

## TRANSCRIPT OF WEBINAR:

# CONSULTATION FOR KIDS - MODELS OF PSYCHIATRIC CONSULTATION IN PEDIATRIC PRIMARY CARE

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### **BEGIN TRANSCRIPT:**

SARAH STEVERMAN: Good afternoon everyone and welcome to the SAMHSA HRSA Center for Innovative Health Solutions webinar Consultation for Kids, Models of Psychiatric Consultation in Pediatric Primary Care. My name is Sarah Steverman, a consultant for the SAMHSA HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health and your moderator for today's webinar.

As you may know, the SAMHSA HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether they're seen in specialty behavioral health or primary care setting.

In addition to national webinars designed to help providers integrate care, the center is continually posting practical tools and resources to the website providing direction and consultation to providers and stakeholder groups and directly working with SAMHSA primary and behavioral healthcare integration grantees and HRSA funded health centers.

Today we're happy to be hosting this webinar as part of SAMHSA's 10<sup>th</sup> anniversary National Children Mental Health Awareness Day activities.

[01:14]

Children's Mental Health Awareness Day is a recognition of the needs of children, youth, and young adults with mental health or mental health and substance use challenges and their family and will be [inaudible – 01:24] on Thursday, May 7<sup>th</sup> with an event at the Williamsburg Theater in Washington, D. C. The event will highlight strategies for integrative behavioral health with primary care, child welfare and education and will be streaming live at 1:30 Eastern time.

We encourage you to check out the National Children's Mental Health Awareness webpage to check out other ways you can get involved, including the social media activity encouraging everyone to tweet or host about the Heroes of Hope in your community.

High school students are also encouraged to get together with friends to join a conversation about mental health. Prompted by text enabled questions, youth can discuss how to take care of their mental health and help friends in need. And there's more, so please go to SAMHSA National Children's Mental Health Awareness Day materials, resources and ideas for celebrating in your community.

[02:16]

Before I introduce your speakers for today's webinar, I have a few housekeeping items. Today's webinar is being recorded and all participants will be kept in listen only mode. You can find the...you should be getting the audio through your computer speakers. Let us know if you're having problems by typing questions in to the dialogue box at the bottom of your screen.

You can also ask questions about content throughout the webinar. Again, that is down at the bottom of your screen.

I encourage you to submit your questions if you have them, and we'll answer as many of your questions as time allows.

The webinar slides are currently posted online at [www.integration.SAMHSA.gov](http://www.integration.SAMHSA.gov) under the webinar section.

Lastly, at the end of the webinar, please take a moment to provide your feedback by completing a short survey.

[03:16]

Those are the slides being shown right now.

FEMALE VOICE: Yes they are.

SARAH STEVERMAN: Okay. They're not showing up on my screen, so I'm not sure which ones we. Rose, are you seeing, "Today's purpose" right now?

ROSE: Yes.

SARAH STEVERMAN: Okay, great. Thank you. Sorry about that.

On today's webinar, our speakers will be presenting The Pediatric Psychiatric Consultation model used in primary care settings. You will learn about how the model works at the clinical and organizational level as well as how states and regions have implemented funded and now sustaining their consultation services.

To begin, we are pleased to have Dr. Michael Lu, the Associate Administrator for Maternal and Child Health in the Health Resources and Services Administration of the U. S. Department of Health and Human Services with us today to provide a welcome. That is a mouthful. Dr. Lu oversees the work of the Maternal and Child Health Bureau at HRSA which is the agency responsible for improving the physical and mental health, safety and well-being of mothers, children, and families. Dr. Lu.

[04:37]

DR. MICHAEL LU: Well, thank you Sarah, and good afternoon; good morning to some of you. My name is Michael Lu. I am an Associate Administrator at HRSA and Director of the Maternal Child Health Bureau. And HRSA is very pleased to bring this webinar to you today in collaboration with our colleagues at SAMHSA in recognition that the National Children's Mental Health Awareness Day on May 7<sup>th</sup>.

And I want to start by just giving a shout out to my colleagues here at HRSA, both Alex Ross and [Matrina Andren – 05:08]. [inaudible -05:08] are partners at SAMHSA Center on integrative solutions. Dana Morrisett, Kelly Bates, and the center's director, Laura Galbreath. For all their hard work in organizing this webinar and I think, more importantly, for all that they do to improve children's mental health in our nation.

Today we're going to talk about Consultation for Kids, Models of Psychiatric Consultation in Pediatric Primary Care. And there are three driving reasons why immigration of mental health and pediatric primary care is so important.

[05:46]

First, at the prevalence of mental and behavioral health problems among our nation's children and adolescents, mental disorders are common. About 1 in 5 or 20% of children and adolescents have had serious mental disorder at some point in their lives. And 1 in 8 or 13% of 8 – 15 year olds have had a diagnosable mental disorder within the past year.

Half of all mental disorders show first sign before a person turns 14 years old and two quarters of mental disorders begin before age 24.

Second, too many kids [inaudible – 06:30] in this country with a mental or behavioral problem by not getting the treatment that they need. Based on our national survey of children's health in 2011/2012, only about 61% of children and adolescents between the age of 2 and 17 with a mental health problem received treatment by parent report. That means that nearly 40% are not getting the treatment that they need. And while that's a lot better than over a decade ago when 80% of children and adolescents 6 to 17 with mental health problems were not getting treatment. We still have a long way to go in this country because we know that early mental health support can make a difference for children before problems interfere with other developmental needs.

[07:17]

And third, a big reason why kids aren't getting treated for mental and behavioral problems is because they are not following through with the referral to mental health specialists. Only about 60% of children and adolescents who are referred for mental health services actually follow through with the referral.

Now, this is a big problem because most primary care pediatricians, they see their role as managing and treating mental behavioral disorders. But while surveys show that 80% - 90% of primary care pediatricians agree that they should be responsible for identifying and screening ADHD, depression, anxiety, substance abuse, eating disorders and other problems. Only about 20% - 30% thought they should be treating or managing these problems. Most pediatricians believe that their role was to refer patients with these problems to a mental health specialist.

Now pediatricians have identified a number of barriers for caring for children and adolescents with mental health problems. Seventy-seven percent cited lack of time, 65% reported lack of training, 62% reported lack of competence in their ability to treat mental health problems, 61% talked about the lack of mental health specialists they can refer to, and 74% talked about the long waiting period to see the child/adolescent mental health specialist. And that's why the models of mental health consultation and primary pediatric care is so exciting and promising because they bring much needed mental health support to primary care pediatric practices that might otherwise have had trouble getting the support for their patients.

[09:03]

The model that you will hear about today has been successful in a large number of states starting in Massachusetts and is not active in 30 states plus D. C. This model allows children and adolescents to obtain the comprehensive range of services from their primary care provider whenever possible, but allows for rapid response from a mental health specialist if necessary referral.

The webinar also illustrates one of the key goals that SAMHSA HRSA Center for Integrative Health Solutions to assure access to needed services to qualified and well-trained work force highlighting the value of integrating care.

The center has a wide range of valuable archived webinars, PA and training materials available for your use. I hope you will take the time to explore the center's website after this webinar if you haven't already.

HRSA [inaudible – 09:56] have brought investment in programs to support a healthy development of children and adolescents including Healthy Start, home visiting, and school based services which focus on school based health centers and comprehensive school mental health programs. And I'm very pleased to welcome you to this very important presentation and our expert presenters.

I'm just as pleased that HRSA's collaborating with the center to bring you this webinar in honor of the National Children's Mental Health Awareness Day which takes place as part of Mental Health Month.

Thank you for participating today. And thank you for all that you do around the country on behalf of the nation's children and families.

And with that, let me turn it back to you Sarah.

SARAH STEVERMAN: Thank you so much Dr. Lu. Today we have two great presenters for us. First up will be Dr. John Straus who is the founding director of the Massachusetts Child Psychiatry Access Project known as the MCPAP. He's also the president of the National Network of Child Psychiatry Access Programs, and he'll be discussing that today as well. He is also Medical Director of Special Projects at the Massachusetts Behavioral Health Partnership.

Dr. Straus is a general pediatrician having practiced in primary care settings for 22 years and has always been part of an integrated behavioral health setting, or a primary care setting that integrates behavioral health. He has worked for over 25 years in managed care as well. He was Vice President of Medical Affairs at the Massachusetts Behavioral Health Partnership before his current position and was Medical Director of the Fallon Community Health Plan.

He did his medical training at Columbia University and his pediatric training at Strom Memorial Hospital in Rochester, New York. He also has been a [inaudible – 11:58] and clinical scholar at John's Hopkins Medical School.

[12:01]

And joining him will be Dr. Vincent Biggs, who is a board certified pediatrician, American Academy of Pediatrics Fellow, member of the Council on Community Pediatrics and the Massachusetts Chapter of the AAP. He is currently at the Holy Oak Health Center and has been there for over eight years working as a pediatrician primarily working on pediatric healthy weight program development issues. He also is a user of the psychiatric consultation services that we'll be discussing today.

Dr. Biggs attended medical school at the University of Massachusetts and completed pediatric and chief residency at the University of Washington in Seattle. Prior to joining Holy Oak Health Center, he also was in Ship Rock, New Mexico as part of Indian Health Services as a general pediatrician at the Northern Navajo Medical Center.

We thank both Dr. Straus and Dr. Biggs for joining us today. Before I turn it over to Dr. Straus, we have a poll question that we just want to get the sense of who's on the line today. So we're asking this question. You can enter your answer on the screen. How would you identify your role in primary care behavioral health integration? Are you a primary care provider or administrator? Are you a behavioral health provider administrator? Are you a policy maker? Are you another stakeholder other than those listed? I'll just give you a minute and you can answer your answer. And the results coming in real time. We have a very small; only 2.3 % of those online are

primary care providers. The vast majority are on the behavioral health side. It's a little bit higher now. People are continuing to sign in. We have lots of other stakeholders; about 10% or 9% are policy makers. So, that just gives us a sense of who's on the line. Primarily behavioral health providers and administrators who might be interested in providing the service. That's excellent.

[14:22]

The next poll question. For those of you in primary care, we're wondering if you have any sort of access to behavioral health consultation. So you can answer yes; within your primary care setting you have someone in-house. Yes, through consultation with an external behavioral health provider, like with an outside consultation, psychiatric consultation service, or do you have access to both? Both in-house for some things and then you have further consultation that you can utilize outside the primary care setting or no, you do not have that at all?

So if you are in a primary care setting and you want to answer that, you can enter your results there. Alright. So some, it looks like 41% of you do have access, but it is internal. Just about 7.4% of you have access to consultation externally. It's a little higher now. People continue to enter. And then 40% have both internal and external. The good news is that only 10% of you don't have any access to consultation, behavioral health consultation. Alright. Thank you for answering our poll questions. That gives us a better sense of who's on the line and how we can better tailor our discussion to meet your needs.

So right now, I want to turn it over to Dr. Straus. He's going to give us an intro of his program in Massachusetts and then we'll also be speaking with Dr. Biggs about how he uses it. So I'm going to turn it over now to you, Dr. Straus. Thank you for being with us.

[16:24]

DR. JOHN STRAUS: Thank you Sarah. And welcome everybody. And thank you Dr. Lu for such a wonderful, informative introduction. I also would like to thank SAMHSA and HRSA and the Center for Innovative Health Solutions for making this presentation possible. And it's exciting to be doing this as part of Children's Mental Health Awareness Week and I hope that you are all doing something to support children's mental health this week. And if nothing else, if this talk inspires you to work towards creating a child psychiatry access program in your state, we will have been very successful.

As you've heard from Sarah, we're going to be talking today about the Massachusetts Child Psychiatry Access Project better known as MCPAP. And like you said, at the offset, that were funded by the Massachusetts Department of Mental Health and we have at MCPAP, an administrative team consists of Barry Servet (sp) as Medical Director, Marci Ravage as Director, and Chris Harris as Policy Analyst, and Mary Holden as Project Coordinator. And, obviously, I couldn't be doing this presentation without the help of all those folks.

[17:51]

Just to reiterate a little bit about what we hope that you'll learn today, you're going to learn about how MCPAP works and hear from Vinny about how it works on the ground. You're going to learn about MCPAP as a key component of behavioral health integration for primary care practices serving children. And you're going to learn how MCPAP is being disseminated nationally, including some common variations.

I thought I'd start with just a very brief overview just so you have sort of a beginning feeling for what we're doing. We define MCPAP as being a system of regional children's mental health consultation teams designed to help primary care providers meet the needs of children with behavioral health problems. And we are concerned with all children in the state regardless of their insurance status and for much of this talk, I'll be talking about behavioral health, using the term "behavioral health" so we include in that both mental health and substance use.

We're available to all PCPs who see children so that includes pediatricians, family med physicians, nurse practitioners, physician assistants or co-located behavioral health clinicians. I'm a pediatrician, so every once in a while I probably have said a mouthful of saying pediatric PCP. I may say pediatrician. But I mean anyone who's in a primary care setting.

[19:36]

MCPAP was developed after a pilot at the University of Massachusetts medical school and we started in 2004. So I'll be talking about 10 years of experience. And we've really seen, as you'll learn through this talk, an amazing change across the country in the last 10 years.

Okay. Dr. Lu mentioned some of the background problems about why access to behavioral health is a problem, and I won't go over all those detailed numbers again, but the increasing prevalence of behavioral problems in children has been well documented. It is an unrecognized behavior...there are many unrecognized behavioral health conditions in primary care and in general, and that leads to under treatment. There is a severe shortage of child psychiatrist.

If you look at the numbers, Massachusetts actually has more than anywhere else in the country at 21[inaudible – 20:39] thousand, going down to Alaska at 3.1 and averaging 8.6 across the country. That's been shown to be clearly inadequate. And interestingly, there's been no, it was no change between, in 1995 and 2006 and we...and it's not forecasted to be much improvement over the next number of years.

There's limited training of pediatric PCPs in diagnosis and treating behavioral health conditions which leads to under recognition. And then from the family side, there is often a belief that mental health professionals, especially child psychiatrists, are the only providers suitable to treat children with behavioral health conditions.

[21:34]

If we look in Massachusetts, back in 2002 when we were beginning to get organized to start MCPAP, the family advocates organization known as the Parent Professional Advocacy League did a study of parents calling in to them and they found that 33% of the parent respondents

waited more than one year for an appointment with a pediatric mental health provider. Fifty percent reported that the pediatrician never asked about the child's mental health, and 77% reported that pediatricians were not helpful in connecting them to resources. So, with this data, we had our work cut out for us.

I want to spend a few minutes talking about screening because access begins with identification. And without screening, using a standardized screening tool, significant numbers of behavioral health problems will not be found. Some reports up to 40%. And in Massachusetts, there was a class action law suit filed on behalf of Medicaid children, known as the Rosie D. lawsuit, where Medicaid children with serious emotional disturbances and the lawsuits key issue was the lack of community-based mental health services.

However, when the remedy was crafted, the remedy included the need for the mandate for Medicaid to pay PCPs to administer the standardized age appropriate behavioral health screen at all well child visits. And PCPs used a CPT code known as 96110 and the rate of screening has gone from 17% to 80% between 2009 and 2013. So many more kids being recognized. The [inaudible – 23:42] have gone along with that, so we think that this 80% number really applies across the board. Pediatricians would not have been willing, all pediatric PCPs, would not have been willing to do this if they hadn't been able to get help through MCPAP when the screen was positive. If you want more information about screening, I really recommend down at the bottom there, it says the report from the Academy of Pediatrics by Weitzman in the February issue of Pediatrics.

[24:19]

So what were our goals? Well, to increase the pediatric PCPs knowledge, skills and competence to manage children in primary care with mild to moderate behavioral health needs, particularly ADHD, depression, and anxiety. We wanted to mitigate the shortage of child psychiatrists by promoting the rational utilization of psychiatrists for the most complex and high risk children, particularly those on multiple medications.

Advanced the integration of child's behavioral health and pediatric primary care. And we wanted to have public health approach that addressed the need for the PCPs for all 1.5 million children in the Commonwealth to be able to deliver good behavioral health services.

If you look at this sort of picture, we think of the behavioral continuum from the less complex to the more complex and with the PCP on the left side being in charge for the less complex with help from the consultation from the child psychiatrist whereas the child psychiatrist is going to be leading the team on the more complex side with communication back to the PCP.

If you think of a physical health problem like asthma, if PCPs did not manage most of the kids with asthma and they all went to pulmonologist, the things would fall apart. There would not be enough pulmonologists. But right now, there's a nice balance between PCPs taking care of most kids with asthma and pulmonologists being left for those kids with particularly complex problems. And we want to produce the same kind of balance on the behavioral health world.

[26:23]

Integration increases access, especially as we move towards primary care practice being patient centered medical homes. The teams increasingly include a behavioral health component, but that person is usually a licensed clinician, a social worker, a psychologist; very rarely a child psychiatrist. The PCP still needs to be the prescriber, the diagnostician. And they shouldn't need to send the child to a specialist when the therapy is available in the patient centered medical home. And, therefore, the PCP needs to be able to consult with the child psychiatrist and we do that telephonically.

Supporting PCPs also makes sense from the family's point of view. Patient's families often feel more comfortable and trusting of their primary care providers. Primary care providers have the opportunity for prevention and screening. Primary care providers know the developmental context of symptoms of the kids. And in the primary care setting we can reduce the stigma of mental health issues.

Okay, now I'm going to spend a few minutes going through some of the nuts and bolts of how MCPAP works. We have six regional hubs. Each service area or hub team includes an FTE full-time equivalent of a child psychiatrist, usually three or four different individuals who take slots during the week so that there is full coverage. We have an FTE of a licensed behavioral health clinician and an FTE of a care coordinator. We also have a part-time administrator.

[28:28]

We prefer those hubs to be at an academic medical center where the child psychiatrist to use to mentoring and teaching. And can more easily recruit the scarce child psychiatrist a little more easier than in the community.

The number of hubs and locations need to match the local resources and population distribution. So we have 1.5 million kids and six hubs. So each hub has about 250,000 youth. And each hub enrolls all the pediatric practices in their region. And if you look on this slide, you can see how the teams, the six teams are distributed across our state with two teams covering the metro Boston area. I won't read through, you all the names, but I guarantee you that if we didn't have as good a skilled workforce doing this consultation, we would never be as successful as I think we've been.

So what services do we provide? The main service we provide is a telephonic child psychiatry consultation to any pediatric PCP within three minutes Monday thru Friday. And we really keep to that. In the last quarter, 93% of our consultations occurred within 30 minutes. So that the PCP can often get the, do the consultation while the family's in the office.

Now they don't have to. They can call up and just say, you know, have someone call me back at lunch time when I have more time to talk. But oftentimes, most of the time, they call right away.

We also can do a face to face consultation. And 18% of the youth served generally receive that and that consultation is not to help with the real complex kids, it's to help the PCP manage those kids in their office or occasionally, if we're not quite sure which direction to go.

[30:45]

We have care coordinators whose job is to hook families up with resources in the community, both child psychiatry or other forms of behavioral health therapy. And interestingly, we've been doing this for a while and I think Dr. Lu mentioned how referrals often don't end up being followed up and following through. We did a pilot study, and yes, we, even with us knowing that there was a...care coordinators keep a very close eye on availability at any place they're referring to and still 50% of our families didn't end up keeping the referral. So now we've built in a follow-up process to call the family four to six weeks after the care coordination event and make sure that the family not only has followed through, but intends to keep with the referral.

And if it's a problem with the referral itself, we'll try and correct that. And if there's a problem with the family deciding not to keep their referral, we feed that back to the PCP. We also can provide transitional support when the use youths are waiting for behavioral health services, but often that does not need to happen very often because we generally get kids in. And then we provide PCP education through newsletters, practice meetings, brown bag lunches, regional continuing medical education and a website. And we have a new website that just rolled out last week and I urge you all to look at MCPAP.org.

[32:41]

Here's sort of a pictorial presentation of that process where you have, on the left, a puzzled PCP who can call up and talk to either the child psychiatrist or the child therapist, usually a social worker, or the care coordinator. And they have the option of either answering the question right then and there, suggesting a face to face consultation and not only answering the question, but maybe suggesting some care coordination if the PCP needs help finding a resource.

Okay. I want to turn it over to Vinny Biggs. As you heard, the pediatrician at the Holy Oak Health Center to really talk about how this works on the ground. Vinny?

DR. VINCENT BIGGS: Thanks John. And thank you all for attending the call. As mentioned, I'm a general pediatrician. I've been practicing for about 20 years and most of that time has been with a community health center. And I've been working with MCPAP and using it as consultation since its inception in 2004.

So how is MCPAP useful to me? Right. I think it's useful in three ways. So clinical consultation. So if I have questions around assessment, diagnosis, treatment, side effects, then I can speak to somebody about that. Actually having somebody obtain a clinical visit, so that's another way that it's useful to me so I can get them to see one of the MCPAP providers. And then also to locate resources. So if I have a patient that needs a therapist, needs a medication prescribed or they can assist in that. So clinical consultation, a visit with the provider, or locating resources is how I use them.

How does the process work for me? It's really pretty simple and I think that's the beauty in this project. So I call 794-3342. Typically, our own [inaudible – 34:58] on the other end picks up the phone. Says hello. You know. It's Vinny Biggs, again. And, you know, it's "Hi, how are you?" back and forth and let me get your call back number. I typically give them my cell phone to give easier access to that I can get the call when they make it. And it's really that easy to kind of initiate the process.

I feel like the ability to access the providers at MCPAP is so important because I think, certainly, in my practice, and I bet on the practice of most of the people on this call, you know, the understanding that the majority of the patients that I see have some behavioral health needs. And even though sites have behavioral health integration, which ours does as well, and an excellent one at that, I think it's the real time psychiatric provider consultation that is often needed from the general pediatrician or primary care perspective. You know. In behavioral health integration, you don't have that psychiatrist available to you every moment of every day and you can access that through MCPAP.

[36:13]

So I used MCPAP for kind of common behavioral health diagnoses. Right. ADHD, depression, anxiety, the assessment and treatment. I may use it for a single visit consultation depending on the complexity. Again, may use it for finding a therapist or a prescriber. And I may use it for these very complex patients that show up to try to get them access to a higher level of care.

Probably what I use it most for is medication management. Kind of have that in the moment, in, you know, immediate, while the patient's there a lot of times, you know, kind of conversation about medication management. And for those highly complicated patients that are disconnected from psychiatric care. And I think everybody on this call can understand that.

So, from the primary care perspective, it's your hardest patient, you know. They come through the door. They've missed a few appointments with their behavioral health provider, and they've been discharged from care. So they show up at your door. The prescriber at the agency leaves. They show up at your door. The therapist leaves and the family really want to kind of think about seeing somebody else, so they show up at your door. That happens all the time. To have the ability to pick up the phone and have a conversation for me is very helpful in managing these patients.

So I've placed a call and now I get the call back. So this is how it typically goes. So I get a call back from Barry, that would be Dr. Servet, to you all, or Jack. That would be Dr. Fanton to you all. And, you know, these are people I know. Even if I've never met them in person, I've spoken to them many times on the phone and we have a relationship. You know, it's "Hey, Vinny, how are you?" You know, "What do you have for me today?" They know my skill set, you know, what I'm capable of, and I know them. So it makes a conversation very efficient.

[38:32]

So let me give you a couple of examples of how it might go in my day. So Barry picks up the phone and I say, "Hey, Barry, I've got this 10-year old that's got ADHD symptoms. Rating scales are positive for ADHD, but he's got significant mood related symptoms as well. He's been in therapy. Really hasn't had much benefit from that and I'm not really sure where to go with medications. So what...can you kind of give me some guidance?"

And so he may say, "Well, here's what I would," you know, "I might think about these medications or might go in this direction." Or I might say, "You know, I'm really not comfortable with managing this person. Do you think you could see them for a single visit, do an assessment, get some meds started, and then send them back to me?" So that may be how it goes in that conversation. Either way, I have kind of what I need; kind of in that moment I have something to do with the family and we can kind of move to the next step.

Other patients that...another example of a patient that's pretty common, so this would be, you know, "Jack, I have this 14-year old that's got a diagnosis of PTSD, Explosive Behavior Disorder, ADHD, developmental delay, sleep issues. Comes to me, you know, because they've lost their psychiatric prescriber. They're on an anti-psychotic. They're on a long acting methyl phenidate. They're on another mood stabilizer. They're on Clonidine for sleep. You know, this is way over my head, right. So this is a combination of meds I don't want to be primarily managing. So we have that conversation. So that conversation may go, "Okay," you know, "that combination of medicines is okay. I think you would be okay prescribing those for a period of time until that patient gets connected to a psychiatric prescriber. And I agree that you shouldn't be managing that person." Or it may be, "Yeah, absolutely." You know, "Send them to us. We will kind of take a look at the meds, we'll take a look at the patient, we'll make sure that we feel comfortable with the combination and then we will connect them to a prescriber," or it may be just, "Fine, we'll connect them to a prescriber. Agree, this is a higher level of care than you should be providing." So all of those are very supportive to me. And that is a patient that shows up at my door a lot more frequently than you might expect.

[41:20]

So that, for me, is a general overview of how MCPAP works for me in the primary care setting. I feel like it's a tremendous resource to the community, and I think we will have some questions if you have any questions for me as this presentation moves forward. But that's all I had for today.

DR. JOHN STRAUS: Thank you, Vinny, that was very helpful. And I hope gives all the listeners a real feeling for how we can meet whatever problem the PCP calls with. We meet where they're at.

And as we've developed the program over the last 10 years, we really thought about how we can keep PCPs engaged. When we started, there were a whole lot of folks who didn't want to do very much. Right now we pretty much have everybody willing to, they certainly are screening 80% and they're beginning, becoming much more engaged in the process. And we think some of the reasons for that is that we've been helpful. We try to be helpful on every call, just as many said. We really take a mentoring/coaching approach with each individual. And there's that personal

localized relationship that Vinny talked about. Each team relates to about 80 practices and they get to know those practices very well.

We provide the care coordination because as Vinny said, some of the, some kids really should not be managed in primary care and we can provide some of that bridging so, at least the prescription is refilled safely while they wait for a true child psychiatry visit.

[43:13]

And we provide the CME and the outreach to practices. We've been very careful that there are no system required tasks for PCPs. So just as Vinny said, you can just call up and say whatever, ask whatever question you want. You don't have to fill out a form or send in a history or spend any bureaucratic time getting an answer to the problem that you may be having.

Okay. I'm going to spend a few minutes just giving some of the data that Vinny sort of gave you qualitative information about. And then we'll open it up to questions. So, in Massachusetts, we cover 443 practices with over 2,800 individual clinicians. We believe we're covering the PCPs for more than 95% of the 1.5 million Massachusetts youth. So, really, it's a universal program.

We, in fiscal year 2014, we had over 22,000 encounters which included 6,600 calls from PCPs, 2,600 in person visits, almost 7,000 care coordination encounters, and we served over 6,000 unique youth.

One of our goals, as you may remember I talked about, was to relieve the burden on child psychiatrists. So we're very happy that prescriber level care remains at the PCP 70% of the time.

In terms of funding, we've been funded by a line item in the state budget and so it's been totally out of state funds. But interesting, over the last 10 years, the average is that, over all our calls, 60% of the kids are insured commercially. And they have not been contributing to the cost of the program. Beginning, the legislation this year has mandated that they do so. And they'll be covering their portion of the appropriation of the state appropriation for the program.

[45:52]

MCPAP costs about \$3.3 million, which works out to about \$2.20 per child per year. So it's a pretty good deal for all concerned.

As Vinny said, when you look at the slide of the disorders we get calls about, the main three are depression, anxiety, and ADHD down at the bottom. And then a smattering of everything else.

Medications; the main medications are the SSRIs and the stimulants. But if you look at the bottom bar, we're very pleased that 50% of our calls last year did not involve a recommendation for medication. So we're getting a lot of calls where the PCP wants to know, well, what kind of therapy should they get? Who is best to take care of this issue? And/or do they even need a referral?

So the types of questions that come in, sometimes it's just help. Other times it's diagnostic questions, treatment planning, resource, trying to find resources, a second opinion, screening support. Actually, when we...when the state, in 2009 implemented universal screening, we hired four part-time screening tool consultants to work with the practices to help them develop, choose the tools and implement them.

We get medication questions around selection or side effects. Management; the interim management is around folks that were bridging treatment until they get into specialty care. And we have therapy questions.

[47:56]

If you look at outcomes, we do an annual survey and these slide shows that from the baseline, jumps up. And the top line is that consultations are useful, which we would hope.

The next slide, the next line that, the first dashed line is, looks at is the PCP able to receive child psychiatry consult in a timely manner. And we talked about 90%, 93% within 30 minutes.

And then the third line is probably the most important is that they're now, usually able to meet the needs of children with psychiatric problems. It's not perfect, but it's a lot better than it was. And the bottom line is adequate access to child psychiatry for my patients. And we haven't increased the number of child psychiatrist in the state at all. And even with that, the PCPs feel that there's better access, both because of better care coordination because they need to use those folks less often.

Okay. Sarah, well, let's open it up to questions.

SARAH STEVERMAN: Thank you very much Dr. Straus and Dr. Biggs for your presentation. We now have a little bit of time to answer any questions that you may have. You can type them into the box on your screen, the question box on your screen, and we will get them here. We are going to have a few minutes of questions, and then we will have more time at the conclusion. So, if we don't get to your question, stand by. We will hopefully get to it later.

We haven't had...several quick questions about the use of tele-psychiatry or tele-health. Have you considered including, in the model, instead of just a couple of patients, including some sort of video conferencing that could bring a [inaudible – 50:03] provider in to the room with the patient and the pediatrician, or the pediatric provider?

DR. JOHN STRAUS: Thank you Sarah. Excellent question. I think that depends on your, the geography. As I pointed out, about 18% of the time we're doing a face-to-face consultation and with the geography and our distribution of teams, in general, families don't mind driving to where the consultation will happen.

Keep in mind, if they do conferencing, it really will only help the family. It doesn't save the psychiatrist any time. So the...but even in Massachusetts, we are now discovering some areas

which there may be an over...the drive may be hindering some families from being willing to get a consultation. So we're going to be implementing tele-psychiatry.

However, certainly programs across the country use tele-psychiatry a lot and it's very successful. I know the program in Seattle that covers Alaska will do a video conference 2000 miles away at the end of the illusion. So it's definitely a component that for many areas it's needed.

[51:31]

SARAH STEVERMAN: Great. Thank you. And this question, I think, will be great if both of you responded. When you send a patient, Dr. Biggs, you spoke about sending a patient to the consulting psychiatrist when they needed further help. What percentages of the time do they make it to that next appointment? And then what happens after that? Do you see them again? Do they make their way back into the primary care setting for post follow-up? Or does it depend on, you know, kind of how their treatment course goes? How do you follow-up after you send a patient to the consulting psychiatrist?

DR. VINCENT BIGGS: Sure, I can do that. So I think, you know, typically, the families are, you know, when we're accessing for a visit, which is different than just accessing MCPAP for questions. Usually, the families are in crisis, right, so they really are in need or very interested in this appointment. So it's usually prompted by the family as much as by me. So, we don't track a percentage of who shows up, but, you know, the information gets given to Arland, so that care coordinator from MCPAP's end communicates directly with the family. So it takes me out of the loop and not kind of chasing people around, which is very nice. And then they set up the appointment. So my sense is that the follow-through is pretty good with those appointments.

So, and then, you know, they are my patients, right, so they will come back to see me. So, typically, we will try to close that loop and have a scheduled follow-up appointment after their MCPAP appointment so we can discuss those recommendations. So we continue to make sure that the follow-through is happening.

[53:39]

DR. JOHN STRAUS: Just that's helpful Vinny. Just to add that we're very careful that anything we do on behalf of the PCP for a family that we report that back to the PCP so they're aware of what's going on. Including many times the consultant will actually call the PCP back and discuss the recommendation with the PCP.

SARAH STEVERMAN: This may be a bit of a technical question, but several people are wondering about liability or who is kind of in charge of the patient when there's a PCP and a consulting psychiatrist or consulting behavioral health provider? Are there any legal issues or liability issues that you've had to think through as you developed the model?

DR. JOHN STRAUS: Yes. Good question. In order to have lia - , they did separating the two components. One is the telephone consult, and the other is the face-to-face.

When we're doing a telephone consult, we're not establishing a doctor/patient relationship therefore at this point in time there doesn't seem to be any liability. And this has been...actually, we didn't put this in...there are some references in. Maybe we can add that in. We didn't have it in here, but we've actually done a study and we have a paper that has addressed this issue. But the main thing is to make sure that there's not a doctor/patient relationship, which talking to the PCP does not establish.

[55:30]

On the other hand, when we do a face-to-face, then that's a full consultation and those patients are registered and do consent forms and they're treated as would be anybody who's having a face-to-face visit.

SARAH STEVERMAN: Great. Thank you. Maybe one last question here; one for each of you, Dr. Straus and Dr. Biggs and then we'll move on to the next one of our presentations. This is a question about how you engaged the pediatricians, the PCPs into the program. How did you get people on board and then to you, Dr. Biggs, how did you learn about the program and how did you become involved and start utilizing it to the extent that you do now?

DR. STRAUS: Let me start out with what we did. As the program, then Vinny can talk about what happened and how he learned about it or Holy Oak.

We had a very deliberate enrollment process where each team went out and enrolled practices one by one, usually going to their practice meeting talking to them about behavioral health, sometimes even giving them a little bit of didactic session. And I explained how the program works. And this is really key, because again, it's establishing that personal relationship so that they know who they're talking to. And it took us pretty close to two years to enroll all the practices across the state. And we're still finding a few practices that need to be enrolled or a few practices that now want to. But that doesn't happen very often at this point.

And Vinny, how did you hear about it?

[57:33]

DR. VINCENT BIGGS: Since it's been over 10 years, I'm not sure that I know the answer to that. I do know that there was, I think, a concerted effort from MCPAP providers to reach out and to begin to form relationships with primary care providers. And as I mentioned in my segment, I think the relationship is really key and it adds to the trust piece and it adds to the efficiency of the consultation.

SARAH STEVERMAN: Great. Thank you. Thank you for your questions. If you have any others, as Dr. Straus continues along with the presentation, please feel free to include them and write in with those questions.

I'm going to turn it back over to Dr. Straus and he's going to discuss how the consultation model has caught in other parts of the country and how you can consider implementing that in your region or your state.

DR. STRAUS: Okay. Thank you Sarah. So here on this slide, you'll see states that are part of the national network of Child Psychiatry Access Programs. There are 32 of them. And I should have had Hawaii on here because Hawaii joined last week when I actually was talking to them. And I think there are some of them on the phone today. So that makes us up to 33.

And if you look at the force, there are six states in red. The four that are not bolded are trying to form a program. And the two that are bolded are starting this year. And actually, D. C. is starting, I think, in the next couple of weeks. So we're very excited about that. And we've, Connecticut, Wisconsin, New Jersey and D. C. legislatures have all, or a council in D. C., have all passed bills around consultation programs in the last year.

[59:52]

I should point out that not all the states are...the lists on the slide have statewide programs. Some are just in a particular region of the state. And we think that about the PCPs or about a third of all the children in the country now have telephonic access to a child psychiatry consult. So that's a pretty amazing change over 10 years.

As I said, we formed an organization, a national network of child psychiatry access programs. You can go to our website at MCPAP.org and you can look up what's happening in your state and who you might contact. If you had got a program or wanted to form a program, you're welcome to do join the organization. You can participate in national conference calls. In fact, we have one tonight. And you also will receive e-mails from time to time. We're now officially a 501c3 nonprofit. And we're working with the American Academy of Child and Adolescent Psychiatrist to expand our website to be a resource center for programs collaborating with PCPs around child psychiatry.

I want to spend a few minutes talking about some of the variations that are occurring across the country as folks think about how to provide help to PCPs.

So some programs include a didactic component that they try and have all PCPs participate in, particularly New York, Minnesota and Colorado are using the Reach Institute, run by Peter Jensen, to provide a set of learning experiences and ongoing learning collaborative. And yes, some states or programs include a learning collaborative, which means that folks talk periodically with the child psychiatrist.

[1:02:23]

Some states or programs, or I should say some programs are promoting standard algorithms for their program and of particular note, and you'll see reference of this at the end, the program out of Seattle, Washington, which covers Wyoming and Alaska as well, has a very nice set of learning materials. If you go on their website, it's known as the PAL program.

Some programs have a pre-consult form in which they expect the PCP to give them some history and to pose what the question is. And as I mentioned before, we don't do that because we thought that would be a barrier. But there are some...one real advantage to that is you are sure that you PCP has asked some of the questions that you might not have time on a telephone call to make sure they did, such as is there substance use, are there substance use issues, history of trauma, that kind of thing; that really needs to be done whenever you're confronting a behavioral health issue.

Some programs rotate a child psychiatrist through the practices and have the psychiatrist available at that time. And this is a most notably the North Carolina program that's done this. And then, again, the Washington program has added, because of the concern over psychotropic medication use, particularly with kids in state custody, they have added a component to provide review and prior approval to outlier psychotropic medication prescribing. And this also becomes a source of funding.

[1:04:32]

Funding sources vary across the programs from state legislature, like in Massachusetts; some programs are funded purely from the Medicaid side, from the Medicaid program. So even those programs, in general, allow a call to come in on any kid because PCPs are very frustrated if they've got a problem in their office and they know that they could learn what to do with this kid even though they don't have Medicaid. It'll help a Medicaid kid who comes in tomorrow.

I believe Massachusetts is the first state to actually provide a commercial surcharge and make sure that the commercial pubs, the private payers, are paying their share of the program. And then some programs are using foundation and grant funding.

I'd like to note that several, over the last 10 years, several states have tried a fee-for-service funding mechanism, but it generally doesn't work because the fee-for-service would pay for, you know, it would allow the child psychiatrist to bill, but or the PCP to bill, but it doesn't pay for all the time waiting for the phone to ring. So, we really want that availability and that's what the PCPs need. And just paying for the telephone call itself would, is problematic, plus it has medical/legal issues as someone raised. Because if you do do billing, then you do have a...that does generate a patient. Probably most people would consider that generating a doctor/patient relationship that would have medical/legal implications.

[1:06:17]

And also the volume of calls really vary. We need a stable source of funding. So most programs are based on a cost plus kind of contracting basis.

Some of you may be wondering how to get this going in your own area. And let me show you just how we did it in Massachusetts. And I know several other states have gone a similar way. We formed, back in 2002, a child mental health task force. This is usually led by the state chapter of the American Academy of Pediatrics representing pediatricians because they're

the...PCPs probably have the most to gain from this. But it's important to have all stakeholders, the kind of stakeholders that we would recommend would be child and adolescent psychiatrists, family advocates, various providers from PCPs to medical centers to child psychiatry programs, to psychiatrists, health plans, legislators, now folks from your state health service administration, mostly Medicaid, and representatives from state health and social service agencies, particularly your Department of Mental Health or however that is called in your area.

Okay. Moving ahead, what are some of our lessons learned? Well, I think one of our lessons is MCPAP, a program like MCPAP can be a platform to build system improvements. We talked about how that's been helpful getting screening applied universally. As part of that Rosie D remedy, the state was required, Medicaid was required to provide additional behavioral health services, home-based behavioral health services including system of care wrap around services and local crisis, and in-home therapy, and we've been able to help the PCPs understand those services – when to use them, how to refer to them. And so we've promoted the remedy.

[1:08:49]

Current programs that we're working on? Most proud of we're calling MCPAP for Moms. We want all pediatricians to screen for post-partum depression. And if you screen, you want to be able to make sure that a mom who is nursing can go to a provider who's comfortable with any medications that that person may need. And so MCPAP for Moms provides a 1-800 number that any adult provider treating a mom who's pregnant or post-partum can call and get on the phone a perinatal psychiatrist who is an expert in this period of time.

And interesting, 2/3 of post folks who get post-partum depression are actually identifiable before delivery. And we, so we're training all the obstetricians across the state to screen and be primary treaters of depression during the pregnancy period.

We're implementing, improving the screening and management of teen substance use. Some of you may be familiar with the craft, which has sort of been the tool most people use to screen teens. There's a new tool coming out known as S2BI, Screening to Brief Intervention, developed by Sharon Levy of the Boston General Hospital. And we'll be teaching our practices across the state to use that new, much easier tool.

[1:10:30]

We've surveyed practices for treating kids under 6 and identified that pediatricians were most in need of parent training for disruptive behavior. And we've been training co-located PCP clinicians in an evidence-based practice known as triple P.

And I think I talked already about structuring our follow-up process for care coordination activities. And we'll be looking to how to improve any system barriers we find in that process.

Okay, finally, a few lessons learned. The relationships between the PCP and the regional staff, as you heard from Vinny, and the PCPs are critical for success. The staff must meet PCPs where they are and we really, real personal basis relationship between the PCP and the consultant.

We cite the regional hubs and academic, medical centers because they provide child psychiatrists who are skilled in teaching and mentoring.

Over time, PCPs who regularly use MCPAP has increasingly sophisticated questions. And not only that, some pediatricians who were totally didn't want to do a behavioral health are now engaged.

We're often asked, well, how do we know that kids are better and what's the return on investment? What is the cost worth it? Well, the problem is, we are improving access and no one really has, that I know of, that has a good way of measuring the value of access. But we do expect better access and screening and better trained PCPs who improve outcome and lower long term costs. But that's going to be hard to prove with a brief intervention such as we do with MCPAP.

[1:12:32]

Two more lessons learned. Integration of clinician into PCP practices. Change in the nature and cause of PCP, but does not remove the need for telephonic consultation. Just as Vinny has pointed out, they now have a co-located clinician, but he still has times when he needs to talk to a psychiatrist. And however, we are also changing our consultation to be very much available to those co-located clinicians.

We think that with the formation of accountable care organizations, ACOs, that that may change some of the relationships between hubs and the children, but very few ACOs are going to be as large as to cover the 250,000 children that one FTE of child psychiatrists in MCPAP can do. And they may increasingly co-locate a child psychiatrist in some practices, but they're going to be busy seeing children with complex needs and they're not going to have the telephone availability that's needed.

We didn't start out with PCPs having structured standardized algorithms for our recommendations. But as PCPs are more accepting of their role in managing behavioral health, we think that that's now needed, and we're working with the Boston Children's Hospital [inaudible – 1:14:08] practices to have standardized protocols and processes.

[1:14:19]

A few references and some resources and we're open to questions.

SARAH STEVERMAN: Great. Thank you so much Dr. Straus. You are reminded that you...there's still time to ask questions, so please enter those in to the question box and we'll try to get to as many as we can. You have about 14 minutes left to ask questions.

I wanted to ask, start off with a question about substance use. We talked mostly about the...we talked mostly about how mental health problems are emerging and identified by the PCPs and

then the consultation that they receive through the service. But I was wondering where the role of identifying substance use issues comes in and then how that is part of the model?

DR. STRAUS: Well, that's why I think I mentioned I've been talking about behavioral health because, including substance use is very much part of the model. It very much mirrors SAMHSA's interests as well. And we've been promoting folks to use the craft, but it's a little cumbersome and the new tool, the S2BI is going to be much easier to use. It's three simple questions. And we hope to get; we do certainly get substance use questions about kids with substance use problems, but we hope to get more when we have everyone screening.

We've been doing periodic surveys and we went from about 22%, I believe, of folks using a standardized screen to 47% in the fall of this year. And we hope to move that up to over 90% by a year from now after we've done the training with the new tool. So it's very important with substance use that you just don't ask an open-ended question, but did you use a structured set of questions. And we're trying to implement that in all practices.

The good news is that we've also gone from 50% or so of PCPs saying they asked a question about substance use to at least over 90%, I think it's 93% of folks. At least asking a question. But they're not all...only 47% are using a standardized tool.

Vinny, are you...what are you using? Are you using anything at Holy Oak?

[1:17:08]

DR. VINCENT BIGGS: We are not using a standardized substance abuse tool currently. But I thought I would answer a separate question. There was a question about instruments that we're using.

So, in our practice, we currently use the Pediatric Symptom Checklist, so PSC, and the PSC-Y, for youth. We're also, for ADHD, typically use Vanderbilt rating scales. And then for depression screening, we use PHQ9 and many of us will follow that up with a Columbia Depression Scale. And those are all...all of those tools are, they're approved through Massachusetts. You know, again, as part of this Rosie D legislation, they put out a list of what would be approved screening tools. So we pretty much had to pull from that list and I don't know if, John, if you have any other thoughts about screening tools.

DR. JOHN STRAUS: No, I think most people using the PSC, the PSC-Y for older kids and for younger kids using either the PEDS or there's a new tool called the SWYC, SWYC, that Allen Parrin, at Tufts, has developed as well as an autism screening tool, the MCHAT.

DR. VINCENT BIGGS: Right.

SARAH STEVERMAN: Great. Thank you. We did have several questions about what screening tools you have been using.

For, you know, we know that some children's behavioral health and adult behavioral health issues emerged from, or at least closely related to social determinants of things like housing and income and violence and things like that. Do you, beyond diagnosis, medication, consultation, treatment recommendations, does this service allow for any addressing of those social determinants whether that's getting housing or helping a family with income, you know, applying for income or food stamps? That sort of thing, to help them to kind of improve their situation, which is obviously related to their health and their mental health.

[1:19:50]

DR. JOHN STRAUS: Good question. We don't directly provide those services, but I think what we do is make sure that the PCP is thinking about that as a cause for why someone, why a child may be having behavioral difficulties, particularly, that aren't responding to, let's say, a kid with ADHD who's not responding to medication. Well, what else is going on in the family? And particularly if you're, if we're...and then, in terms of how that practice would get help? You hope you're a community health center that has some of those resources. And obviously, that's difficult in some of the private group practices, but it's very much, and I mentioned trauma. We know how pervasive trauma is and we want to make sure that folks are asking questions about that.

But we don't directly...we have resource lists for some of those, certainly, but most practices do know what kind of resources they can find for helping families in those situations.

SARAH STEVERMAN: Great. Question for the participants who are in rural settings. How do you handle – and this is a question not for what's going on in Massachusetts because I think access is pretty, child psychiatrists and specialists are more accessible – but in rural settings, do you know how those consulting psychiatrists who are remote to the patients, how do they handle getting treatment when there isn't a child psychiatrist who they can actually refer them to?

DR. JOHN STRAUS: Well, I think we talked a little bit about, earlier about tele-psychiatry. That certainly helps. But also, I think, the experience is that when you're in a rural area, the PCP really doesn't have access or the family doesn't have access to specialized resources. The PCP probably does some; get some advice to do some things that might not happen in a more urban setting where they could get to a specialist. So it sort of changes the dynamic between what happens, what we would expect a PCP to be able to do.

And PCPs, in general, if they're in a very rural area are much more, I think, and tend to be more open to realizing that they're the only game in town and they may have to step up what they do. But I think tele-psychiatry is really going to change that. And as I used the example of the Seattle program that covers all of Alaska, and they're doing tele-psychiatry many many miles away.

SARAH STEVERMAN: You mentioned, I think that you mentioned, at the beginning, that you have the consultation services available during office hours. For those who are dealing with after hours or people who are in crisis, is there a model or have other states or regions thought about, or have you thought about in Massachusetts, some sort of afterhours or, you know, consulting psychiatrist who can be available, on-call after hours?

[1:23:40]

DR. JOHN STRAUS: Well, let me give you the Massachusetts...

SARAH STEVERMAN: Or is that not needed?

DR. JOHN STRAUS: Yeah, in Massachusetts, we have regional emergency service providers who provide crisis care after hours predominantly for Medicaid kids, but they will do it for others when...and, I think we're, we teach the PCPs to use the crisis services that are available. And really a telephone call is probably not going to, in our experience, is not going to be helpful. At that point, you have to decide whether or not the child really needs services. So being able to call the crisis line...but, I think, that will vary across the country depending upon what kinds of crisis services are available.

SARAH STEVERMAN: Great. Dr. Biggs, we had a question about how you, as a provider, manage your time. So do you feel like you have enough time during appointments to address the presenting problem as well as the behavioral health screening? And then if the behavioral health screening identifies an issue, do you feel like you have time to then make that call and get some further assistance with that or do you feel crunched during your appointments? How do you manage that from a time management perspective?

[1:25:19]

DR. VINCENT BIGGS: I would say that you constantly feel crunched for time. I mean I think that is the reality of primary care in most people's lives. You know, I think it depends on what happens. You know, they're, you know, if it's somebody who, you know, that has, you know, they do a PSC-Y and there are some areas of concern and, but everybody seems stable and interested in dealing with it, then, you know, then we schedule another appointment and we come back. Maybe I give them some Vanderbilts to take with them. Or if it's something that looks a little more concerning, maybe depression is the concern; I may give them a PHQ9 and a Columbia Depression scale. And then I'll step out of the room and go see the next patient and then I'll come back and check in with them and take a look at that and have a conversation.

So I think, you know, there is some flexibility and sometimes the call to MCPAP is when the patient is already gone. You know, you have access to the patient by phone. And then probably that's more often than not. And then sometimes it's in real time depending on how urgent the issue is.

So I think it really varies a little bit with the complaint, the level of concern, the complexity, but I weave it in to the day as best that I can and it's really only, I think, disruptive for those, what I think are very complex kids who pop up on multiple psychiatric meds that there is true discomfort on my part so there has to be some conversation in real time before they...we make a plan. I think that's how I approach it.

[1:27:20]

SARAH STEVERMAN: Great.

DR. JOHN STRAUS: Sarah, we've heard from many PCPs such as Vinny is talking, describing where you have to realize if you didn't have this service, what it would be like. Those problems would still be there, but you'd have nothing to do and you'd be running around pulling out your hair trying to get a psychiatrist on the phone, which is just about impossible. So, to get a community psychiatrist on the phone isn't going to happen. So it's not as much, the world is never going to be perfect from a primary care providers point of view in terms of time. But it's a lot easier when you can pick up the phone and get help.

DR. VINCENT BIGGS: And I would just reiterate that. I think, you know, I've practiced in the pre-MCPAP, pre-behavioral health integration setting and it's very hard and that is, I would agree. It's much more disruptive to your day than if you have access to somebody. And, you know, there's nothing worse than having somebody you're worried about giving them a list of people that they could call and sending them out the door. Because that's not really taking care of the patient.

SARAH STEVERMAN: We are going to leave it there. Thank you so much to both of you. I think that that's the lesson of this, that your jobs are hard on both sides, on the primary care side and on the behavioral health side. And this is a model that at least tries to alleviate some of that difficulty and improve access and improve care for patients.

So thank you both. I just wanted to remind everyone that the slides are up online and there are some resources that we included including the website for MCPAP and the National Association, the National Network, and then also here are some CHS slides that, or resources, I'm sorry, on behavioral health integration for children, specifically.

You can get in touch with Dr. Straus here if you want to learn more about the program and the service in Massachusetts or the National Network and get hooked up with that. Please reach out to him. As always, there are more resources on the National Council's website.

We really appreciate you all being on today and we hope that you will access more of CHS good information online.

Once again, the recording and transcription of the webinar will be available on the Center for Integrated Health Solutions website. And once you exit the webinar, you're going to be asked to take a short survey. And if you could, please offer your feedback on the webinar today. We would really appreciate it. We need your input to inform the development of future CHS webinars and resources.

I would really like to extend a big thank you to our presenters, Dr. John Straus and Dr. Vinny Biggs for joining us on today's webinar. Your information, insight, and experiences have been so useful to us. And thank you all for participating in our webinar. Please try to stay tuned for more CHS webinars in the future. There are more coming down the line.

Thank you so much and have a great afternoon.

**END TRANSCRIPT**