PA Project LAUNCH Policy Targets:

Integration of Behavioral Health into Primary Care

Behavioral health integration in the pediatric primary care setting offers great potential for identifying and effectively treating children's behavioral health concerns. Inadequately managed childhood behavioral health conditions not only contribute to high health care utilization and costs over the life course, but also impacts the child welfare, juvenile justice and education systems substantially. Given the prevalence of behavioral health conditions in children, the severe shortage of child and adolescent psychiatrists in PA[6] and the unique opportunity for early identification in the primary care setting, integration and related services should be promoted and supported by reforms in Pennsylvania's health insurance policy and reimbursement structures i.e. Medicaid, CHIP and commercial payer policies.

Below are 7 recommendations put forth by the Allegheny County Project LAUNCH Behavioral Health/ Physical Health Integration Work Group. Please note that these recommendations focus on strategic secondary prevention opportunities within the pediatric primary care setting, and are not meant to be a comprehensive account of potential improvements to Pennsylvania's health care delivery system.

Target 1: Validated social-emotional health screenings in young children (0-10) with appropriate follow-up

First onset of mental and behavioral health conditions usually occurs in childhood or adolescence[1]. Typically, treatment does not start until much later[1], yet only 1/8 children will ever receive treatment for their disorder[2]. Tragically, the leading causes of death in adolescents - accidents, homicide and suicide - are likely to be related to behavioral health issues[3]. Early identification and timely treatment could reduce severity-persistence of primary disorders and prevent or delay secondary disorders[1]. Screening children within the primary medical home and linking them to care at the time of their health visit is a strategy that has been associated with increased rates of treatment[3]. **The use of a validated social-emotional/psychosocial screen(s) in every well-child (e.g. EPSDT, yearly physical) primary care visit should be required across all age ranges. Validated socioemotional/psychosocial screen(s) should be the gold standard of care for all children, regardless of insurance provider.**

Target 2: Reimbursement for behavioral health services rendered by physicians

Given the shortage of behavioral health providers that work with very young children, treatment for behavioral problems are inaccessible for many in this group[4,6]. Primary care physicians, when trained and supported, can prevent, identify, threat and manage many conditions commonly seen in the pediatric population[3]. **Payment for behavioral health screening, treatment, and management, as well as pre– or poste-visit time (e.g. phone time for psychiatric consultation) should reflect the added complexity and time necessary to support comprehensive care for young children with complex health needs.** PA OMAP could achieve this by opening existing codes i.e., CPT Code 99484 which is used to bill for "general behavioral health integration services" rendered to Medicare recipients.

Target 3: Post-partum maternal depression screening as a criterion for early intervention tracking

Given Maternal depression has been proven to pose developmental risks for infants and can have a lasting impact on a child's health and well-being. Low-income mothers are at especially high risk of experiencing postpartum depression symptoms. We support the Strong Mom Strong Baby effort that has been introduced to PA State legislature (HB 200 and SB 200) to amend the existing early intervention law (Act 212 of 1990) and add postpartum depression as an at-risk condition. This amendment would allow infants to undergo assessments, parents to receive assistance in bonding with their babies and if needed, early intervention services to ensure moms and babies have the best start together[7].

Target 4: Reimbursement for behavioral health care coordination

The Patient-Centered Medical Home (PCMH) model is widely regarded as the gold standard of primary care for both children and adults, and focuses on critical care coordination across providers and settings for those with complex health care needs. However, behavioral health conditions are generally not recognized by private and public payers as a chronic illness befitting of care coordination and the resultant chronic-care management payment. Care coordination (sometimes referred to as care -navigation or –management) for behavioral health facilitates information sharing among providers, efficient coordination of services, and monitoring of service utilization[4]. Additional benefits of this service include improved parent satisfaction with behavioral health services and therapies[3], higher rates of treatment initiation and completion, and improvement in behavioral problems[4]. **Payment systems must support time for behavioral health care coordination and communication** in parity to chronic conditions.

Target 5: Sustainable payment for co-located care

Newer models of pediatric care including co-located care can help to improve access, care coordination and referral completion[4]. Importantly, integrating behavioral health into the primary care setting can reduce stigma associated with mental health services[3]. Pediatricians are likely to feel more confident when addressing behavioral health concerns if they are supported by behavioral health professionals[4]. **Existing regulatory and payment structures must be amended to support systems-level changes that recognize the value of integrated care models and support the transformation of pediatric primary care practices**.

Target 6: Sustainable payment for care consultation time

"Innovative collaborations have been well described and include colocation and integrated and consultative models, such as the Massachusetts Child Psychiatry Access Project, the North Carolina Chapter AAP/NC Pediatric Society (ICARE), and the Washington Partnership Access Line[…] These relationships help build the capacity of pediatricians to manage various behavioral and emotional problems in the office. This is particularly true for the management of subthreshold problems not meeting the severity level warranted to refer for treatment."[2] Currently, the PA Health Choices Telephonic Psychiatric Consultation Service Program (TiPS) provides real time resources to PCPs and other providers who desire immediate consultative advice for children with behavioral health concerns, covered by Medical Assistance, up to age 21. **Children's TiPS should be expanded to serve all children regardless of insurance enrollment, to ensure that providers are equipped to address the needs of young children with behavioral health concerns.** Commercial plans or hospital-based health systems could be encouraged to provide financial support in return for provider and beneficiary utilization.

Target 7: Tele-psychiatric and tele-psychological services

Pennsylvania has a severe shortage of practicing child and adolescent psychiatrists[6]; consequently, children and families lack access and referrals to appropriate behavioral health services when and where they need them[4]. **Innovations in care, such as tele-psychiatric, tele-mental health clinical services rendered by psychologists and other advanced practice/licensed professionals, should be supported and expanded to ensure that all children have access to quality care.**

Pennsylvania The Policy Target recommendations deliverable was conceived to connect and collaborate with State partners and to advance the goals of the PA Project LAUNCH Partnership's local BH/PH Integration Workgroup. Many stakeholders, external to the local workgroup, reviewed, collaborated on and contributed to this document. The represented parent/family member, third party payor, behavioral health, physical health, child policy expert/advocacy, and research/subject expert (n=15 with overlapping roles noted). This document was prepared by Makeda Vanderpuije, MPH, CPH formerly from Allegheny County DOH.

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