

I'm Sandra Fritsch, MD, Training Director of the Child and Adolescent Psychiatry Residency Program at Maine Medical Center, the physician leader of the Child Psychiatry Access Program, and Associate Clinical Professor at Tufts University School of Medicine.

I wanted to lend my support of the committee's recommendation(s) on page 29 of the draft report to implement a monitoring program for MaineCare recipients' use of Anti-psychotic medications and strengthening "rational" prior authorization requirements for the use of these medications in youth, adults and seniors. This support should in no means be seen as an attempt to limit access to these medications for people who need them and may benefit. Rather my support of these recommendations is an attempt to reduce unnecessary, unsafe and inappropriate use of these medications for conditions where the efficacy is not evident, when possible side effects or adverse reactions outweigh any potential benefit, and when proven alternative treatments may be available.

The Child Psychiatry Access Program (CPAP) is a program with the goal to improve behavioral health and mental health access to care for child and adolescents in the state of Maine. We accomplish this by providing education to pediatric primary care providers to enhance their knowledge and sense of efficacy for providing mental health screening and treatment of uncomplicated conditions, provide further support by easy access and telephone consultation with a child psychiatrist within 45 minutes of request, and help the primary care provider access local resources. CPAP was originally funded by a grant from the Maine Health Access Foundation in 2009 for three years and continues with funding from a philanthropist. Currently CPAP works with over 25 pediatric primary care providers in Portland, Westbrook, Bath, Brunswick, Yarmouth, and Norway to cover roughly 38,000 pediatric lives. Our staffing includes a child psychiatrist and a clinical care coordinator. Each point of contact with the primary care providers and office staff is an opportunity for education and judicious use of resources. We have required formal lunch and learns for the enrolled practices around topics such as mental health screening tools, appropriate use of stimulant medications, treatment of anxiety in the primary care setting, treatment of the oppositional child in the primary care setting, suicide and self-injurious behaviors, integrative medicine and complementary treatments for mental health conditions, the aggressive child, depression and antidepressant medications, use of atypical antipsychotic medications and the recent monitoring recommendations for the child in foster care in Maine, and other topics.

Each point of contact also includes the opportunity aid the primary care clinician/office with appropriate referrals and to "gatekeep". We noticed a disturbing "shotgun" approach to seeking consultation by some primary care providers; seeking consultations simultaneously from a pediatric neurologist, a developmental behavioral pediatrician and a child

psychiatrist. Our telephone consultation helps the primary care provider prioritize consultations to best answer the concerns; ultimately leading to a more efficient and cost effective approach.

CPAP was modeled after the first such program in the United States (please see attached poster presentation about CPAP from October, 2011, presented at the Annual Meeting of the American Academy of Child & Adolescent Psychiatry) the Massachusetts Child Psychiatry Access Program (MCPAP; www.mcpap.org). MCPAP is a fully funded state program and provides for coverage of roughly 96% of the children and adolescents in Massachusetts. New York has recently developed a program focusing highly on education of pediatric primary care provider followed by a telephone consultation model; CAP-PC, Minnesota is developing a partnership with Mayo Clinic to provide telephone consultation and education. The Pediatric Access Line (PAL) is a highly successful telephone consultation model in the state of Washington and Wyoming, and PAL is linked with their state Medicaid program to provide oversight, guidance, and monitoring of atypical antipsychotic medication use in youth. Each state's program has child psychiatrists providing telephone consultation and education to pediatric primary care providers.

I urge the committee to consider including in the final report, examples from other states of models proven to be successful in changing prescribing patterns of atypical antipsychotic medications in children including Washington, Arkansas, Wyoming, and Minnesota. These states' programs are far more extensive than what Maine currently has in place and involve rationale treatment algorithms including feedback loops to prescribers. They have actually measured changes in prescribing habits. Washington State's program which includes a 2nd opinion Telephone Mental Health Consult Service led to significant reduction in the utilization of antipsychotics both among Medicaid children (8.6%) and among foster care children of about 34.7%

I urge the department to consider developing a credible and effective monitoring program that would include a strong telephone consultation model. Maine is a small enough state to effectively encompass most if not all of the providers of the state. I personally know individual prescribing practices of a number of CAP's and there are clearly areas to help to educate and promote change.

But the other huge dilemma is the lack of therapeutic resources to change behaviors in families, individuals and schools. In my experience working with pediatricians in Norway, Bath/Brunswick, and the greater Portland area, often medications are suggested by schools and allied mental health providers when therapeutic modalities such as cognitive behavioral therapy, trauma-focused CBT, in home evidence-based treatments, and school resources are not available. One telephone consultation for a pediatrician in Brunswick was for a 10 year

old boy who had been prescribed an atypical antipsychotic medication upon the strong recommendation of a school psychologist for acting out in school; this child had yet to have his language-based learning disability addressed in the educational system. Developing effective coping strategies and emotional regulation requires an investment of time and therapeutic resources that may be lacking in specific areas of Maine. Consumers are also seeking a "quick fix" for any negative emotion, for changing lifestyles around sleep hygiene issues, for anger, for normal sadness. Due to direct consumer marketing there is a belief that medications will solve the problem without needing to address any behavioral concerns.

Although the prime focus of my testimony is around implementing a monitoring program for MaineCare recipients regarding the use of Anti-psychotic medications and strengthening "rational" prior authorization requirements for the use of these medications with children, adults and seniors, I would like to comment on two other recommendations in the current draft proposal. I offer these observations as a practicing child psychiatrist in the state of Maine. Pages 27 and 30 propose requiring a prior authorization for all psychiatric services for MaineCare recipients less than 21 years of age. This proposal is offered at a proposed savings of \$20,000 for SFY 2013 and \$50,000/year for SFY 2014 and 2015. This appears to be a rather draconian proposal with minimal savings and could potentially create further barriers and stigma for treatment of behavioral health and mental health conditions in childhood. Yes requiring prior authorization for assuring a member meets hospital level of care criteria clearly is a prudent move; but to declare all psychiatric services; inpatient, outpatient, consultation and evaluation for further care would require a prior authorization is a recommendation fraught with difficulties. A more rationale approach could include credentialing child psychiatric providers who assess for the appropriate level of care, to develop clear guidelines for all levels of services from outpatient to case management to home-based treatment services to inpatient level of care.

As the state moves towards longer term planning and Value-Based Purchasing, programs such as CPAP will be vital to aid the primary care providers in their approaches to population-based medicine. Without clear and readily available support for the primary care provider, recruitment and retention of primary care providers into the more rural areas will be challenging.

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Child Psychiatry Access Project: A Pilot Project in Maine

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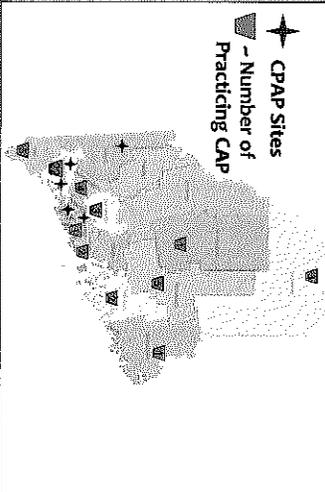
Objective

This research poster describes an innovative program developed in Maine to address work force shortage issues of child and adolescent psychiatrists by helping primary clinicians deliver mental health care more effectively in the primary care office.

Background

The ability to address the mental and behavioral health care needs of children and adolescents in the United States is severely challenged due to a shortage of child mental health providers and inadequate training of primary care clinicians (1,2). Additionally, there is a severe maldistribution of child psychiatric services in the U.S., with children in rural areas and areas of low socioeconomic status having significantly reduced access. The ratio of child and adolescent psychiatrists per 100,000 youth ranges from 3.1 in Alaska to 21.3 in Massachusetts with an average of 8.7. The state of Maine is largely rural and child mental health resources beyond Cumberland County are extremely limited. It has been estimated that the prevalence is 8 - 13% of children & adolescents suffer emotional/mental health illness in Maine, of which 71.6% do not receive treatment. The recent increase of fuel costs and decline of the economy have further increased the burden to receive evaluation and treatment for mental health issues in a timely manner. The Maine Health Access Foundation (MHAFA) set a strategic mission to support the development of models to increase mental health delivery in primary care settings and funded the Child Psychiatry Access Project (CPAP). The CPAP was modeled on the highly successful Massachusetts Child Psychiatry Access Project (3,4) and additionally developed a formal Collaborative Office Rounds model with the providers enrolled. The goals of CPAP are to increase access to child mental health services by assisting primary care clinicians finding resources, providing telephone and electronic (e-mail) consultation within 45 minutes of the request, providing direct face-to-face consultation for difficult diagnostic treatment cases, and enhancing the effectiveness of the primary care clinicians assessment and treatment of mental health conditions through an established educational series.

Map of Maine

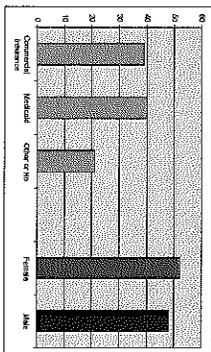


Methods:

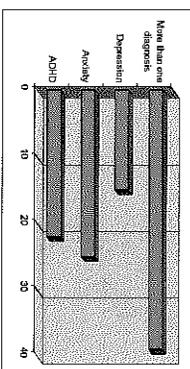
CPAP is a grant-funded service providing 0.25 FTE child & adolescent psychiatrist (CAP) and 0.5 FTE clinical care coordinator (CCC). Practices enrolled were determined by previously established outpatient consultative relationships, "rural" and urban sites. In year one, all pediatric practices (4) in Brunswick (rural) were enrolled. In year two, pediatric practices in Westbrook and Yarmouth (urban), and Boothbay Harbor (rural), were enrolled. In year three the lone pediatric practice in Norway (very rural) was enrolled. At each first formal meeting, the parameters of the program were discussed, a formal "contract" was signed, and a baseline provider satisfaction survey was completed. Once enrolled, primary care providers initiate contact with the CCC leading to a telephone consultation with the CAP or aid for resources. Data about each encounter is collected including demographics, diagnoses, time spent in the encounter, services sought, and outcome from the encounter. All data is entered into an Excel database by the CCC. Provider satisfaction data is collected every six months. Quarterly learning sessions ("Lunch & Learn") are scheduled with each site. A survey was developed to assess the value and effectiveness of the "Lunch & Learn". Further, data was collected from families coming for a face-to-face consultation including distance traveled, time away from work and school, level of comfort with the family receiving mental health treatment from the primary care clinician, and employer paid time off for medical visits.

Results

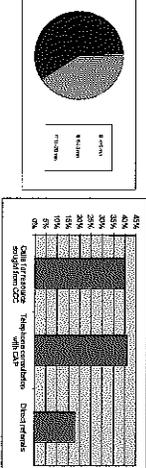
Data were transferred into SPSS Version 19 for analysis. Descriptive analysis was done on patient demographics, encounter data, and provider satisfaction. At this time a total of eight practices and twenty-five providers are participating in the CPAP program. These practices have over 31,000 pediatric patients among them. Between Q1 of 2010 through Q2 of 2011, there were 335 contacts with the CPAP program. 52% were about female patients and 48% about males. For those whom insurance information was available, 39% had commercial insurance, 40% had Medicaid, and 21% had other or no coverage.



60% of the children were already taking psychotropic medications. Mental health diagnoses included: ADHD (22%), anxiety disorders (25%), depression (15%) and many other diagnoses. 39% of the children had more than 1 diagnosis.



Description of Contacts:



Provider Satisfaction Data

Pre-CPAP Participation Survey
N=149

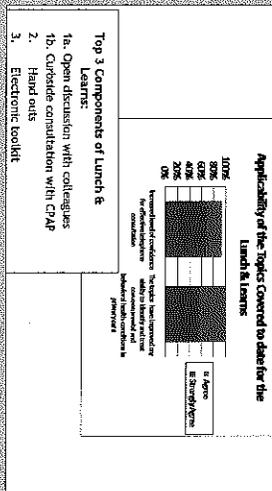
Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
I thought there was adequate access to child psychiatry for my patients.	37%	63%	0	0	0
With the existing resources, I was usually able to meet the needs of children with psychiatric problems.	15.7%	73.6%	5.2%	5.2%	0
When I needed a child psychiatric consultation (corridor or phone), I was able to receive one in a timely manner.	36.6%	52.6%	0	10.5%	0

12 Months or Greater Post-CPAP Survey
n=153 (16 month survey)

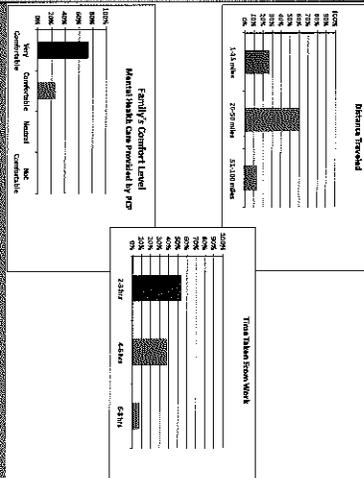
Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
There is adequate access to CAP for my patients.	2.2%	42.2%	4.6%	48.8%	2.2%
I feel that I am usually able to meet the needs of children with psychiatric problems.	0	2.2%	6.6%	80%	11%
When I need a CAP phone consultation, I am able to receive one in a timely manner.	0	2.2%	2.2%	62.2%	33.3%
Find CAP phone consultation to be helpful.	0	0	6.6%	51.1%	42.2%

Lunch & Learn Survey

Year One	Year Two	Year Three
Formal signing up the practice	Fundamentals of Antidepressant Medications	Encopresis & Enuresis
Medical Health Screening Tools	Crisis and Crisis in the PCP Setting	ODD, "Just Say Yes"
Basics for ADHD, Medications and Treatments	Treatment of Anxiety in Primary Care	Natural Therapies for Mental Health Issues and Sleep
What is Therapy? What are the Systems of Care in the PCP?	Depression and Suicide and the Role of the PCP	Substance Abuse



Travel Survey Summary



Conclusions

CPAP is an effective model to increase the both the comfort and delivery of mental health treatment by primary care clinicians for children and adolescents. This model helps to address the unmet training needs of primary care clinicians to better prepare them for the complexities of behavioral and mental health problems that occur daily in the primary care office. What is not readily apparent in the data is the importance of developing relationships between the primary care clinician and the collaborative care team. The value of the collaborative learning sessions through the "Lunch & Learn" format has fostered greater knowledge and sense of efficacy for the primary care clinician and has fostered long term collegial relationships between the primary care clinicians and the CAP. Although a highly effective model, finding the resources to sustain the model through state policy requirements, commercial carrier per member per month charges, or Medicaid waiver programs is essential.

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