Consultation, Shared Care, Co-Location, and Medical Homes: Models to More Effectively Address Behavioral Health Issues in Young Children

Close coordination between primary care providers and behavioral health specialists is considered necessary for quality care for infants and young children to obtain optimum well-being. Managed Medical Assistance (MMA) health plans can encourage more effective coordination through several identified strategies to achieve both better care and potential cost savings.

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PURPOSE

The need for early screening, assessment, intervention, and treatment for at-risk infants and young children is well-established. Research shows that many children experience trauma in their environment from many sources. These traumatic experiences without the support of a nurturing adult may damage children's social, emotional, behavioral, and physical development and may lead to a lifetime of problems that must be addressed later in the healthcare system.

Screening, intervention, and treatment as needed are essential in mitigating damage and propelling children on a positive life trajectory that avoids monetary costs in the future. In unmanaged systems, children with mental health issues are served, if at all, by fragmented programs and providers characterized by too little communication and inconsistent coordination of services. Yet, few of the children who need mental health and substance abuse services receive them—only 20 percent do. Reasons that so few receive needed services include the shortage:

- and inaccessibility of parenting programs and social-emotional interventions for families of children younger than 5 years.
- of specialty mental health services, especially in rural areas and for children from low-income families who do not fall within the target population for public/community mental health services.
- of preschool-based mental health programs and services, despite evidence of the effectiveness of many of these programs.
- or lack of awareness of emergency mental health services for children and adolescents in crisis, which causes these patients to rely on overcrowded emergency departments for care.

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Minority populations suffer disproportionately from lack of access to mental health services. Unmet childhood social-emotional, mental health, and substance abuse needs contribute to poor educational, social, and economic outcomes.[1,2] MMAs can encourage various strategies that increase coordination, including shared care, co-location of primary care with behavioral care, and medical homes. This paper is designed to provide information on strategies that providers can pursue to gain the benefits of better coordination.

MODELS FOR COORDINATING PRIMARY AND BEHAVIORAL HEALTH CARE

Up to 20 percent of American children are estimated to experience a mental health disorder in a given year, and the number seeking treatment continues to rise.[3] Fewer than 20 percent of children with mental health needs receive services, which without careful coordination, are often provided in a patchwork "system" involving primary care physicians, behavioral health specialists, and human services programs.[4]

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It is widely recognized that better coordination among providers will lead to more effective identification and treatment of young children with socio-emotional problems. According to the American Academy of Pediatrics (AAP), "A quality children's mental health service delivery system relies on the ability of providers to collaborate, coordinate services and activities, and share health information related to the treatment of a patient. In the absence of this integration, services can become fragmented and duplicated, and children's access to care can be compromised."[5] The AAP advises that primary care practices must engage in some form of collaboration with behavioral health specialists to deal with growing needs of children from birth to age 5. Primary care physicians increasingly are becoming the gateway for families seeking help for early childhood social and behavioral problems; three-quarters of children with diagnosed mental health disorders access care through primary care practices.[6] The Task Force on the Vision of Pediatricians 2020 concluded that trend will continue and quicken at a pace that will transform primary care practices.[7] Because some primary care providers lack the professional training to deal with social and emotional problems alone, models of coordinated care can ensure a child receives appropriate care.[8]

Primary Care Only and Primary Care with Consultation

In some cases, the social and behavioral care of some young children can be addressed solely by a primary care provider through routine surveillance and screening. However, many young children identified with behavioral health issues need behavioral health care from specialists. One way they can be treated is through a primary-care-with-consultation model, in which the pediatrician conducts the initial screen and assessment. He or she then consults a mental health professional—non-physicians such as psychologists and licensed clinical social workers, or as needed, physician specialists. The consulting behavioral specialist may confirm the diagnosis, suggest treatment approaches, and offer other advice to the primary care physician. The primary care physician coordinates services provided by behavioral specialists with other identified medical care. These forms of coordination may occur with face-to-face visits between the consulting specialist and the child, or through occasional consultation with the primary care provider.[9]

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Shared Care

Shared care is an advanced model of collaboration. Shared care forges a tighter bond between the primary care practitioner and the behavioral specialist. Close collaboration allows the primary care physician and the behavioral therapist to "share" the mental health care of the child including monitoring symptoms, medications, and response to therapy. The primary care provider may share care with a psychiatrist, psychologist, social worker, or a multidisciplinary team with a care coordinator, child welfare professional, and intervention programs such as Early Steps. Key features of the shared-care model, according to the AAP, include:

- centrality of the child and family in developing the care plan.
- mutual understanding of the roles of the family, the providers, and other components of the care plan.
- general responsibility for the health of the child by the primary care physician, including coordination of special services.
- a communication protocol, including parental consent for sharing information, and mechanisms for sharing information among providers.[10]

Co-Location

Another way to achieve greater coordination is through co-location. In some models of coordination, including shared care, the actual delivery of services may occur in different settings even though both physical and behavioral health issues are addressed collaboratively. Co-location, however, provides primary care and specialized behavioral care in the same location. Co-location helps clinicians and caregivers to view the young child as a whole—a person with both physical and mental health concerns, rather than someone with two separate problems required to go to two different locations to address both issues.

Co-locating can be accomplished in many ways. An employee of a mental health agency may be "out-stationed" in the physician's office. A self-employed behavioral health specialist may rent or use space in the primary care office. Or the primary care physician may employ a behavioral health specialist in his practice.[11]

Physical co-location of a primary care provider and a behavioral health specialist provides several advantages.

- Treating common mental disorders in primary care settings is cost effective. Co-location of primary care and behavioral care has "been found to decrease the use of general health care services by children with unidentified and untreated mental health problems and has resulted in improved outcomes and reduced costs."[12] Physical health care costs may be lower because of less emergency department utilization and fewer hospital admissions, for example.[13] There are also reports that co-location may result in lower utilization of healthcare services, as the pediatrician and behavioral specialist combined can address the kind of underlying problems that had led to higher utilization.[14]
- Pediatricians and other family healthcare providers have existing relationships with children and families.[15]
- Children may feel more comfortable visiting the pediatrician's office instead of a mental health practice or center. Because parents and young children are accustomed to the pediatric primary care office, it is the most practical location for co-located care.[16]
- Co-locating care is convenient for families, which increases access to behavioral health care and the likelihood that the family will follow through.[17,18]
- Co-location reduces the stigma about behavioral health care. Patients who come to a primary care provider with a medical problem and are subsequently referred to a mental health provider may resist the referral because of the stigma associated with behavioral health services. If the behavioral specialist is co-located, the referral may feel like any other part of primary care instead of a special referral for behavioral health problem.[19]
- Physical proximity of providers creates easier communications between the pediatrician and specialist. Regular contact results in increased consultation and referral.[20]
- Co-location can reduce the wait time for behavioral health services.[21]

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The Medical Home: A Highly Integrated Model

The "medical home" is a highly integrated model of increased coordination among providers of primary and behavioral care.[22] This model goes beyond the coordination activities of a co-located or shared care practice, and is closest to a full system integration of physical and behavioral health care.[23] A medical home is an approach to providing comprehensive, high-quality care—not a building or place. "[I]t extends beyond the walls of a clinical practice [and] builds partnerships with clinical specialists, families, and community resources."[24] The American Academy of Pediatrics first defined "medical home" in 1992 and expanded the concept in 2002, saying that

> …the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home."[25]

The Agency on Healthcare Research and Quality further describes the functions and operations of a Patient Centered Medical Home:

- Provides **comprehensive care** to meet a patient's physical and mental health care needs. Comprehensive care requires a team of care providers, including physicians, nurses, social workers, educators, and care coordinators. Some of these providers may be co-located in the same location, while other teams can be built on virtual ties linking individual caregivers.
- Is **patient-centered**, oriented toward the whole person, partnering with the patients and their families, and understanding and respecting each patient's needs, culture, values, and preferences. In the context of coordinated care for infants and young children, a medical home also should understand the importance of child-parent relationships and what treatments may be needed to address problems. Patients are encouraged by the medical home to learn about, manage, and organize their own care to the extent that the patient desires. Patients and families are fully informed partners in developing care plans in the medical home concept.
- Provides **coordinated care** of all the components of the broader health care system, including specialty care, hospitals, behavioral health care, home health care, and community services. Clear and open communication exists among patients, families, the medical home, and others in the care team. When the medical home provides care for families with possible domestic abuse or child maltreatment, it must be cognizant of state and federal rules for reporting child maltreatment. The medical home would be a member of the team keeping the child safe.
- Delivers accessible services with shorter waiting times for urgent care, extended in-person hours, and around-the-clock telephone or electronic contact with a member of the medical home's care team. If behavioral health concerns of a child and/or family are involved, the medical home would also need to provide access to behavioral health assistance after-hours.
- Committed to quality and safety. The primary care medical home uses evidence-based medicine and clinical decision-support tools to guide shared decision-making with the patient and family. Performance measurement and improvement, measuring and responding to patient concerns and satisfaction, practicing population health management, and sharing quality and safety data publicly are indicators of quality. [26,27]

Obtaining Recognition as a Medical Home

The National Committee for Quality Assurance (NCQA) provides recognition for patient-centered medical homes. Today more than 6,000 primary care practices or about 10 percent of all such practices and representing more than 30,000 clinicians,[28] have received NCQA recognition. About three-fourths have achieved Level 3 Recognition, representing the most advanced capabilities. Level 1 Recognition is for practices beginning transformation.[29] Recognition is granted to practices that offer enhanced access after-hours and online, provide for long-term relationships between patients and providers, engage in shared decision-making, involve the patient in his or her health and care, provide care in a team, and achieve better quality care, and reduced use of emergency departments and hospitals.[30]

In Florida, a few thousand physicians and practices, including pediatricians, have received some level of NCQA patient-centered medical home recognition. MMA coordinators can use this NCQA database if patients are looking for a different primary care setting.

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EXAMPLE OF A PEDIATRIC MEDICAL HOME IN FLORIDA

Overview

The Pediatric Partners Primary Care Practice is a NCQA Patient-Centered Medical Home and is recognized as a Level 3 practice in that it demonstrates well-established capabilities to provide a better patient experience, better health, and lower per capita cost. The practice has eleven pediatricians and three nurse practitioners in three offices in Palm Beach County and utilizes a co-location model. Pediatric Partners offers a co-located psychotherapist and a developmental specialist. These services are a tremendous support to the families of Pediatric Partners and complement the physicians' care. The therapists specialize in age appropriate developmental evaluations, parenting concerns, behavioral and psychological issues, adolescent support, ADHD and other school related concerns. They also work to connect parents with a wide variety of community resources. In addition, a speech language pathologist offers evaluations and treatment for speech-language and feeding/swallowing issues.

This co-location of a behavioral health practitioner and ancillary specialists in a primary care office setting improves patient care, relieves the load of the primary care physician, facilitates greater collaboration between the practitioner and physician, and encourages greater patient understanding of and participation in their plan of treatment. Furthermore, having a co-located practitioner in a primary care setting can increase patient or parent satisfaction with the practice.

The primary care physicians routinely discuss behavioral, developmental, emotional, or mental health issues in a large percentage of sick or well child visits. These issues range from simple parenting of infant and toddlers to complex adolescent problems. These demands were the impetus to augment and enrich the medical care offered at Pediatric Partners by integrating mental health services.

Improved Patient Care

With the co-location, the practice has found that the physicians have the opportunity to consult with a practitioner on diagnosis and treatment planning. Parents benefit from having both points of view and can more easily understand and accept the diagnosis of their child, the treatment plan, and ultimate prognosis. Communication between all providers in the practice, as well as peripheral support persons such as caregivers and teachers, has increased. In addition, patients and families feel less stigmatized coming to the pediatrician's office for treatment of behavioral, emotional, or mental health issues rather than going to a designated practice for behavioral health care.

Relieving the Load of the Primary Care Provider

Prior to the co-location of practitioners, the pediatricians expressed great frustration about having to deal with behavioral or mental health issues during office visits. The efficiency designed into an appointment structure does not accommodate the management of the potentially complex and intense problems associated with behavioral health. Behavioral health issues can be time-consuming and cumbersome to discuss and treat in a primary care office. Dealing with sensitive issues and obtaining appropriate history and assessment of the problems takes more time than is allocated to the appointment and causes problems with patient flow. The ability to have a practitioner talk with the parents helps the physician address the patient's physical health care needs while still managing the other patients' care.

Facilitates Greater Collaboration

Having a co-located behavioral health practitioner increases patient participation in treatment and creates a more cohesive treatment approach to behavioral and mental health related issues. Having a behavioral health practitioner on site can also increase patient accountability because the practitioner and physician have better access to each other and can share any concerns of treatment compliance with one another. Additionally, working together in a co-located practice facilitates greater trust between the providers. The referral process is smoother as the pediatrician knows first-hand who will be treating the patient. Parents and patients feel comfortable with their pediatricians and highly value a professional who is directly recommended by them. The office location, staff, and practice activities are already familiar to these families and it is the

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perception of the participating primary care physicians that this increases the likelihood they will follow through with a mental health referral.

Satisfaction

Surveys completed by parents indicate high levels of satisfaction with the medical practice. In this survey, questions inquire about the comfort level parents have with discussing behavioral, emotional, and mental health issues with their physician and how frequently these issues arose in any given appointment. Within the sample of surveys collected, the data indicated 100 percent of the respondents felt comfortable discussing these issues. The data collected demonstrates that behavioral, emotional, or mental health issues are being discussed during 87 percent of office visits, whether sick visits or well child visits. What is suggested by this data is that parents are more satisfied with the practice when the physician engages them regarding mental health issues. Having a behavioral health practitioner is also convenient for the patients and their families as it seems to reduce the stress of seeking outside treatment and increases compliance as they use the mental health services available more frequently than if outside referrals are made. This indicates the co-location of a behavioral health practitioner in a primary care office serves as a facilitator of greater satisfaction with the practice treatment and increases the patients' compliance with their health care

Summary

There are many benefits to co-locating a behavioral health practitioner within a primary care setting. Because the practice of primary care and the medical home model encompasses health maintenance and treating the whole person, there is an implied value in integration. Having a co-located practitioner offers a prime opportunity to diagnose and treat patients with mental illness and behavioral health issues and potentially prevent significant psychological issues. In addition, data indicate that parents want and support having a practitioner on staff. Therefore, this can serve as a great asset in marketing to potential and future patients.

EXAMPLES OF EFFORTS TO IMPROVE COORDINATION FROM OTHER STATES

Across the nation, health plans and providers increasingly are looking toward more integration of physical health and behavioral care, both to improve the quality of care and as a cost-saving measure. Possibilities, on a continuum from less to greater coordination, include shared care, co-location, and the medical home. No single model of increased collaboration exists that is appropriate to all primary care or behavioral care practices. "[L]ocal implementation of an integrated practice depends on local resources, constraints, and conventions, which further add to the variability."[32]

Examples of innovations from other states to promote integration of mental health into primary care include: 1) reimbursement to embed behavioral consultants in primary care teams; 2) creation of a network of psychiatric consultants for primary care providers; and 3) provider training for mental health assessments.

Some sites have coordinated care across providers and systems via: 1) case management; 2) formal agreements that lay out referral and care arrangements across organizations; and 3) preferred provider networks to increase access to mental health care in the community. This last strategy, use of preferred provider networks, is crucial for children and youth with severe emotional disturbance.

Some health plans have established joint working groups with their pediatric and behavioral health specialists to consider the issues and requirements of providing mental health services in the pediatric setting from both perspectives and to identify potential support that the health plan can provide to assist with the integration process.

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Promising Integration Strategies in the States

Integrating primary care and behavioral health care can be difficult. It involves care coordination, generally not billable in a conventional fee-for-service system. In addition, there is inconsistency about who will submit a bill for Medicaid services.

Tennessee and Missouri have found solutions for integration in safety net settings providing access to low-income, uninsured, and vulnerable populations. Lessons can be learned from their examples to be applied to other settings. Tennessee has delivered Medicaid services for both medical and behavioral health care through managed care organizations since 2006. Tennessee pays for certain billing codes for Screening, Brief Intervention, Referral, and Treatment (SBIRT services); allows same-day billing by both primary care and behavioral providers; and requires managed care contracts to included integrated care.

Missouri's Behavioral Health and Primary Care Integration Pilot has been assisted by a $1.4 million appropriation from its legislature. Missouri supports same-day billing and tele-health, is broadening SBIRT availability, and promotes CyberAccess.

These examples provide lessons that are generalizable. State Medicaid agencies can provide integration incentives by setting behavioral health expectations in managed care and alter payment strategies to reward integrated performance. Medicaid management care organizations in Tennessee have flexibility in creating integrated networks and supporting integration through innovations in payment. Missouri provided flexibility at the provider level, including integration pilots. These changes have created conditions for an integrated care system to develop.[33]

The Commonwealth Fund provided general recommendations for managed care derived from a study of providers and care coordinators in four U.S. cities.[34] Recommendations include more intensive care management and service coordination; using data consistently in a timely manner; helping providers make referrals by providing them with up-to-date network lists; and reimbursing for service innovations and for patient navigators.

Another example is the CentraCare Health System in St. Cloud, Minnesota, that works with Blue Cross and Blue Shield of Minnesota and the Medical Health Foundation to integrate behavioral health into its primary care settings. To accomplish this, they are supporting mental health screenings at all well visits, using crisis assessments conducted by mental health professionals at the primary care sites, providing consultations by child and adolescent psychiatrists for primary care providers, patient education, and providing for emergency care. All of these services are reimbursed by the health plan. Treatment and management protocols for various conditions have been developed to further enhance the collaborative relationship.

In Kentucky, Passport Health Plan uses monthly roundtables to bring together all providers treating an individual with behavioral health conditions, including the primary care provider and the behavioral health specialist. While this approach is currently used for adults, such case conferencing is highly applicable to the pediatric population.

Health plans have also provided training for their provider networks on new care models like the patient-centered medical home; determined areas with a high level of need for behavioral services; where there is interest and capacity, pursued strategies to advance the goal of more collaborative care; and considered pilot projects to examine different approaches to increasing collaboration.[35]

Blue Cross and Blue Shield of Minnesota and the Medical Health Foundation are supporting mental health screenings at all well visits, crisis assessments conducted by mental health professionals at the primary care sites, consultations by child and adolescent psychiatrists for primary care providers, patient education, and provisions for emergency care. All of these services are reimbursed by the health plan.

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SUMMARY

MMA plans can support more effective coordination and integration of behavioral health and primary care through strategies that encourage the use of shared care, co-location, and the creation of medical homes. Increased levels of coordination among providers strengthens efforts to prevent, screen, assess, intervene, and treat early social, emotional, and behavioral conditions and may achieve cost-savings from reduced expenditures for physical health care.

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