SYSTEMS-BASED PRACTICE
THE PRIMARY HEALTH CARE SYSTEM
Updated May 2020

Authors: Abigail Schlesinger, MD, Justine Larson, MD, MPH, Alessandra Kazura, MD, William French, MD, & Christopher Bellonci, MD

SYSTEMS-BASED PRACTICE: PRIMARY HEALTH CARE SYSTEM OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of:

1) The definition of a medical home and its implication for working with youth, families, and their primary care providers.
2) Potential cultural, geographic, and socio-economic disparities accessing a medical home and how these may affect patient care.
3) Federal legislation and mandates that impact primary care services for physical health, mental health, developmental delays, and anticipatory guidance for youth.
4) Reasons why primary care is often considered the "de facto mental health system."
5) A comparison between content and processes of a traditional child and adolescent pediatric inpatient consultations and consultations with outpatient primary care providers.
6) Confidentiality rules and how these affect patient care.
7) Models for improving mental health treatment in primary care.

Skills

The resident will demonstrate the ability to:

1) Successfully use verbal and written communication skills when working with primary care providers.
2) Achieve an appropriate transfer of care between primary care provider and child and adolescent psychiatrist and vice versa.
3) Share target goals, treatment plans, and implications of these interventions with primary care providers.
4) Share knowledge about mental health-related services, indications, and the role of components of the continuum of care with primary care providers.
5) Educate the primary care provider about psychiatric diagnoses, indications for treatments, and treatment risks, benefits and alternatives.
6) Encourage patients to access and use the medical home appropriately.

Attitudes

The resident will commit to understanding and supporting the following:

1) How differences between pediatric and child and adolescent psychiatry training and practice cultures may affect patient care and the collaboration between providers.
2) The quality of the relationship between primary care providers and families and how this relationship can support the health and wellbeing of families.

* **Appendix 1 describes the systems-based practice competency in the RRC Program Requirements**

3) The use of system resources, including data collection and analysis, to provide quality patient care and to promote patient safety.
4) Good communication between the child and adolescent psychiatrist and primary care provider to promote high quality, safe, and efficacious care.
5) The role of the medical home in supporting safe, child centered and family focused management of medical, developmental and mental health concerns.

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OVERVIEW

This module should help the trainee develop an appreciation of the values, mandates, and practice culture of primary care providers and their treatment of mental illness and psychosocial issues. Primary care providers are often the first professionals to identify developmental, behavioral, and mental health problems. They see children frequently in the first years of life and ideally develop a continuous relationship with a youth and family through late adolescence and sometimes the next generation of children. The collaboration between the primary care provider and the child and adolescent psychiatrist, along with other members of the health and mental health team, supports the highest and most comprehensive quality evaluation and treatment processes.

At the completion of this module, child and adolescent psychiatrists (CAPs) and other mental health care providers should have a better understanding of the primary care system. They should be able to identify differences between interacting with primary care providers in outpatient settings and the traditional inpatient consultation-liaison experience, so that they can effectively apply system principles in their ongoing management of youth in whatever setting they may treat patients.

I. DEFINING PRIMARY CARE

Primary care is typically the "point of entry" for a patient into the health care system. Primary care providers are typically the "main" health care provider for a person. They are trained to provide comprehensive initial and continuing care for patients. Primary care includes health promotion, disease prevention, diagnosis, and treatment, and referrals to specialists and/or more intensive levels of care. Primary care providers are often the first professionals to identify patients with acute and chronic disease, including mental health disorders. This contact may occur in a variety of health care settings, including outpatient offices, inpatient hospitals, emergency and urgent care facilities, long-term care facilities, in-home care, and school-based clinics. Primary care providers are patient advocates in the health care system. Part of this advocacy is helping patients attain effective and efficient care with coordination of services.

Primary care physicians typically work with a practice team that may include nurse practitioners and physician assistants as well as nurses, medical assistants, care managers, nutritionists, and other health professionals. This section will highlight some of the roles and responsibilities of pediatric primary care providers and the members of their team. [2]
It also reviews some considerations of medical decision-making and confidentiality in primary care practice. The use of referrals for consultation and ongoing treatment of mental health problems may vary by professional training, experience, and level of comfort across these professions.

Patients under three years of age typically account for up to two-thirds of pediatrician visits due to frequent health promotion appointments during the first few years of life. Annual visits are recommended for children and adolescents between the ages of 3 – 21 years old.

Pediatricians

- After medical school, pediatricians are trained in a three-year residency with a focus on the evaluation, treatment and health promotion of children and adolescents.
- Training includes normal physical, cognitive, and emotional development as well as pathology and atypical development. Unlike child and adolescent psychiatrists, primary care pediatricians work with many healthy children and families. They gain experience to a wide range of normal variation in development.
- May see adolescents for part or all of the visit alone or with parents, depending on provider, patient and parent preference. State laws and local customs may impact adolescents' ability to seek health care independent of parents.
- May continue to see patients throughout college, although may be less prepared to address system needs of this population than they are with systems needs of younger children.

Triple Board Physicians

- In this section, triple board physicians are physicians who have completed a residency program that confers eligibility for board certification in pediatrics, general psychiatry, and child and adolescent psychiatry.
- Training involves a five-year residency with training in each of the specialty areas. Triple board residents train alongside residents in traditional pediatric, general psychiatry and child and adolescent psychiatry programs.
- Graduates of these programs typically focus in one of these specialties. However, they are well prepared to bridge the cultures across them and to provide consultation for integration of medical and mental health services.

Family Physicians

- After medical school, family practitioners complete a three-year family medicine residency. Their training includes a wide range of pediatric service rotations, but with less time in each and less pediatric specialty exposure than pediatric and triple board providers.
- May evaluate and treat family members of all ages, including adults.
- Benefits of training and practice culture
    - Aware of many strengths and weaknesses of a family system, including psychosocial, psychiatric, medical, genetic, etc.
    - May be able to bolster supports within the family due to providing direct

services to parents (e.g., helping a parent access services or being able to recognize and treat problems with parents).
    - May continue to see patients across the lifespan for direct health care services.
- Drawbacks of practice culture and training
    - The child may not trust physician to maintain his or her confidentiality if the physician is also the physician for their parent or other family members.
    - Family practitioners receive less training and unless they restrict their practice to children and or adolescents, they acquire less total post-training experience with childhood disorders than pediatricians do.

Nurse Practitioners

- A nurse practitioner is a registered nurse with advanced classroom and clinical training, with professional certification requirements for an extended practice role.
- Primary care nurse practitioners who treat children are typically are trained as advanced practice nurse specialists in pediatric or family medicine.
- Nurse practitioners are able to evaluate, diagnose, prescribed medication and other treatments, and promote health and prevent disease.
- In many states, nurse practitioners are legally able to work as independent practitioners, but in others, they require active supervision by a physician. They may work as part of a multidisciplinary care team in either of these statutory requirements.

Physician Assistants

- Physician assistants have completed four years of college plus two to three years of post-graduate medical training that includes assessment and treatment of children with less pediatric intensity and training hours than the combined medical school and residency training received by pediatric and family medicine physicians.
- At the time of this update, physician assistants are typically working in a supervisory relationship with a physician. However, changes in regulation in some states that permit or will likely soon permit physician assistants with specified qualifications to practice autonomously.

Other team members

- Primary care practices are usually supported by a number of other professionals, both clinical and administrative.
- Team members may include registration or patient service representatives, schedulers, billers, care managers, nurses (registered and/or licensed practical), and medical assistants.
- Some primary care practices may include social workers, nutritionists, psychologists, and parent peer support staff.
- A system approach will recognize the roles of these team members and will identify opportunities for these team members to support the mental as well as physical health needs of their families. These opportunities include coordination of paper/pencil or electronic device assisted screenings with check-in, empathic responses to patient and parent calls about problems,

processing of referrals to mental health specialists, maintaining patient psychoeducation materials, explaining insurance co-pays and pre-authorizations, and offering non-stigmatizing emotional support.

II.Decision-Making and Confidentiality in Primary Care

- Age of majority is the age at which youth are able to assume control over their own medical and legal decisions. This varies from state-to-state, ranging from 18-21 years. States may have statutes that allow younger adolescents to apply for decision-making, e.g. emancipated minor status. Health care providers will need to obtain official documentation of this status.
- Rules of confidentiality and ability to consent to medical care vary by state, procedure, and condition.
- Rules regarding who can make medical decisions may vary by condition. Specifically, services related to sexual disorders, gynecologic treatment, and obstetric treatment are often separated from other medical conditions, and providers will need to access information about relevant local laws. Decision-making about termination of pregnancy may have even more restrictive rules regarding adolescent decision-making and providers will need to be familiar with and keep current with federal and state laws
- Mental health and substance abuse may also have different rules regarding confidentiality and consent that vary from state to state. Child and adolescent psychiatrists should be prepared to assist primary care providers with information and resources about these rules.
- In youth with significant physical, mental health, or developmental disability, medical power of attorney by a parent or other guardian may need to be pursued prior to reaching age of majority in order to assure that parents can maintain continuity of care. Providers should be aware of shared decision-making models for healthcare decisions in the process of preparing for transition from children to adult years.
- Typically, confidentiality practices are emphasized to a greater degree in the training and culture of child and adolescent psychiatrists than they are with primary care providers. This can create challenges within each provider culture, for example, unnecessary withholding of critical information during communications between mental health providers and primary care providers.
- Mental health providers may be more likely to have specific office and legal procedures in place to protect the confidentiality of sensitive information concerning medical record releases. Identification of this issue and sharing of information about these procedures may be helpful in practice-based consultations to primary care providers and their staff.
- Primary care and mental health providers need to understand how electronic health records manage sensitive information, e.g. use of “glass walls”, and to communicate this information with their patients and families. Pros and cons of maintaining, “hidden” versus “open” information should be discussed, and appropriate permission and releases of information obtained.
- The physical layout of primary care settings may be less conducive to confidentiality than in mental health settings. This should be considered when determining who, where, and how sensitive information such as suicidal

ideation, intimate partner violence and substance use is obtained.
- Billing and insurance practices, e.g. mailing bills to the home of the insured parent's name, should be considered, with appropriate modifications in the management of these processes.

III.PRIMARY CARE/MENTAL HEALTH INTERFACE

Primary care was first described as the "de facto mental health system" by Regier and colleagues in 1978.[5] The reasons for this are numerous and are outlined in the following section. In order to provide better collaboration with colleagues in primary care, it is essential for the child and adolescent psychiatrist (CAP) to understand the multiple referral sources into the mental health system, the inherent cultural and role differences between the primary care and mental health systems, and potential gaps between the systems. The medical home model strives to increase communication and collaboration, and bridge the gaps that exist between primary care and mental health.[6]

Primary care as a first point of entry into the mental health system:

- Primary care is often the first place that behavioral/emotional/psychosocial problems present. Primary care physicians are in a natural position to develop a rapport with families beginning in the child's infancy and lasting throughout childhood and adolescence during routine well-child and illness visits, which provide multiple opportunities to screen for mental health concerns.
- Schools may suggest a need for treatment, and parents often first take these referrals to the primary care physician, with whom they are most familiar and whose role is to give anticipatory guidance on developmental and behavioral concerns, assess problems and intervene directly or refer to specialty care.
- Although primary care physicians identify and treat common and less complex mental health problems, such as uncomplicated ADHD, they also frequently identify complex and serious mental illness that will require referral and ongoing collaborative management.
- While the mortality from acute medical conditions has declined in the past 50 years, the morbidity from chronic health care problems has increased. The sequelae of premature births as well as federal mandates to screen and identify disabilities through the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) (Title V) have increased the identification and treatment of psychosocial issues in primary care.

Barriers to accessing mental health services through the primary care office:

- Insufficient resources for mental health problems in many public and commercial behavioral health plans that cover children and adolescents. These resource gaps may include number and availability of providers on insurance panels and availability of the full range of levels of care. For example, community-based wrap-around services are not usually available in commercial insurance contracts.
- Stigma and embarrassment or resentment may influence the success of referrals to and acceptance of treatment in formal behavioral health programs.

- Rural and other underserved areas often have no child and adolescent psychiatrists, resulting in the need for primary care physicians to treat illnesses they might not otherwise treat.
- In addition to stigma, multiple other challenges may contribute to low show rates by patients referred to mental health services. These may include Low show rates for patients who are referred for specialty care results from the burden of extra specialty care appointments, familial struggles secondary to family members with mental illness (e.g., housing, employment, legal, or other health problems), and the burden of navigating the mental health system.

Cultural differences between primary care and mental health:

- With the high volume of healthy, typically developing children in primary care, "watchful waiting" and anticipatory guidance are key parts of the philosophy and practice of the primary care provider. Child and adolescent psychiatrists are expected to identify strengths as well as challenges in their patients and families, with training historically having a focus on identification and treatment of problems. Training trends are helping to move both specialty areas to a comprehensive view of patient care that supports early identification and intervention in primary care and health and wellness promotion in child and adolescent mental health care.
- Primary care physicians tend to see patients as having a medical home at their practice, and many think all information including mental health should pass through them so they can track all health care issues and understand their patients holistically. Even if they don't know how to evaluate the appropriateness of certain mental health treatments, most still desire information about the treatments that are occurring, especially regarding medication.
- Primary care physicians tend to like referring to specialists that they know so that they can be confident they are sending "their patients" to good providers.
- Primary care physicians have many brief, often 10 or 15 minute, appointments and are accustomed to diagnosing and treating focused medical problems during that time frame. Some may be concerned that addressing mental health problems or psychosocial problems will reduce productivity, especially if they feel a pressure to "diagnose and treat" the mental health or psychosocial problem in one session.
- Primary care physicians desire timely feedback from specialists for acute concerns that they referred the patient. A mechanism for timely feedback is not built into most mental health systems, and CAPs are not currently reimbursed for this activity, often leading to a "disconnect" in communication.
- Confidentiality is traditionally a higher level of concern in the mental health field, and may hamper communication verbally and with regard to accessing patient records.
- Pediatricians get very little required training in the diagnosis and treatment of mental health concerns. Their only specific requirement in residency is 4 weeks of developmental and behavioral pediatrics.[8]

Bridging the Gaps - A history of barriers preventing the development of strong relationships between primary care and mental health systems:

- Lack of reimbursement for either primary care providers or CAPs to communicate

with each other.

- Lack of interoperability of electronic medical records between primary care and CAPs.
- Differing levels of training and expertise between CAPs and primary care physicians regarding the medications they are willing to prescribe.
- The tendency of mental health systems to have initial contact with an ancillary provider, such as a therapist, prior to a visit with a prescribing clinician may interfere with the primary care physician's traditional expectations for specialist consultation.
- Psychiatrists may be concerned that if they open themselves up to referrals from a primary care physician for fear of becoming overwhelmed with referrals and not responding adequately.

IV. THE MEDICAL HOME

A *medical home* is defined as "a community-based primary care setting that provides and coordinates planned, family/youth-centered, high quality health promotion and chronic-condition management."[9] A medical home is not a physical structure or building, but rather an approach to providing comprehensive primary care. The concept was developed by the American Academy of Pediatrics (AAP) to deliver primary care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youth, including youth with special health care needs."[10] The AAP has adopted the definition of *youth with special health care needs* as "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".[11] The medical home is also referred to by some organizations for those with chronic health conditions as a *health home*.

Scope of the Medical Home

- A medical home provides patients with enhanced access to providers and timely, organized care.
- Having a medical home is meant to improve quality and safety by assuring that one physician/practice has access to all up-to-date information regarding the health and development of the patient across multiple systems.
- The primary care office helps the patient as they navigate specialty systems and has records related to all care services that are provided regardless of specialty.
- The medical home model places emphasis on reminding patients of preventive care services, including screenings and immunizations.
- The medical home concept encourages the primary care physician to look beyond the patient's medical needs and help the family coordinate services between systems such as schools, child welfare, out-of-home placement, mental health, etc. This aids in the development of a comprehensive, multidisciplinary treatment plan.

Socioeconomic Disparities in Identifying the Medical Home

- Patients with medical homes are better prepared to manage chronic conditions and have better outcomes overall than those without access to a medical home.[12]
- In general, the presence of insurance, more education, and higher income are associated with the identification of a medical home.[12]

- The impact of ethnic, racial, and income factors is mitigated by the presence of insurance.[13-15]

Importance of Medical Home for CAPs

- Supporting the medical home concept should encourage safe, high quality care.
- CAPs can support the medical home concept by communicating with primary care physicians about all interventions that are implemented with the child and family.
- A primary care physician who is informed about medications prescribed, dosages, and indications can help ensure that there are no unrecognized adverse interactions with other prescribed medications.
- Good communication between the CAP and primary care physician can facilitate the evaluation, diagnosis, and treatment of medical issues that may cause or exacerbate psychiatric symptoms.
- Primary care physicians can help support the multidisciplinary treatment plan, which ultimately helps the child, family, and all care providers.
- The medical home has been endorsed by federal healthcare reform in the accountable care organization model and CAPs need to be an integrated part of these models.[16]

Medical Home and Case Management

- Complete implementation of the medical home concept requires primary care practices to perform significant case management services, many of which are not reimbursed. This is especially true for youth with complex physical or mental health needs.
- There are many strategies that primary care offices can utilize, especially by utilizing the skills of physician-extenders and non-professional staff, in order to improve implementation of the medical home concept.[9]

V.WORKING WITH A PRIMARY CARE CLINICIAN IN OUTPATIENT CONSULTATION VERSUS TRADITIONAL CAP INPATIENT CONSULTATION-LIAISON RELATIONSHIP

Primary care providers often consult CAPs in both the inpatient and outpatient medical settings. In addition to identifying psychiatric comorbidity, child and adolescent psychiatrists can help children and their families optimally cope with the burdens of disease as well as support optimal social and emotional development. Child and adolescent psychiatrists can also assist medication providers to develop the differential for medical conditions that may be causing or contributing to psychiatric symptoms. This section will outline the consultation process, as well as important differences and considerations in consultation between these settings. For more information about types of formal consultation relationships, please refer to the Consultation Module.

Process of Consultation

- Identify role – Are you answering a specific question with a one-time consultation? Will you be assuming long-term management? Will you have long-term availability for follow-up consultation? Will you be stabilizing the patient and then returning the patient to their primary care provider for ongoing management? How will you share oversight with the primary care physician?[7]

- Clarify the consultation question, including direct communication with the primary care physician if needed before the start of the consultation.
- Communicate in a clear and timely manner.
    - Respond to the consult question asked.
    - Provide formulation and diagnosis, as well as rule-out other possibilities, if pertinent.
    - Provide clear rationale for any medication and plan for monitoring.
    - Clearly delineate roles and responsibilities of primary care physician, CAP, and other care providers that may be involved (especially mental health and developmental professionals).
    - Provide information about medication changes.
    - Communicate with the primary care physician verbally when planning to transfer patient back to them and when you do a consult and ascertain that intervention is not needed at that point.
    - Provide a discharge summary to the primary care physician when ending treatment relationship.
    - Consider socio-cultural milieu of primary care.
    - Assess strength of relationship of patient's parents to primary care physician.
- Build relationships with the treating clinicians.
    - Timely and clear communication between clinicians is essential for optimal patient care.
    - Provide education activities about common behavioral problems in primary care (e.g., ADHD, ODD, depression, anxiety, somatization, developmentally appropriate stages of grief, or reaction to divorce).

Outpatient Consultations

- In the outpatient mental health setting, patients are most likely to be seen by a mental health provider other than an M.D. (such as a therapist) prior to psychiatric evaluation.
- Primary care providers may have had minimal training about how to define the behavioral health concern that prompts a referral. Direct communication between the receiving CAP and the primary care provider may be helpful for specifying the nature of the consult question and the services requested of the CAP, i.e. a consultation with recommendations for the primary care provider to implement versus evaluation and ongoing management of the mental health needs. Child and adolescent psychiatrists should be prepared to provide education about the various mental health disciplines and who may be best for addressing a specific concern, e.g. a referral to a psychologist may be the optimal initial referral when there is a concern about a cognitive disorder.
- The level of involvement of an outpatient psychiatrist may vary depending on the clinical need of the patient, availability of providers in the area, or other factors the primary care physician may not understand unless they are actively involved in the process of determining the ongoing needs of the family.

Inpatient Consultations

- Linked to the regulation history regarding coding and billing requirements, consultations to CAPs coming from inpatient medical care providers are

typically well defined regarding single consultation and recommendations versus evaluation and ongoing psychiatric management roles.
- Members of the primary medical team are generally aware of services available for ongoing management in the hospital setting, including social work and case management, and have a more established relationship with these providers.

II. COLLABORATION WITH PRIMARY CARE AND MODELS FOR IMPROVING MENTAL HEALTH TREATMENT IN PRIMARY CARE

As discussed in the sections above, collaboration with primary care is important in the care of children and adolescents with mental health problems. There is a lack of mental health care access because of an inadequate workforce. As there are increasing psychosocial problems in primary care settings and increased use of medication for common behavioral problems, primary care physicians often act as the gatekeepers to other systems of health care and are in a prime position to partner with CAPs in the diagnosis and management of youth with mental health problems. Although not inclusive, the following section discusses several ways in which mental health has been integrated with primary care practice.

Residency Training Programs

- Since 2000, the AAP has renewed its commitment to the treatment of mental health problems[17] and the Pediatric RRC of the ACGME has increased the mental health training requirements in residency.[8] Individual residency programs have incorporated mental health training opportunities in addition to the required one month rotation in developmental pediatrics in a variety of ways.
- Family practice programs have a history of including a mental health faculty member, who is often a psychologist.
- "Triple Board Programs" produce physicians who are board-eligible in Pediatrics, Adult Psychiatry, and Child and Adolescent Psychiatry. This 5-year combined training has the potential to produce leaders in the field who understand and overcome the traditional boundaries between physical and mental health treatment providers.
- "Post Pediatric Portal Programs" were approved by the ACGME in 2009. These 3-year post-residency programs are designed to "fast track" pediatricians to a Child and Adolescent Psychiatry certification to increase the youth mental health workforce.

Opportunities for Educating Practicing Primary Care Providers

- CAPs have the opportunity to educate primary care providers (PCPs) regarding child mental health issues and treatments that allow PCPs to extend their involvement in mental health care beyond their usual scope of practice. They also have the opportunity to guide PCPs in the education of their patients and their families. This can occur in a variety of forums:
    - The implicit case-based teaching that occurs with consultation and psychiatric services provided to patients.
    - "Lunch and learn" in primary care practices to discuss cases, diagnosis, treatment, best practices, therapies, and community resources.
    - CME training events, case conferences, and collaborative office rounds, in which CAPs and PCPs discuss cases of selected patients.[6]

- Goodfriend et al. tested a model meant to improve capacity of pediatricians to work with mental health complaints by having them see their own patients and families with a CAP.[18] Participating pediatricians and CAPs provided positive feedback about the model, but there have been no other formal outcomes reported and the model may not be financially feasible for many settings.

Telepsychiatry

- Telepsychiatry has potential for bringing CAP services to underserved and/or remote areas and improving the problems that result from uneven distribution of child and adolescent psychiatrists.
- AACAP has published a set of guidelines for successful implementation of telepsychiatry services.[19]
- Telepsychiatrists provide direct care services such as ongoing treatment and consultative evaluations.

Collaborative and Co-Located Models

- AACAP and AAP joined forces to recognize promising models for improving access to mental health services for children, and published a position paper recognizing promising models and needed system changes for implementation.[20]
- AACAP published two papers to help providers and payers build collaborative and integrated programs.[6,7]
- Co-located models bring the mental health system physically to the primary care site. Patients are seen by therapists of CAPs in their PCP's office, but interaction between the mental health and primary care providers is not formally incorporated.[21]
- Reverse co-located models bring primary care practitioners physically into the mental health setting. For example, an RN may perform screening for metabolic syndrome in a psychiatrist's office for patients on atypical antipsychotic medications.
- Collaborative models have formal mechanisms in place for encouraging collaboration between providers. Collaborative models have been shown to improve short-term outcomes and be cost-effective in the treatment of adult mental health disorders.[22-24] Less is known about the efficacy and cost-effectiveness of collaborative models for youth mental health treatment with the most evidence available for treatment of adolescent depression[25] and ADHD.[26]

Examples of Collaborative and Co-Located Models

- Massachusetts Child Psychiatry Access Project (MCPAP) – A primary care physician within a region calls that region's MCPAP hotline to find community services such as therapy, referral to a child psychiatrist, crisis services. The telephone consultation may be provided while the patient is still in the primary care physician's office for efficient communication and implementation of the recommendation, with support for primary care management of medications and other interventions as appropriate. Participation in this model requires that the primary care practice participate in educational events provided by the CAPs to enhance PCP knowledge and skills for mental health care management ("lunch and learns").[27]
- Nurse practitioner with mental health training provides ongoing chronic care for

youth with mental health needs and works in an onsite team of a pediatrician, a CAP, and a therapist. The CAP and therapists were originally available to provide ongoing care in concert with the pediatric nurse practitioner and the pediatrician, and the role of the CAP later shifted to that of a consultant available for complex cases as the model matured.[28]

III. FEDERAL LEGISLATION AND YOUTH MENTAL HEALTH SERVICES

The following timeline is a brief historical summary of federal legislation contributing to current funding of youth mental health services, with more specific focus on Title V, Medicaid, EPSDT, SCHIP/CHIP, and the Patient Protection and Affordable Care Act of 2010. This overview is intended to provide a snapshot of notable historical legislation that has bridged medical and mental health care availability to youth in the United States, as well as an introduction to future planned initiatives under the current administration. The following information is in part obtained from the Health Resources and Services Administration through the U.S. Department of Health and Human Services, as well as the Commonwealth Fund.[29,30]

1912 – Children's Bureau created by Congress in Department of Commerce and Labor

1935 – Title V of Social Security Act of 1935

- Maternal Child Health Program established the only federal legislation devoted to promoting and improving the health of our nation's mothers and children.
- Original legislation specifically did not provide health insurance in response to concerns from the American Medical Association and insurance industry.
- Administered by Health Resources and Services Agency (HRSA).
- Between 1967 and 1989 amendments included working with Medicaid, coordinating EPSDT, providing toll-free numbers to youth or families requesting Title V or EPSDT, providing outreach to women and youth who qualify for Medicaid, and others.[30]

1965 – Social Security Amendments establish Medicaid

- Medicaid is a publicly funded health insurance program designed to provide increased access to health care for the poor.
- It is a *Federal-State entitlement fund* – a right granted by the government that is paid for by both the state and the federal government.
    - "Sponsored" by federal government and administered by states.
    - The federal Centers for Medicare and Medicaid Services (CMS) monitors the state-run programs and oversees requirements for service funding, delivery, quality, and eligibility.
    - Federal government provides matching funds to states.
    - It is not required for states to participate, but all states have participated since 1982.
    - Some states subcontract Medicaid to private health insurance companies, other states pay health care providers directly.
- Eligibility: U.S. citizens or legal permanent residents, low-income parents and children, elderly, some disabled individuals.
    - Children make up >54% of beneficiaries.
    - Most disabled individuals are eligible because they receive assistance through social security disability insurance through Medicaid.
- It is the largest purchaser of health insurance in the U.S.

- It was not designed to control (or even consider) the price of health care.
    - Problem with escalating prices of health care from the 1970s to present, and no original built-in mechanism to control costs, resulted in growth that outpaced expectations.
- Large program, with many components, susceptible to fraud.

1967 – EPSDT

- The child health component of Medicaid.
- EPSDT includes a comprehensive package of benefits to provide early detection of physical, mental health, and developmental problems; periodic assessment of those with these issues and those at risk; screening for potential medical, mental health, or dental conditions; diagnosis of conditions; all medically necessary treatment services; includes assistance in scheduling and getting transportation to appointments; and intensive home and community based services.
- It is a Federal-State entitlement fund.
- Eligibility: all youth under 21 years of age enrolled in Medicaid.

1981 – Omnibus Budget Reconciliation Act

- Combined five programs related to maternal and child mental health (including Title V) and administered *block grants* to states. A block grant is a sum of money provided by the federal government to a regional government with only general provisions about how it is to be spent (as opposed to a categorical grant, which is has more strict and specific provisions).
- Gave states more discretion with where to direct funds for children and families.
- This discretion resulted in larger variation from state to state. Therefore, although Medicaid and EPSDT are "federal laws", the politics and rules are very local in nature.

1989 – Amendments to increase reporting and tighten rules about use of funds.

1990 – Maternal Child Health Bureau (MCH) established to administer Title V programs.

1991 – Healthy Start enacted

- Increase access to learning and family supports in schools and the community to close the achievement gap.
- Centers might help with finding academic support, family support (child protection, parenting education, case management, ESL), assistance with basic needs, medical and mental health care, employment assistance (career counseling, job placement) on an as-needed basis for the child or family.

1995 – Deficit Reduction Act

- Created Medicaid waiver program so states could modify how they administered EPSDT.

1997 – Title XXI of Social Security Act results in State Children's Health Insurance Program (SCHIP), now known as CHIP (Children's Health Insurance Program)

- CHIP gives states federal funding to fund public insurance for "targeted low income" children who are not eligible for Medicaid or other "creditable coverage."
- It is NOT considered a Federal entitlement. Each state receives a capped allotment of funds, so there is no individual entitlement.
- Provides funds to states at enhanced matching rate compared to Medicaid.
    - States have significant discretion in how they administer funds,

including program design and eligibility.
    - States can use funds for separate program for "targeted lower income children" or can expand youth who qualify for Medicaid.
- Eligibility: 1 in 3 children under age 6 is eligible; serves 1/5 of children in U.S.

2005 – House Budget Reconciliation Bill
- Allowed states to shift children from EPSDT to CHIP, effectively reducing the amount of mental health coverage available to some children.

2009 – Children's Health Insurance Reauthorization Act of 2009 (CHIPRA)[31,32]
- SCHIP became more simply known as CHIP.
- Expanded CHIP to more children and to include legal immigrants without a waiting period.
- Expanded coverage to pregnant women. Prior to this, states could cover pregnant women under CHIP by covering "unborn children."
- Requires mental health parity for states that chose to include mental health or substance abuse services in their CHIP plans.

2010 – Patient Protection and Affordable Care Act (aka ACA or ObamaCare)[33]
- Extended authorization of federal CHIP program through September 2015.
- Required states to maintain current income eligibility levels for CHIP through September 30, 2019, and states cannot implement eligibility requirements that are more restrictive than those in place as of March 23, 2010, with exception of waiting lists for enrolling children in CHIP.
- Prohibits insurance plans from denying coverage to children with pre-existing conditions. Applied to all persons in 2014.
- Required new private health plans to cover preventive services with no co-payments, and for preventive services to be exempt from deductibles. Will apply to all plans in 2018.
- Extends coverage of young people through age 26 under their parents' insurance, at the choice of the parents, regardless of the youth's marital status.
- Created state health exchanges to provide individual coverage to those currently without health insurance.
- Created Accountable Care Organizations to manage care based on quality, including coordination of care through health and medical homes.

2015 – Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Extended authorization of federal CHIP program through September 2017.

The Mental Health First Aid Act
- Provided funding for training primary care providers, school staff, police officers and other professionals to better recognize, respond, and appropriately refer individuals with mental illness and SUDs.

CMS/SAMHSA/NIMH Joint Bulletin on Coverage of Early Intervention Services for First Episode Psychosis
- Provided funding to assist states in designing a benefit package to guide early treatment intervention options that will meet the needs of youth and young adults experiencing first episode psychosis.

2016 - 21st Century Cures Act

- Established grant program to identify early intervention in infants and children who are at risk of mental disorders, including SED.
- Increased attention and access to pediatric mental health care, including Health Resources and Service Administration (HRSA) grants to promote integration with pediatric primary care, eligibility requirements for statewide or regional pediatric mental health care telehealth programs, and funding authorized at $9 million.
- Eliminated the prohibition on same-day billing for mental health and primary care services covered under Medicaid.
- Provided grant funds to create programs that divert individuals with mental illness from prisons and jails to court-supervised intensive treatment programs.
- Provided funding for law enforcement grants for crisis intervention teams and for mental health purposes.
- Authorized The Sequential Intercept Model intended to collect and track data to keep individuals with mental illness from going further into the criminal justice system.

The Comprehensive Addiction and Recovery Act (CARA)

- In response to the opioid abuse epidemic expanded prevention and educational services for youth and their parents for preventive services, treatment, and recovery
- Expanded recovery support for high school students and those enrolled in institutions of higher learning
- Provided resources for the prompt identification and treatment of incarcerated individuals with SUDs using evidence-based treatments and promotion of collaboration among justice stakeholders.

2018 - The Family First Prevention Services Act

- Directed federal child welfare funds to provide services to families at risk of entering the child welfare system.
- Provided federal reimbursement mechanisms for in-home parenting skill training and SUD and mental health treatment designed to prevent youth from entering foster care.
- Provided financial incentives to states to in order to prevent children already in foster care from being placed into congregate care.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

- Authorized funding for expansion of prevention and treatment services for opioid use disorders, including provisions for first responder training in the use naloxone and authorizing a grant program to create comprehensive opioid recovery centers.

2020 - Families First Coronavirus Response Act

- Expanded Medicaid and CHIP coverage for COVID-19 related services including those associated with diagnostic testing, EPSDTs, prescription medications,

emergency transportation, hospitalization, and reimbursement for and relaxation of rules for telehealth utilization.

CONCLUSION

Because of their frequent and long-term interactions with youth and families, primary care providers are in a prime position to identify and treat mental health and psychosocial issues. However, effective identification and treatment may be limited by factors such as provider education, clinical training and supervision and comfort in diagnosis and management, and availability and/or knowledge of mental health resources. The medical home model facilitates collaboration between the primary care and mental health systems in the comprehensive, multidisciplinary care of the patient. Child and Adolescent Psychiatrists can interact with PCPs in multiple ways including formal consultation, curbside consultation and education, co-location of practice, and collaboration of care between providers. Issues such as child adolescent psychiatry work force limitations, and funding of collaboration between primary care and mental health systems continue to pose challenges to optimal delivery of integrated primary care and mental health care.

***APPENDIX 1**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

∗ Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.

APPENDIX 2

Additional resources:

AAP Mental Health Initiatives Website

https://www.aap.org/en-us/advocacy-and-pollicy/aap-health-initiatives/Mental-Health/Pages/default.aspx

AACAP Primary Care Resources

https://www.aacap.org/AACAP/Resources_for_Primary_Care/Home.aspx

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Primary Health Care System – Discussion Vignette I – Trainee Version

Annie, a three-year-old child with insulin dependent diabetes, is brought to the pediatrician by her mother, Ms. Knock, because of increased irritability, mood swings and difficulty sleeping through the night. She has become increasingly irritable when receiving her shots over the past months, and in the last week the only people with the ability to administer her shots are her mother and father. Her other caretakers at daycare were previously quite adept at giving the shots, but now feel uncomfortable because of her thrashing and screaming. They still are trying, but admit that they have missed a few shots over the last two weeks. Both the pediatrician and parents are in distress over this situation. The child's labs currently reveal that the diabetes is not controlled as well as it was 6 months ago, although it doesn't quite reach the need for inpatient hospitalization or a trip to the ER yet. Nevertheless, the pediatrician fears that this child could be headed for complications if intervention is not taken soon.

To complicate matters more, the father has just lost his job and the family is now without insurance coverage. The mother is distraught and asks for help because they cannot afford Annie's medicine or the office visits. The pediatrician is feeling overwhelmed and calls you for a curbside consultation saying, "what medication can I give in order to sedate this child so that her diabetes can be properly monitored and controlled?" There is a family history of psychiatric disorder, specifically generalized anxiety disorder and obsessive compulsive disorder.

What are some possible suggestions you could give to the pediatrician?

Primary Health Care System – Discussion Vignette II – Trainee Version

You are talking to a colleague who is a pediatrician and is interested in treating mental health problems. She has heard that behavioral health treatment provided by a primary care provider is a federal entitlement (right granted by law or government) but doesn't understand the specifics. She states, "The entitlement means that I can provide childhood immunizations and well-child care checks."

Please describe the relationship of EPSDT, Medicaid, and CHIP for your colleague as it relates to mental health treatment.

Which children are eligible for SCHIP in your state?

Primary Health Care System – Discussion Vignette III – Trainee version

You are a CAP in a mental health clinic in a small town in the Midwest and have a patient referred to you by a primary care doctor because they have begun to have panic attacks. The youth's mother also has panic attacks and sees a psychiatrist for treatment of an anxiety disorder. When you complete the evaluation, you recognize that the youth's "panic attacks" began soon after a drastic increase in the use of his albuterol inhaler in conjunction with a worsening of his asthma. Many, though not every, panic attack has been precipitated by the use of his inhaler. The child has never been diagnosed with a psychiatric disorder. You receive this referral sheet a week before the patient's appointment.

Discuss your approach with the pediatrician.

You have discussed the patient's presentation and clarified your role with the pediatrician. The pediatrician wants you to complete a consultation and send the patient back to them with recommendations. You perform a complete psychiatric evaluation and believe that the panic attacks are entirely precipitated by the inhaler. Discuss how you would manage this situation.

Once you have met with the child and family you contact the pediatrician. What would you discuss?

