CONNECTing Children and Families to Care

FINAL REPORT

Assessment of the System of Mental Health Care for Children: a Focus on Pediatric Primary Care

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Hezekiah Beardsley Connecticut Chapter

FOREWORD

The Connecticut Chapter of the American Academy of Pediatrics is pleased to collaborate on the Assessment of the System of Mental Health Care for Children: a Focus on Pediatric Primary Care. With ACCESS Mental Health and the Emergency Mobile Psychiatric Services system there has been growth in children's behavioral health services and care coordination since the tragic events at Sandy Hook, but as the report illustrates, pediatricians and mental health providers still see significant gaps.

This report lays out recommendations to improve mental health care access, coordination of care, and outcomes for children and teens by examining issues from the perspective of the pediatric medical home. We agree with the conclusions regarding support for pediatric practices and robust training and education as one important component in improving the complex system of mental health care for children.

It is important to remain aware that pediatric mental health issues frequently have educational consequences, and the role of schools will be important in creating a supportive system. A disruption to a child's education is often one of the major morbidities of mental health problems. Schools are frequently involved in assessment and treatment, either through educational accommodations, the school psychologist or nurse, or as part of a school based health center.

This report largely addresses the needs of children in crisis or with a mental health diagnosis. Equal emphasis must be made on the issues of infant mental health, with strong support for screening and services for identified problems. There must be an equal effort to identify and help at risk children, as there is to help children in crisis if we hope to make any progress in solving this complex problem.

Another area where there is a lack of services for youth in Connecticut is in substance abuse services. The need is much greater than the available age appropriate services.

Finally, in any plan for children with special health care needs, including mental health, the issue of transition to adult services must be addressed.

This report approaches mental health care from the medical perspective. We recognize that other perspectives will be needed to develop a system that is responsive and effective. It is important as we go forward to hear the voices of parents, children and teens along with the providers of care.

We look forward to taking concrete steps to strengthen and improve mental health care for all children in Connecticut.

I. Executive Summary

This report explores the factors that promote the integration of mental health care for children within the context of pediatric primary care. Pediatricians are but one piece of a complex system of mental health care. As such, the specific findings and recommendations from this work are analyzed against the strategies and goals established within the broader Children's Behavioral Health Plan.

A crucial step to improving mental health care for children is in understanding the pediatric primary care perspective and experience around the treatment and management of children's mental. In late Fall of 2016, a 48-item survey on children's mental health was sent to a sample of 132 pediatricians in the State of Connecticut. Sixty-four percent (64%) of pediatricians who were sent the survey completed it. Additionally, six focus groups from around the state comprised of pediatric primary care staff and community mental health staff engaged in a process known as system support mapping to determine priority areas for action to improve children's mental health care.

Survey results reveal that 100% of pediatricians surveyed experienced having a patient in mental health crisis in the last year. And while most pediatricians felt at least somewhat comfortable in managing and treating mental health concerns, 72% reported not feeling adequately trained. The vast majority of pediatricians reported only limited use of Emergency Mobile Psychiatric Services (EMPS), but about half reported frequent use of ACCESS Mental Health. Pediatricians also reported gaps in collaboration with schools.

These results demonstrate the need for improvements and additional supports for pediatric primary care within the current system, particularly steps that will be relevant and feasible from the perspective of pediatricians. The focus groups asked pediatricians and other participants to identify those action steps which will improve the integration of mental health care within pediatric primary care. These action steps were grouped into eight priority themes: Capacity/Access; Communication; Information; Insurance/Cost; Training and Education; Techniques/Technologies; Management; and, Parents/Families.

II. Project Description

The purpose of this effort is to explore the factors that promote the integration of services, agencies, and sectors within the mental health care system for children within the context of pediatric primary care. This exploration will inform the process of reform for children's mental health by describing the factors impacting pediatrician adherence to best practice recommendations, creating visualizations of the system and identifying opportunities for action towards a truly integrated system of children's mental health care. This report uses survey and focus group data to describe the variability in mental health practice by primary care pediatrician by: assessing pediatrician knowledge, skills, and attitudes; identifying the extent of connectedness to mental health professionals; and, understanding the impact of pediatric practice characteristics on the provision of care.

Lack of access to early mental health care for children has contributed to a mental health crisis. More than 156,000 children in Connecticut have unmet mental health needs (CT-DCF, 2014). Despite professional mandates, training and outreach, and focused mental health services being available to pediatric primary care providers (PPCPs), there has been slow progress within pediatric practice to develop an integrated approach to children's mental health care (Hooper, 2012). And, far too many children in mental health crisis end up in the holding place of last resort, a pediatric emergency department. Each year, approximately 149,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at Emergency Departments across the United States (CDC, 2015). In fact, local reports reveal that at times half of the beds at one Connecticut pediatric emergency department are taken up by children with mental health-related issues (Dworkin, 2012; Chedekel, 2014). Connecticut is not alone. Nationally, pediatric mental health emergency department visits have increased from an estimated 491,000 in 2001 to 619,000 in 2010 (Rogers, et al., 2017; Pittsenbarger, 2014). This increase reflects a significant resource burden in our nation's and our state's health care system.

When parents first express concerns regarding behavioral problems with their children, it is often to a pediatrician (Godoy, 2013). This seems to stay true as concerns progress with approximately 45% of people who die by suicide having contact with a primary care provider like a pediatrician within one month of their death compared to 19% of people who have contact with mental health services (Andersen, 2000; Luoma, 2002). Barriers to seeking care include societal stigma around being identified as having a mental health issue (Corrigan, 2014). Young people experience significant mental health issues with some reports finding that up to 20% of children and adolescents are affected (Williams et. al., 2004). While a mere 2% of children with a diagnosable disorder ever see a mental health specialist, approximately 75% of these children are seen by a primary care provider (Williams et. al., 2004). Almost a quarter of all primary care visits involve a discussion of behavioral, emotional, or mental health concern (Cooper, 2006).

A better understanding of the system of care from a pediatric primary care perspective will lead to a focus on the actions needed to bring about integration between traditionally siloed systems

involved in the provision of mental health care to children and adolescents. The purpose of this project is to describe the factors impacting the provision of mental health care by primary care pediatricians and to identify opportunities for action towards a truly integrated system of the children's mental health care. This report details the results of efforts to gain the input of pediatricians on the system of care for children's behavioral and mental health through a survey of pediatricians and structured focus groups engaged in system support mapping (SSM). This report is incomplete without also considering the roles and responsibilities of schools, community mental health providers, and families and should be understood within this context.

III. Project Team

Steven C. Rogers, MD, MS-CTS, is an attending physician in the emergency department and is the Coordinator of Emergency Mental Health Services and co-leads the IPC's efforts to reduce youth suicide in the State of Connecticut with Mr. Borrup. Dr. Rogers is an Associate Professor at the University of Connecticut School of Medicine. Dr. Rogers has focused his work on improving care for this unique patient population including expanded support for suicidal patients and their families.

Kevin Borrup, JD, MPA, is the Associate Director of Connecticut Children's Injury Prevention Center (IPC). Mr. Borrup co-leads the IPC's efforts to reduce youth suicide in the State of Connecticut with Dr. Rogers. Mr. Borrup is an Assistant Professor in Pediatrics at the University of Connecticut School of Medicine. Mr. Borrup has served on the Connecticut Suicide Advisory Board (CT-SAB) for almost a decade. Mr. Borrup has focused his work on systems thinking in addressing children's health and safety issues.

Both Dr. Rogers and Mr. Borrup serve on the Network Analysis Workgroup, a subcommittee of the Children's Mental Health Advisory Board and the CONNECT System of Care initiative.

Connecticut Children's is a nationally recognized, 187-bed not-for-profit children's hospital serving as the primary pediatric teaching hospital for the University of Connecticut School of Medicine and the Frank H. Netter MD School of Medicine at Quinnipiac University, as well as a research partner of The Jackson Laboratory. Critical to our mission is a dedication to the health and well-being of the communities around us. Each year more than 60,000 children seek care at Connecticut Children's Emergency Department, of which 3,300 are children in mental health crisis.

Connecticut Children's has taken its commitment to promoting children's healthy development to a new level through the establishment of the **Office for Community Child Health (OCCH)**. Social determinants—the circumstances in which people live and work—powerfully affect health. Our programs tackle critical contemporary issues in children's day to day lives that can adversely affect their health and development including asthma, home hazards, domestic violence, teen driving safety, teen suicide prevention, and sexually transmitted diseases.

IV. Methods & Results

A. Pediatrician Survey

A 48-item survey was sent to a representative subset of pediatricians consisting of 133 primary care pediatricians across Connecticut. Sixty-four percent of pediatricians who were sent the survey completed it (n=84). Items on the survey included demographic data (e.g., age, gender, race, professional training, primary practice site), attitudes, knowledge, management and intervention practices, and barriers to working with children and youth reporting mental health concerns.

Demographics

The pediatricians surveyed were representative of pediatricians in Connecticut. The majority of pediatricians were between the ages of 41 and 60 and female (54%). Pediatricians surveyed primarily identified as White (82%), with Asian (11%) being the second largest self-identified group. Only 7% identified as being either Black, Hispanic, or Multi-racial.

Figure 3.

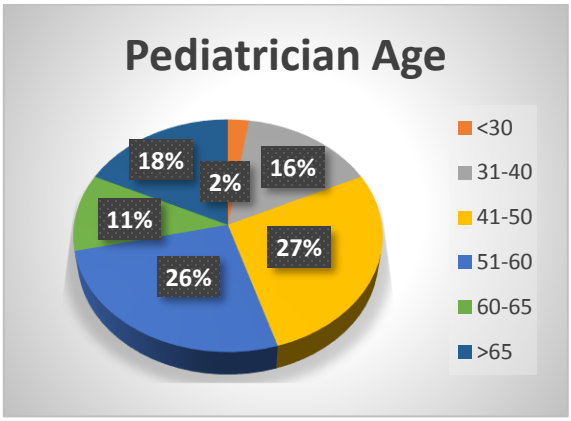
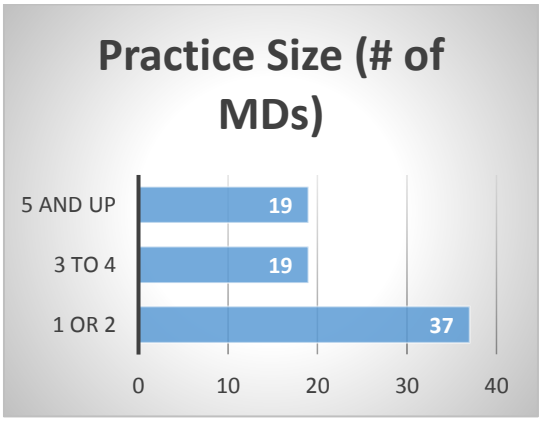


Figure 4.

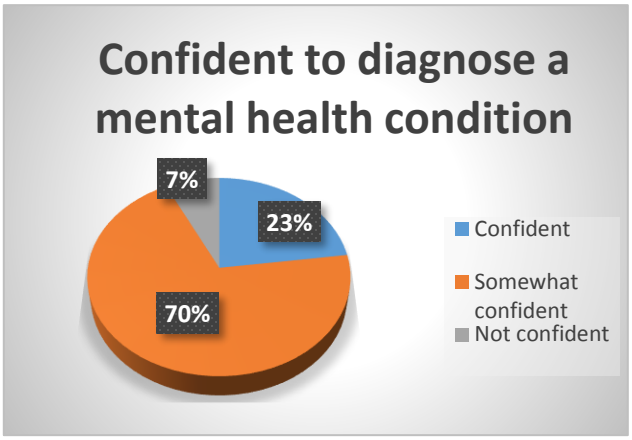


While most pediatricians were 41 to 60 years of age, the ages of those in-practice were pretty well spread across the age from a small number of under 30s to 18% of pediatricians in practice being over 65 years of age. Of the 75 pediatricians who provided information on the size of their practice, nearly half are in pediatric practice with just one or two pediatricians.

Confidence and Training

When asked whether they had a patient experience mental health crisis in the last year, 100% of pediatricians responded "yes." When asked about the level of confidence that they had in their ability to diagnose and treat mental health conditions, 23% were confident, 70% somewhat confident, and 7% were not confident. Those who responded to the statement "How confident are you in your ability to diagnose mental health conditions" with "somewhat confident" or "not confident" were coded as having low levels of confidence, while those who responded with "confident" were coded as having a high level of confidence. When asked about whether they felt they had adequate training to diagnose metal health conditions, 28% indicated "yes" while 72% answered "no."

Figure 5.



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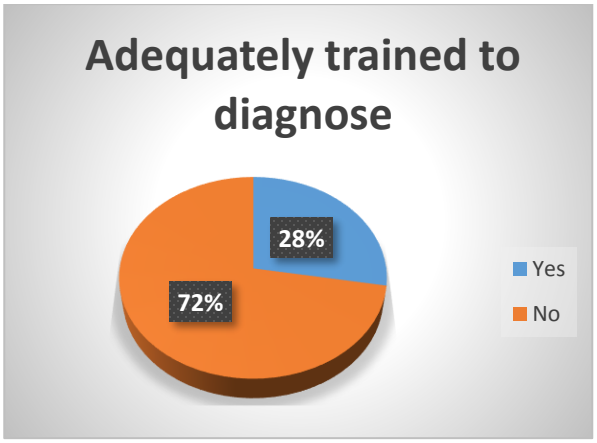
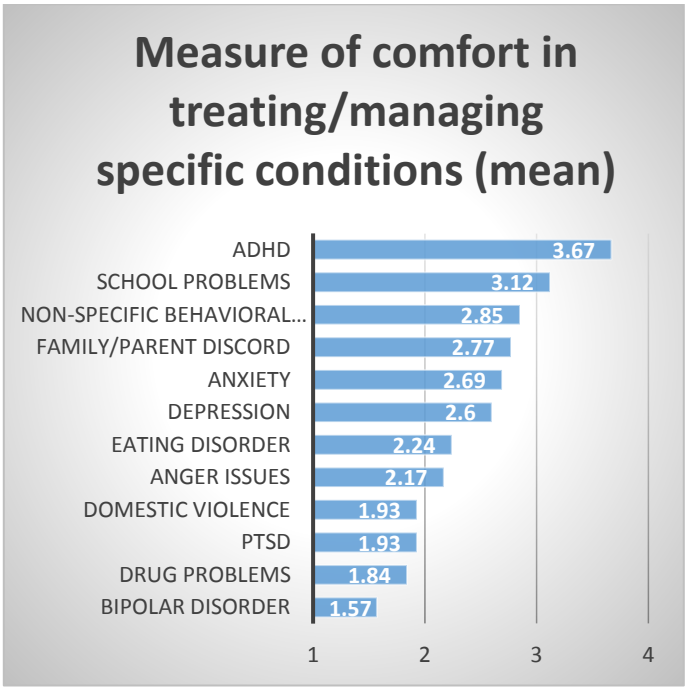


Comfort in Treating/Managing Mental Health Concerns

To measure comfort in treating/managing mental health concerns, respondents were asked to indicate on four-point Likert scale (not comfortable to very comfortable) their comfort in treating/managing 12 specific conditions (ADHD, anxiety, depression, nonspecific behavioral problems, PTSD, eating disorders, anger issues, school problems, bipolar disorder, drug problems, family/child discord, domestic violence). Conditions specified in the survey were taken from the American Academy of Pediatrics recommendations. These 12 items, each scored 1 to 4, were combined to create a single scale for comfort. In addition, a single dichotomous "comfort" score was also created. The potential range in respondent score was 0 to 48 and respondents were dichotomized using the midpoint. Those scoring 24 and below were scored as "low comfort" and those scoring 25 and above were scored as "high comfort." An additional question asked pediatricians to assess their comfort level in prescribing antidepressant on a three-point scale.

Those reporting "not comfortable" or "somewhat comfortable" were coded as "low comfort" while those reporting being "comfortable" prescribing were coded as "hi comfort."

Figure 7.



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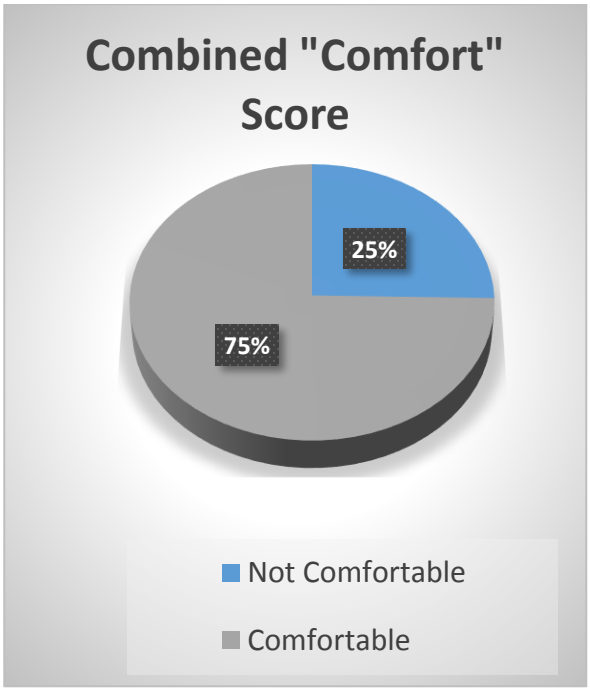
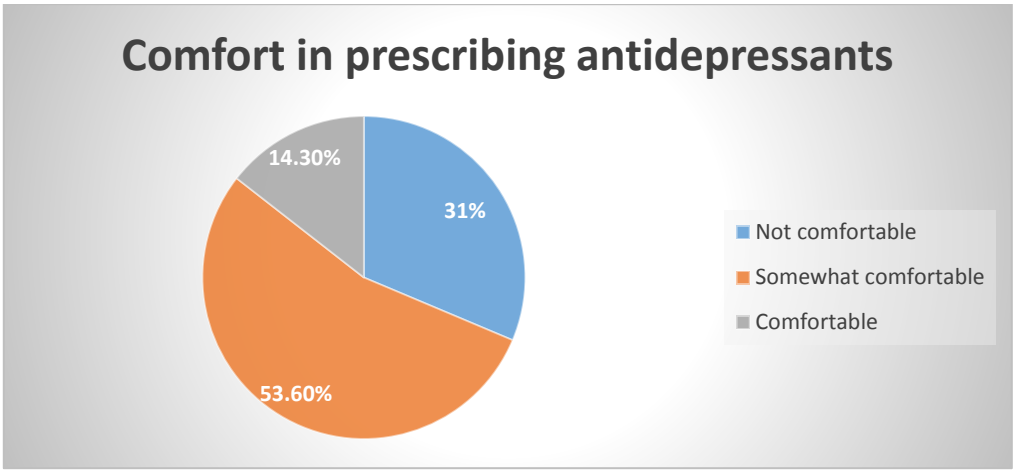


A combined "comfort" showed that across the range of presenting issues 75% felt low comfort and 25% felt a high level of comfort.

When asked about comfort in prescribing antidepressants, 31% answered that they weren't comfortable, 53% answered somewhat comfortable, and only 14% answered that they were comfortable in prescribing.

Figure 9.

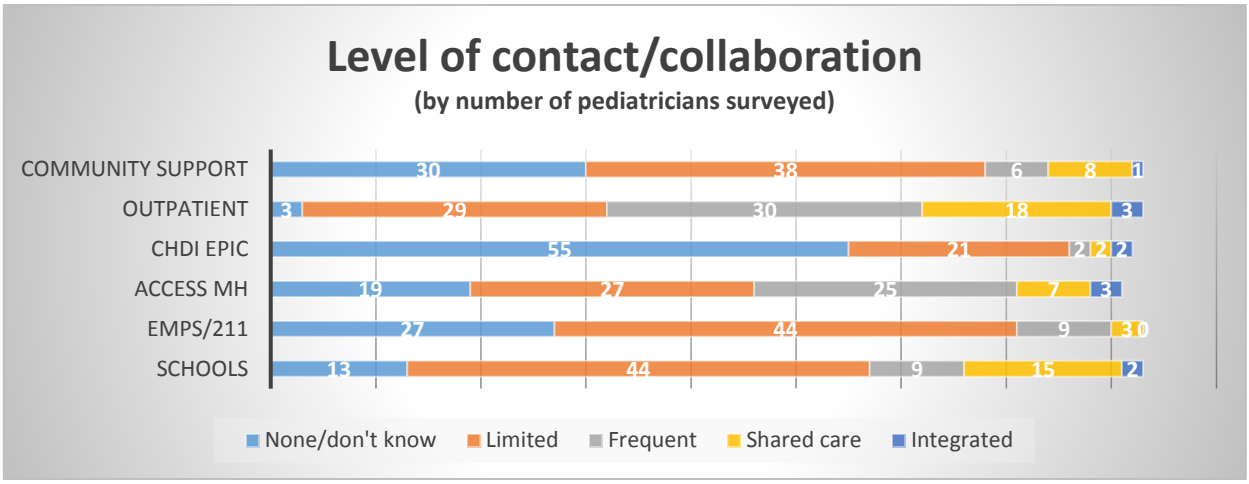


Integration/Collaboration

To measure the level of integration of pediatric primary care with the larger system of mental health care for children respondents were asked to assess their level of contact with six common points of contact or resources available to pediatricians in Connecticut. These resources/points of contact were specified by the PA 13-178 Network Analysis Subcommittee and were created through a consensus process. The six resources are a) school mental health providers, b) Emergency Mobile Psychiatric Services (EMPS) – a Connecticut resources providing a mental health care response within 45 minutes, c) ACCESS Mental Health – a Connecticut resource providing pediatricians with access to a child psychiatrist by telephone with a 15 minute guaranteed response, d) Educating Practices in the Community, a Connecticut resource providing educational sessions on mental health within practices that provide Continuing Medical Education (CME) credits, e) Outpatient behavioral health providers, f) Community support services (peer support group, family support services, pastoral care). Pediatricians were asked to rate these six (6) resources/contacts on a five-point Likert scale 1) no contact/don't know, 2) limited contact, 3) frequent contact, 4) shared care, and 5) integrated within practice. These six (6) items, each scored 0 to 4, were combined into a scale and then into a dichotomous "integration" score for purposes of analyses. The potential range in respondent score was 0 to 24 and respondents were dichotomized using the midpoint. Those scoring 12 and below were scored as "low integration" and those scoring 13 and above were scored as "high integration."

In the figure below, the grey and yellow bands indicate the greatest levels of contact/collaboration in the figure below. The use of outpatient care and ACCESS Mental Health scored higher than all other contacts. While the majority of pediatricians reported none or limited collaboration with schools, a significant number of pediatricians indicated shared or integrated care in collaboration with schools. Community support services, CHDI's EPIC program, and EMPS/211 scored lowest on the assessment of contact/collaboration.

Figure 10.

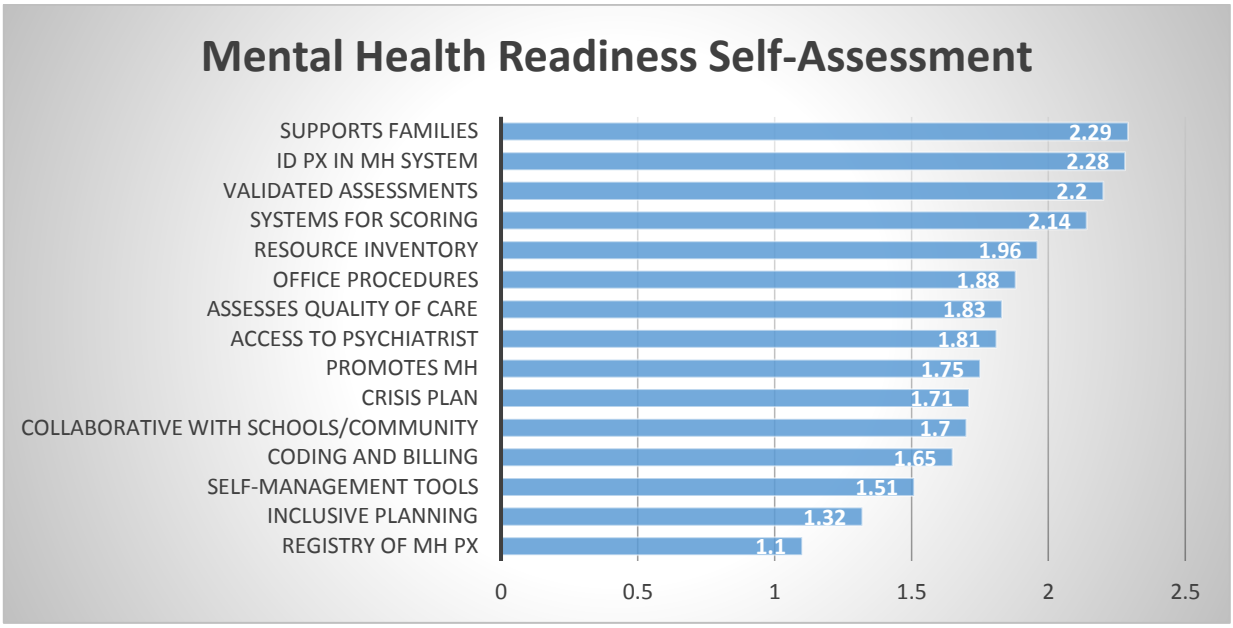


Practice Readiness

To measure pediatric practice readiness to manage patients with mental health concerns, pediatricians were asked how well they do specific practice-based behaviors related to the care of children with mental health concerns. Fifteen (15) items were adapted from the American

Academy of Pediatrics self-assessment tool for pediatricians (see Appendix XXXX). The included items range from billing and coding practices, and procedural supports (i.e. requesting consent) to the use of validated instruments and collaborative relationships with other providers. Pediatricians rated each item on a scale of 1 to 4 ranging from "we do not do this" to "we do this well."

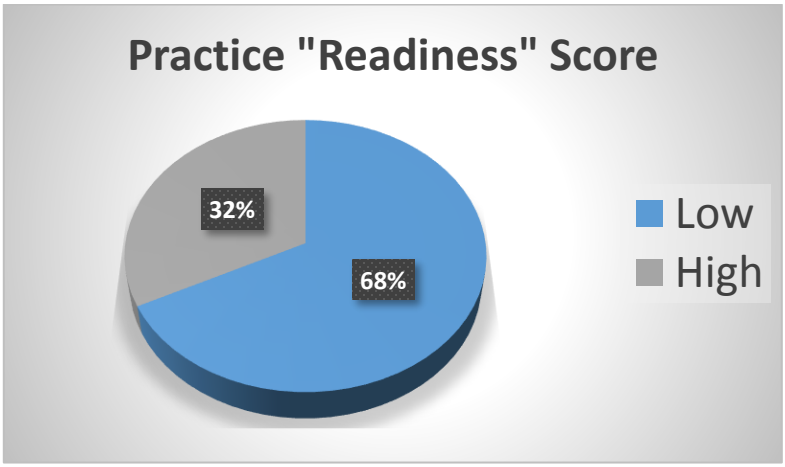
Figure 11.



Three practice behaviors were reported most favorably, 1) supporting families, 2) identifying children in the mental health, and 3) using validated assessments with patients. Pediatricians reported four behaviors least favorably 1) maintaining a registry of mental health patients, 2) being inclusive in planning, 3) using self-management tools, and 4) coding and billing issues.

The fifteen items were combined to create a single dichotomous readiness scale. In creating a single measure of practice integration 68% reported low readiness and only 32% reported high readiness.

Figure 12.



Collaboration: Factors, Barriers, Needs

The survey also contained four open-ended questions to gain the insight of pediatricians into what they think is needed to improve collaboration, the barriers to that collaboration. The four open ended responses were scanned for common responses and coded in Excel. A simplified list of barriers and collaboration needs by respondent was created.

Table A.

Collaborations wanted		**Collaboration factors**		**Barriers**		**Needs**	
MH provider	24	Communication	23	Insurance	16	Communication	13
Schools	10	Access to care	19	Confidentiality	3	More MH providers	11
ACCESS MH	11	Information	1	Communication	18	Information	6
EPIC	2	Co-located staff	3	Lack of Information	2	Access to care	15
Community	14	ACCESS MH	5	Time	7	Insurance	10
Multiple	3	Other	6	Access to care	17	Other	9
Other	2			Other	5		

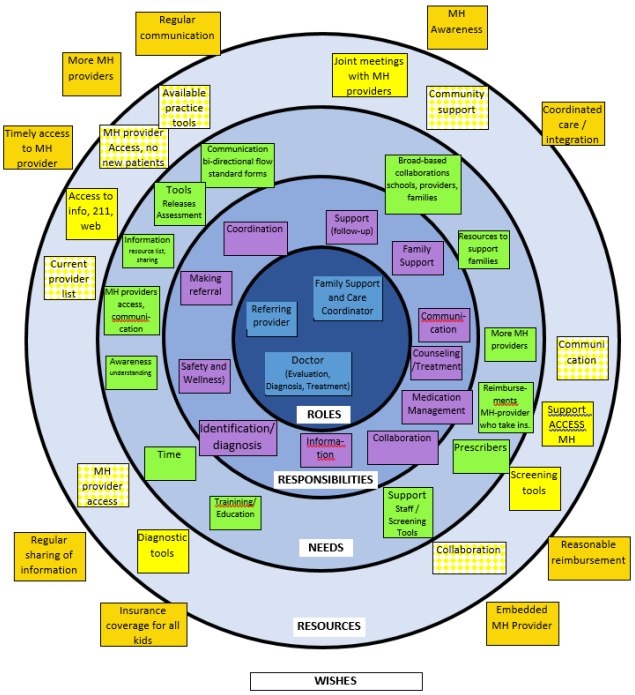
What emerges from this review of written responses is that pediatricians want an improvement in the quantity and quality of relationships with community mental health providers. Communication issues are predominant in pediatrician's identification of factors facilitating collaborations.

B. System Support Mapping (SSM)

System Support Mapping (SSM) is a guided process in which individuals within a group or network seek to clarify their roles, responsibilities, needs, resources, and wishes as these pertain to a particular system under study. From the list of pediatricians who completed the survey of primary care pediatricians, one pediatrician representing a practice was selected from each of Connecticut's eight counties to be involved in the SSM process. Each of the eight pediatricians was successfully contacted. Seven (7) of the eight (8) practice locations agreed to participate and one (1) did not. Of the seven that agreed to participate six (6) completed the two-session SSM process (90 to 120 minutes of total time). The seventh practice location could not be accommodated due to a series of scheduling conflicts. In addition to having at least four staff from each practice participate in the SSM focus group, community mental health providers were contacted through a provider network and asked to participate in the sessions. The SSM sessions were conducted from February to April of 2017. During this process 48 system support maps 6 priority action lists were created. All information was transcribed and coded using a data management system for analyses.

Of the 48 system support maps created through the group sessions, thirty-three (33) system support maps represent the view from pediatric primary care and fifteen (15) system support maps represent the view from a community mental health perspective. The system support map below consists of a series of rings, each ring representing an aspect of the system. Starting with the inner ring and moving outward the sections are: Roles; Responsibilities; Needs; Resources; and, Wishes. Within each ring are "notes" that summarize the collective views of pediatric primary care providers (PPCPs).

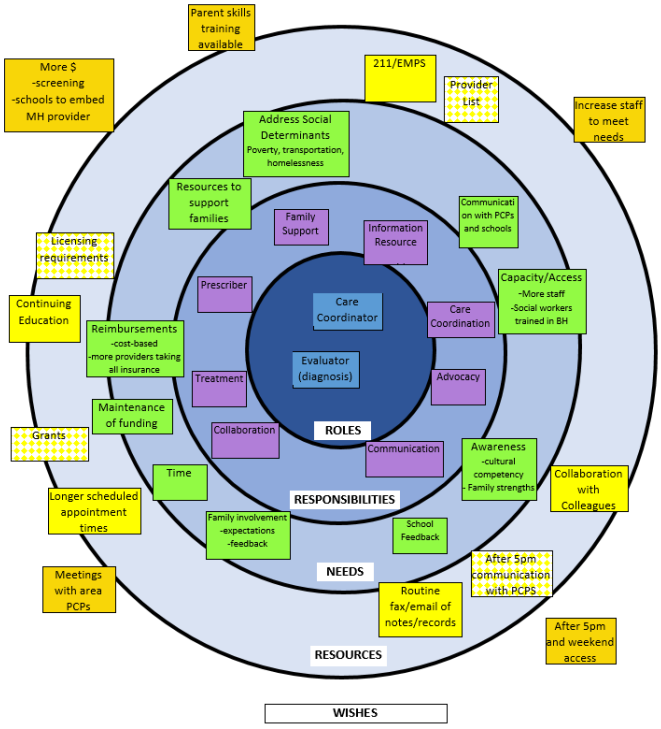
Figure 13. Pediatrician SSM



In considering their role, PPCPs identified most strongly with three primary roles: Doctor (Evaluation, Diagnosis, Treatment); Family Support/Care Coordinator; and, Referring Provider. The level of agreement for each was 27%, 21%, and 17% respectively among all participants. Moving out to the second ring with purple rectangles, we find that PPCPs identify a number of responsibilities: making referrals, ensuring safety and wellness, identifying/diagnosing, providing of information, collaborating, managing medications, counseling/treating, communicating, supporting families, general support and coordination. The next ring with green rectangles places needs close to relevant responsibilities. As we move outward, resources have been identified, some specific and some general, that serve to support a PPCP's needs. Darker yellow rectangles indicate resources that have proven valuable while the lighter yellow resources were either neutral or negative in effect. Outside the last ring sits the "wishes" of PPCPs within orange/gold rectangles. These wishes track closely to the identified SSM Priorities described in the next section.

Below, a similar SSM depicts the system of pediatric primary and mental health from the view of a mental health clinician interacting with the pediatric medical system.

Figure 14. Mental Health SSM



Representatives of community mental health identified two main roles as Care Coordinators or Evaluators. As with the PPCP SSM, roles occupy the central ring. The next ring details responsibilities. The eight responsibilities identified by community mental health providers (collaboration, treatment, prescriber, family support, information resource, care coordination, advocacy, and communication) closely align with priorities identified through the SSM process that are detailed in the next section. Needs and Resources described in the next two rings also serve as

support for the identified SSM priorities. Finally, community mental health provider wishes have a 100% overlap with the PPCP SSM wishes ring.

Importantly, these maps reveal the factors that have promote integration, indicating resources that have worked and those that have been less effective. These factors informed the development of eight SSM priorities: Capacity/Access; Communication; Information; Insurance/Cost; Education and Training; Techniques/Technology; Management; and, Parents/Families. The prioritized areas are described in detail below.

Table B. SSM Priorities

1.	Capacity/Access
	Gaps exist in a primary care pediatrician's ability to address mental health concerns that include staffing capacity and effectiveness in linking children to mental health services: a) **Insurance** issues continue to serve as a barrier and the State should resolve issues of insurance so that both public/private insurance provide coverage that mental health clinicians accept. b) Availability of mental health clinicians **impedes access** for children and should be resolved in part by increasing non-traditional hours (after 5pm), co-locating with PCPs, and increasing the number of mental health clinicians available to treat children. c) Children's **hospital should increase capacity** for addressing mental health concerns and explore the use of satellite offices or additional beds at an alternative location.
2.	Communication
	The bi-directional flow of information between pediatricians and community mental providers is crucial for the effective care of children with mental health concerns: a) A **standard communications protocol** should exist that allows for the multi-directional sharing of information between PCPs, community mental health providers, and schools. The protocol should include standard MOUs and parent authorizations. b) **Communication should be ongoing** with PCPs receiving notes, discharge summaries, and updates. c) The State should continue to work towards an **integrated records system** that allows for a single shared patient record. d) **Opportunities** for pediatricians and community mental health providers to meet and develop relationships should continue (training events, forums, etc.).
3.	Information
	Data and information systems were identified to have the potential to strengthen the delivery of mental health services to children: a) A **central information resource** should be developed that is accessible by PCPs that contains complete and up-to-date information on mental health provider agencies and individuals, family support groups, and insurance information. b) **The complete array of support services** should be more clearly presented to PCPs, including EMPS/211 and CHDI's EPIC.
4.	Insurance/Cost
	Insurance reimbursements and overall health care costs remain a barrier to care given that diagnosing and treating mental health concerns takes significantly longer than an average visit: a) Stakeholders need to advocate for **adequate reimbursement** for mental health services, including home visitation. b) Mental health providers/clinicians should be incentivized to **accept all private and public insurance.**
5.	Training & Education

Continuing training and education on children's mental health issues is vital to ensuring that PCPs understand mental health care and are comfortable in managing a child's mental health issues:

a) Implement **webinars and conferences** on special issues relevant to pediatric mental health, providing CMEs.
b) Deliver **in-service trainings** that cover practical in-office therapies.

6. Techniques/Technology

Tools, techniques, and technologies are available to support PCPs in the identification and treatment of children's mental health concerns:

a) Common or **shared screening tools** should be widely disseminated.
b) Technologies should be utilized in solving the **lack of a shared medical record**.

7. Management

The management or treatment of mental health conditions is an appropriate function for pediatricians in many cases without referral:

a) Further **develop the available spectrum of services** for children including day treatment programs.
b) PCPs should be provided with **additional tools to address patient and family needs** in-office (such as teaching coping skills to parents).

8. Parent/families

Parents and family members are critical members of the care team.

a) Support to families should be provided around **building resiliency** in children.
b) **Ensure that families are consulted** during mental health visits and are included in behavioral health planning.

The explanatory text for each goal of the CBHP was compared to the SSM derived priorities. Within the CBHP there are five (5) goals that apply directly to pediatric primary care providers with the remaining thirty-four goals having a broader scope. Overall, some level of alignment was found with 18 (46%) of the CBHP goals. Within the pediatric primary-specific goals, four out of five goals had full alignment and one was only partially aligned.

Table C. Alignment of Pediatric Mental Health Priorities Derived from the System Support Mapping (SSM) Process with the Connecticut Children's Behavioral Health Plan (CBHP) Goals

CBHP Goals	**SSM Priorities** ⭘ = partial CBHP alignment; ● = full CBHP alignment
A.1.1 Redesign of the publicly funded system	1. Capacity/Access ⭘ 4. Insurance/Cost ⭘
A.2.1 Design and implement a Care Management Entity (CME)	
A.2.2 Develop a family support clearinghouse	3. Information ⭘ 8. Parent/families ⭘
A.3.1 Data driven analysis	4. Insurance/Cost ⭘
A.3.2 Apply findings	
A.4.1 Convene a data driven accountability committee	
A.4.2 Utilize reliable standards to data collection	
A.4.3 Data collection systems to serve in an integrated system	
A.4.4 Increase state capacity to analyze data/results	
B.1.1 Enhance ability of caregivers, providers and school personnel to promote social and emotional development	8. Parent/Families ⭘
B.2.1 Expand the use of validated screening	6. Techniques/Technology ⭘

CBHP Goals	**SSM Priorities** ⭘ = partial CBHP alignment; ● = full CBHP alignment
B.2.2 Link all children who screen positive	1. Capacity/Access ⭘
B.3.1 Conduct statewide trainings on infant MH competencies	5. Training & education ⭘
B.4.1 Cross agency collaboration and coordination	
C.1.1 Planning of the array of services	
C.1.2 Finance the expansion of the services	1. Capacity/Access ●
C.2.1 Expand EMPS	3. Information ⭘
C.2.2 Enhance partnerships between EMPS clinicians and EDs	1. Capacity/Access ⭘
C.2.3 Explore alternative options to EDs	1. Capacity/Access ●
C.3.1 Expand school-based BH services	6. Technique/Technology ⭘
C.3.2 Create a blended funding strategy to support expansion of school-based BH services	
C.3.3 BH professional development for school personnel	
C.3.4 Formal collaborations - schools and the community	
C.4.1 Support the new initiatives for prevention	
D.1.1 Support co-location of BH providers in child health sites	1. Capacity/Access ●
D.1.2 Support the development of educational programs for BH clinicians	1. Capacity/Access ●
D.1.3 Require child health providers to obtain CME credits each year for BH topic	5. Training & education ⭘
D.1.4 Ensure public/private insurance reimbursement for care coordination services	4. Insurance/Cost ●
D.1.5 State confidentiality laws allow sharing of BH info	2. Communication ●
E.1.1 Conduct needs assessment	
E.1.2 Culturally appropriate services	
E.1.3 Service delivery contracts are culturally appropriate	
E.2.1 Enhance training in cultural comp.	
E.2.2 Ensure culturally appropriate communications	
E.2.3 provide financial resources dedicated to recruitment and retention to diversify the workforce	
F.1.1 Increase # paid family members on statewide governance structures	
F.1.2 Expand capacity of organizations providing family advocacy services	
F.1.3 Increase # of parents who are trained in parent leadership curricula.	
F.1.4 Provide funding to support at least annual offerings of the Community Conversation and Open Forums	2. Communication ⭘ 8. Parent/Families ⭘

SSM priority #1 - Capacity/Access

The SSM process identified capacity and access issues as major barriers to care. Insurance issues, availability of mental health clinicians (not just a matter of the number of clinicians) and tertiary care institutional structures were all identified by the SSM groups. The CBHP also addressed capacity and access issues that were fully or partially aligned across seven (7) CBHP goals:

- A.1.1 addresses financial issues and calls for identification of existing spending, a consideration of re-aligning spending, and issues of workforce development.
- B.2.2 addresses the need to link children with services and is at least partially aligned with the SSM's identified capacity/access priority.
- C.1.2 calls for an expansion of services that is in line with the SSM-identified priority that calls for increased services by hospitals and their satellites.
- C.2.2 and C2.3 each address Emergency Department (ED) care enhancements.
- D.1.1 addresses co-location within pediatric primary care.
- D.1.2 supports education to advance co-location.

SSM priority #2 – Communication

Issues of communication dominated recommendations and discussion by the SSM groups. Within the CBHP there were only two strategies for which the SSM's Communication priority recommendation was in some way implicated.

- D.1.5 calls for any needed changes to confidentiality laws in the State to allow for this free flow of information needed to provide the best possible care. Ensuring that behavioral health information is shared in a bi-directional flow of information is was a repeated issue within the SSM process.
- F.1.4 calls for the continuing use of open forums and other opportunities to share information and get feedback which is fully consistent with creating more opportunities for pediatricians to meet and develop relationships with others involved in community mental health.

SSM Priority #3 – Information

Strengthening data and information systems was roundly identified as a priority issue within the SSM groups. The CBHP was found to be partially aligned with the SSM priority recommendation for two strategies.

- A.2.2 calls the creation of an information service focused on providing information to the community, including providers, on services available in multiple forms.
- C.2.1 calls for continued outreach to families as a key strategy to increase the utilization Emergency Mobile Psychiatric Services (EMPS) and this is vital to ensuring that parents and providers have the information they need in seeking appropriate care/services. Partial alignment with SSM Priority #3 is due to the limited nature of the CBHP strategy in comparison to the call for an information resource that contains complete and up-to-date information on mental health provider agencies and individuals, family support groups, and insurance information.

SSM Priority #4 – Insurance/Cost

Lack of coverage or inadequate insurance coverage remains a barrier to care for many children seeking mental health services. The CBHP and SSM Priorities both address this issue and agree to some extent on three items:

- A.1.1, while also implicating Capacity/Access issues, is mainly concerned with determining total available funding and ensuring that funding structures are used in a way to strengthen services and coverage for children.
- D.1.4 calls for care coordination reimbursement for Medicaid covered children. This in well-aligned with SSM Priority #4's call for adequate reimbursement for mental health services. Where a gap may exist between the CBHP and the SSM is in the in the latter's call for incentives to attract more individual private providers into accepting both public and private insurance for mental health care services.
- A.3.1 has some partial alignment with SSM Priority #4, but A.3.1 goes much further in addressing the regulatory and/or industry issues that may be blocking better coverage for mental health reimbursements.

SSM Priority #5 – Training & Education

Primary care pediatricians must be comfortable with evaluating and diagnosing mental health concerns to provide effective care to children. Continuing training and education on children's mental health issues is vital in this effort. Education and training can take a range of forms from webinars and conferences offering CMEs to in-service trainings that cover practical therapies. Two strategies had at least partial alignment with the SSM Priorities.

- B.3.1 addresses training and education with regard to infant mental health and is partially aligned with the SSM Priority.
- D.1.3 calls for mandatory training on behavioral health and is well-aligned with the SSM Priority although by contrast it does not contain a mandate.

SSM Priority #6 – Techniques/Technology

Common and shared tools were a theme within the SSM work that as an SSM priority is aligned with two CBHP Strategies.

- B.2.1 calls for the expanded use of validated screening tools for use in early detection that can complement assessments in pediatric offices and is at least partially aligned with SSM Priority #6. A gap exists in B.2.1's silence as to the connection between screening and shared information across sectors.
- C.3.1 calls for standardized screening instruments in schools and is well-aligned with SSM Priority #6 calling for the use of tools in common between sectors.

SSM Priority #7 – Management

Treatment options for use by pediatricians in their own practice settings is at the heart of SSM Priority #7. Additional treatment/management of conditions through an available array of services is also included. Within the CBHP there were no strategies identified as wholly or partially aligned with this need. Potentially Strategy D.1.3 could be modified to take into account the expressed need of pediatric practices to be better equipped with in-practice treatment options through training, in addition to the inclusion of options for parent training.

SSM Priority #8 – Parent/Families

The SSM priority-setting process revealed a recognition on the part of pediatric care providers of the vital role that parents and family members play in the care team for children. This priority set by the SSM groups prioritize parent training around resiliency and consultation within the context of determining care. Within the CBHP, SSM Priority #8 is implicated in no less than four of the CBHP Strategies.

- A.2.2 calls for an information clearinghouse for parents.
- B.1.1 is at least partially aligned in addressing the need for parents/caregivers to enhance their competence in social emotional skills.
- F.1.4 is indirectly related as it covers community conversations and open forums.

VI. Findings

Mental health issues among children and adolescents are well known by Connecticut's pediatricians, with 100% confirming that within the last year they had a patient in mental health crisis. Pediatricians' professional association, American Academy of Pediatrics (AAP), has provided the pediatric field with a number of resources to support pediatricians in the provision of these services (AAP, 2009). Pediatricians are part of the system of mental health care and will need to continue to play a major role given that the gap in mental health providers is likely to continue (Gabel, 2012).

Training & Education

Pediatrician responses point to a need for additional and ongoing professional training. Pediatricians can have a long career and, although working to incorporate mental health training into medical schools will help, there is a need for ongoing education for practicing pediatricians. The agenda for such trainings should be pulled from identified opportunity areas self-identified by pediatricians. In our survey pediatricians reported feeling most comfortable treating ADHD. Special attention should be paid to areas where pediatricians can take a meaningful role in identification, treatment, and/or referral where comfort is lowest. Treating some diagnoses, such as bipolar disorder, may well be outside the scope of practice for pediatricians. In these cases, pediatricians need to have supports in place and to be aware of resources for these patients. Overall, pediatricians reported feeling least comfortable with treating or managing bipolar disorder, drug problems, PTSD, domestic violence, anger issues, and eating disorders. In addition, in identifying levels of contact with mental health resources, pediatricians reported having limited contact with other partners in mental health such as EMPS and schools. Future efforts should focus on increasing pediatrician awareness of these resources and how these services can be used to supplement/support pediatricians in their treatment of individual patients. Pediatricians also self-identified a need for more information regarding billing/coding and additional efforts should be made to support pediatric office administration.

Supports for Pediatric Practices

Pediatric care providers identified several practice areas that could be strengthened. Notably, there have been prior efforts to increase the adoption and use of validated tools and these efforts should continue (Grasso, 2014). The SSM process identified eight core areas of focus: Capacity/Access; Communication; Information; Insurance/Cost; Education and Training; Techniques/Technology; Management; and, Parents/Families. The existing Connecticut Children's Behavioral Health Plan should be reviewed with a goal of ensuring that these identified focus areas are fully addressed.

The following specific recommendations should be operationalized as soon as possible:

> Availability of mental health clinicians **impedes access** for children and should be resolved in part by increasing non-traditional hours (after 5pm), co-locating with PCPs, and increasing the number of mental health clinicians available to treat children.
>
> Children's **hospitals should increase capacity** for addressing mental health concerns and explore the use of satellite offices or additional beds at an alternative location.

A **standard communications protocol** should exist that allows for the multi-directional sharing of information between PCPs, community mental health providers, and schools. The protocol should include standard MOUs and parent authorizations.

Communication should be ongoing with PCPs receiving notes, discharge summaries, and updates.

The State should continue to work towards an **integrated records system** that allows for a single shared patient record.

Opportunities for pediatricians and community mental health providers to meet and develop relationships should continue (training events, forums, etc.).

A **central information resource** should be developed that is accessible by PCPs that contains complete and up-to-date information on mental health provider agencies and individuals, family support groups, and insurance information.

The complete array of support services should be more clearly presented to PCPs, including EMPS/211 and CHDI's EPIC. Additional supports for pediatric practices should be developed.

VI. Conclusions & Next Steps

This effort is focused on identifying the factors that promote a system of mental health care for children in which the pieces and parts of the system appear virtually seamless. From the literature and professional practice recommendations we crafted a survey and developed a focus group approach best suited to eliciting the input of pediatricians on moving toward this vision of a future state of care. These considerations of integrated care are the main focus of the constructs used in coding and in considering inter-relationships. The American Academy of Pediatrics (AAP) calls on pediatricians to broadly apply the chronic care model to children with mental health needs (Foy, 2010) and in this effort we hold the AAP guidelines as a de facto model in evaluating practice behaviors. We know that relationships are keys to integrated care, and in Connecticut as many as 45% of pediatric care providers have no relationships with mental health care providers (Pidano, 2014).

The Connecticut Children's Behavioral Health Plan provides a blueprint for addressing the weaknesses, inequities, and needs within the system of mental health care for children. Findings from this report can be used to strengthen the plan and its implementation by focusing efforts addressing pediatric primary on the eight priority areas identified by the SSM focus groups (see Table B. above). The existence of gaps in communication between and among providers and families emerged as a central finding of this work. These gaps serve to create and reinforce the difficulties and deficiencies in access to appropriate care.

This report focuses on only one component of a complex system of mental health care, pediatric primary care. This report should not be interpreted as placing the sole responsibility for children's mental health on pediatric primary care. Schools, community mental health providers, and families are partners with significant responsibilities for children's mental health. This report calls for additional supports for pediatric primary care with increased collaboration with these other partners.

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