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Case Study
High-Performing Health Care Organization • March 2010

The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care

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Commonwealth Fund pub. 1378
Vol. 41

ABSTRACT:
Massachusetts has successfully demonstrated the Massachusetts Child Psychiatry Access Project (MCPAP), a program that provides timely telephonic psychiatric and clinical guidance to primary care providers (PCPs) treating children with mental health problems. The program allows enrolled PCPs to get assistance for any child in their care. On the basis of an initial phone consultation, MCPAP may provide an in-person psychiatric or clinical assessment, transitional therapy, and/or facilitated linkage to community resources. Six regional teams based in academic medical centers reach out to and support enrolled PCPs in their catchment area. The program has enrolled most primary care practices, representing an estimated 95 percent of all youth in the state, and has high rates of PCP participation. PCPs report higher ratings of their ability to serve children with mental health problems as a result of the program.

THE ISSUE

Insufficient access to child psychiatry is a nationwide problem in children's mental health systems. A recent study estimated a national need for 30,000 child psychiatrists, but found only 6,300 in practice.[1] Some states have very few child psychiatrists; Montana has no child psychiatrist in the eastern part of the state. Even in states like Massachusetts, which has more psychiatrists per capita than other states,[2] many do not accept health insurance and community mental health centers report difficulty in recruiting psychiatrists.[3] In Massachusetts, waits of four to six weeks for psychiatric appointments are common, and several community mental health centers report three-month waiting lists, thereby limiting many families' access to these services.

Children's primary care providers (PCPs) meet much of this need. For a number of years, they have been the most frequent prescribers of psychotropic

medications, accounting for 85 percent of all such medications prescribed to children in 1997.[4] This rate may have dropped because PCPs reduced prescribing antidepressants after the U.S. Food and Drug Administration issued an advisory and imposed a black-box warning in 2004 stating that antidepressants increase the risk of suicidality in pediatric patients.[5] However, PCPs remain important prescribers of psychotropic medications.[6] Approximately 12 percent of all children and adolescents in primary care pediatric settings have substantial psychosocial difficulties, and psychosocial problems are an increasingly frequent reason for pediatric office visits, growing from 7 percent to 19 percent between 1979 and 1996.[7] Pediatric primary care providers' roles in mental health care will likely become more important: the number of child psychiatrists in practice is expected to increase by less than 10 percent in the next 15 years,[8] while the number of pediatricians is expected to increase by 60 percent.[9]

Despite their critical role in identifying and treating psychosocial and mental health problems, most primary care providers have relatively little preparation. They are also less likely to have established referral relationships with psychiatrists and mental health therapists than with other specialists. A nationally representative survey of physicians found that two-thirds were unable to get outpatient mental health services for at least some of their patients.[10] An earlier survey of Massachusetts physicians, meanwhile, found that few felt comfortable and well-prepared to prescribe psychotropic drugs and manage behavioral health conditions.[11] They were most comfortable diagnosing and prescribing for attention deficit hyperactivity disorder (ADHD) and depression, but less so for other mental health problems without psychiatric consultation. Few physicians had access to formal psychiatric consultation programs to assist them with difficult cases, though some were fortunate to have access to informal sources of consultation—a spouse, a close friend, or a nearby colleague.[12]

These limitations add to PCPs' burden in caring for behavioral problems and can affect the quality and effectiveness of their response to those problems. A survey of parents of children with behavioral problems found that the parent frequently consulted the child's primary care physician before any other medical professional, but few were satisfied with the assistance offered them.[13] The parents cited the following difficulties:

- problems getting a physician to take the problem seriously ("she'll probably grow out of it");
- misdiagnosis; and
- problems with psychotropic prescriptions, often related to misdiagnosis.

> *"As a pediatrician, I am not really trained to do the extent of social work and psychiatry that is necessary."*
>
> Toby Milgrome, M.D.,
> Fallon Clinic, Leominster, Mass.

Clearly, additional training and support for primary care providers' treatment of children's mental health problems is warranted.

ABOUT THE MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT

The state of Massachusetts has developed a promising intervention—the Massachusetts Child Psychiatry Access Project (MCPAP)—to increase primary care clinicians' access to child psychiatry consultation and to support referrals to mental health specialists. The program provides PCPs with timely access to child psychiatry consultation and, when indicated, transitional services for their patients while helping families make arrangements for ongoing behavioral health care. Six regional teams, consisting of one full-time equivalent (FTE) of a child psychiatrist, 1.5 FTE of a licensed social worker, one FTE of a care coordinator, and appropriate administrative support, build relationships with the PCPs in their area. They operate during business hours to provide telephone consultation for PCPs—often immediately, but no later than 30 minutes after the request. Depending on the needs of the child and family, services provided may include:

- an answer to the PCP's diagnostic or therapeutic question;

- routine referral to the team care coordinator to assist the family in accessing local behavioral health services, with the understanding that there may be a four-to-six-week wait;
- referral to the team social worker for a clinical assessment, or for transitional face-to-face care or telephonic support until the child accesses services; or
- referral of the child to an MCPAP child psychiatrist or clinical nurse specialist for an acute psychopharmacologic or diagnostic consultation.

The program is designed to give PCPs consultative support to manage children with less complex mental health needs, thereby freeing the limited child psychiatry workforce to manage children with more-complex needs.

TARGET POPULATION

MCPAP's ultimate target population is all children in the Commonwealth of Massachusetts with mental health needs, regardless of insurance status, as long as the point of entry is their PCP. MCPAP is a program designed by and for physicians, and its immediate target is primary care practices, which it recruits, enrolls, and supports. As of July 2009, 365 PCP practices in the Commonwealth have enrolled in this program. The Massachusetts Behavioral Health Partnership (MBHP), which runs the program, estimates that the enrolled practices cover at least 95 percent of the approximately 1.5 million children in the Commonwealth. The participation rate is quite high, with 65 percent to 75 percent of enrolled practices using MCPAP services during each quarter.

Children served by MCPAP (through PCP consultation or directly) span the entire age range (Exhibit 1). School-age children make up the bulk of children served, with a slightly higher percentage falling into the teen category. Small percentages of children are under age 5 or over age 18. More boys (61%) than girls are served.

The children who receive MCPAP services have a range of mental health needs. Some may have relatively uncomplicated problems but require assistance with arranging mental health therapy. Some are receiving medication prescribed by their primary care physician, but the physician needs advice on some aspect of diagnosis, selection of medication, or dosing. Other children have multiple, complex conditions, and the PCP may need assistance with diagnosing as well as with developing a treatment plan and locating specialized services.

Exhibit 2 shows the number of diagnoses of children served during FY2009 on the left, and the specific diagnostic groups on the right. This distribution suggests that many MCPAP cases are likely to be complex. Virtually half have two or more diagnoses, and for 11 percent the diagnosis has not yet been

Exhibit 1. MCPAP Patients by Age and Gender (July 1, 2008 to June 30, 2009)

Ages	Female	Male	Total	Percent
0–3	69	166	235	5%
4–5	165	319	484	9%
6–11	593	1,311	1,904	37%
12–14	415	565	980	19%
15–18	640	631	1,271	25%
19–23	129	88	217	4%
Unknown	2	6	8	0%
Total	**2,013**	**3,086**	**5,099**	
	39%	**61%**		

determined. The top three diagnoses addressed by MCPAP at the time of encounter are ADHD, anxiety, and depression. Each account for 15 percent to 20 percent of mental health encounters. Oppositional defiant disorder accounts for over 6 percent, and the remaining diagnoses account for 4 percent or less of all encounters.

MCPAP collects data on the medications prescribed for the specific patients they consult on and serve. Despite the number of complex conditions, many children (52% in FY2009) are not on psychotropic medications. One-third (32%) are on one medication, and the remaining 16 percent are on more than one medication. MCPAP staff report that they are often able to offer PCPs and families suggestions for effective and appropriate non-medication interventions, and frequently recommend that course of treatment.

MCPAP also collects data on the medications that are being prescribed. Stimulants and selective serotonin reuptake inhibitors (SSRIs) are most frequently being prescribed in MCPAP encounters, with each accounting for close to 20 percent. Atypical antipsychotics and alpha-agonists were being prescribed in 3 percent to 5 percent of encounters. All other medication groups were being prescribed in 2 percent of encounters or fewer. MCPAP reports also show that most encounters do not result in a change of medication; only about 20 percent do.

HOW MCPAP WORKS

The Massachusetts Child Psychiatry Access Project is funded by the state's Department of Mental Health (DMH) through a contract with a managed care organization, the Massachusetts Behavioral Health Partnership (MBHP). This organization is responsible for managing the Medicaid behavioral health benefit for enrollees in the state's primary care case management program, and it also conducts quality

Exhibit 2. MCPAP Patient Diagnostic Complexity*
(July 1, 2008 to June 30, 2009)

MCPAP unduplicated patients by number of diagnoses	No. of patients	%	MCPAP encounters by diagnosis	No. of encounters	%
			Attention deficit hyperactivity disorder (ADHD)	6,061	21.3%
Patients with more than 1 diagnosis	2,454	48%	Anxiety	4,637	16.3%
Patients with 1 diagnosis	2,065	40%	Depression	4,467	15.7%
			Deferred diagnosis	2,823	9.9%
Patients with no diagnosis or deferred diagnosis	580	11%	Oppositional defiant disorder (ODD)	1,837	6.5%
Total diagnosis	**5,099**		Adjustment disorder	1,150	4.1%
			Pervasive developmental disorder (PDD)	986	3.5%
			Mood disorder (not otherwise specified)	928	3.3%
			Bipolar	633	2.2%
			Post-traumatic stress disorder (PTSD)	594	2.1%
			Obsessive compulsive disorder (OCD)	539	1.9%
			Social anxiety (SA)	425	1.5%
			Eating disorder	317	1.1%
			Other	2,657	9.3%
			Not applicable	338	1.2%
			Grand total	**28,392**	

* Patients may have more than one diagnosis.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, queries run on 7/20/2009 (specific diagnoses) and 8/12/09 (number of diagnoses); date parameters between 7/1/08 and 6/30/09 for both queries.

> *"The caliber of MCPAP psychiatrists is very impressive. We are privileged to have them. I really feel that we do have a partnership with child psychiatry and are working toward a common goal."*
>
> Carole Allen, M.D., director of pediatrics for Harvard Vanguard and president of the Massachusetts Chapter of the American Academy of Pediatrics

improvement for primary care case managers, giving it a unique tie to both behavioral health and primary care. The partnership's vice president of medical affairs, a pediatrician, oversees MCPAP with the assistance of a part-time project manager and a dedicated part-time data analyst. MCPAP also has two part-time medical directors, both child psychiatrists, who each oversee three regional programs.

Each of the six MCPAP regional teams has been sited in an academic medical center that serves the region. This has two key benefits: it does not reduce existing community psychiatric capacity, and it draws upon the prestige of these organizations and their natural role as sources of expert specialty consultation. Teams hire sufficient psychiatrists and/or clinical nurse specialists to provide full-time coverage. Psychiatry staff may perform other work during MCPAP coverage, but must be able to respond to phone calls within 30 minutes of a request.

Each team also has 1.5 FTE of a licensed independent clinical social worker, responsible for clinical assessments and transitional therapy, who may also consult with PCPs and facilitate referrals for the cases they are involved with. Both the psychiatrists and social workers are credentialed through the hospital and apply to participate in all the insurance panels in which the hospital participates. One FTE of a care coordinator actively facilitates referrals, contacting families to find out their needs and preferences and identifying well-matched therapists or psychiatrists who have openings. MCPAP recognizes the shortage of therapeutic and psychiatric resources and prepares PCPs and parents for a wait of four to six weeks before being able to begin a relationship with a community provider.

MCPAP emphasizes building relationships between each team and the primary care practices in its catchment area. Each team is expected to conduct active outreach at start-up and maintain outreach on an ongoing basis. Staff visit primary care practices to explain the service and begin a relationship, and sometimes visit local clinics to introduce themselves and learn about local mental health resources. Teams are expected to reach out to practices that have not used MCPAP services in the prior quarter.

The teams strive to create a culture of PCP empowerment, and the guidance they provide to PCPs is intended to increase their willingness to take on the management of more challenging conditions. This also requires recognition by psychiatrists and clinicians that some mental health treatment can be provided effectively by PCPs. For example, MCPAP has adopted a policy that its staff do not write prescriptions; instead, MCPAP psychiatrists work with the PCP, who writes the prescriptions. This prevents patients from becoming dependent on the MCPAP psychiatrist and maintains the role of the psychiatrist as a consultant. If the case is complex and the PCP is willing to prescribe for the child on a transitional basis until a community psychiatrist can take over, the MCPAP psychiatrist may see the child during the transition to help monitor medications, and will communicate frequently with the PCP and the family.

Each team uses the medical information system of its hospital for case files. Any direct-service visits are billed by the hospital. MCPAP's data system, a Web-based electronic medical record, is used to report to MBHP, the contracted managed care organization. The system blocks patient names and identifying information outside of the regional office so that confidentiality is maintained. A unique identification number is assigned to allow MBHP to analyze service patterns and unduplicated users.

Each team builds its own set of referral information. Some teams have experimented with developing an Excel-style database that allows searches on different aspects of programs and practitioners. They often start with lists provided by health plans, but call

> *"I use all the MCPAP services. A four-month wait for psychiatry is too long for some children, so they get an assessment from MCPAP. Sometimes they give the child back to me with a diagnosis and a treatment plan I can handle. Most often, I use MCPAP care coordination."*
>
> Toby Milgrome, M.D., Fallon Clinic, Leominster, Mass.

providers to verify openings and capabilities. Since the care coordinator and social worker often speak with clinics and therapists in the course of seeking a good match, they build a rich understanding of the available resources. Because they work with families with many different types of insurance, they come in contact with a wide range of the practicing clinicians.

Teams vary in how they work together. The social worker and case manager are sometimes sited in proximity to the psychiatrists, and sometimes they are in a separate site. The degree of consultation between team members varies accordingly.

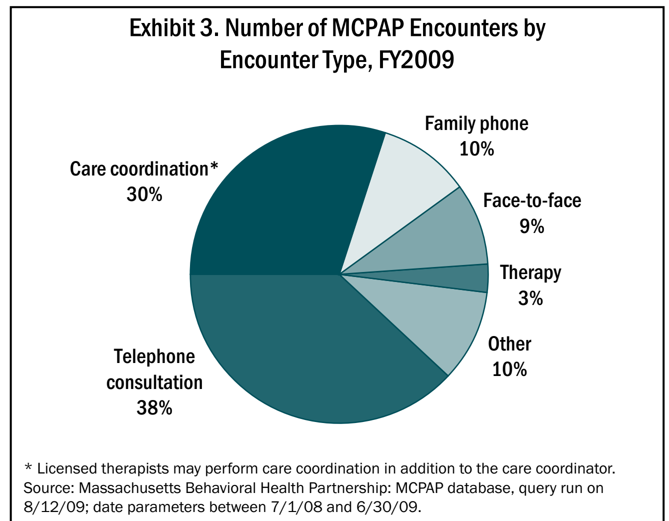
The two most frequent MCPAP services involve telephone consultations with PCPs (almost 40%) and care coordination encounters to arrange for services in the community (30%) (Exhibit 3). Twenty percent of encounters are with families, and these encounters are evenly divided between telephone contact and face-to-face meetings. Only 3 percent of encounters are for transitional therapy.

Encounters are equally split between psychiatric staff and licensed therapists, each of whom account for approximately 40 percent of encounters (Exhibit 4). Care coordinators account for the remaining 20 percent. Many children, almost 40 percent, receive services from more than one team member. Psychiatry is the dominant service, with psychiatrists and clinical nurse specialists together reaching 60 percent of the children served in FY2009. Licensed therapists provide services to 54 percent of children, and care coordinators provide services to 23 percent.

Many encounters (37%) have more than one concern or activity associated with them. Close to half of all reasons for an encounter are clinical, and over a third (36%) are for referrals to community services (Exhibit 5). Sixteen percent involve a face-to-face evaluation. MCPAP psychiatrists and clinicians provide a written summary of their evaluations to the PCP, an important linking function that PCPs complain often does not occur when they make referrals to mental health services. This is an important way for them to assess and gain confidence in the quality of MCPAP services.

Some encounters (29%) are considered to have more than one outcome. For about a third of encounters, a child is returned to the management of the PCP (Exhibit 6). A similar percentage is referred for MCPAP care coordination. Fewer (14%) are referred for services from the MCPAP therapist or referred to a community psychiatrist facilitated by MCPAP (7%). To avoid the use of MCPAP as a strategy to get a child into a specific practice, MCPAP psychiatrists are discouraged from picking up patients in their private practices. Small percentages are referred to a physician other than the PCP or a psychiatrist. A few encounters result in referrals for crisis intervention or inpatient treatment.

Exhibit 3. Number of MCPAP Encounters by Encounter Type, FY2009



* Licensed therapists may perform care coordination in addition to the care coordinator.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, query run on 8/12/09; date parameters between 7/1/08 and 6/30/09.

In addition to consultation and outreach, MBHP maintains a Web site for PCPs (www.MCPAP.com) where it posts informational materials developed or identified by MCPAP teams. MBHP also periodically

Exhibit 4. MCPAP Encounters and Patients by Provider Type (July 1, 2008 to June 30, 2009)

MCPAP Encounters by Provider Type			MCPAP Number of Patients Served by Provider Type		
	No.	**%**		**No.**	**%**
Physician	6,094	31%	Physician	2,213	43%
Clinical nurse specialist	1,786	9%	Clinical nurse specialist	881	17%
Licensed therapist	8,005	40%	Licensed therapist	2,766	54%
Care coordinator	3,896	20%	Care coordinator	1,162	23%
			More than one provider type	1,923	38%
Total	**19,781**		**Total**	**5,099**	

Note: Multiple encounters per patient may occur; patient may be served by more than one provider type; does not include any non–patient-specific consultation or continuing medical education.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, query run on 8/12/09; date parameters between 7/1/08 and 6/30/09.

Exhibit 5. MCPAP Encounters by Reasons for Contact (July 1, 2008 to June 30, 2009)

Contact Reason	No.	%
Clinical Questions		
Diagnostic	6,436	21.5%
Medication question	3,668	12.3%
Parent guidance	1,806	6.0%
School issues	945	3.2%
Other	1,297	4.3%
Total clinical questions	***14,152***	***47.3%***
Resources—Community Access	***10,839***	***36.3%***
Evaluations		
Medication evaluation	4,471	15.0%
Second opinion	425	1.4%
Total evaluations	***4,896***	***16.4%***
Grand total	**29,887**	

Note: More than one reason for contact may exist.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, query run on 7/20/09; date parameters between 7/1/08 and 6/30/09.

Exhibit 6. MCPAP Encounters by Outcomes (July 1, 2008 to June 30, 2009) All Regions Combined

Outcome	No.	%
Return to management of PCP	8,955	33.7%
Care coordinator	8,747	32.9%
Therapist appointment	3,835	14.4%
Refer to a new psychiatrist	1,874	7.1%
Psychopharmacological evaluation	1,433	5.4%
None	691	2.6%
M.D. appointment	665	2.5%
Refer to an existing psychiatrist	214	0.8%
Refer to emergency services	125	0.5%
Inpatient	26	0.1%
Grand Total	**26,565**	

Note: More than one reason for contact may exist.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, query run on 7/20/09; date parameters between 7/1/08 and 6/30/09.

sends pertinent information about child mental health issues to PCPs willing to receive this kind of e-mail communication. When Massachusetts Medicaid required PCPs to administer a behavioral health screen at all well-child visits and commercial insurers began to pay for this screening MCPAP offered training for PCPs on the recommended screening tools.

PROGRAM DEVELOPMENT AND IMPLEMENTATION

Program Implementation

The Massachusetts Child Psychiatry Access Project grew out of discussions among Medicaid personnel in the New England states, who were brought together in 2002 by Ronald Preston of the Centers for Medicare and Medicaid Services (CMS) New England Regional Office. They investigated the reasons for the growing number of children on psychotropic medications and the small but growing number on multiple psychotropic medications. Most children on complex psychotropic regimens, they found, were being treated by pediatricians, many of whom were continuing children on the medications that had been started during a hospital stay. A relatively small number of these children were under the care of child psychiatrists for complex conditions. It seemed clear that more children needed access to child psychiatrists, and PCPs needed assistance treating children with more-complex mental health conditions.

In 2003, the Child Division of the UMass/UMass Memorial (UMMS) Department of Psychiatry, under the leadership of Dr. Ron Steingard, developed the Targeted Child Psychiatric Services (TCPS) model to address this defined problem. TCPS envisioned the PCP as the customer and held focus groups to find out what they wanted and needed. With funding from the Massachusetts Department of Mental Health, UMMS implemented a program to provide psychiatric support for its affiliated PCPs. The PCP would continue to manage most of the children, but would receive education, training, and support to do so.

Primary care physicians did not warmly welcome TCPS when it was first introduced. Physicians at an early presentation to the Massachusetts Medical Society were furious. They feared that they would be asked to take on more responsibility and required to do work for which they were inadequately trained. They

also wondered what kinds of strings were attached to this "free" service. They feared that the state could cut the program and leave PCPs with difficult patients who they could not safely manage by themselves. A continued marketing effort that involved hosting breakfasts for PCPs and having them attend Medical Association meetings was successful in addressing these concerns and building trust.

The demonstration ran for 18 months and produced measurable improvement in clinical functioning as well as customer (PCP) satisfaction. The goal of replicating this program statewide had top-level support from Ron Preston, who had left CMS to become commissioner of the Massachusetts Executive Office of Human Services, with jurisdiction over DMH and MassHealth. In addition, creating a statewide PCP support program was seen as a way for the state to demonstrate its commitment to addressing child mental health access problems in the face of a class action lawsuit.

The project became one of the Massachusetts Behavioral Health Partnership's Performance Improvement Incentives for the following year. At MBHP, Dr. John Straus, the vice president for medical affairs, who had actively lobbied for this opportunity, took the lead in developing a feasible plan for statewide implementation, which included review of TCPS, literature review, stakeholder input, analysis of sizing and pricing, and recruitment of potential host sites.

Coincidentally, a committee of the Massachusetts chapter of the American Academy of Pediatrics was addressing children's mental health issues faced by primary care physicians. Led by Dr. Walter Harrison, the Children's Mental Health Task Force was raising the issue of the disconnect between the number of children presenting with mental health needs in primary care, and the difficulty finding community resources for treatment and prescribing. This group grew to include state human service administrators, primary care physicians and psychiatrists, providers, the major public and commercial insurers, families and advocates, and academic centers. Its broad representation has allowed the group to incubate a number of policy changes adopted by both public and private payers. The task force followed the implementation of TCPS and was ready to become a major stakeholder when MBHP presented its model.

The result of these plans was MCPAP, which was proposed essentially as it has been described above, with a request for $2.5 million in funding. With the active support of the task force, support was built among legislators as well as state agencies. These funds were requested by DMH and appropriated by the legislature, not just as a component of the DMH budget, but as a line item. This is evidence of the strong political support that had been developed, and gives the program a stronger foothold in the budget and a high level of visibility to the legislature.

Implementing the Program

MBHP contracted with six academic medical centers that had been active in planning meetings and were appropriately positioned to serve their designated region. PCP practices that prefer to maintain an existing referral relationship with a particular hospital are allowed to enroll with that hospital's team, even if it is serving a different catchment area.

Managing the Program

MBHP staff make periodic site visits and meet with regional staff. In addition, two medical directors each oversee three regional teams. This type of communication is critical in keeping the program consistent: MBHP wants to see the same kind of response to the same needs in all regions. They review utilization on a quarterly basis, seeking to have 75 percent of PCPs participating each quarter. When participation is lower, regional staff are required to reach out to nonparticipating PCP practices in their area to reinforce use of the program.

There are regional variations. The western region is so large that it has both a main office and a satellite. A part-time social worker staffs this satellite office, working quite independently. This team has piloted school-based services. Leaders of the central region team are involved in piloting a

geriatric psychiatry consultation model. The attention of psychiatric staff in some regions is wholly focused on MCPAP, while others have competing interests that make their involvement less intense. This shows in some variation in practice patterns.

FINANCING AND SUSTAINABILITY

MBHP envisioned MCPAP as a service that could and should be supported by health insurers. However, it was not seen as a program that could be financed through claims, since much of the service would not be face-to-face, and some of the support would not even be client-specific. Instead, it was conceived as a kind of public health intervention that would benefit all insurers by improving quality of care and preventing the need for more intensive services. The financing model planned that insurers would share the operating costs of MCPAP on the basis of their share of covered lives in the participating practices. This program likely meets the criteria for administrative Medicaid, which would provide the state with a 50 percent federal match for the expenses due to MassHealth members. However, planners decided not to pursue this form of funding, because they were not sure that they could appropriately document the MassHealth share and might therefore be at risk for recovery in an audit. As a result, the full $2.5 million was funded by the state, and other health plans were not asked to participate.

Exhibit 7. MCPAP Encounters by Insurance Type (July 1, 2008, to June 30, 2009)

Insurance*	No.	%
Private		
BlueCross BlueShield	5,194	30.3%
Harvard Pilgrim	1,497	8.7%
Tufts	1,177	6.9%
Aetna	603	3.5%
United Behavioral Health	471	2.7%
Other Commercial	417	2.4%
Cigna	378	2.2%
Health New England	181	1.1%
Tricare	75	0.4%
Total Private	***9,993***	***58.3%***
Public Only		
Mass Health-Primary Care Clinician Plan	3,616	21.1%
Network Health	1,157	6.8%
Boston Medical Center HealthNet	774	4.5%
Children's Medical Security Plan	47	0.3%
Total Public Only	***5,594***	***32.7%***
Mixed Public & Private		
Fallon	810	4.7%
Neighborbood Health Plan	540	3.2%
Total Mixed Public & Private	***1,350***	***7.9%***
None	191	1.1%
Grand Total	**17,128**	

Note: excludes 1,833 encounters (approximately 10% of the total) where the payer was not identified.
* Non–patient-specific consultation and continuing medical education encounters are not included.
Source: Massachusetts Behavioral Health Partnership: MCPAP database, query run on 7/20/09; date parameters between 7/1/08 and 6/30/09.

At full implementation, MCPAP costs $3.2 million annually to operate. This amount covers contracts with the regional teams that reimburse for the budgeted expenses of each team, plus a standard 12 percent overhead rate, as well as the two part-time medical directors and a dedicated part-time MBHP data analyst. MCPAP calculates that the cost is $0.18 per child per month for the 1.5 million children in Massachusetts, or $160 per encounter.

Approximately 16 percent of all MCPAP encounters are face-to-face visits for direct in-person assessments and therapy that can potentially be billed to health plans. Each MCPAP regional team host hospital is responsible for billing these services to the relevant insurance plan. Because the MCPAP hospitals are teaching hospitals, they and their staff are credentialed in a wide variety of panels, minimizing payment problems because of nonparticipation in insurance panels, and there has been little difficulty getting insurance authorization for these services. The hospitals keep 25 percent of their insurance receipts and must credit the remaining 75 percent to MBHP. However, some of the hospitals are not billing and collecting for all eligible services. Total insurance billings account for about $160,000 annually, or 5 percent of total costs.

MCPAP has comprehensive data on the insurance coverage of the children it consults about and serves (Exhibit 7). MassHealth, together with its Medicaid-only managed care plans and a public plan for disabled children, is responsible for 33 percent of all encounters, closely followed by Blue Cross Blue Shield, the largest private insurer, responsible for 30 percent. Overall, solely commercial plans account for 58 percent of encounter activity. Plans with both Medicaid and commercial enrollees account for 8 percent. According to MBHP, these percentages are quite similar to the percentage of the population insured by each plan.

"When there were concerns linking antidepressant use and increased risk of teen suicide, MCPAP helped us to understand what was happening and how to discuss it with our patients."

David Keller, M.D.,
South County Pediatrics, Webster, Mass.

RESULTS AND NEXT STEPS

MCPAP has achieved impressive results on a number of dimensions. It has succeeded in enrolling virtually all of the pediatric PCP practices in the state, and it provides services to approximately 70 percent of enrolled practices each quarter. However, teams believe that participation is less robust the farther a practice is from the team site. There is a sense that outlying areas do not participate as much as those in greater proximity, though this may just reflect the greater population density around the site of each team.

PCP satisfaction scores show dramatic increases as a result of their access to and use of the service. PCPs are surveyed at the time their practice enrolls with MCPAP, and periodically thereafter, and their scores are compared. (Response rates are moderate and results have been consistent over time.) As shown in Exhibit 8, surveys measured the dramatic increases in PCPs' ratings of the adequacy of access to child psychiatry for their patients, their ability to meet the needs of their clients with psychiatric conditions using existing resources, and their ability to consult with a child psychiatrist in a timely manner. They also rated their satisfaction with MCPAP consults highly.

Our interviews found variation in how primary care physicians use MCPAP. PCP leaders who are most interested and active in addressing behavioral health believe that MCPAP is widely used and has considerably improved support to PCPs. However, they themselves are not frequent users, because they have developed considerable capability in treating behavioral health problems and have their own network of referral sources. Several PCPs who do use

Exhibit 8. Survey Results for All Regions
June 2009

	Pre-MCPAP				Post-MCPAP			
	Strongly Disagree	Disagree	Agree	Strongly Agree	Strongly Disagree	Disagree	Agree	Strongly Agree
There is adequate access to child psychiatry for my patients	60.5%	32.5%	4.4%	1.5%	24.4%	40.2%	28.8%	5.2%
With existing resources, I am usually able to meet the needs of children with psychiatric problems	38.7%	48.0%	7.7%	0.7%	3.7%	25.1%	53.1%	10.0%
I am able to consult with a child psychiatrist in a timely manner	43.9%	42.4%	6.6%	1.8%	3.0%	12.9%	53.5%	26.9%
I find the MCPAP consults to be useful					1.1%	1.5%	55.7%	35.8%

Source: Massachusetts Behavioral Health Partnership, Results of MCPAP PCP Survey as of June 2009.

MCPAP frequently spoke of identifying many behavioral health problems in their caseload but not having the psychiatric and social work training they need to effectively address them. They were grateful both for psychiatric consultation on complex cases and medication issues, and for assistance to families in finding therapists. One doctor said, "Now when a family does not connect to services, I know that it is probably about their ambivalence, not difficulty getting services." They also felt better supported in meeting challenges, such as caring for a child discharged from a psychiatric inpatient stay with multiple, and unfamiliar, medications.

Parent and Family Perspective

Massachusetts' chapter of the Federation for Children's Mental Health, the Parent Professional Advocacy League (PPAL), believes that PCPs are more willing to identify potentially significant behavioral health problems because MCPAP offers the specialty back-up they may need. They are also more willing to care for a child who may already have a complex medication treatment on a transitional basis while arrangements with a new psychiatrist are being made. More subtle effects are also likely. For example, discussing a behavioral health problem with a pediatrician rather than a psychiatrist can make parents feel less stigma, making it more likely that they will raise these issues with their child's school and/or accept services. Adolescents can explore their concerns in a nonstigmatized setting, often in the context of a longstanding relationship, rather than seeking a previously unknown provider or clinic identified as a mental health service. However, despite the assistance of MCPAP's care coordination and linkage services, PPAL's recent member survey found that the wait time for services continues to be a major problem.

Community Mental Health Providers

Community mental health centers are not as uniformly enthusiastic about MCPAP as primary care physicians and families. They struggle to hire child psychiatrists, lose money on outpatient psychiatric services, and can have waitlists of up to three months. Those who are critical of MCPAP do not question the basic program design or its utility to PCPs, but they do question the allocation of the $2.5 million in annual state funding. They would prefer that $2.5 million be used to expand the child psychiatric time available in community mental health centers, allowing them to reduce wait times and serve more of the children with complex conditions that PCPs are not comfortable treating. They point to this as an alternative strategy that would also reduce the pressure on PCPs.

MCPAP's primary ties are to PCPs and local medical centers, rather than to community mental health centers, though MCPAP case managers and clinicians regularly facilitate referrals to them. MCPAP is

in a position to help better define and strengthen the collaboration needed between PCPs and community mental health providers to serve children with more complex needs, and this represents opportunity for improvement in the future.

LESSONS LEARNED

Building on Respected Academic Medical Centers

MCPAP's identification with its host medical centers has been important, taking advantage of the medical centers' reputation and physicians' familiarity in working with their specialists. The Massachusetts Behavioral Health Partnership has intentionally kept a low profile so that MCPAP will not be identified as an insurance company program. MCPAP leaders believe that the regional focus helps foster relationships of PCP practices with their MCPAP team, and the teaching orientation of MCPAP psychiatrists promotes MCPAP's goal of teaching PCPs to manage less complex conditions.

Relationship Building Approach for Recruiting PCPs

Recruitment of PCPs has been extraordinarily successful. Involving psychiatrists in direct outreach to PCP practices has been very effective. When psychiatrists called PCPs directly or visited their practices, it demonstrated that MCPAP was serious about providing access. Word of mouth was also an important way of establishing credibility.

Building a New Kind of Service Takes Time

The MCPAP model does not fit exactly into the traditional business model of an academic medical center. As a very small program, it can take time for a hospital's key administrative staff to fully understand the business model, which does not expect to cover program costs through service claims. In addition, some clinicians are not experienced in taking a consultative and transitional role and need time to learn it.

Physicians Are Learning, but Balance Is Necessary

MCPAP teams believe that the nature of psychiatric consultation they provide has been changing over time. Physicians are learning to handle some common conditions and medications themselves, and their questions increasingly concern more complex cases. However, MCPAP has also experienced some challenging situations. PCPs who have been willing to take on difficult cases with MCPAP support have sometimes found that the demands were beyond their practice's capacity. MCPAP's medical directors are discussing how they could help PCPs accurately assess their practice's ability to handle complex cases, and the number of such cases they can carry at one time.

The Value of the Care Coordination Function

Though care coordinators' work is not well represented in encounter data, the importance of their role in an environment of workforce limitations and barriers to access has been emphasized both within and outside the program. Their legwork in identifying potential services, matching services to family logistics and needs, and verifying that openings exist eliminates multiple barriers that frustrate, discourage, and all too frequently prevent families from engaging in services that their child needs. Care coordinators also often handle new cases within the team. PCPs we interviewed very much value coordinators' for referring and supporting patients who need therapy, rather than giving patients a few names and leaving them on their own to navigate the system.

Information

One of the program's untapped resources is the information it has on children's mental health needs and on the capacity of the service system. Since MCPAP is available to virtually all children, regardless of insurance, it is an unprecedented source of information about children's needs. For example, MCPAP has begun plans to augment its data system to keep records of wait times for services; this will permit measurement of how promptly needs are being met by

community resources. This information can be used at the public health level to assist Massachusetts in strategic health planning, or at the health plan level to help monitor the adequacy of insurance panels by better assessing the real wait time for services.

Trends That May Affect the MCPAP Model

Three important movements are likely to create significant changes in the way primary care is practiced over time, and may affect the MCPAP model:

- The creation of medical homes will strengthen the capability of primary care providers to manage care for children with special health care needs, though many will continue to need support in addressing mental health needs.
- The move toward colocation of mental health practitioners in or near primary care offices and creating infrastructure and processes for coordination will increase families' access to mental health services and PCPs' access to mental health consultation. This can reduce the number of PCPs needing such support from MCPAP.
- Finally, as family involvement and peer support are increasingly recognized as core principles of service delivery, families are playing a larger role in the provision of children's mental health services. Including a role for parent partners is a potential next step for MCPAP.

CONCLUSION

The Massachusetts Child Psychiatry Access Project has successfully demonstrated a model for supporting primary care providers in the provision of mental health treatment for children and youth. Combining timely access to psychiatric and clinical consultation, linkage to community resources, and options for assessments and transitional services, the program has achieved very high enrollment of state primary care practices and high rates of utilization and PCP satisfaction. Families benefit from assistance in finding appropriate matches to community resources, and those with urgent needs have access to timely assessment and transitional therapy during the wait for community services. MCPAP has also been a platform for further efforts to educate and support PCPs, with varying success.

Fully state-funded until now, the program has solid data on the health plans of children served that can provide a basis for a shared funding model. Sustaining a 20 percent cut, generating financial support from private payers, and possibly accessing federal matching funds are its current challenges and possibilities.

Both PCP mental health treatment capacity and specialty mental health services are essential components of the children's mental health system, and states need to consider how to best draw upon their child psychiatry resources to strengthen both components. So that it can provide PCPs with timely telephonic access to psychiatry during business hours, MCPAP is well resourced. But given many states' budgets for children's mental health services, the program is relatively expensive. MCPAP's need to cut costs by 20 percent may provide a test of whether the program can successfully operate with fewer resources.

As originally designed and operated, MCPAP is likely best suited to states with a larger psychiatry workforce and well-distributed academic medical centers. States with limited child psychiatric resources may not be able to staff a program at an equivalent level; in Texas, the Hogg Foundation piloted a primary care/mental health integration model that used less psychiatry time.[14] Using resources to expand child psychiatry in the community may be a preferred alternative for some states.

MCPAP's success in supporting primary care providers may be a model that is adaptable beyond children's mental health. UMass/UMass Memorial is currently piloting a psychiatric consultation model for geriatric primary care, though early results show limited uptake among PCPs. MCPAP may also offer a model for leveraging other scarce specialty resources. Dr. Barry Sarvet, MCPAP medical director for the western part of the state, suggests that psychiatry is well suited for this consultation model because it does

not always require a physical examination and much of the work involves diagnosis and testing medication approaches. Medical specialties that similarly focus on assessment and treatment design would be most suited to this model, rather than those that require physical examination and/or continued involvement during a long-term treatment process.

The principles used to design the MCPAP model may be applicable to designing other PCP support and consultation models, such as the Health Care Cooperative Extension Service proposed by Grumbach and Mold.[15] These principles include: finding out from PCPs what they need and want; generating support from PCPs and specialist leaders, as well as broader stakeholders; building on existing resources and relationships; and designing a model that encourages the development of ongoing relationships between PCPs and specialists.

FOR MORE INFORMATION

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Appendix A.

LIST OF MCPAP STAFF INTERVIEWED

John Straus	Vice President, Medical Affairs
Barry Sarvet, MD,	Co-Medical Director
Martha Page	Project Director
Irene Tansman	Data Analyst
Jodi DeVine, MSW, LICSW	Western Mass. Therapist
Arlyn Perez	Western Mass. Care Coordinator
William O'Brien, MSW	Central Mass. Program Administrator
Mary Jeffers-Terry, APRN	Central Mass. Program Director and CNS
Matthieu Bermingham, MD	Central Mass. Child Psychiatrist
Martha Moore, MSW LICSW	Central Mass. Therapist
Deanna Pedro, MSW, LICSW	Central Mass. Therapist
Kelly Chabot	Central Mass. Care Coordinator
Leah Grant, MSW, LICSW	Boston Metro Region I Therapist
Diane Ventura	Boston Metro Region I Care Coordinator
Alexis Hinchey, MSW LICSW	Boston Metro Region II Therapist
Jessica Thompson	Boston Metro Region II Care Coordinator

About the Author

Wendy Holt, M.P.P., is principal at DMA Health Strategies. Her work includes considerable focus on children's mental health, including early identification of children's mental health problems in primary care and other child serving settings. She is primary author for a SAMHSA guide on this topic due to be published later this year. Other work in children's mental health includes contributing to a survey of the licensed children's mental health workforce in Massachusetts in collaboration with The Lewin Group. She directed the fourth year of DMA's Children's Mental Health Benchmarking Project, and supported two planning and proposal processes to develop systems of care for youth and young adults with mental health problems. Before working for DMA, Ms. Holt served as Manager of Policy and Planning for the MHMA, the first statewide Medicaid behavioral health carve out in the nation. She had key roles in network development, provider performance profiling, and client outcomes measurement. Ms. Holt has a B.A. in economics from the University of Wisconsin, and a master's degree in public policy from the Kennedy School of Government at Harvard University.

Acknowledgments

I spoke to many people in the course of compiling this case study. Joan Mikula and Suzanne Fields of DMH and MassHealth, respectively, described how future planning is building on what has been learned from MCPAP and the possibilities for generating broader sharing of MCPAP finances. John Straus, MBHP vice president of medical affairs was most generous in sharing his time, his staff's time, and MCPAP data. I spoke with three MCPAP teams and one of the medical directors (listed below). Lisa Lambert, the executive director of PPAL, was most generous with her time and referred me to her Worcester office and the Worcester Medical Home project. I also spoke with Dr. Michael Yogman of the American Academy of Pediatrics and the Children's Mental Health Task Force, and several other pediatric primary care physicians who shared their experiences with MCPAP.

Editorial support was provided by Paul Frame.

This study was based on publicly available information and self-reported data provided by the case study institution(s). The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund's case studies series is not an endorsement by the Fund for receipt of health care from the institution.

The aim of Commonwealth Fund–sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.