The Massachusetts Child Psychiatry Access Program

The First 15 Years: Lessons Learned

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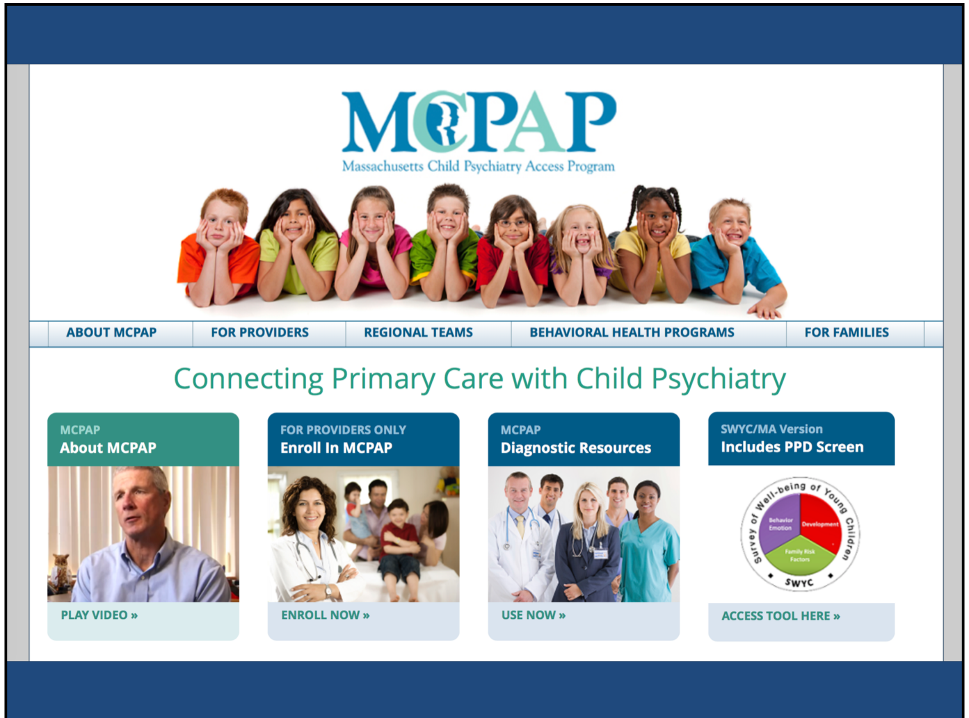
Outline

- Overall Program Description
- Start-up Considerations
  - Staffing
  - Enrollment of practices
  - Training
- Building engaged relationships with PCPs
- Program evaluation considerations
  - Measuring engagement
  - PCP satisfaction
  - Service quality
  - Clinical evaluation: peer review
  - Outcomes
- Future Directions



Overarching Purpose of MCPAP

1. Define and Support the role of Pediatric PCPs in addressing mental health needs of children and adolescents in the primary care setting
2. Connect Primary Care Practices to the pediatric healthcare system
3. Improve the quality of mental health service delivery in the primary care setting

CPAPs are systems of relationships

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3 Teams/7 Sites

- Each Team operates call center
- Face-to-Face evals conducted at site most convenient for Family

Western & Central Massachusetts Team
844-926-2727
Baystate Medical Center
UMass Memorial Medical Center

Eastern Massachusetts Team: Boston South
844-636-2727
Boston Children's Hospital
McLean Hospital Southeast
Tufts Medical Center

Eastern Massachusetts Team: Boston North
855-627-2763
Massachusetts General Hospital
North Shore Medical Center

MCPAP Structure – 3 teams (1,500,000 youth)

Boston South
- Boston Children's Hospital
- Tufts Medical Center
- McLean Southeast

Boston North
- Mass General Hospital
- North Shore Medical Center

West/Central
- Baystate Medical Center
- UMass Memorial Medical Center

Each team:
- 2 FTE child psychiatrist
- 1 FTE behavioral health clinician
- 1 FTE resource & referral specialist
- 1 FTE program coordinator

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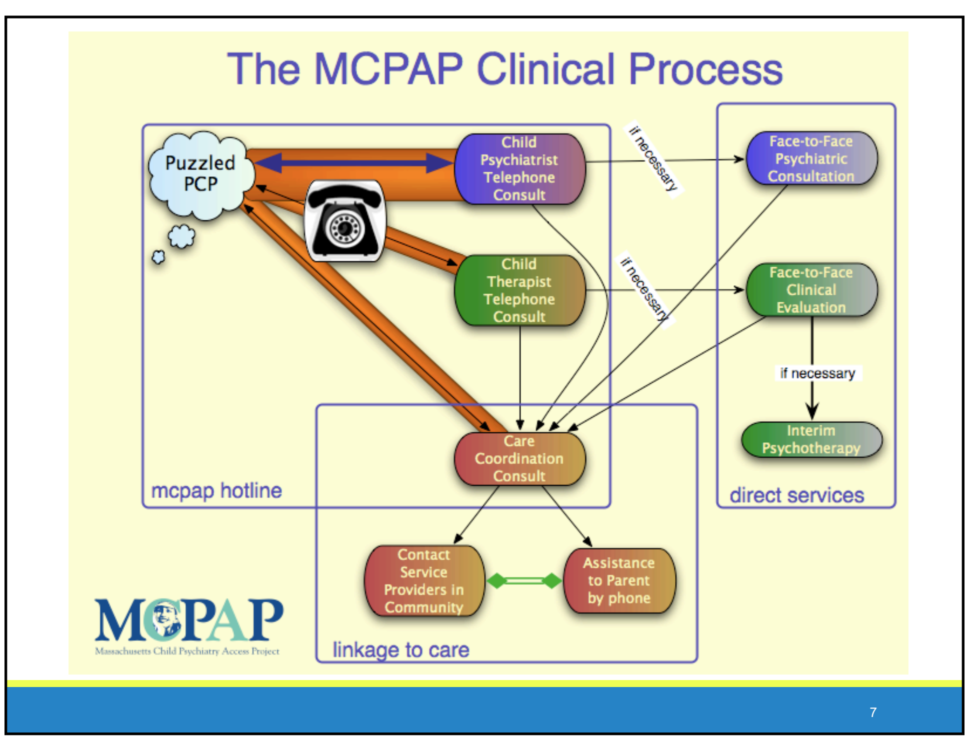
The MCPAP Clinical Process
Puzzled PCP
Child Psychiatrist Telephone Consult
Child Therapist Telephone Consult
Care Coordination Consult
if necessary
if necessary
Face-to-Face Psychiatric Consultation
Face-to-Face Clinical Evaluation
if necessary
Interim Psychotherapy
mcpap hotline
direct services
Contact Service Providers in Community
Assistance to Parent by phone
linkage to care
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MCPAP Services
Telephone Consultation
Face to Face Assessment
Resource and Referral
Training and Education
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Telephone Consultation

Telephone consultation is the primary currency of this relationship and the "engine" of a CPAP.

Telephone consultation is derived from a time-honored tradition of "curbside consultation".

Face-to-Face Assessment

Reasons may include:

- Diagnostic Question
- Medication Question
- Second Opinion
- Reassurance to PCP
- Bridging

Followed by a consult letter within 48 Hours.

Criteria for F2F encounters

Can't answer question on the telephone

Or

PCP really wants it

And

Agreement that PCP can/will be managing the patient

Or

Second Opinion Consult

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Resource and Referral

Community services can include:

- Psychiatry
- Psychotherapy
- Child home and wraparound services
- Neuropsychological testing
- Other services such as support groups, group therapy, social skills groups, parent education, early intervention, etc.

MCPAP contracts for statewide database of resources.

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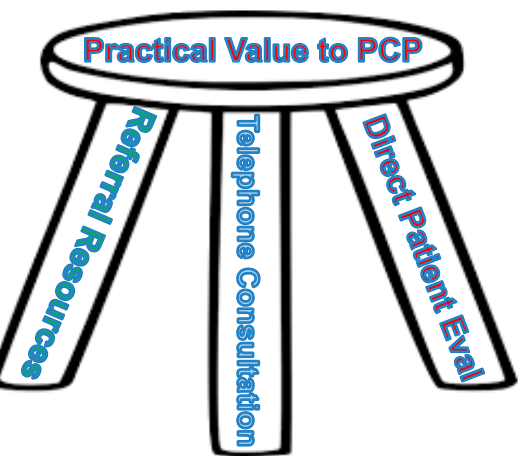
3-legged stool of MCPAP



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Training and Education

On-site at practices, via webinar, videoconference, newsletter:

- Screening and toolkits – SUD (S2BI)
- Clinical topics (brown bag lunch)
- Resources and mental health system
- Clinical guidelines and Clinical Pearls
- Practice transformation, BH integration
- Case rounds – learning collaborative
- Monthly clinical conversations (webinar) between expert and PCP

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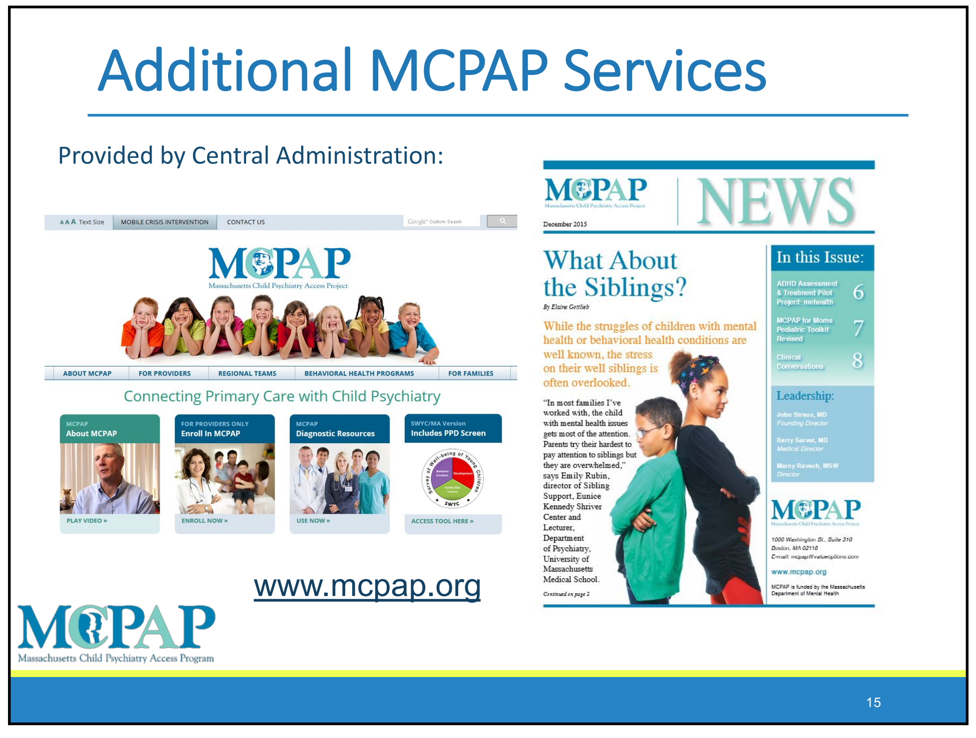
Additional MCPAP Services
Provided by Central Administration:
MCPAP
Connecting Primary Care with Child Psychiatry
About MCPAP
Enroll in MCPAP
Diagnostic Resources
Includes PPD Screen
www.mcpap.org
MCPAP NEWS
December 2015
What About the Siblings?
While the struggles of children with mental health or behavioral health conditions are well known, the stress on their well siblings is often overlooked.
In this Issue:
Leadership:
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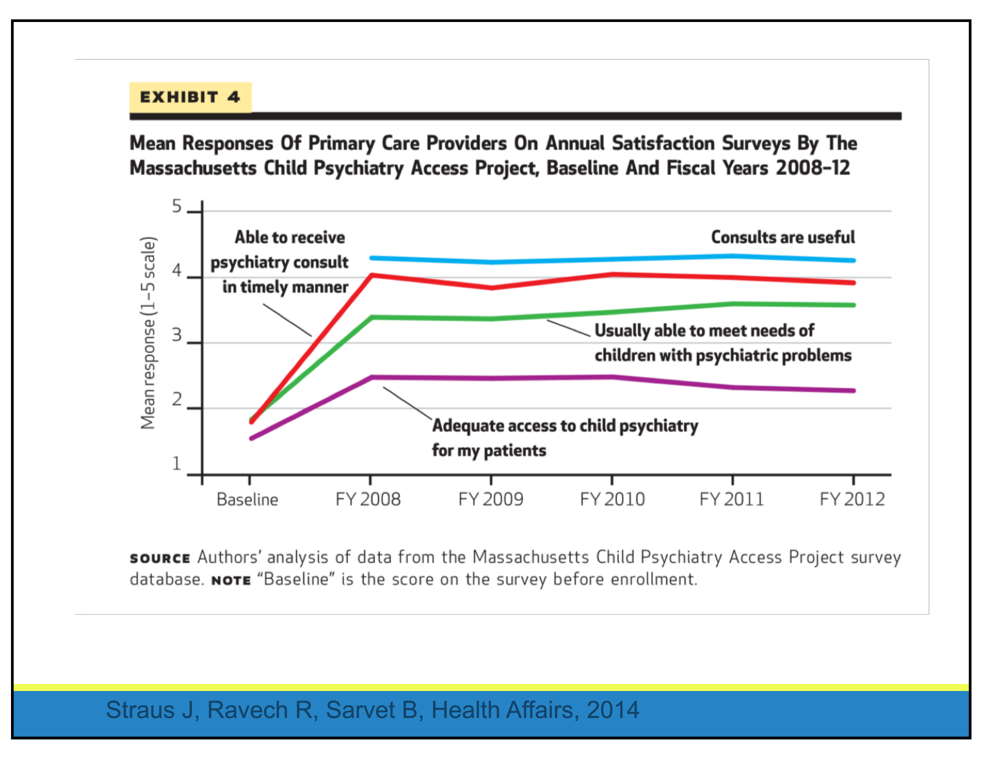
EXHIBIT 4
Mean Responses Of Primary Care Providers On Annual Satisfaction Surveys By The Massachusetts Child Psychiatry Access Project, Baseline And Fiscal Years 2008–12
Mean response (1–5 scale)
5
4
3
2
1
Able to receive psychiatry consult in timely manner
Consults are useful
Usually able to meet needs of children with psychiatric problems
Adequate access to child psychiatry for my patients
Baseline
FY 2008
FY 2009
FY 2010
FY 2011
FY 2012
SOURCE Authors' analysis of data from the Massachusetts Child Psychiatry Access Project survey database. NOTE "Baseline" is the score on the survey before enrollment.
Straus J, Ravech R, Sarvet B, Health Affairs, 2014

MCPAP Results: PCP Knowledge

PCPs reported comfort treating:

ADHD – 77%

Depression – 68%

Anxiety – 67%

SUD – 15%
(SIM grant support to increase SUD competence.)

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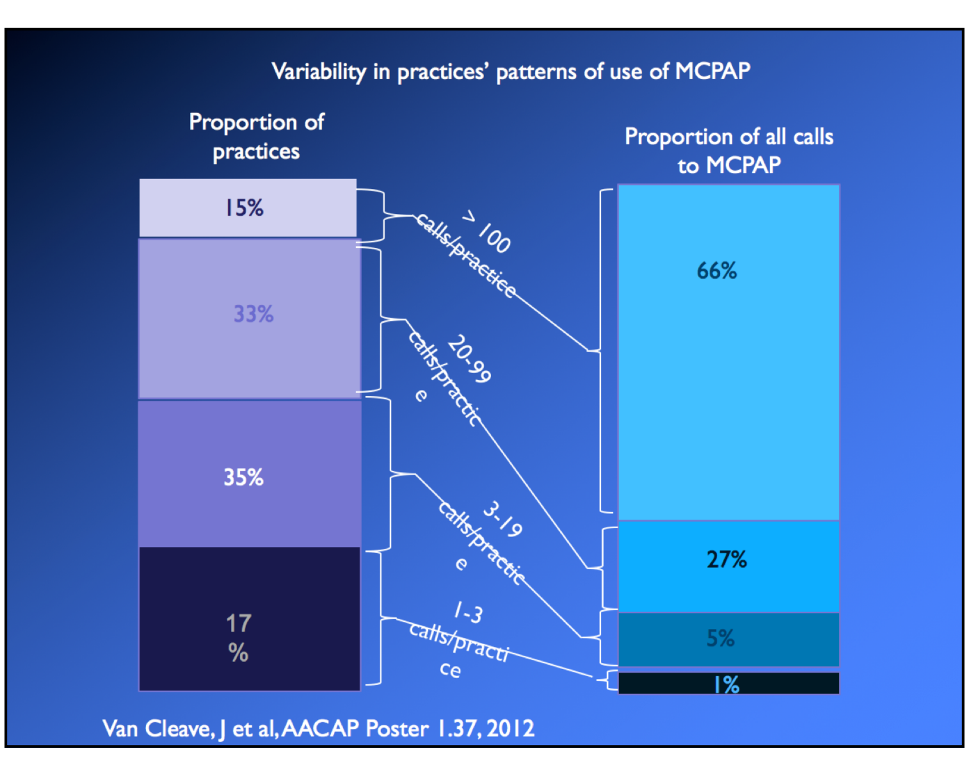

Getting started: Enrollment vs. Grand Opening

Enrollment allows:

1. Framing expectations
2. Initiating a longitudinal relationship
3. Samples of informal consultation
4. Gradual ramp up—allowing you to work out the kinks

Grand opening allows:

1. Faster ramp up
2. Conserves resources

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Marketing the program

- Press releases
- Grand Rounds, AAP chapter meetings
- Public service announcements/Direct to consumer marketing
- Presentations to community mental health providers

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Recruitment of CAPs

Suitable child psychiatrists for the program are:

-Flexible

-Practical

-Confident

-Gregarious

-Creative

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Recruitment of CAPs

Less suitable child psychiatrists for the program are:

-Perfectionistic

-Ponderous

-Risk-averse

-Socially avoidant

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Concerns of prospective psychiatrists

Concern	How to address
My clinic is already full	Differentiate clearly from outpatient clinic
Patients expecting longitudinal relationship after F2F	No prescription pads (ever), Careful patient education
Malpractice liability for PCP error	Provider education
Inadequate time	Structured schedules, Protected time

Training

- CAPs: Focus on Telephone Consultation Skills
- Care navigation and administrative staff: Keeping the trains running on time
  - Customer service orientation
  - Ensuring that phones are answered during hours of operation
  - Ensuring that CAP schedules are built correctly
  - Data systems are operational
  - Reliable follow up to phone consults
    - Scheduling F2F evals
    - Providing support for referrals
    - Circling back to PCP when plans can't be implemented

Telephone Consultation

Telephone consultation is the primary currency of this relationship and the "engine" of a CPAP.

Telephone consultation is derived from a time-honored tradition of "curbside consultation".

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Telephone consultation as educational encounter

—a teachable moment

—identifying learning need vs giving the answer

—"the bite-size chunk"

—avoiding use of psych jargon

—finding the right level of depth

—not pushing them past their "edge"

—emphasize the PCP's agency, avoid dictating or directing treatment

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Telephone consultation as relationship-building activity

—notion that every phone conversation is an opportunity for developing and enhancing a personal collegial relationship

—collegial attitude (not talking down to the PCP)

—positivity

—building trust

—expressing appreciation for their use of the CPAP

—encouraging follow-up

—promote CPAP functions (handoff to care coordination)

—making collaborative overture

—checking at the end of the call that the PCP has a clear sense of what to do next

Telephone consultation as opportunity to promote practice-level change

—promoting measurement-based care (could be touched upon in every call)

—promoting systematic screening

—promoting strength-based and family driven care

—promoting use of registries

—promoting practice-level care coordination

Engagement

May be the most important driver of the overall performance of program

Call volume works well as an indicator of engagement, may be even better than satisfaction surveys

Need regular data to evaluate engagement by team, region

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Measuring engagement

Call volume and frequency, changes over time

- By individual provider
- By practice
- By network

Presence/absence of embedded resources for care coordination

Presence/absence of adjacent child psychiatry resources

Variability by hub

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PCP Engagement Factors

- Perceived usefulness of encounters
- Customization: to practice variables
- Quality of relationships with: CAPs, Coordinator, Referral specialist
- Efficiency of process
- Trust: in clinical judgment of consultant

  in reliability of program to follow through
- Patient/Parent satisfaction

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Utility of encounters

Practical:
- vs scholarly/academic

Clear next step: make sure to negotiate this. What you think is realistic may not actually be realistic

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Customization

To PCP

- Wide range of skill, confidence
- May need to see more patients for F2F consults from less experienced/nervous PCPs
- May need to have lower threshold for specialist referral

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Customization

To Practice

- Presence/Absence of embedded therapist
- Role of medical assistant, referral coordinator, case manager
- Practice workflow/communication policies and preferences

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Customization

To Network/ACO

- What quality measures related to behavioral health are they focused on?
- Network policies and practice guidelines
- What kind of population health resources do they have

Quality of Relationship

Friendliness and positivity

Building trust: reliability, consistency

Important for program staff (not just CAPs)

Continuity features

Efficiency of encounter

No telephone tag

Avoid long-winded explanations

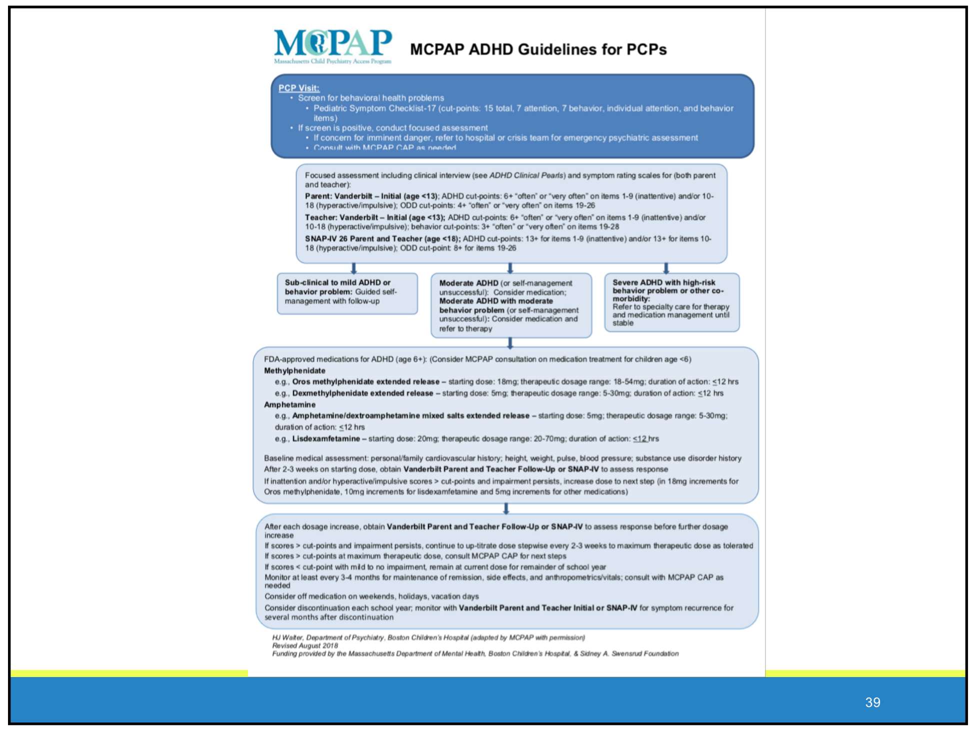
Ask PCP how much time they have before going deep

Don't collect data from PCP that's not absolutely necessary for the service

For clinical researchers: be careful about recruiting subjects from your telephone consultation work

Trust

- Reduce variability in recommendations about common questions
  - Practice guidelines come in handy for this.
  - Need to negotiate these with members of your CAP team.
- Fulfill promises:
  - Have systems to ensure follow-through on post-consult action steps: setting up F2Fs, providing resource navigation
- Feedback loops for PCPs around scheduling F2F and making referrals



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MCPAP ADHD Guidelines for PCPs

PCP Visit:
- Screen for behavioral health problems
  - Pediatric Symptom Checklist-17 (cut-points: 15 total, 7 attention, 7 behavior, individual attention, and behavior items)
- If screen is positive, conduct focused assessment
  - If concern for imminent danger, refer to hospital or crisis team for emergency psychiatric assessment
  - Consult with MCPAP CAP as needed

Focused assessment including clinical interview (see *ADHD Clinical Pearls*) and symptom rating scales for (both parent and teacher):

Parent: Vanderbilt – Initial (age <13); ADHD cut-points: 6+ "often" or "very often" on items 1-9 (inattentive) and/or 10-18 (hyperactive/impulsive); ODD cut-points: 4+ "often" or "very often" on items 19-26

Teacher: Vanderbilt – Initial (age <13); ADHD cut-points: 6+ "often" or "very often" on items 1-9 (inattentive) and/or 10-18 (hyperactive/impulsive); behavior cut-points: 3+ "often" or "very often" on items 19-28

SNAP-IV 26 Parent and Teacher (age <18); ADHD cut-points: 13+ for items 1-9 (inattentive) and/or 13+ for items 10-18 (hyperactive/impulsive); ODD cut-point: 8+ for items 19-26

Sub-clinical to mild ADHD or behavior problem: Guided self-management with follow-up

Moderate ADHD (or self-management unsuccessful): Consider medication; **Moderate ADHD with moderate behavior problem** (or self-management unsuccessful): Consider medication and refer to therapy

Severe ADHD with high-risk behavior problem or other co-morbidity: Refer to specialty care for therapy and medication management until stable

FDA-approved medications for ADHD (age 6+): (Consider MCPAP consultation on medication treatment for children age <6)

Methylphenidate
- e.g., **Oros methylphenidate extended release** – starting dose: 18mg; therapeutic dosage range: 18-54mg; duration of action: ≤12 hrs
- e.g., **Dexmethylphenidate extended release** – starting dose: 5mg; therapeutic dosage range: 5-30mg; duration of action: ≤12 hrs

Amphetamine
- e.g., **Amphetamine/dextroamphetamine mixed salts extended release** – starting dose: 5mg; therapeutic dosage range: 5-30mg; duration of action: ≤12 hrs
- e.g., **Lisdexamfetamine** – starting dose: 20mg; therapeutic dosage range: 20-70mg; duration of action: ≤12 hrs

Baseline medical assessment: personal/family cardiovascular history; height, weight, pulse, blood pressure; substance use disorder history

After 2-3 weeks on starting dose, obtain **Vanderbilt Parent and Teacher Follow-Up or SNAP-IV** to assess response

If inattention and/or hyperactive/impulsive scores > cut-points and impairment persists, increase dose to next step (in 18mg increments for Oros methylphenidate, 10mg increments for lisdexamfetamine and 5mg increments for other medications)

After each dosage increase, obtain **Vanderbilt Parent and Teacher Follow-Up or SNAP-IV** to assess response before further dosage increase

If scores > cut-points and impairment persists, continue to up-titrate dose stepwise every 2-3 weeks to maximum therapeutic dose as tolerated

If scores > cut-points at maximum therapeutic dose, consult MCPAP CAP for next steps

If scores < cut-point with mild to no impairment, remain at current dose for remainder of school year

Monitor at least every 3-4 months for maintenance of remission, side effects, and anthropometrics/vitals; consult with MCPAP CAP as needed

Consider off medication on weekends, holidays, vacation days

Consider discontinuation each school year; monitor with **Vanderbilt Parent and Teacher Initial or SNAP-IV** for symptom recurrence for several months after discontinuation

HJ Walter, Department of Psychiatry, Boston Children's Hospital (adapted by MCPAP with permission)
Revised August 2018
Funding provided by the Massachusetts Department of Mental Health, Boston Children's Hospital, & Sidney A. Swensrud Foundation

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Parent/Patient satisfaction

PCPs are happy when their patients are pleased with the service. (Makes PCP look good ☺)

Focus on customer service issues around resource navigation, scheduling and delivery of F2F consults

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Program Evaluation Domains

1. Utilization (ie Engagement)
2. PCP Experience
3. Service Quality: Patients, Primary care staff
4. Clinical Quality
5. Outcomes

Engagement

Measure telephone consultation encounter volumes
- By Provider, Practice, Hub
- Outreach to low-utilizing practices

Longitudinal relationships/Shared care
- Follow up consultation rates

PCP Experience (survey methodology)

Can measure annually and/or post-encounter

Measure:

1. Overall satisfaction
2. Usefulness
3. Personalized
4. Experience of support
5. Development of confidence
6. Self-assessment of skills for particular diagnoses

Service quality

1. Patient (parent) experience surveys: Effectiveness of resource navigation, completed initial appointments for referrals
2. Response time for telephone consultation
3. Wait times for F2F evals

Clinical quality

- Peer review of telephone consultations (recording of telephone consults)
- Peer review of face-to-face consultation (record review)
- Assess fidelity to practice guidelines, rapport with PCP, best practices for telephone consultation

Outcome Assessment

Beyond the scope of most programs to assess clinical outcomes

Program would either:

- Require PCPs to measure and report
- Conduct follow up PCP medical record reviews
- Directly assess patients and/or administer patient/parent reported outcome measures

With appropriate funding and resources, outcome assessment would be quite valuable.

Limitations and Challenge of CPAP Model

- Push vs. Pull
- Inadequacy of surrounding specialty care system
- Pediatrician Factors
  - Variability in pediatrician motivation
  - Variability in PCP practice readiness
- Geographic vs network model
- Perceived competition with integrated and collaborative care models

Future innovation of CPAP model to support CoCM

CPAP-enabled CoCM

- Systematic Screening
- Embedded child/family therapist devoting portion of time to:
  - Consultation/brief intervention/care coordination and "warm hand-offs"
  - Measurement-based care for a selected diagnosis
- CAP provides weekly case review with therapist focused on MBC group
- CPAP runs in the background to support the educational needs of the PCPs and to provide consultation for patients with ambiguous or complex diagnostic pictures

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Sustainability Factors

- First and Foremost: Quality of relationships with pediatricians
- Becoming a part of mental health and public health infrastructure
  - Examples in MA: Enablement and support for MA Children's Behavioral Health Initiative
    - MCPAP role in implementing universal screening, MCPAP for Moms, collaboration with crisis teams, collaboration with community mental health)
- Relationship with health systems and networks (ACOs)
- Visibility and collaboration with stakeholder coalitions, MCAAP, consumer advocacy groups
- Public awareness

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