, geography, health system affiliation, or other circumstances.